

The London School of Economics and Political Science

*Presidential Rhetoric Justifying Healthcare Reform:
Continuity, Change & the Contested American Moral
Order and Social Imaginary from Truman to Obama*

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Declaration

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Abstract

The original contribution to knowledge of my thesis is a comparative historical analysis of the rhetoric used by four Democratic presidents to expand access to and affordability of healthcare.

Specifically, the thesis situates Democratic presidential healthcare reform rhetoric in relation to opposing conservative Republican ideologies of limited government and prioritization of negative liberty and their increasing prominence in the post-Reagan era. It examines how the American moral order and social imaginary has evolved and how Democratic presidential healthcare reform rhetoric was both informed by and responded to it.

I employ Aristotle's tripartite categories of ethos, pathos and logos to undertake rhetorical analysis. I illuminate how each president sought to persuade audiences, what rhetorical strategies they used and how they justified their healthcare reform efforts. I pay particular attention to the compromises entailed by the usage of specific strategies and their rhetorical effects.

The thesis illustrates how Presidents Harry Truman and Lyndon Baines Johnson contextualized healthcare reform within their broader efforts to secure positive liberty and social and economic rights in the Fair Deal and Great Society, respectively. This is in contrast to Presidents Bill Clinton and Barack Obama who did not advance a comprehensive vision of government guaranteed positive liberty and citizen welfare. Rather, they made arguments for healthcare reform based on pragmatism and economic efficiency and appropriated tropes of conservative rhetoric such as efficiency to critique market failure. They showed deference to the conservative principle of maximizing the role of the private sector in healthcare provision.

There is a marked contrast between Truman and Johnson's explicit expressions of care for economically disadvantaged and working class Americans and Clinton and Obama's rhetorical elision of these populations, and their focus on the 'middle class.' Despite these substantive differences a major continuity in the rhetoric is an enduring appeal to communitarian solidarity.

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Chapter 1 Introduction

1.1 The Significance of Healthcare in Contestation of the American Moral Order and Social Imaginary

My thesis¹ makes an original contribution to scholarship by filling a gap in the academic literature by using rhetoric analysis to illuminate the moral order and social imaginary that Democrats, specifically presidents Truman, Johnson, Clinton, and Obama have offered as justification for their healthcare reform plans to expand access to healthcare² in the United States irrespective of income. It is a temporal study of Democratic presidential healthcare reform rhetoric between 1945 and 2013. It analyzes the rhetoric of these four presidents comparatively and examines how Democratic presidential healthcare reform rhetoric has evolved. In so doing, it also explores how it responds to opposing Republican social imaginaries which have emphasized limited government and reject the principle of universal or near-universal healthcare insurance to be guaranteed to American citizens by the government.

This change in the American moral order and social imaginary advanced by Democratic presidents affirms the traditional liberal American values of equality and liberty associated with the Constitution and Declaration of Independence but also seeks to expand the concept of liberty from a primarily negative one restricting the

¹Part of this thesis, in an edited form, was published in *Human Rights Review*, Volume 13, Number 1, 2013. (Primarily Chapters 1 and parts of Chapter 5.) In accordance with University of London regulations, the article is attached to the thesis. Parts of the thesis in a different form as it was developing and undergoing revision were presented at the Annual Meetings of the American Political Science Association in 2011 (Seattle) and 2013 (Chicago,) the Northeastern Political Science Association Annual Meeting in 2011 (Philadelphia,) the Policy History Conference in 2012 (Richmond, Virginia,) and the University of Indiana, Bloomington Conference on Empathy in 2011.

²Each of the four presidents whose rhetoric I analyze proposed plans for either expanding or universalizing access to and affordability of health *insurance*. Such access to health insurance comes with the concurrent commitment that adequate healthcare *provision* will follow from the expansion of health insurance, with legal requirements to guarantee this. As such, references to ‘universal healthcare’ are sometimes made by presidents, commentators, and academics in a colloquial sense which generally refers to universal health insurance rather than the actual provision of health services, but the distinction between the two is often overlooked. In effect the phrase ‘universal healthcare’ is used to mean entitlement to affordable, accessible healthcare services.

government's role in the lives of citizens – reflected in the Constitution and Declaration of Independence – towards a positive one - in which the government actively enables the welfare of citizens by providing government guarantee of health insurance to the economically disadvantaged and to all American citizens. In this way it seeks to recognize vulnerable members of American society, to mitigate their suffering and the injustice they face, and to address their needs through a practical expression of communitarian social solidarity that guarantees them access to quality healthcare and in so doing creates greater equality of opportunity in American society.

In analyzing this Democratic presidential rhetoric I also consider how these four presidents respond to Republican conservative discourse around the issue of the size of the government and its corresponding characteristics and responsibilities.³ In Republican rhetoric⁴ the phrase 'limited government' and 'small government' focuses at its most basic and obvious level on matters of size. But the size of government is often a coded way of referring to a range of implicit assumptions about which social issues and sectors of the population deserve the attention and resources of the government. Size entails much more than a quantitative measurement – it is also a word loaded with qualitative ethical, ideological, and social meanings which merit examination. As David Shipler writes, “The liberal-conservative divide is not only about how big government should be;

³ For more on the history of the Republican party and its increasingly conservative politics see Robert Mason and Iwan Morgan, *Seeking a New Majority: The Republican Party and American Politics, 1960-1980*, (Nashville: Vanderbilt University Press, 2013.)

⁴ Future references to 'conservative rhetoric' refer specifically to conservative rhetoric in the United States and its anti-statist character and tendency to be skeptical of and hostile to centralized government and government social welfare programs. In using the term 'liberal' throughout the thesis I am using it as it is generally used in the United States to refer to a political ideology that emphasizes egalitarianism and equal opportunity, the necessity of government programming to ensure the well being of citizens, and concern for positive liberty as well as negative liberty, rather than a pronounced emphasis on negative liberty, which reflects the conservative tendency in the United States. Alan Finlayson explains that conservatism as a political ideology has many streams and internal diversity. However, he cites some common features of conservatism which closely reflect the ideology of limited government conservatism in the United States: disapproval of large scale societal planning, support for hierarchy, the belief that responsibilities should outweigh rights, liberty as a higher value than equality, and support for free markets. Alan Finlayson, “Conservatism,” in *Contemporary Political Thought: A Reader and Guide*, ed Alan Finlayson (New York: New York University Press, 2003), 154.

it is also about what government should do. Liberalism is the use of the state for some purposes; conservatism is the use of the state for other purposes.⁵”

Healthcare is significant because it represents one of the most fundamental human needs, along with shelter, access to food and clothing, and education. The lack of universal healthcare for Americans has been one of the great social injustices that tens of millions of Americans have suffered for almost a century; its impacts on life expectancy, quality of life, individual freedom, family stability, economic productivity, and social cohesion are substantial.⁶ Lack of health insurance has severe detrimental health impacts that can cause serious physiological and psychological damage.⁷ Almost 45,000 Americans die of treatable medical problems every year because they lack health insurance according to a 2009 research study at Harvard Medical School.⁸ During the first half of the twentieth century, as Harry Truman noted in one of his campaign speeches, that number was substantially larger.⁹ As Jill Quadagno explains,

Many uninsured people do not have a regular family doctor and thus do not receive preventive health services... As a result, their health problems are often diagnosed at more advanced stages, resulting in higher mortality rates. Frequently the care they do receive is in an emergency room where there is no primary care and no follow-up care.¹⁰

⁵David K. Shipler. *The Working Poor: Invisible in America*. (New York: Knopf, 2004.)

James Morone, “Morality, Politics, and Health Policy” in *Policy Challenges in Modern Health Care*, ed. David Mechanic et al. (New Brunswick: Rutgers University Press, 2005),13-24.

Lawrence Jacobs, “Health Disparities in the Land of Equality” in James A. Morone and Lawrence R. Jacobs, editors, *Healthy, Wealthy and Fair: Health Care and the Good Society*. (New York: Oxford University Press, 2005),37-62.

⁶JM McWilliams. “Health Consequences of Uninsurance Among Adults in the United States: Recent Evidence and Implications.” *Milbank Quarterly* 87 (2009): 443-494.

John Z. Ayanian et al. “Unmet Health Needs of Uninsured Adults in the United States.” *The Journal of the American Medical Association* 284 (2000): 2061-2069.

⁷James A. Morone and Lawrence R. Jacobs, eds, *Healthy, Wealthy and Fair: Health Care and the Good Society*.

⁸Susan Heavey, “Study Links 25,000 Deaths to Lack of Insurance,” *Reuters*, September 17, 2009.

<http://www.reuters.com/article/2009/09/17/us-usa-healthcare-deaths-idUSTRE58G6W520090917>

Andrew P. Wilper et al., “Health Insurance and Mortality in US Adults”, *American Journal of Public Health*, 99, (2009).

⁹Tom Daschle. *Critical: What We Can Do About the Health-Care Crisis*, xi. T.R. Reid, *The Healing of America*. (New York: Penguin Press, 2009), 2.

Daschle, *Critical: What We Can Do About the Health-Care Crisis*, 6-7, 24-28.

¹⁰Jill Quadagno, *One Nation Uninsured: Why the U.S. Has No Health Insurance*. (New York: Oxford University Press, 2005), 4. “In 2003 45 million Americans, more than one out of every six people, had

The consequences are often devastating as illnesses and injuries that do not receive regular medical attention increase in gravity and often become more difficult and expensive to treat and cause the deterioration of an individual's health.

I choose healthcare as a case study with which to analyze American political discourse because it is one of the major policy areas that Democrats and Republicans have fiercely contested for decades, indeed in its most comprehensive form since the 1940s and Harry Truman's presidency and his efforts to advance universal health insurance. Currently over 45 million Americans lack health insurance and over 20 million are underinsured,¹¹ although by 2014 Obama's Affordable Care Act will provide coverage and improve coverage for the majority of these Americans. The United States is a highly unusual outlier in not providing universal or near-universal health insurance coverage (until implementation of the Affordable Care Act) among wealthy industrialized nations. Almost all EU member states, Canada, Australia, New Zealand, Japan, South Korea, Taiwan and some Latin American countries provide universal health insurance to all citizens.¹² While the United States under the leadership of Franklin Delano Roosevelt adopted certain social insurance programs such as Social Security, and later under Lyndon Baines Johnson the social insurance program of Medicare and the social welfare program of Medicaid, government guarantee of universal access to health insurance has remained a key area of political contention in the United States since Theodore Roosevelt's failed efforts to establish such a program in 1912. After Truman's failed

no health insurance... In 2002 and 2003 nearly 82 million people – one out of every three Americans – went without health insurance for all or part of the two years.” Quadagno, *One Nation Uninsured*, 3.

¹¹The ‘Underinsurance’ Problem Explained.

<http://www.kaiserhealthnews.org/stories/2009/september/28/underinsured-explainer.aspx>.
KaiserHealth News.

<http://www.kaiserhealthnews.org/Daily-Reports/2012/September/13/census-numbers.aspx>

¹²Noam N. Levey, “Global Push to Guarantee Health Coverage Leaves US Behind,” *LA Times*, May 12, 2012. <http://articles.latimes.com/2012/may/12/nation/la-na-global-health-reform-20120512>
Madison Park, “Where in the World Can You Get Universal Health Care?” *CNN Health*, June 29, 2012. <http://www.cnn.com/2012/06/28/health/countries-health-care>

G.F. Anderson and JP Poullier, “Health Spending, Access, and Outcomes: Trends in Industrialized Countries,” *Health Affairs*, 18 (1999).

efforts, several presidents made sustained efforts to create such a program with Richard Nixon proposing expanding health insurance,¹³ Bill Clinton universalizing it, and finally Barack Obama near-universalizing it. All of these Presidents failed except for Obama. Given that Obama faced a Congress and nation at its partisan apex, following three decades of increasingly hegemonic conservative power, Obama's success is noteworthy.

Healthcare provision has a huge impact on the well being of US citizens, and given the central place of healthcare reform in political conflicts between Democrats and Republicans, it is appropriate to consider how the debate over healthcare reflects the larger discursive struggle over the moral and social obligations of the United States government to its citizens. Enabling healthcare reform or disabling it has profound implications on how Americans imagine themselves, the moral and social bonds that tie them, and the obligations of government to United States citizens. As Robert Asen writes, "Implicated in struggles over meaning, policies express a nation's values, principles and priorities, hopes and ideals, and beliefs about citizens' responsibilities and obligations to each other."¹⁴ This thesis applies healthcare reform as a case study of wider American political and moral values and their rhetorical contestation, revisions, and ultimately, policy expression.

1.2 Democratic and Republican Conceptualizations of the American Social Imaginary

The empirical assumption of my research is that the contemporary American social imaginary, the ways in which people imagine their co-existence in a national space and the moral values, relationships, and responsibilities entailed, is discursively

¹³We will discuss Nixon's proposed healthcare reforms in Chapter 2 of the thesis. See pages 45 and 49-53.

¹⁴Robert Asen, "Reflections on the Role of Rhetoric in Public Policy," *Rhetoric and Public Affairs* 13 (2010): 127.

constituted through the use of key signifiers. These signifiers relate to the role of government in American society as it applies to healthcare provision and to the politically contested claims of citizens to have government guaranteed healthcare insurance. Republican rhetoric shows a strong tendency to favor the use of these signifiers in ways that exclude and sometimes denigrate particular groups on the basis of economic class by a politically conservative discourse of morality and political and social ideals.¹⁵ What emerges as a result of this Republican conservative discourse is a struggle for the definition of just forms of governance, with Republicans generally employing a definition of justice that excludes human health and Democrats generally arguing that human health is fundamental to a just society.¹⁶

Consequently, Democrats argue in defense of liberal values that the government is obligated to do everything in its power to advance healthcare for all citizens equally, without discrimination on the basis of economic status.¹⁷ Democrats seek to reimagine and redefine the American social imaginary and its moral order in order to include those very economically and socially disadvantaged groups whose needs are challenged and marginalized by Republicans. But every Democratic president who can reasonably be classified as 'liberal' in orientation does so in a different way. My thesis aims to explore the continuities and discontinuities in this rhetoric, revealing the internal diversity found amongst these Democratic presidents each of whom share a commitment to a more inclusive and expansive moral order and social imaginary but propose in both rhetoric and policy distinctive pathways towards their realization.

¹⁵ For more on negative representations of the poor in US politics see M. David Forrest, "Consensus and Crisis: Representing the Poor in the Post-Civil Rights Era," *New Political Science* 35 (2009).

¹⁶ In the recent presidential campaign vice-presidential Republican candidate, Paul Ryan, for example, proposed massive cuts in Medicaid funding which would likely result in millions of Americans losing access to Medicaid health insurance. Abby Goodnough, "2 Campaigns Differ Sharply on Medicaid, Seeking Vast Growth or Vast Cuts,," *The New York Times*, August 31, 2012. http://www.nytimes.com/2012/09/01/us/politics/campaigns-have-sharply-different-visions-for-medicaid.html?src=recg&_r=2&

¹⁷ A small minority of Democrats sometimes contest this, particularly those from more conservative states and those who lean towards fiscal conservatism.

Barack Obama's recent electoral campaign and election victory is one example of this competing use of key signifiers towards different, egalitarian, and inclusive ends by Democrats and which champions greater government involvement in provision of social services. These efforts have largely been reactive in nature, as limited government conservatism exercised hegemonic domination of American politics and much of American culture during the eight years of the Bush administration, from 2001-2009.¹⁸ Prior to that, beginning in the early 1980s with the election of Ronald Reagan limited government conservatism began an ascendant trajectory that enabled it to dominate American culture far beyond the Republican party.¹⁹ Its rhetorical tropes about justice, rights, and responsibility largely excluded the principle of access to health insurance on an equal basis.

Although the ideology of limited government had informed Republican political ideology since the Truman era, the conservatism of the Republican party prior to the Reagan era was more open to government programming as a means of addressing inequality and less aggressively anti-statist and hostile to government. Reagan and his followers defined government as intrinsically inefficient, hostile to the welfare of citizens, unaccountable, intrusive, and unlikely to improve overall social conditions.²⁰ They conceived of healthcare as a capitalist commodity, rather than an entitlement of citizenship. This made it increasingly difficult to advance liberal arguments for government guaranteed health insurance without conflicting with dominant conservative definitions of justice and rights centered on negative liberty and individual responsibility for finding healthcare. These presuppose that government guarantee of health insurance

¹⁸ For a description and critical assessment of George W. Bush's conservative policies see Iwan Morgan and Philip Davies, *Right On? Political Change and Continuity in George W. Bush's America*, (London: University of London Press, 2006). See also Iwan Morgan and Philip John Davies, *Assessing George W. Bush's Legacy: The Right Man?* (New York: Palgrave Macmillan, 2010).

¹⁹ John Micklethwait and Adrian Wooldridge, *The Right Nation: Why America is Different*. (London: Penguin, 2004).

²⁰ *Ibid.*

would inevitably violate the liberty of some Americans by possibly requiring them to purchase health insurance²¹ and/or by limiting their insurance choices in the private market and demanding taxes that would redistribute wealth from the rich to the middle class and the poor.²² They deny the principle that healthcare is a right and/or a social need which sustains both individual and communal well being which government must provide on an equitable basis.²³

Transforming a social imaginary requires initiating a shift in socially accepted ideas, beliefs, ethical values, and emotions about them. Michael Freeden argues that,

Ideologies reflect, and attempt to determine, substantive collectively held interpretations of the political world, such as: what change is legitimate? How and with whom should we encourage social cooperation? What constitutes fair distribution? They compete with each other over the control of political language necessary to further their views of the good society and of the public policy that will realize those views. That control is no symbolic sideshow but a vital means of moulding and directing a society. To monopolize, channel, or contain

²¹ A legal requirement to purchase health insurance (with partial or full government subsidy if necessary) is known as an 'individual mandate.'

²² Factually some of these claims have validity. To make universal health insurance viable an individual mandate would be necessary unless a single-payer system similar to Britain's NHS were to be established and Obama signalled early on that he was not interested in pursuing this nor would it be politically realistic. Whether or not an individual mandate violates one's liberty is debatable, depending on how one conceptualizes liberty and how one situates it in relation to other democratic values such as justice and equality. The Affordable Care Act would entail some redistribution of wealth from those individuals and businesses who are relatively well off to individuals who have fewer economic resources although the cost-control and administrative savings built into the Act rather than tax increases provide its main source of revenue and its tax increases/penalty collections are not particularly high. It is factually wrong that Obama's plan would prompt private markets to offer fewer health insurance options with the passage of the Affordable Care Act which, in fact, is likely to increase competition amongst health insurance providers and expand consumer health insurance options. It is correct, however, that some Americans would need to change their insurance if their current coverage does not meet new legal guidelines for adequate minimal standards of health insurance coverage.

Elizabeth Dwoskin, "Why Obamacare's Tax Increase Isn't the Biggest Ever," *Bloomberg BusinessWeek*, July 3, 2012, <http://www.businessweek.com/articles/2012-07-03/why-obamacares-tax-increase-isnt-the-biggest-ever>

²³ It is important to note that although ideologies of limited government characterize American political culture amongst conservatives with regard to healthcare and government provision of social services many social conservatives (but not libertarians) do believe that the government should have an expansive role in the individual lives of citizens with regard to laws regulating bodily rights and interpersonal relations denying a woman's right to have an abortion and denying equal rights to marriage and other legal protections and benefits to gays and lesbians. Furthermore, their concern with maximizing consumer choice does not extend to maximizing choice for indigent Americans as egalitarianism is not a priority for proponents of limited government.

understandings prevailing in that society's language is also to preside over its practices and processes.²⁴

My primary concern then is *how* liberal Democratic ideologies argue for expanding healthcare access and quality and the moral, social, emotional, and policy components of their rhetorics.

I analyze how the rhetoric of individual Democratic American presidents seeks to create, shift, and revise the American social imaginary and in so doing integrate two different approaches to political history, with an emphasis on how on the micro level American presidents both attempt to create and respond to the social imaginary on the macro level. As we will soon discuss, there are diverse components of the social imaginary and different parts of society that contribute to it – from politicians to the media, business to academics, laypeople and professionals from various sectors of the economy. American presidents are therefore prominent actors in the creation, revision, and dynamic ongoing transformation of the social imaginary which is never static.

The social imaginary evolves continually, in relation to changes in society which include political, economic, socio-cultural, demographic, and environmental changes which impact human relations. For example, during the 1930s and the 1940s Franklin Delano Roosevelt's New Deal inspired significant changes in the American social imaginary – pulling it in a liberal direction. In the 1980s, in contrast, Ronald Reagan and the policies he pursued contributed to a shift in the American social imaginary towards a more conservative direction.

Presidential rhetoric matters because it has far reaching potential to impact politics, policy, and public debate. As David Blumenthal and James Morone state,

²⁴Michael Freeden, "Thinking Politically and Thinking About Politics: Language, Interpretation, and Ideology" in *Political Theory: Methods and Approaches*, ed. David Leopold and Marc Stears (Oxford: Oxford University Press, 2008), 198.

The presidency is a great dynamo producing fresh ideas. Each incumbent can inject a small number of deeply felt views into the political process... Forceful presidencies offer an overarching framework – Lyndon Johnson’s claims that a great society should be judged by how it treats its weakest citizens or Ronald Reagan’s insistence that government is the source of our national problems – and then find policy prescriptions that reach for the vision... Presidents control one of the world’s great megaphones – as Teddy Roosevelt put it, a bully pulpit.²⁵

Although presidents are but one factor in the formation, evolution, and contestation of the American social imaginary, given the central role of the Presidency in American democracy both formally with regard to power, resources, and the attention US presidents command, and their more informal place in American society as not only the highest political authority but as symbols of the state, they are uniquely placed and resourced to shape the social imaginary and its underlying moral order. With regard to advancing healthcare reform, American presidents have played a central and decisive role. As Beatriz Hoffman writes, “It is not coincidence that the historic attempts to establish universal health care in the U.S. are associated with presidents (Harry Truman, Lyndon B. Johnson, Bill Clinton)...Major health care reform efforts in the twentieth century were led primarily by elites.”²⁶ Alan Finlayson explains, “Politics is... where the ‘web of belief’ is ruptured because rival traditions and narratives have clashed²⁷” and presidential address on healthcare reform allows us to examine the changing nature and conflicts of these beliefs and narratives.

²⁵David Blumenthal and James Morone, *The Heart of Power: Health and Politics in the Oval Office*. (Berkeley: University of California Press, 2009).

²⁶Beatriz Hoffman, “The Challenge of Universal Health Care” in *Social Movements and the Transformation of American Health Care*, edited by Jane C. Banaszak-Holl et al. (New York: Oxford University Press, 2010), 39-40.

²⁷ Alan Finlayson, “From Beliefs to Arguments: Interpretive Methodology and Rhetorical Political Analysis,” *British Journal of Politics and International Relations* 9 (2007): 549.

1.3 Core Concepts

In order to pursue my research project what is needed are the following three key concepts, the first of which I have already introduced:

1. The social imaginary: how people imagine their co-existence in a national context and the moral values, relationships, and responsibilities entailed.
2. The public realm or domain, as the space in which political performance and struggle takes place and where public opinion is formed. This thesis focuses on the public realm of the presidency, specifically presidential oratory delivered to Congress.
3. Discourse, as the symbolic and rhetorical resources and strategies through which political struggles take place in the public realm and through which the social imaginary is reproduced or challenged.

The theoretical assumption of my thesis is that social imaginaries, evolving but relatively stabilized forms of meaning that are historically-specific and culture-bound, have the symbolic power to create imagined communities by articulating particular values and sustaining particular hierarchies of power, inclusion and exclusion, conditions of justice or injustice. I characterize these values and relations as potentially hegemonic in nature because they can create conditions of inequality and oppression and often seek to monopolize power. Social imaginaries, in other words, legitimize the moral order of a society and can be used to naturalize the patterns of power and resource exclusion that sustain this moral order or they can be used to challenge and transform them. They are developed and contested in the public realm through discursive struggle that invokes morals, emotions, pragmatism, and political ideology.

1.4 Thesis Structure and Research Questions

The thesis begins by setting out the historical background and intellectual problematic that informs my research: namely how the 2009-10 healthcare reform debate reflects and rearticulates the American social imaginary and how that has evolved and been contested historically since Harry Truman's efforts to pass universal health insurance. I situate the history of the reform within existing critical literature in the social sciences, particularly history and public policy, in order to establish the continuities with and distinctiveness of my own research to the existing body of studies. In this chapter I discuss the relationship between healthcare reform and human rights, in particular, social and economic rights and the weakness of support for these rights in the United States and situate this discussion in relation to the national healthcare programs of other wealthy industrialized nations. In Chapter 2 I offer a historical overview of liberal and conservative healthcare reform rhetoric and policy and discuss healthcare reform milestones. Chapter 3 discusses the theoretical foundations of the thesis and the concept of the social imaginary. Chapter 4 addresses the methodology of rhetoric analysis. I then apply rhetoric analysis in the next four chapters to speeches on healthcare reform given by Truman, Johnson, Clinton, and Obama. I conclude by reflecting upon the changing American social imaginary and moral order today as it relates to healthcare reform and other socially contested issues.

These are the research questions which guide my research:

- a. What type of social imaginary does Truman, Johnson, Clinton, and Obama's rhetoric create and to what moral and practical policy ends? How does this social imaginary evolve?

- b. How does this rhetoric contrast with Republican/conservative rhetoric and what does it have in common with Republican/conservative rhetoric? What emotions and moral principles does it generate and depend upon? How does it depict and address different social and economic classes of Americans, particularly the working class and middle class and the most economically disadvantaged?
- c. Do the rhetorical strategies used by Truman, Johnson, Clinton, and Obama lead to distortions in rendering of the history of public policy, current social and economic inequalities, and the reasons for the current lack of universal health insurance provision in the US? What social groups (if any) are marginalized in this rhetoric so as to make it appeal to as broad a segment of the American people as possible?

1.5 Empirical Focus and Corpus Construction

In light of my research questions I look into the rhetoric of four Democratic US presidents. I examine the conservative social imaginary and moral order to which they respond and which they try to change and shift in a more liberal direction to be more inclusive of all US citizens. This reflects concern for the principle of equal opportunity; the conviction that all citizens should have equitable level of services in areas such as education and healthcare that enables them to participate freely and as fully as possible in society without discrimination on the basis of their economic and/or social status. It also reflects concern for communitarian social solidarity, which insists that alongside government protection of negative liberty governments must enact programs that enable positive liberty and common values that reflect the social, collective nature of a democratic society in which citizens with diverse needs and levels of vulnerability and disadvantage are cared for and treated with respect and dignity in a way that contributes to the well being of society as a whole. I will explicate the rhetorical strategies of

persuasion used by Truman, Johnson, Clinton, and Obama as they advance liberal notions of the legitimate purposes of government and its moral responsibilities in relation to inadequate healthcare insurance and provision.

The texts selected for analysis are major presidential speeches on healthcare reform that were self-consciously aimed to convince the public of the legitimacy of healthcare reform efforts and to defend the principle of expanding access to healthcare. Alan Finlayson and James Martin explain the significance of political speeches and in so doing illustrate why they are worthy of analysis and the way in which they both construct and respond to the social imaginary.

The political speech is an argument of some kind: an attempt to provide others with reasons for thinking, feeling or acting in some particular way; to motivate them; to invite them to trust one in uncertain conditions; to get them to see situations in a certain light. Such speech must, in some measure, adapt to audiences, confirming their expectations and respecting their boundaries, even as it tries to transform them.²⁸

I will apply rhetoric analysis on major speeches addressing healthcare reform of these four presidents and in so doing examine the ways in which these speeches both reflect and strive to adjust the American social imaginary and moral order. Their scope is focused in nature and the speeches are doctrinal in that they reflect political leadership at the highest level.

Some of these speeches were touchstones in the healthcare reform debates, particularly Harry Truman, Barack Obama, and Bill Clinton's speeches to Congress on healthcare reform. Although Truman's speech did not lead to immediate policy change it laid important groundwork for Lyndon Baines Johnson to pursue the creation of Medicare and Medicaid twenty years later. Johnson's speech at the signing of the

²⁸ Alan Finlayson and James Martin, "It Ain't What You Say...": British Political Studies and the Analysis of Speech and Rhetoric," *British Politics* 3 (2008): 450.

Medicare and Medicaid bills marked a pivotal moment in the meeting of both rhetoric and policy as Johnson presented to the American people a justification for and celebration of Medicare and Medicaid as well as recognition of Harry Truman's role in seeding them through his efforts to expand healthcare.

The speeches I will analyze are as follows:

1. Harry Truman's November 19, 1945 Special Message to the Congress Recommending a Comprehensive Health Program
2. Lyndon Baines Johnson's Remarks with President Truman at the Signing in Independence of the Medicare Bill, July 30, 1965 & The Great Society Speech, May 22, 1964 with references to other speeches on the Great Society and War on Poverty.
3. Bill Clinton's September 22, 1993 Address to Congress on Healthcare.
4. Barack Obama's September 9, 2009 Address to Congress on Healthcare.

The thesis is divided in this manner:

Thesis Chapters:

Chapter 1: Introduction

Chapter 2: History of American Liberal and Conservative Healthcare Rhetoric and Public Policy

Chapter 3: Theory: The Social Imaginary and its Moral Order

Chapter 4: Methodology: Rhetoric Analysis

Chapter 5: Harry Truman's November 19, 1945 Address to Congress on Healthcare Reform

Chapter 6: Lyndon Baines Johnson's Remarks at the Signing of the Medicare Bill, July 30, 1965 and Related Speeches

Chapter 7: Bill Clinton's September 22, 1993 Address on Healthcare Reform to Congress

Chapter 8: Barack Obama's September 9, 2009 Speech on Healthcare Reform to Congress

Chapter 9: Conclusion How Liberal Arguments for Healthcare Expansion Have Evolved from Truman to Obama & The Patient Protection and Affordable Care Act: Rhetorical and Policy Conflicts Now and in the Future

1.6 Rights, Liberty, and Individualism in US Law and Politics

The US Constitution and the Bill of Rights that forms the first ten amendments to the Constitution covers a broad range of rights – particularly ‘negative’ liberties such as freedom of religion, assembly, press, and association. But no American court has ever ruled in favor of a constitutionally protected right to healthcare.²⁹ Although the Declaration of Independence famously asserts the self-evidence of the right to “Life, liberty, and the pursuit of happiness³⁰” and both the right to life and the pursuit of happiness are predicated on having access to healthcare and maintaining a decent standard of health, the Declaration of Independence is not a legally binding document. The right to life it affirms never entered the US Constitution or other US law. Similarly, although the preamble to the Constitution states that promoting the ‘general welfare’ is one of the goals of the Constitution as is to ‘establish justice,’ neither principle has been interpreted as guaranteeing a right to healthcare and the Constitution places great emphasis on individual rights and negative liberty rather than collective solidarity and positive liberty.

The passage of Barack Obama’s healthcare bill ushers in an era where US law moves closer to making healthcare a citizen entitlement, but polls show that even with the passage of this legislation there is far from widespread consensus amongst Americans that there is or should be a right to healthcare, although there is general support for

²⁹ Audrey Chapman, *Health Care Reform: A Human Rights Approach*, (Washington, DC: Georgetown University Press, 1994), 74.

³⁰ The US Declaration of Independence, <http://www.ushistory.org/declaration/document/>.

improving access and affordability of healthcare in principle.³¹ Surveys show Americans ambivalent about government guarantee of health insurance³² even though majorities of Americans for several decades have repeatedly indicated that they believe all Americans should have access to healthcare irrespective of their economic and social status and their ability to pay.³³ Ian Shapiro illustrates this ambivalence by explaining how Americans conceive of rights.

The Anglo-American liberal tradition can be characterized as follows: (1) rights are predicated on a highly individualistic and atomistic view of human nature; (2) rights are conceptualized as negative in character, as fences or barriers protecting the individual from intrusions; (3) freedom is considered to be the most important goal or social good; and (4) the primary (or sole) role of government is to protect the liberty of the individual³⁴

As a consequence, he concludes, “This liberal tradition, particularly its libertarian stream, has been inimical to the recognition of a right to health care understood as an entitlement that requires positive public action.”³⁵ This contrasts significantly with the dominant European conception of rights and freedom, which incorporates social rights alongside

³¹Robin Toner and Janet Elder, “Most Support Guarantee of Health Care,” *The New York Times*, March 2, 2007. <http://www.nytimes.com/2007/03/02/washington/02poll.html?pagewanted=all>.

Robert Blendon and John Benson, “The American Public and the Next Phase of the Health Care Reform Debate,” *New England Journal of Medicine* 48: (2009).

Ed O’Keefe, “Americans Still Divided on Health-Care Reform: Poll,” *Washington Post*, July 9, 2012. http://www.washingtonpost.com/blogs/2chambers/post/americans-still-divided-on-health-care-reform-poll/2012/07/09/gJQAfRwzYW_blog.html.

David Jackson, *USA Today*, June 6, 2013, “Poll: Americans Still Leery of Obama Health Care Law.” <http://www.usatoday.com/story/theoval/2013/06/06/obama-health-care-nbc-news-wall-street-journal-poll/2395541/>

Gallup Polls on American Public Attitudes Towards Obama’s Healthcare Reforms:

<http://www.gallup.com/poll/155447/Americans-Issue-Split-Decision-Healthcare-Ruling.aspx>

<http://www.gallup.com/poll/155513/Americans-Economic-Harm-Good-Health-Law.aspx>

<http://www.gallup.com/poll/155300/Gallup-Editors-Americans-Views-Healthcare-Law.aspx>

³² Mark Trumbull, “Health-care Reform: What Polls Say Ahead of A Supreme Court Ruling,” *Christian Science Monitor*, June 22, 2012.

³³ Seymour Martin Lipset, *American Exceptionalism: A Double Edged Sword*, (New York: W.W. Norton, 1997.)

³⁴ Chapman, 18.

³⁵Franz-Xaver, Kauffman; John Veit-Wilson; Thomas Skelton-Robinson, *European Foundations of the Welfare State*, (Oxford: Bergahn Books, 2012).

civil and political rights and sees the two as being mutually interdependent³⁶ and which expects of the government to secure the right to healthcare.³⁷ Entitlements to positive government action on a range of social issues – not only healthcare provision - are fundamental to the post World War 2 European welfare state.³⁸ Indeed, historically, the major turning point when the United States began to stand apart from Western European countries who were developing and expanding programs of universal healthcare³⁹ for their citizens was just after World War 2, as the nations of Europe developed their welfare state model, committing their governments to a central role for government guarantee of social needs from healthcare and housing to childcare.⁴⁰

The theorization of T.H. Marshall in his 1950 essay “Citizenship and Social Class”⁴¹ that there was a historical progression in England from an initial commitment to protecting civil and political rights towards a more expanded definition of rights, incorporating social and economic ones, is far truer for Western European societies generally than the United States. While social and economic rights were expanded considerably under Franklin Delano Roosevelt, they did not achieve the level of comprehensiveness that the post World War 2 European welfare state realized, setting the United States apart from most other democratic industrialized nations. This is not merely a case of the United States lagging behind Europe chronologically in the

³⁶ Ibid. This is also the case in international law. See for example the United Nations International Covenant on Economic, Social and Cultural Rights.

³⁷ For more on the value of solidarity in Europe and how this relates to Western European models of near universal and universal health insurance in comparison to the United States, see James Morone, “Morality, Politics, and Health Policy” in *Policy Challenges in Modern Health Care*, ed. David Mechanic et al, 13-24.

³⁸ Here I am referring primarily to France, Germany, Britain Belgium, the Netherlands, Austria, and the Scandinavian countries. Spain, Portugal, and Greece share this philosophy but it came to fruition decades after those of the aforementioned countries due to extended periods of dictatorship post World War 2.

³⁹ Some of these insurance programs were for near-universal healthcare, as in France and Germany. In Germany the overwhelming majority of citizens were covered but a small percentage could choose to opt out of insurance coverage – and still can - although they must have some form of private health insurance. In France coverage reached the majority of citizens in the post World War 2 era, but some of the most impoverished were not covered. Currently, the French healthcare system is universal and covers all French citizens.

⁴⁰ Kauffman, et al. *European Foundations of the Welfare State*.

⁴¹ TH Marshall, *Citizenship and Social Class*, (London: Pluto Press, 1987).

implementation of social and economic rights because of differing political systems and institutions, but a result of a distinct American political culture that is more cautious towards, ambivalent about, and sometimes even hostile to centralized government efforts to realize and protect social and economic rights and actualize positive liberty.

In referring to ‘political culture,’ Talal Asad’s definition is useful in defining its qualities and parameters.

When people refer to “American political culture” they signify the political practices, legitimations, and discourses that are integral to the way the United States works as a bounded nation state, to the various ways these elements define Americans as citizens, and to an important way that Americans identify themselves. There is nothing essentialist in such usages. It is precisely because culture is circumscribed in this case and attributed to a named political entity, to the agents who make it up, that it can be meaningfully assessed and criticized.⁴²

What is a generally universally accepted concept in Western Europe is highly contested, ideologically fraught, and deeply divides Democrats and Republicans in the United States, with Republicans being sceptical of social and economic rights, particularly because, as noted, they are excluded from the US Constitution.

Democrats, too, have become weary of the principle of social and economic rights. As my thesis explores, there is an intense contrast between the prominence of social and economic rights which powerfully dominates Harry Truman and Lyndon Baines Johnson’s major addresses on healthcare reform and the almost total absence of such references in the speeches of Bill Clinton and Barack Obama. Truman and Johnson advocated for social and economic rights and in so doing challenged the American moral order and social imaginary robustly and aggressively. Clinton and Obama, in contrast, when calling for healthcare reform, were cautious. While calling for equal opportunity

⁴² Talal Asad, “What Do Human Rights Do? An Anthropological Enquiry,” *Theory and Event*, 4, (2000).

and communitarianism they opted not to refer to and advocate for social and economic rights in general and a social and economic right to healthcare in particular.

Given this political and cultural reality, in the history of healthcare reform in the United States it is noteworthy that a communitarian solidarity defense of universal healthcare was considered to be potentially more palatable to American political culture and the American social imaginary than a rights paradigm. The 1980 *President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research* was mandated by Congress to study the “ethical and legal implications of differences in the availability of health services as determined by the income or residence of the person receiving the service.”⁴³ The report that resulted, entitled, *Securing Access to All*⁴⁴, concluded in a carefully balanced formulation between the rights and responsibilities of citizens and government, the private and the public sector that:

1. Society has an ethical obligation to ensure equitable access to healthcare for all;
2. Individuals have an obligation to pay a fair share of the cost of their care
3. Equitable access to healthcare requires that citizens be able to secure an adequate level of care without excessive burdens.
4. When private forces produce equitable access there is no need for government involvement, though ultimate responsibility for ensuring that society's obligation is met through a combination of public and private sector arrangements....⁴⁵

As Audrey Chapman notes, “An important feature of *Securing Access to Health Care for All* is that the Commission explicitly chose not to frame its conclusions in terms of the human rights of individuals to health care.”⁴⁶ Indeed although the first draft of this document included an explicit reference to the right to healthcare it was later revised so

⁴³ Chapman, 1994, p. 24.

⁴⁴ Abram, Morris et al. 1983. *President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research*.
http://bioethics.georgetown.edu/pcbe/reports/past_commissions/securing_access.pdf.

⁴⁵ Ibid.

⁴⁶ Chapman, 25.

that the final, accepted and disseminated draft, focused on collective societal obligation, making a communitarian rather than a rights based argument for universal healthcare.

A communitarian argument may have been perceived as less controversial because it amounts to a moral argument rather than both a moral *and* a legal argument. Any claim to a ‘right’ raises the authority of the law and given the range of opinions on universal healthcare it may have been considered inflammatory to argue for a legal basis for universal healthcare even if all sides of the argument acknowledged that there was no explicit legal guarantee of universal healthcare in the Constitution or any federal laws.⁴⁷ Seen in an American context, communitarianism provides a contrast to the dominant conception of rights in American culture as being concerned primarily with maximizing individual negative liberty, with communitarianism generally more sensitive to and interested in pursuing positive liberty through improved social conditions which maximize collective welfare and are sympathetic to efforts to increase equal opportunity. As the theorist of communitarianism, Amitai Etzioni explains, liberty is a very important value but not one that can be isolated from other values that communitarians emphasize as essential for a healthy democratic society, such as caring, sharing, and civic mindedness. Etzioni insists, “No society can flourish without some shared formulation of the common good... It provides a rationale for the sacrifices members of every society have to make sooner or later for their children, for the less endowed, and for the future.”⁴⁸

⁴⁷ Chapman, 75.

⁴⁸ Amitai Etzioni, *The Common Good*, (Cambridge: Polity Press, 2004), 2.

1.7 The US in Comparative Perspective: Healthcare as a Legally Guaranteed Right in European and other Nations

In Europe conservative parties such as the Christian Democrats in Germany have long since reconciled themselves to government provision of universal healthcare. Even in countries where adjustments have been made to universal healthcare provision making policies stricter in their healthcare allocation generosity and requiring greater individual citizen subsidy of services – such as the Netherlands – the fundamental commitment to universal healthcare remains across the political spectrum.⁴⁹ Indeed rather than having to grudgingly reconcile themselves most European conservative parties have long supported universal healthcare and not sought to dismantle it – even if they proposed reforms to make it more market friendly or what they believe to be as economically efficient.⁵⁰

The healthcare provision policies of European countries, however, reflect the belief that while markets provide the ideal way of organizing the economy in most domains of life they are uniquely unable to deal effectively with the moral and practical

⁴⁹This is particularly true in Scandinavia and the Benelux countries but is the case across Western Europe where universal healthcare is one of the fundamental pillars of the welfare state. In the UK the Tories have initiated reforms to the NHS (National Health Service) that are being met with scepticism by many as potential threats to its character; but the NHS remains the ‘third rail’ of British politics and any attempts to undermine its universal and public nature are likely to be widely rejected due to strong support for the NHS across virtually all sectors of British society.

See *Access and Choice* by Melanie Lisac, et al.

Zeynep Or et al, “Are Health Problems Systemic? Politics of Access and Choice under Beveridge and Bismarck Systems,” *Health Economics, Policy, and Law* 5, (2010).

Avik Roy, “Why Switzerland Has the World’s Best Healthcare System,” *Forbes*, April 29, 2011.

<http://www.forbes.com/sites/aroy/2011/04/29/why-switzerland-has-the-worlds-best-health-care-system/>.

Helena Bachman, “Switzerland Has its Own Kind of Obamacare and Loves It.” *Time*, August 16, 2012.

<http://nation.time.com/2012/08/16/health-insurance-switzerland-has-its-own-kind-of-obamacare-and-loves-it/>.

Patrick Butler, “NHS Reform Bill Passes with Government Bloodied, But Unbowed,” *The Guardian*, March 20, 2012.

Anna Dixon, “NHS Reforms: What Next for the Health Service?” *The Guardian*, April 4, 2012.

<http://www.guardian.co.uk/healthcare-network/2012/apr/04/nhs-reforms-health-social-care-bill>

⁵⁰ As in the case in the Netherlands. See, ‘Going Dutch.’

Jonathan Cohn, “Going Dutch: Life After the Public Option,” *The New Republic*, September 29, 2009.

<http://www.tnr.com/article/health-care/going-dutch>.

demands of healthcare provision.⁵¹ Acknowledging this does not make Europeans anti-market or anti-capitalist, it simply yields a less ideological and more empirically based response than the one provided by the most uncompromising advocates of limited government. Many American conservatives perceive government guarantee of healthcare as an *ideological* attack on capitalism rather than a realistic assessment of its inability to adequately meet the needs of all citizens in a democracy adequately, equitably, and in accordance with principles of justice and human rights. Indeed proponents of limited government and most Republicans do not claim that the free market will guarantee every American health insurance as this is not a relevant concern for ardent supporters of limited government; the United States is the only Western country with uninsured citizens precisely because the markets dominate healthcare provision and are minimally regulated.

Bismarck created the first universal healthcare system in the world in Germany in 1883 and he did this in part because of what is a conservative conviction in many European countries that universal healthcare provision contributes to social cohesion and unity.⁵² This belief and attitude has never achieved currency in the United States. Although the signers of the Constitution stated that one of its aims was to ensure ‘domestic tranquillity’ neither they nor legislators serving in Congress and US state government legislatures ever advanced plans to enable a system of universal healthcare so as to advance domestic tranquillity. All Western European countries which have offered near universal or universal healthcare to their citizens for decades, including government run single-payer systems such as those in Sweden and the UK exist alongside vigorously

⁵¹For more on the moral limits of markets see Michael Sandel, *What Money Can't Buy: The Moral Limits of Markets*, (New York: Farrar, Straus, and Giroux, 2012).

⁵² Bismarck was also concerned with the practical realities of creating a unified German state. “Frontline: Sick Around the World: Health Care Systems – The Four Basic Models” <http://www.pbs.org/wgbh/pages/frontline/sickaroundtheworld/countries/models.html> For more on Europe and the Welfare State see, Xaver et al, *European Foundations of the Welfare State*.

capitalist philosophies and practices of government. However, in American political culture and conservative ideology in particular there is presumed irreconcilable tension between support for free market policies and capitalism and government provision of social services aiming to equalize opportunity and provide for the basic needs of citizens.

A majority of national constitutions, 67.5%, guarantee healthcare of some form or at least acknowledge its importance and the rights of citizens to access it, though not necessarily in a universal or comprehensive manner.⁵³ In Europe, the European Union's Charter of Fundamental Rights which guarantees many of the legal protections of the US Constitution differs markedly from its American counterpart, the US Bill of Rights, in that it explicitly defines and protects a right to healthcare.⁵⁴ It states that,

Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all of the Union's policies and activities⁵⁵

Some nations' constitutions explicitly guarantee healthcare to all citizens. The Czech Constitution, for example, states that, "The state is obliged to guarantee the right to life and the right to protection of health, and health care for all."⁵⁶ The Portuguese, Belgian, Spanish, and Polish constitutions all guarantee a right to health.⁵⁷ The right to health protection is found in Article 11 of the preamble to the 1946 French Constitution and

⁵³Eleanor Kinney and Alexander Clark, "Provisions for Health and Health Care in the Constitutions of the Countries of the World," *Cornell International Law Journal* 37 (2004): 285-287. Also available at: http://indylaw.indiana.edu/instructors/Kinney/Articles/kinney_Constitutions.pdf

73 UN member states (38%) guarantee the right to medical services.

Jody Heymann et al, "Constitutional Rights to Health, Public Health, and Medical Care: The Status of Health Protections in 191 Countries," *Global Public Health*, 8 (2013).

⁵⁴ *Charter of Fundamental Rights of the European Union*. <http://eur-lex.europa.eu/en/treaties/dat/32007X1214/htm/C2007303EN.01000101.htm>

⁵⁵ T. R Reid, 2010. *Charter of Fundamental Rights of the European Union*, <http://eur-lex.europa.eu/en/treaties/dat/32007X1214/htm/C2007303EN.01000101.htm>

⁵⁶Kinney and Clark, "Provisions for Health and Health Care in the Constitutions of the Countries of the World," 290.

⁵⁷Hiroaki Matsuura, "The Effect of a Constitutional Right to Health on Population Health in 157 Countries, 1970-2007: The Role of Democratic Governance," July 2013. *PGDA Working Paper No. 106*. *Harvard Initiative for Global Health*. www.hsph.harvard.edu/pgda/working/htm, 18.

was reaffirmed and incorporated in the preamble to the Constitution of the Fifth Republic of 1958.⁵⁸ Furthermore, the European Union’s Charter of Fundamental Rights incorporates social and economic rights alongside civil and political ones and in this way is markedly different from the US Bill of Rights and Constitution. Article 33 of the Charter guarantees the right to “paid maternity leave and to parental leave following the birth or adoption of a child.” Article 34 addresses social security, and affirms “entitlement to social security benefits and social services providing protection in cases such as maternity, illness, industrial accidents, dependency or old age.”⁵⁹ Many of the constitutions of nations in the developing world also guarantee healthcare provision.⁶⁰ However, whether or not a country’s constitution and/or laws explicitly guarantee government provision of healthcare or government guarantee of health insurance may have little relationship to the actual provision of healthcare in a particular country. As noted earlier, universal healthcare is largely limited to wealthy industrialized countries. While there are some exceptions to this such as Rwanda,⁶¹ and many Latin American

⁵⁸ UNHCR UN Refugee Agency. Preamble to the Constitution of 27 October, 1946, Republic of France. <http://www.unhcr.org/refworld/country,,NATLEGBOD,,FRA,,3ae6b56910,0.html>
Dorothy Pickles, “The Constitution of the Fifth French Republic,” *The Modern Law Review* 22 (1959) 1-20.

Constitution of the Fifth Republic of France. <http://www.assemblee-nationale.fr/english/>
Whether or not the preamble to the French Constitution is legally binding has been a subject of various rulings of French courts.

⁵⁹ *Charter of Fundamental Rights of the European Union*, <http://eur-lex.europa.eu/en/treaties/dat/32007X1214/hm/C2007303EN.01000101.htm>

⁶⁰ Kinney and Clark, “Provisions for Health and Health Care in the Constitutions of the Countries of the World,” 311.

⁶¹ Rwanda’s universal Mutuelle de Sante healthcare program preceded passage of the Affordable Care Act. Although it is far more basic than the healthcare coverage the United States government will provide its citizens it is a highly unusual example of a developing country – indeed one of the world’s poorest in the bottom 50 of the United Nations Human Development Report - guaranteeing a basic level of healthcare to all citizens within the economic means of the government.

See, “Working Towards Universal Healthcare Coverage in Rwanda,” Brookings Institution and Donald McNeil, “A Poor Nation, With a Health Plan,” *New York Times*, June 15, 2010. <http://www.nytimes.com/2010/06/15/health/policy/15rwanda.html>.

The Brookings Institution: http://www.brookings.edu/events/2007/1022_rwanda.aspx.
Bulletin of the World Health Organization. 2008 86: 3-4.

World Health Organization. “Sharing the Burden of Sickness: Mutual Health Insurance in Rwanda,” <http://www.who.int/bulletin/volumes/86/11/08-021108/en/index.html>. 17 May 2011.

See also Tina Rosenberg, “In Rwanda, Health Care Coverage that Eludes the US,” *The New York Times*. July 3, 2012. *The New York Times*, <http://opinionator.blogs.nytimes.com/2012/07/03/rwandas-health-care-miracle>.

countries⁶², the implementation of universal health insurance has been overwhelmingly limited to wealthy, middle and upper-income countries. Some of these countries, like the Czech Republic have constitutions that explicitly guarantee a right to health, while others such as the Netherlands and Germany offer universal health insurance although there is no constitutional right to it. In Great Britain, the right to health was formalized by the Human Rights Act of 1998 but in effect, due to the National Health Service, such an entitlement of citizens had existed for almost 50 years.⁶³ In all countries where universal insurance is offered, however, there is a legal basis for it and legislation providing for citizen access to healthcare codifies the health rights of citizens and the programs of healthcare to which they are entitled to avail themselves.

Many of the world's poorest nations have constitutions which guarantee healthcare but which are systematically disregarded by governments both because of lack of resources and because of other government priorities. Thus while countries like Cambodia affirm the rights of citizens to healthcare in their constitutions this has little if any impact on actual healthcare provision due to their lack of financial and human resources and government policies that do not prioritize healthcare and often prioritize military expenditures, subsidies to business, infrastructure, and other social services. Such nations also face problems with corruption, waste, and inefficiency in healthcare expenditure and contracts.⁶⁴

⁶² These include Argentina, Brazil, Chile, Costa Rica, Cuba, Mexico, and more recently Peru and Colombia. Nevertheless, with the exception of socialist Cuba where private healthcare is not available, there are large gaps between the quality of healthcare provided by government supported public healthcare programs and private insurers and healthcare providers in these countries.

Kinney and Clark, "Provisions for Health and Health Care in the Constitutions of the Countries of the World."

⁶³ Hiroaki Matsuura, "The Effect of a Constitutional Right to Health on Population Health in 157 Countries, 1970-2007: The Role of Democratic Governance, 19. July 2013. *PGDA Working Paper No. 106. Harvard Initiative for Global Health.* www.hsph.harvard.edu/pgda/working/htm, 19.

⁶⁴ It is important to acknowledge that in many developing countries public health efforts such as sanitation, provision of clean running water and nutritious diet, and disease prevention are of greater urgency and more likely to substantially improve overall health than medical care. See Buchanan, page 204, for more on this issue.

Allen Buchanan, *Justice and Health Care: Selected Essays*, (Oxford: Oxford University Press, 2009.)

1.8 Healthcare Reform Today: Barack Obama's Affordable Care Act

The national healthcare policy debate Barack Obama initiated in advancing legislation for near universal health insurance in 2009 and 2010 which culminated in passing the Patient Protection and Affordable Care Act (the Affordable Care Act) which expands health insurance to cover most Americans, irrespective of income, revealed deeply polarized stances between Democrats and Republicans, with Republicans vigorously rejecting the legislation and none voting for it in the House of Representatives where it relied exclusively on the votes of Democrats and one independent for passage.⁶⁵ Since its passage, Republicans in the House of Representatives have voted to repeal the Act at least 37 times, and continue to press for its repeal.⁶⁶

Highlights of the law, signed March 23, 2010, include the ban on discriminating against individuals with pre-existing conditions, government subsidies for individuals who cannot afford healthcare, an individual mandate requiring Americans to hold healthcare, a ban on lifetime limits on essential medical services, and insurance exchanges where citizens can pick amongst a variety of health plans offered by private insurers that must meet certain government criteria for quality and affordability.⁶⁷ Even with the passage of the Affordable Care Act, however, healthcare remains a highly contested right, with a close Supreme Court ruling which affirmed its legality with five justices defending

⁶⁵Robert Pear and David M. Herszenhorn, "Obama Hails Vote on Health Care as Answering 'The Call of History,'" *The New York Times*, March 21, 2010.

<http://www.nytimes.com/2010/03/22/health/policy/22health.html>

⁶⁶Jeremy W. Peters, "House to Vote Yet Again on Repealing Health Care Law," *The New York Times*, May 14, 2013. http://www.nytimes.com/2013/05/15/us/politics/house-republicans-to-vote-again-on-repealing-health-care.html?_r=0

⁶⁷Phil Galewitz, 2010. "Consumers Guide to Health Reform." *Kaiser Health News*.

<http://www.kaiserhealthnews.org/stories/2010/march/22/consumers-guide-health-reform.aspx>

Lawrence Jacobs and Theda Skocpol. *Health Care Reform and American Politics: What Everyone Needs to Know*. (Oxford: Oxford University Press, 2010.)

Washington Post Staff, *Landmark: The Inside Story of America's New Health-Care Law and What it Means for Us All*, (New York: Public Affairs, 2010.)

it and four denying its constitutionality – a victory for the law but a clear indication of the strength of its detractors.⁶⁸

The Affordable Care Act will make healthcare affordable and accessible to most Americans but its coverage will not be completely universal. Individuals will be able to opt out of the individual mandate for religious and/or financial reasons. However, in principle, it will make healthcare near- universally accessible and affordable through government regulated cost control mechanisms, subsidies, and legally sanctioned requirements for substantive and qualitative healthcare insurance and provision standards. Still, even when fully implemented, there will still be a substantial percentage of Americans without health insurance, up to approximately 10%.⁶⁹

Recent changes to the implementation of the Act, as a result of the Supreme Court ruling which affirmed the legality of the Act but simultaneously protected the right of states not to expand Medicaid as widely as the Act demands, now call into question how much coverage the indigent will receive from it in states (overwhelmingly states with Republican governors and/or Republican majorities in state government) which are choosing not to expand Medicaid as extensively as the Act had initially mandated prior to the Supreme Court ruling which struck down the required expansion of Medicaid.⁷⁰

⁶⁸Adam Liptak, “Supreme Court Upholds Health Care Law in 5-4 Victory for Obama,” Liptak, *The New York Times*, June 28, 2012. <http://www.nytimes.com/2012/06/29/us/supreme-court-lets-health-law-largely-stand.html?pagewanted=all>

⁶⁹Jacobs and Skocpol, 2010.

⁷⁰Robert Pear explains that, “The refusal by about half the states to expand Medicaid will leave millions of poor people ineligible for government subsidized health insurance under President Obama’s health care law even as many others with higher incomes receive federal subsidies to buy insurance.” States which are refusing to expand Medicaid include Texas, Florida, Kansas, Alabama, Louisiana, Mississippi, and Georgia. Pear further explains, “More than half of all people without health insurance live in states that are not planning to expand Medicaid. People in those states who have incomes from the poverty level up to four times that amount (\$11,490 to \$45,960 a year for an individual) can get federal tax credits to subsidize the purchase of private health insurance. But many people below the poverty line will be unable to get tax credits, Medicaid or other help with insurance.” In Kansas, for example, “adults with incomes from 32 percent to 100 percent of the poverty level (\$6,250 to \$19,530 for a family of three) will have no assistance.”

Robert Pear and Peter Baker. “Health Law is Defended with Vigor by President,” *The New York Times*, May 11, 2013.

Until states change their policies and/or the federal government provides new subsidies for those indigent Americans unable to access Medicaid but also shut out from government subsidies fewer Americans than intended will receive the full benefits of the Act.

Republicans depicted the Affordable Care Act as a government take-over of healthcare, a giant bureaucratic mess which some described as ‘socialized medicine’, and a waste of precious government resources. They argued that it is antithetical to their philosophy of limited government and maximal individual freedom and they ignored or outright rejected the principle that healthcare provision should be universal in the United States: guaranteed for every American citizen as it is in every industrialized Western country.⁷¹ Sometimes patently false claims were made, such as Sarah Palin’s insistence that Obama’s legislation would create ‘death panels’ that would determine which senior citizens would have access to life-saving care and which would not, leading to the premature deaths of many senior citizens who allegedly would be robbed of their right to healthcare.⁷² But, ironically, Obama’s legislation in part reflected historical Republican efforts to expand health insurance and is a centrist plan which strongly favors private insurers and the healthcare industry.⁷³ Indeed Barack Obama’s healthcare reform efforts are in part based on Republican healthcare expansion proposals.

http://www.nytimes.com/2013/05/11/us/politics/obama-to-makes-new-pitch-on-health-care-law.html?ref=politics&_r=0.

⁷⁰We see this through the way in which Obama appropriates conservative tropes such as attacks on government bureaucracy and vigorous defense of free markets.

⁷¹ Transcript: “GOP Response to Obama’s Health Care Address,” *Fox News*, September 9, 2009. <http://www.foxnews.com/politics/2009/09/09/transcript-gop-response-obamas-health-care-address/> “The Republican Response to the State of the Union,” *New York Times*, January 27, 2010. <http://www.nytimes.com/2010/01/28/us/politics/28mcdonnell.text.html>

“GOP Leaders McConnell, Boehner, Reply to Obama on Healthcare,” *Los Angeles Times*, July 22, 2009. <http://latimesblogs.latimes.com/washington/2009/07/gop-response-mitch-mcconnell-john-boehner.html>

Paul Starr. *Remedy and Reaction: The Peculiar American Struggle Over Health Care Reform*. (New Haven: Yale University Press, 2011), 23.

⁷²Jim Rutenberg and Jackie Calmes, “False Death Panel Rumor Has Familiar Roots,” *The New York Times*. August 14, 2009. http://www.nytimes.com/2009/08/14/health/policy/14panel.html?_r=0

⁷³ As Alec MacGillis, a Washington Post reporter writes about Obama’s healthcare reform in *Landmark*, “It will reach into almost every corner of the health-care system. But for all its scope, the

The law seeks to expand the number of people covered and begin the work of restraining costs by building on the existing structures of private insurance. This market-based approach bears clear resemblance to the leading Republican alternative to the Clinton plan, to proposals developed by the conservative Heritage Foundation.⁷⁴

Since the Nixon era and in the lead up to Clinton's healthcare reform plans Republicans – when forced by political necessity due to Democratic healthcare reform proposals – have demonstrated a tentative and tenuous pragmatic willingness to consider with some degree of openness near universal or universal health insurance if it maximizes individual choice in picking a health insurer, protects free markets, and minimizes government bureaucracy. Ideological and political polarization, however, contributed to the near total Republican opposition to Obama's healthcare reforms.

1.9 The Evolution of Democratic Healthcare Reform Rhetoric

Despite the moral urgency that healthcare reform presents it has not always been addressed primarily through a moral lens. Although Harry Truman and Lyndon Baines Johnson placed great emphasis on moral obligations and government responsibility to ensure the well being of citizens in their efforts to expand healthcare, more recently, in the discursive struggle that took place between Obama and Republicans Obama favored practical and administrative arguments about efficiency, economic growth, and economies of scale. Republicans advanced a more ideological line of argument, attacking

law is a relatively moderate and incremental document – evolutionary, not revolutionary. It does not seek to replace the country's system of private health insurance with a government run 'single-payer' system such as Canada's – the 'Medicare for all' approach advocated by many American liberals for years, but sharply opposed by insurers and many medical providers... It does not go nearly as far as President Bill Clinton's failed plan in 1993-1994 in trying to set insurance premium levels and medical provider rates."

Landmark: The Inside Story of America's New Health-Care Law and What it Means for Us All, 68.

⁷⁴Ibid.

the notion of an increasingly invasive government that would force Americans to take on health insurance plans against their will and that would purportedly undermine their healthcare and their freedom to choose amongst a range of insurance options. While Obama sometimes made a moral argument for improved healthcare access and quality in his main address to Congress on healthcare reform in 2009 it was not the central argument of his speech, indicating that Obama favored a discursively technocratic and more practically oriented strategy to articulate the necessity of universal health insurance for Americans. This reflected, I argue, a historical shift in the American social imaginary.

We will now transition to examine the history of healthcare reform rhetoric and policy and the reasons why the United States is exceptional amongst wealthy industrialized nations in lacking universal or near universal government guaranteed health insurance until the passage of the Affordable Care Act. We will trace this history from an initial emphasis on positive liberty and social and economic rights by Harry Truman and Lyndon Baines Johnson to one with greater attention paid to economic and pragmatic arguments, rather than moral ones by Bill Clinton and Barack Obama. Their rhetoric, in contrast, shows deference to Republican preferences for limited government and minimal government spending. It reflects Republican rejection of the principles of social and economic rights and in so doing neglects to offer a broad vision of citizen welfare and positive liberty encompassing the full range of human needs: housing, education, employment, and economic assistance to reduce poverty. These were paramount concerns for Truman and Johnson and in which Truman and Johnson's healthcare reform efforts were fully integrated and inextricably linked. What can be found, however, as unifying thread that links the speeches of all four presidents are arguments based on communitarian principles of social solidarity and a concern with maximizing equality of opportunity – though the latter is argued more vigorously in the rhetoric of Truman and Johnson than Clinton and Obama.

Chapter 2 History of American Liberal and Conservative Healthcare Rhetoric and Public Policy

2.1 Historical Efforts to Expand Access to Health Insurance

The first American attempt for the government to universally guarantee health insurance to citizens was endorsed by Theodore Roosevelt in 1912 but nothing substantive came of these tentative and unsustainable efforts. Theodore Roosevelt did not win re-election and thus could not advance the proposed expansion of health insurance of his Progressive Bull Moose Party.⁷⁵ Franklin Delano Roosevelt's New Deal programs were an important precedent for the creation of universal health insurance. Roosevelt initially considered including universal health insurance as part of his package of his New Deal⁷⁶ social insurance and social welfare programs, including Social Security, but ultimately he chose to set it aside and remove it from his legislative agenda because of concern that it would face stiff opposition and potentially prevent the passage of the other measures.⁷⁷ President Harry Truman, another Democrat, took up where Roosevelt left off; he continued to vigorously advocate for and try to create a universal health

⁷⁵Taruna J. Madhav et al. "From Sickness Insurance to Health Insurance." American Academy of Orthopaedic Surgeons. <http://www.aaos.org/news/aaosnow/apr11/advocacy6.asp>

⁷⁶The main aim of the New Deal programs was to generate employment and grow the economy. Even the most moderate proposals for incorporating some form of government sanctioned framework for the expansion of health insurance were met with great hostility by doctors.

"During the Great Depression, the American Medical Association waged a ferocious campaign to prevent federal officials from including national health insurance in the Social Security Act of 1935. The AMA president, Dr. Morris Fishbein, condemned even a modest proposal for "voluntary" private insurance, claiming it smacked of socialism and communism and might incite revolution..."

Jill Quadagno, *One Nation Uninsured: Why the U.S. Has No Health Insurance*. (New York: Oxford University Press, 2005), 7. In 1944 Roosevelt returned to promoting health care now that Social Security had been passed. The 'Economic Bill of Rights' he proposed included 'the right to adequate medical care' and the "opportunity to achieve and enjoy good health." He campaigned on this platform in 1944 and called in his State of the Union address in January of 1945 for 'adequate medical care.' But Roosevelt died later that year and it was Truman who would continue to advance the cause of expanding healthcare coverage.

David Blumenthal and James A. Morone, 2009, 52. For more on Roosevelt's failed efforts to address healthcare reform see Paul Starr's, *Remedy and Reaction*, pages 35-40.

⁷⁷Theda Skocpol, *Boomerang: Clinton's Health Security Effort and the Turn Against Government in US Politics*. (New York: W.W. Norton, 1996), 165.

insurance program as part of his Fair Deal legislation although his efforts did not succeed and legislation to create universal health insurance was never voted upon in Congress.

Truman's efforts, formally announced in his November 1945 address to Congress, were a response to a system of health insurance which depended on workers receiving health insurance through their employers. It left tens of millions of unemployed and/or underemployed Americans without insurance. It also limited labor mobility, as it was too risky to leave one job and search for another with the prospect of months or years in between without insurance. It gave great power to healthcare related corporations and insurers to charge exorbitant fees and practice discrimination against the sick and individuals with conditions predisposing them to disease by refusing to grant them insurance policies. As private insurers grew in the 1950s and 1960s they would increasingly spend large sums of money on marketing and administration which had no positive impact on healthcare quality but drove the price of health insurance up considerably.⁷⁸ These same problems continued to vex the American healthcare system until Obama's healthcare reforms.

However, as mentioned earlier, healthcare reform, specifically healthcare reform with progressive aims to expand coverage to disadvantaged Americans has historically not been the exclusive domain of Democrats, although the impetus for universal health insurance has almost exclusively stemmed from the Democratic party. Expanding access and affordability of health insurance has been an overwhelmingly Democratic legislative and presidential priority with the single greatest expansion of healthcare provision under the Johnson administration in the creation and implementation of Medicare and

⁷⁸ Kant Patel and Mark Rushefsky. *Health Care Politics and Policy in America*. (Armonk: M.E. Sharpe, 2006), 31-38.
Quadagno, *One Nation Uninsured: Why the U.S. Has No Health Insurance*, 44
Starr, *Remedy and Reaction*, 41-43.

Medicaid.⁷⁹ As one considers the history of such attempts at passing universal health insurance it is worth noting that it was none other than Republican Richard Nixon who tried – but failed – to reform and expand access to healthcare to a larger portion of America’s population – though not to all its citizens. It is important to note, however, that the impetus for Nixon’s actions was Edward Kennedy, a Democrat, who had proposed his own plan for universal health insurance. In 1971 Kennedy introduced the Health Security Act calling for universal health insurance through a single-payer plan financed through payroll taxes. In 1972 Nixon introduced the National Health Insurance Partnership Act which, unlike Kennedy’s legislation, was not universal in scope although it would have expanded and improved healthcare access substantially.⁸⁰ Later, Republican Gerald Ford tried to advance these reforms but was also unable to do so and Jimmy Carter also failed to advance healthcare reform. Similarly, Republicans offered their own healthcare reform plans which would have expanded healthcare access in response to Bill Clinton’s Health Security Act legislation to provide universal health insurance, but nothing concrete came of them and they were not as ambitious in both the number of uninsured and underinsured Americans their proposed programs would reach and in the quality and affordability of the coverage to be provided.⁸¹

⁷⁹ Southern Democrats, however, representing states and communities where segregation was enforced and had a wide following amongst whites often rejected healthcare reform and joined with Republicans in efforts to defeat it. They feared healthcare reform would prompt them to forcibly desegregate hospitals and clinics. Quadagno, *One Nation Uninsured*, 33, 204.

⁸⁰ Starr, *Remedy and Reaction*, 50-57.

⁸¹ Theda Skocpol, *Boomerang*, 98, 105. These plans never gained traction and were not priorities of Republicans once Clinton’s healthcare reform efforts were shelved and Republicans preferred to maintain the status quo.

2.2 Policy and Discourse of Proponents of Health Insurance Coverage Expansion

In 1914 the American Association for Labor began drafting legislation to provide workers with free medical care, paid sick leave, and a modest death benefit.⁸² The legislation was introduced in fourteen legislatures. Doctors fiercely opposed it out of concern that it would impede their ability to determine their own fees and thus potentially reduce their profits. Due to their opposition, in most states the legislation failed to advance. The measure gained some traction in California and New York, although in California by 1918 in large part due to the agitation of insurance companies - who feared that it would negatively impact the insurance business - it was defeated.⁸³ In New York the legislation faced a mixed reception. While some doctors – predominantly those from the New York City area supported it, those from more conservative parts of New York state, upstate and in rural areas feared that it would lead to government control over and disbursement of healthcare.⁸⁴ Businesses were weary of potential new taxes, insurance companies were against the death benefits that might cut into their profits, and doctors wanted to prevent the government from regulating their fees.⁸⁵ Organizations such as the American Medical Association, (an association of several hundred thousand doctors,) hospital associations, and insurance companies worked together to defeat the legislation.⁸⁶

Harry Truman similarly faced intense lobbying against his proposed healthcare reforms. In his November 1945 speech to Congress Truman focused on equality of

⁸² Daschle, *Critical: What We Can Do About the Health-Care Crisis*, 47. (New York: St. Martin's Press, 2008), xi.

⁸³ Daschle, *Critical: What We Can Do About the Health-Care Crisis*, 48.

⁸⁴ *Ibid.*

⁸⁵ Theda Skocpol, *Social Policy in the United States*. (Princeton: Princeton University Press, 1995), 279 - 280.

⁸⁶ Quadagno, *One Nation Uninsured*, 11, 16, 212,

opportunity and communitarian solidarity with the most disadvantaged Americans.⁸⁷

Truman was also more willing than Clinton and later Obama to directly attack Republicans and criticize them for misrepresenting his healthcare plan as being ‘socialistic’ and for fear-mongering. He also named and shamed the sectarian interests: doctors and the insurance and healthcare lobby for putting up obstacles to universalizing health insurance. In a radio broadcast he went on the attack using pugnacious language, morally indignant and impassioned, uncompromising in the confidence of the justness of the cause of universal health insurance.

What did the Republicans do with my proposal for health insurance? You can guess that one. They did nothing. All they said was – “Sorry. We can’t do that. The medical lobby says it’s un-American.” And they listened to the medical lobbies in Congress. I put it to you. Is it un-American to visit the sick, aid the afflicted, or comfort the dying? I thought that was simple Christianity. Does cancer care about political parties? Does infantile paralysis concern itself with income?⁸⁸

Truman minced no words by attacking Republicans for impugning the patriotism of Democrats who supported universal health insurance, deriding their rejection of his policy as mere partisanship rather than a principled policy choice, and insisting that the moral issue of equality remained the fundamental one: a low income should not deprive any American of his or her health. His final campaign speech when he ran for election after completing Roosevelt’s term made the moral argument even more explicitly, directly linking Republican refusal to enable universal health insurance to the premature deaths of American citizens.

Each year more than three hundred and twenty five thousand Americans die, whose lives could have been saved if they had proper medical care we know how to provide. This is a greater number of Americans than were killed throughout

⁸⁷ “Truman’s Special Message to the Congress Recommending a Comprehensive Health Program.” <http://www.trumanlibrary.org/publicpapers/index.php?pid=483&st=&st1=>

⁸⁸ David Blumenthal and James A. Morone, *The Heart of Power*, 84.

World War 2. I have been urging the adoption of a national system of health insurance so that the heavy medical expenses of the average family could be paid for out of an insurance fund. This is not socialized medicine. It is plain American common sense!⁸⁹

This type of confrontational fiery oratory would not return under Clinton or Obama, neither its moral clarity and singularity of purpose nor its vehemence. Bill Clinton, in calling for healthcare reform in his February 1993 State of the Union address framed healthcare reform as an economic project saying, “Reforming health care is essential to reducing the deficit and expanding investment.”⁹⁰

All of our efforts to strengthen the economy will fail unless we also take this year – not next year, not five years from now, but this year – bold steps to reform our healthcare system... Reducing health care costs can liberate literally hundreds of billions of dollars for new investment in growth and jobs... I will deliver to Congress a comprehensive plan for health care reform that finally will bring costs under control and provide security to all of our families, so that no one will be denied the coverage they need, but so that our economic future will not be compromised either.⁹¹

Clinton did not relinquish the moral argument, but he made it part and parcel of an economic one and his emphasis was primarily on cutting costs and improving the economy. Barack Obama was reticent about directly criticizing Republicans. He did criticize the healthcare lobby and the insurance industry but only very late into his efforts to pass healthcare reform.⁹² It was a rhetoric which Obama used sparingly and with restraint because of his sometimes strained efforts to project a personal image of transcending partisan politics and because he presented his healthcare plan as a bipartisan initiative. He would also work closely with the healthcare industry to win their support

⁸⁹ Ibid, 85.

⁹⁰ T.R. Reid, *The Healing of America*, 218.

⁹¹ Skocpol, *Boomerang*, 54-55.

⁹² Amy Goldstein and Scott Wilson, “Obama Launches Attack on Health Insurance Companies,” *The Washington Post*, March 9, 2010. <http://www.washingtonpost.com/wp-dyn/content/article/2010/03/08/AR2010030801703.html>

for his healthcare reforms and for the individual mandate requiring Americans to acquire health insurance.⁹³

2.2.1 Richard Nixon's Healthcare Reform Proposal

There is only one Republican president who spoke extensively about the need for increased access to healthcare and made sustained efforts to legislate it, Richard Nixon.⁹⁴ What is notable about the rhetorical strategy he used is its combination of pragmatism and principle, similar in form to the approach that Clinton and Obama later took. In his 1974 speech to Congress proposing his Comprehensive Health Insurance Plan (CHIP⁹⁵) Nixon frames the importance of expanding healthcare to as many Americans as possible in relation to the moral and civic imperatives of American democracy, with particular emphasis on the principle of the government's responsibility to ensure equal opportunity for all Americans to a decent quality of life. He explicitly ties expansion of healthcare to other progressive social causes, a rhetorical approach which Clinton and Obama did not

⁹³Lawrence Jacobs and Theda Skocpol argue that this was necessary to prevent business from unifying against the healthcare reforms as a whole.

Lawrence Jacobs and Theda Skocpol. *Health Care Reform and American Politics: What Everyone Needs to Know*.

But Kevin Donnelly and David A. Rochefort contest that insurers were duplicitous in their commitments to the administration in support of the healthcare reforms. "Even while speaking [insurers] publicly in favor of reform, they maneuvered behind the scenes to help kill or dramatically reshape legislation. According to a report on health reform lobbying activities by the National Journal, AHIP [America's Health Insurance Plans] funneled between \$10 million and \$20 million from a group of the nation's largest insurers to the US Chamber of Commerce to finance attack ads against bills moving through Congress during the summer of 2009."

Kevin P. Donnelly and David A. Rochefort. "The Lessons of "Lesson Drawing": How the Obama Administration Attempted to Learn from Failure of the Clinton Health Plan," *The Journal of Policy History* 24 (2012).

Peter H. Stone, "Health Insurers Funded Chamber Attack Ads," *National Journal*, January 12, 2010. www.undertheinfluence.nationaljournal.com/2010/01/health-insurers-funded-chamber.php

Amy Goldstein and Scott Wilson, "Obama Launches Attack on Health Insurance Companies," *The Washington Post*, March 9, 2010.

⁹⁴ For more on Nixon and healthcare reform see Paul Starr, *Remedy and Reaction*, 52-58. See also *Power, Politics, and Universal Health Care* by Stuart Altman and David Shactman, 27-61. Stuart Altman and David Shactman. *Power, Politics and Universal Health Care: The Inside Story of a Century-Long Battle*. (Amherst: Prometheus Books, 2011.)

⁹⁵ Nixon's CHIP plan is not to be confused with Bill Clinton's CHIP plan which provided health insurance to economically disadvantaged children and stood for 'Children's Health Insurance Program.'

adopt but that would echo Johnson's passage of Medicare alongside other social programs of the War on Poverty and Great Society.

One of the most cherished goals of our democracy is to assure every American equal opportunity to lead a full and productive life. In the last quarter century, we have made remarkable progress toward that goal, opening the doors to millions of our fellow countrymen who are seeking equal opportunities in education, jobs, and voting... Without adequate healthcare, no one can make full use of his or her talents and opportunities. It is thus just as important that economic, racial, and social barriers not stand in the way of good health care as it is to eliminate those barriers to a good education and a good job.⁹⁶

This kind of rhetoric was and is highly exceptional for a Republican, and has become increasingly so since the Reagan era. Its emphasis on social justice, outreach to vulnerable sectors of the population, and its integration of healthcare alongside other social causes such as expanding job opportunity, alleviating poverty, tackling racism and breaking down legal and social barriers to full participation on the basis of equality in American society is all but absent from contemporary Republican rhetoric. Although, as I have noted, Nixon's rhetoric reflected in part tremendous pressure to present a healthcare reform plan because of Edward Kennedy's efforts to do so, it remains significant that Nixon was willing to advocate for such a plan as no Republican president had ever showed such commitment.

Nixon goes on to explain how the high cost of healthcare in the United States is not sustainable, noting that 25 million Americans lack healthcare, and that millions more suffer from lacking coverage which "is balanced, comprehensive, and fully protective."⁹⁷ He then analyzes how underinsurance creates perverse incentives towards higher hospital costs, a lack of adequate preventive care programs, and general waste and inefficiency.

⁹⁶ "Nixon's Plan for Health reform, In His Own Words." Kaiser Health News. <http://kaiserhealthnews.org/Stories/2009/September/03/nixon-proposal.aspx>

⁹⁷ Ibid

After enumerating these predominantly financial concerns he illustrates their devastating human impact.

These gaps in health protection can have tragic consequences. They can cause people to delay seeking medical attention until it is too late. Then a medical crisis ensues, followed by huge medical bills – or worse. Delays in treatment can end in death or lifelong disability.⁹⁸

Acknowledging these gaps in coverage and their destructive consequences is absent from most contemporary Republican rhetoric on healthcare reform. Contemporary Republican rhetoric on healthcare reform focuses on cutting taxes and strengthening the private sector with little attention paid to providing universal and affordable access to healthcare and reducing the waste, administrative costs, advertising expenditures, and money lost to high profit margins that serve insurance companies' economic interests but raise the costs of healthcare substantially, price it out of reach of many Americans, and have no positive impact on the quality of health care.⁹⁹

Despite these liberal arguments and concerns Nixon's plan also shares both the rhetoric and content of current Republican approaches towards healthcare reform with their emphasis on the private marketplace as the main provider of health insurance and on limited government and a small social safety net for the disadvantaged. However, Nixon's plan showed far greater concern with expanding health insurance coverage to tens of millions of Americans, which no Republican plan discussed as an alternative to Obama's healthcare reforms provided. Indeed it is the principle of near-universality (his plan did not have an individual mandate *requiring* all Americans to be insured but it would have reached most uninsured and underinsured Americans) that demonstrates the

⁹⁸ Ibid

⁹⁹ See the addresses of Clinton and Obama. See also the previously cited works by Altman and Shactman, Daschle, Quadagno, Reid, Skocpol, and Starr.

contrast between the willingness of some moderate Republicans to substantially expand health insurance in the 1970s with the increasing antagonism to such government programs since the Reagan era, when Republicans never agreed to this principle in large enough numbers to enable comprehensive healthcare reform. Nixon concludes his speech stating,

The plan that I am proposing today is, I believe, the very best way... But let us not be led to an extreme program that would place the entire health care system under the dominion of social planners in Washington. Let us continue to have doctors who work for their patients, not for the Federal Government. Let us build upon the strength of the medical system we have now, not destroy it. Indeed, let us act sensibly. And let us act now – in 1974 – to assure all Americans financial access to high quality medical care.¹⁰⁰

In his speech he warns of the dangers of creating a ‘huge federal bureaucracy’ if government were to take on too great a role in healthcare provision and insists that private insurers have a central role to play in healthcare provision.¹⁰¹ Once again, these are statements that are similar in content if not quite in tone to those later made by Clinton and Obama when championing their own healthcare plans. There is a clear and unmistakable continuity in both rhetoric and policy content between Nixon, Clinton, and Obama. But as a prominent Republican advocate of expanding healthcare access and improving its quality and cost, no other Republican president or party leader has advanced such a goal so unambiguously and on such a comprehensive scale. Stuart Altman and David Shactman discuss Nixon’s proposed healthcare reforms which centered on an employer mandate to require all employers to offer full time workers health insurance, subsidized insurance to some poor Americans, and a benefit package that had deductibles and coinsurance but with limitations on these total expenditures.

¹⁰⁰ Ibid.

¹⁰¹ Ibid.

Hospital coverage and total annual doctor's visits that were allowed were strictly capped and not as generous as many other health insurance plans. Altman and Shachtman write,

Although the program had shortcomings, it was comprehensive in scope and a radical proposal for a conservative, Republican administration. It is striking to consider how much of its structure and provisions are similar to plans proposed thirty-five years later. Employer mandates, subsidized insurance for the poor, cost sharing, insurance pools, and catastrophic insurance have been included in nearly all subsequent plans."¹⁰²

Thus while the Clinton and Obama plans go substantially beyond the Nixon plan in their aims and comprehensiveness it is noteworthy that many of the core ideas of the Nixon plan informed those of Clinton and Obama.

2.3 Discourse of Opponents of Health Insurance Coverage Expansion

Emotionally laden discourse rather than fact centered discourse justified with evidence has characterized critiques of universal healthcare legislation since their initial, tentative state-based efforts in 1914. Although the explicitness of such rhetoric has somewhat muted since its more excessive qualities at the peak of America's Cold War with the Soviet Union in the 1950s - when fear of Communism reached a zenith and was a major component of political discourse and campaigning¹⁰³ - the overall tone and content remain remarkably similar and consistent. The fear of socialism and the specter of 'socialized medicine,' (always an imaginary specter and all the more potent for being imaginary) or of any such similarly worded phrase became the most powerful and prevalent signifier in healthcare related discourse throughout the twentieth and into the twenty-first century. It would be used relentlessly and successfully to thwart attempts to create universal health insurance by doctor, hospital, and insurance associations and

¹⁰²Shachtman, 43.

¹⁰³Quadagno, *One Nation Uninsured*, 41-42. Patel and Rushefsky, *Healthcare Politics and Policy in America*, 34.

companies and their political allies.¹⁰⁴ The image of the government as a behemoth potentially strangling the freedom of Americans, as individuals and as owners of businesses in conservative rhetoric against healthcare reform remains paramount.

The American Association of Labor Legislation, which initiated the major federal effort to create universal health insurance for all Americans in the 1910s was the first amongst many liberal-minded advocates and later politicians who failed to register the role of ideology and rhetoric in the efforts of various sectors of American business, politics, and society to reject universal healthcare.¹⁰⁵

Both in the 1910s and in the 1930s and 1940s, experts and reformers relied upon rational analyses and arguments about how to solve problems of efficiency or access. Reformers were confident that time was on their side, and that public health insurance (of one sort or another) would ‘inevitably’ be enacted in the United States. But each time, not only were there powerful opponents to reform but debates also quickly took a bitterly ideological turn. This tactic was not expected by the rationally minded experts and led to defeats for proposals that might well have gained broad citizen support, had they been more calmly discussed – or effectively dramatized – in the national political process.¹⁰⁶

While conservatives always proved adept at stoking fears and anxieties that efforts to create universal health insurance would undermine the quality of healthcare and limit patient access, liberals never managed to convincingly articulate how in the absence of reform Americans would have genuine cause for fear. The exponential increase in healthcare costs; discrimination against the sick and those with pre-existing conditions

¹⁰⁴ The use of the terms communism and socialism as epithets to hurl at healthcare reform efforts continues. Republican Devin Nunes of California commented on the Patient Protection and Affordable Care Act with vehemence, “For most of the twentieth century, people fled the ghosts of Communist dictators. Now, you are bringing the ghosts back into this chamber. With passage of the bill, they will haunt Americans for generations... Today, Democrats in the House will finally lay the cornerstone of their socialist utopia on the backs of the American people.”

Kevin P. Donnelly and David A. Rochefort. “The Lessons of “Lesson Drawing”: How the Obama Administration Attempted to Learn from Failure of the Clinton Health Plan.” *The Journal of Policy History* 24 (2012): 210.

¹⁰⁵ Skocpol, *Social Policy in the United States*, 281.

¹⁰⁶ *Ibid.*

that private insurance companies systematically deny for insurance; and the fact that by now roughly 50 million Americans are uninsured and tens of millions of others are underinsured and risk bankruptcy,¹⁰⁷ poverty, homelessness, and family instability as a result are all real threats facing large numbers of Americans. But these concrete, immediate, and ongoing injustices have not been as alarming to Americans as the ill-defined and imagined specter of ‘socialized medicine.’ As Theda Skocpol writes, “Advocates of health care reforms in the 1990s have more to explain to a sceptical citizenry about why *government* can provide desirable solutions to widely felt problems.”¹⁰⁸ As we will see later, this is precisely what Bill Clinton and Democrats failed to do in 1993 and 1994 at which time American political and public culture had been saturated with scepticism, hostility, and outright demonization of government under the conservative presidencies of Ronald Reagan and George W. Bush.

2.3.1 The False Specter of Socialism

The rhetoric Harry Truman faced in response to his efforts to pass universal healthcare starkly illuminates the rhetoric of fear and anxiety that have historically dominated conservative responses to healthcare reform. A 1945 US Chamber of Commerce pamphlet entitled, “You and Socialized Medicine,” claimed that the government sought to take, “another step toward further state socialism and the totalitarian welfare state prevailing in foreign lands.”¹⁰⁹ The use of the word ‘totalitarian’ was particularly excessive and defamatory, an explicit way of creating spurious associations between efforts to create universal healthcare and gross violations of human

¹⁰⁷Teresa A. Sullivan et al. *The Fragile Middle Class: Americans in Debt*. (New Haven: Yale University Press, 2001).

¹⁰⁸ Skocpol, *Social Policy in the United States*, 289.

¹⁰⁹ As cited in Quadagno, *One Nation Uninsured*, 37.

Socialized Medicine: A Medical OPA, p. 3, 1949, Taft Papers, Box 643, File: Health: - National Program for Medical Care (S. 1679-S.1581).

rights entailing violence and the absence of due process. The Chamber attacked Truman's plan claiming that it would "lead to the widespread destruction of our voluntary institutions", and would create government employees who would yield "dangerous political power," that would "jeopardize our civil liberties."¹¹⁰ The Journal of the American Medical Association (AMA) similarly fulminated that, "If this Old World scourge is allowed to spread to our New World [it will] jeopardize the health of our people and gravely endanger our freedom."¹¹¹ It further characterized Truman's proposed plan for universal health insurance in a pejorative and deceptive way stating that it, "... is the first step toward a regimentation of utilities, industries, of finance, and eventually of labor itself. This is the kind of regimentation that led to totalitarianism in Germany and the downfall of that nation."¹¹²

The American Medical Association vigorously attacked Truman's plan and labelled it 'socialized medicine' while engaging in outright defamation and demagoguery by calling the Truman White House "Followers of the Moscow party line."¹¹³ Hospitals, businesses, and healthcare insurers also attacked Truman's healthcare reforms. These accusations of socialism increasingly featured in attacks against Truman's healthcare reform plan and similar ones would be recycled during the Johnson, Clinton, and Obama eras again – this time, with far greater intensity and widespread social acceptance as anti-government rhetoric became increasingly prevalent.¹¹⁴ Indeed just a few years before

¹¹⁰ As cited in Quadagno, *One Nation Uninsured*, 7 & 8.

Chamber of Commerce, *You and Socialized Medicine* (pamphlet) p. 3, Taft Papers, Box 640, Legislative Files, File: Health Legislation, 1945.

¹¹¹ As cited by Quadagno, *One Nation Uninsured*, 7. Statement on Truman Health Plan, *Journal of the American Medical Association* 146 (1949): 114.

¹¹² As cited in Alan Derickson, "Health Security for All: Dreams of Universal Health Care in America," (Baltimore: Johns Hopkins University Press, 2005), 94. *JAMA – Journal of the American Medical Association*, 129 (1945): 950-953.

¹¹³ President Truman's Proposed Health Program, <http://www.trumanlibrary.org/anniversaries/healthprogram.htm>

¹¹⁴ However, such attacks during the Truman era were but one cause of Truman's failure to win legislative passing of his healthcare reforms. Internal divisions within the Democratic Party played a major role in wrecking the chances of Truman's legislation being passed. Southern Democrats committed to racist segregation feared that hospitals and clinics in the south would be forced to

Johnson successfully passed Medicare and Medicaid Ronald Reagan released an LP voice recording in which he skewered universal health insurance as an assault on the freedom of Americans. Reagan stated,

One of the traditional methods of imposing statism or socialism on a people has been by way of medicine. It's very easy to disguise a medical program as a humanitarian project, most people are a little reluctant to oppose anything that suggests medical care for people who possibly can't afford it.¹¹⁵

He argued, even more inflammatorily, that if government guaranteed universal health insurance a tyrannical socialism would become policy in the United States,

behind it will come other government programs that will invade every area of freedom as we have known it in this country until one day as Norman Thomas said we will wake to find that we have socialism... We are going to spend our sunset years telling our children and our children's children, what it once was like in America when men were free.¹¹⁶

Such emotionally manipulative scare tactics and misinformation campaigns have been a hallmark of conservative attacks on universal healthcare.¹¹⁷

In these rhetorics one consistently finds an emphasis on the absolute value of the negative liberty of the right to opt out of insurance and not to have any government guidance or role in even some of healthcare's delivery. There is no acknowledgment of the positive liberty of a right to health insurance which enables an individual to significantly increase his quality of life, both physical and psychological as well as to promote the stability and welfare of families and communities alike. Guilt by association

desegregate if universal healthcare was passed and so they vociferously opposed his proposed legislation. Fierce Republican opposition to the reform also played a role in preventing the passage of Truman's legislation.

Quadagno, 2006.

¹¹⁵http://en.wikipedia.org/wiki/Ronald_Reagan_Speaks_Out_Against_Socialized_Medicine

See also Nicholas Lemann, *New Yorker*, "Kennedy Care", September 7, 2009.

http://www.newyorker.com/talk/comment/2009/09/07/090907taco_talk_lemann.

¹¹⁶ Ibid

¹¹⁷ Skocpol, *Boomerang*.

(and spurious association at that) became a dominant theme of anti-health insurance rhetoric, with slanderous accusations that government guarantee of health insurance is a central plank of all forms of totalitarianism and authoritarianism and that the provision of government guarantee of health insurance to all Americans would increase the likelihood or even make inevitable a collapse of American democracy and the rights and freedoms it protects. House Republicans argued that,

Wherever some form of dictatorship prevails in government, there we also find some manifestation of socialized medicine. The brand name of dictatorship makes no difference – Communism, Fascism, Nazism, Socialism – all are alike in that they enforce a system of State Medicine.”¹¹⁸

Conservative rhetoric depicted an apocalyptic scenario and burned with rage at the impending consequences of government inserting itself into every domain of American life. There was no substantiation of these claims, no reasoning offered, nor any historical reflection on how earlier government efforts to regulate health and safety for workers amongst other issues had never, in fact, caused such a collapse of liberty. Articles in the press sympathetic to Republicans and the insurance and healthcare industry warned of an impending menacing threat,

The medical profession and all our hospitals can be taken over by the federal government and forged into a new gigantic health bureaucracy... it would only be a matter of time until Washington likewise moved into the fields of education, religion, the press, the radio. Freedom soon would be in total eclipse.¹¹⁹

Truman later reflected in his memoirs about this type of rhetoric and its negative impact on his efforts,

¹¹⁸ Quadagno, *One Nation Uninsured*, 31.

¹¹⁹ Quadagno, *One Nation Uninsured*, 32. For more on conservative characterizations of healthcare reform as being aggressively socialist and a danger to freedom see Paul Starr, *Remedy and Reaction*, 45.

I cautioned Congress against being frightened away from health insurance by the scare words of ‘socialized medicine,’ which some people were bandying about. I wanted no part of socialized medicine, and I knew the American people did not... I had no patience with the reactionary selfish people and politicians who fought year after year every proposal we made to improve the people’s health.¹²⁰

This misrepresentative rhetoric served those individuals and groups and their political allies who had vested interests in preventing the establishment of universal health insurance; insurance companies, hospitals and doctors, businesses weary of large scale government welfare legislation,¹²¹ and some unions who wanted to have greater control over healthcare and to negotiate healthcare plans directly with employers.¹²² “In the fractious atmosphere of the Cold War, national health insurance became identified with subversion... the ideal of universal entitlement to care faded from view in the twenty years after World War 2.”¹²³ In a period of just four years Americans had come to question the value and efficacy of Truman’s efforts. Opponent’s efforts steadily eroded support for President Truman’s plan. In 1945, 75 percent of Americans said they supported national health insurance, but by 1949 only 21 percent did.”¹²⁴

The AMA’s discursive struggle was to frame government guarantee of health insurance as something to fear that was not only potentially dangerous, but that was malevolent in intent. There was no acknowledgment of the values of equality of opportunity, communitarian social solidarity, and respect for a right to decent health and the liberty that such health enables in AMA rhetoric. In this way the AMA never entered into debate about the real moral and civic issues that inspired activists and politicians

¹²⁰ Daschle, *Critical: What We Can Do About the Health-Care Crisis*, 53-54. See also the Book Review of *Deadly Spin* by Wendell Potter in the Daily Kos website.

<http://www.dailykos.com/story/2010/12/06/925987/-Book-Review-Deadly-Spin-by-Wendell-Potter>
¹²¹ “G.M. President Charles E. Wilson viewed national health insurance as a threat to the free market and the autonomy of business owners, and he hoped companies would sidestep it by providing insurance themselves.” Sixty years later GM would be struggling to maintain financial solvency because of the huge costs of providing health insurance to its employees.

Daschle, *Critical: What We Can Do About the Health-Care Crisis*, 54.

¹²² Starr, Paul. *Remedy and Reaction: The Peculiar American Struggle Over Health Care Reform*, 32.

¹²³ Derickson, *Health Security for All*, 101.

¹²⁴ Daschle, *Critical: What We Can Do About the Health-Care Crisis*, 23.

seeking to guarantee health insurance to all Americans. Clem Whitaker, a public relations expert hired by the AMA outlined his rhetorical strategy of delegitimization of healthcare reform to enable universal provision,

All you have to do is give it a bad name, and have a Devil. America's opposed to socialism so we're going to name national health insurance 'socialized medicine.' And we've got to have a devil. We first thought of making President Truman the devil, but he's too popular.¹²⁵

At an AMA Convention in 1949 he offered a sample of this rhetoric to inspire conference attendees to mobilize against government backed healthcare reform.

The fight that American medicine is waging is a fundamental struggle against government domination... The trend toward State-ism in America has become unmistakable... it is only a short step from the 'Welfare State' to the 'Total State,' which taxes the wage earner into government enslavement, which stamps out incentive and soon crushes individual liberty.¹²⁶

Under Truman, the AMA's rhetoric and its denial (or, rather, its total ignoring) of the moral and civic issues at stake when tens of millions of Americans lack access to healthcare was steadfast and uncompromising. By the 1970s, however, even the AMA grudgingly would acknowledge that there are flaws in America's provision of health care, and that one of the most glaring of these flaws is the lack of coverage of millions of Americans. The interests of businesses, insurers, and hospital and doctor associations changed in relation to their fears of the possibility of regulations that would impede their profits even more than government guarantee of universal health insurance and, in particular, the exasperation of businesses that they were facing unsustainable healthcare

¹²⁵ As cited by Quadagno, *One Nation Uninsured*, 35. Address of Clem Whitaker, Minutes of the Annual Session of the House of Delegates, American Medical Association, Atlantic City, June 6-10, 1949 reprinted in *Journal of American Medical Association*, June 18, 1949, p. 696. Speeches against healthcare reform were but one component of the AMA's attacks on Truman's proposed reforms. "The public relations firm of Whitaker and Baxter placed advertisements in more than 10,000 newspapers and distributed more than 50 million pieces of literature. This onslaught devastated what remained of the Fair Deal initiative for national health insurance," Derickson, *Health Security for All*, 2005, 109.

¹²⁶ Quadagno, *One Nation Uninsured*, 35.

costs which they now preferred the government would have a role in subsidizing or at least bringing down.¹²⁷

2.3.2 Unions and Corporations

By the time the Clintons introduced universal health insurance legislation¹²⁸ and by the time Obama did as well, unions, many businesses, and large numbers of doctors and hospitals both publicly and privately supported it. Indeed it was already under Richard Nixon that many businesses had aligned themselves with federal plans enabling universal health insurance.¹²⁹ But insurance companies remained overwhelmingly against it and their financial resources and levels of political organization continued to powerfully militate against the possibility of the creation of universal health insurance.

One of the key differences between how provision of health insurance was established in the United States and Europe was the role of unions.¹³⁰ In the United

¹²⁷ “Insurance companies are concerned because competition among them is increasingly focused on finding ever-smaller pools of healthier people to insure. Fearing that public resistance to the exclusion of people with preexisting conditions will fuel tough new regulations that further undercut their already tenuous profits, many large insurers are now acknowledging the inevitability of reforms... Many employers, too, are willing to join government in a quest for cost containment. Large businesses, especially those in unionized industries that already provide employer-sponsored benefits, find their costs rising astronomically and uncontrollably, while small businesses often find it impossible to obtain coverage for their employees at any reasonable cost.” Skocpol, *Social Policy*, 275. For more on the rising costs of businesses and their resulting interest in healthcare reform also see Cathie Jo Martin, “Stuck in Neutral: Big Business and the Politics of National Health Reform,” *Journal of Health Politics, Policy, and Law* 20 (1995).

¹²⁸ For a discussion of the political context in which Bill Clinton proposed his healthcare reforms and the challenges he faced see Chapter 7.

¹²⁹ Nixon’s National Health Insurance Partnership Act aimed to preserve the private insurance market while requiring employers to either cover their workers or make payments into a government insurance fund. This “employer mandate” was endorsed by the Washington Business Group on Health, which was comprised of two hundred corporations, and the National Leadership Coalition for Health Care Reform, which included executives from Chrysler, Bethlehem Steel, Lockheed, Safeway, Xerox, and Georgia Pacific. Ford tried to get Nixon’s plan passed, but it failed. “The AMA and the National Federation of Independent Business denounced it as socialized medicine, and the AFL-CIO viewed it as a sell-out.” Quadagno, *One Nation Uninsured*, 115.

¹³⁰ For an overview of how unions have contributed to the private-sector health safety net in the United States in which employment is the main source of health insurance, and how this has hindered the advancement of universal healthcare see Marie Gottschalk, “The Elusive Goal of Universal Health Care in the US: Organized Labor and the Institutional Straightjacket of the Private Welfare State,”

States, unions were happier to negotiate their own health insurance from their employers and many advanced a sectarian line based on narrow self-interest that prioritized the needs of workers over other Americans. Tom Daschle writes that, Samuel Gompers, president of the American Federation of Labor, denounced the early aforementioned proposal to create a government guarantee of healthcare for workers in New York state in 1918 as a “menace to the rights, welfare, and liberty of American workers.”¹³¹ According to Daschle, unions were confident that they could secure better coverage for workers this way and more generous provisions such as pensions and disability benefits than through any universal nationalized plan.

In contrast, in Europe unions worked on the assumption that government backed universal health insurance would be the best outcome for workers and thus the interests of workers and non-workers alike overlapped and unions supported government backed universal health insurance.¹³² Ironically, even though union leaders in the United States thought they were advancing social and economic justice by driving tough bargains and ensuring that American workers had quality health insurance in the long term they were creating a system that would prove to be economically unsustainable for large businesses with negative consequences for workers. It would lead to more expensive health insurance plans for workers as businesses cut the quality and comprehensiveness of health insurance due to the rising costs of health insurance. In future years, workers would increasingly lose their jobs due to layoffs which became a persistent trend in the last decades of the twentieth century. They remain so today, as corporations maximize profits by reducing the workforce, demanding greater productivity, and moving manufacturing outside of the United States. Many of America’s uninsured are former workers who are now jobless. With time, the unions changed their

Journal of Policy History 11 (1999). See also Colin Gordon, “Dead on Arrival: The Politics of Health Care in Twentieth Century America”, (Princeton: Princeton University Press, 2003), 60.

¹³¹ Quadagno, *One Nation Uninsured*, 8.

¹³² Daschle, *Critical: What We Can Do About the Health-Care Crisis*, 55.

strategy, generally being more open to universal health insurance, rather than maintaining their prior commitment to negotiating for employer based healthcare at the exclusion of mobilizing for universal health insurance for all citizens.¹³³ This is in part because unions are now much weaker than in the pre and immediate post World War 2 years with a far smaller percentage of American workers unionized than at any time over the last 70 years. Still, some unions have continued to express scepticism about universal health insurance.¹³⁴

2.4 Republicans Reject Social and Economic Rights: The Reagan Era and Beyond

With the rise of President Reagan, Republicans challenged the philosophy of government comprehensively guaranteeing the welfare of citizens, and government expenditures on social programs were cut substantially through changes in how the federal government distributed funding for social programs, with the federal government favoring block grants directly to the states which allowed for greater state decision making of how funds would be spent but generally lowered overall federal allocations for a broad spectrum of social welfare programming¹³⁵ The new government focus was on

¹³³ Some major unions, such as the AFL already underwent this shift early on, in the 1940s when they supported Truman's proposed reforms after being vociferously against universal healthcare in earlier years. Quadagno, *One Nation Uninsured*, 8 & 49. In the wake of the Great Depression major unions including the AFL began to call for universal health insurance. AFL President, William Green, called in 1937 for "plans for providing adequate medical services for all" and rejected the union stance under Gompers that preferred employer based health insurance to universal health insurance.

Alan Derickson, *Health Security for All: Dreams of Universal Health Care in America*, 74. Derickson also notes that during much of the Roosevelt presidency the power of unions grew tremendously, with union membership tripling between 1933 and 1941 and an increasingly active and public union membership prone to strikes and dramatic forms of organizing and public action and that by this point major unions strongly supported universal healthcare insurance. The AFL, CIO and United Auto Workers all advocated for universal health insurance vigorously and publicly. 81-82. Very quickly, however, by the late 1940s, union leaders realized that universal health insurance had no chance of passing Congress, and transitioned to focusing on collective bargaining agreements for health care for workers. Derickson, *Health Security for All*, 111.

¹³⁴ Quadagno, *One Nation Uninsured*, 204.

¹³⁵ Robert Collins, *Transforming America: Politics and Culture During the Reagan Years*. (New York City: Columbia University Press, 2009).

lowering taxes and cutting government funded social programs. Reagan insisted that government spending needs to be reined in and attacked government spending – as this was crucial to the moral order and social imaginary of limited government that he advocated. But the gap between his rhetoric and policies was substantial. Reagan raised taxes many times, spent massively on the military, and drove up the deficit.¹³⁶

Iwan Morgan explains that Reagan was largely successful in advancing this conservative agenda. “He pushed through enough of his fiscal agenda to shift public policy from the liberal course of the New Deal order in the direction of a new antistatism.”¹³⁷

These efforts were sometimes accompanied by rhetorical attacks on economically and socially disadvantaged populations depicting them as dependent on the government and exploitative of it. Reagan coined the derogatory phrase ‘welfare queen’ which cast a harsh and hateful light on women on welfare, and many listeners inferred from it that it was an attack on African-American women in particular. In a speech he made in 1976 when he was running for office, Reagan introduced the term and would use it many times when campaigning. “There’s a woman in Chicago, she has 80 names, 30 addresses, 12 Social Security cards... She’s got Medicaid, getting food stamps and she is collecting welfare under each of her names. Her tax-free cash income alone is over \$150,000.”¹³⁸

As elected president, Reagan hammered home on the idea that government is intrinsically bureaucratic, wasteful, and often cannot be trusted and is a threat to liberty. He did this on formal occasions such as State of the Union addresses, when he stated during his first State of the Union address, outlining his governing ideology,

Timothy Conlan. “The Politics of Federal Block Grants: From Nixon to Reagan.” *Political Science Quarterly*, 99: 1984.

¹³⁶Collins, 2009. See also Michael Espinoza, “Myth, Memory, and the Reagan Legacy: Taxes and the GOP,” *49th Parallel*, 31: 2013. <http://www.49thparallel.bham.ac.uk/back/issue31/Espinoza.pdf>

¹³⁷ Iwan Morgan, *The Age of Deficits: Presidents and Unbalanced Budgets from Jimmy Carter to George W. Bush*, (Lawrence: University of Kansas Press, 2009.) x.

¹³⁸ John Blake, “Return of the Welfare Queen.” January 23, 2012. *CNN*. <http://edition.cnn.com/2012/01/23/politics/welfare-queen/index.html>.

Kaaryn Gustafson, *Cheating Welfare: Public Assistance and the Criminalization of Poverty*. (New York: New York University Press, 2012).

“Government is not a solution to our problem, government is the problem”¹³⁹ And he did it more casually throughout his presidency, creating a potent anti-statist, anti-government record that often manifested itself less as critique than as ad hominem attack rarely with nuance or context. Such characterization of government often lacked specific supporting facts but had about it an air of snappy truism, making unsubstantiated claims seem plausible if not downright common knowledge because he stated them with such confidence and conviction, asserting them without feeling the need to support the claims. There were statements of political philosophy such as “I hope we once again have reminded people that man is not free unless government is limited. There’s a clear cause and effect here that is as neat and predictable as the law of physics: As government expands, liberty contracts.”¹⁴⁰ And, “The basis of conservatism is a desire for less government interference or less centralized authority or more individual freedom and this is a pretty general description also of what libertarianism is.”¹⁴¹

The rhetoric remains largely the same today amongst Republicans, but ever since the 1994 Contract with America it has become substantially more extreme.¹⁴² Sometimes it is more shrill - sometimes carefully implicit – but with even more dramatic plans for government cutbacks on social expenditures on programs such as healthcare, housing, education, and other social programs that were at the heart of Truman’s Fair Deal and Johnson’s War on Poverty and Great Society. One exemplar of this anti-government rhetoric – which represents a significant strand of contemporary Republican ideology - is former vice-presidential candidate Paul Ryan. Ryan defines liberty primarily in a negative

¹³⁹Ronald Reagan. 1981. Inaugural Address. Available at, <http://www.reagan.utexas.edu/archives/speeches/1981/12081a.htm>

¹⁴⁰Matthew Lysiak and Bridget Reddan, *The Choice: Ronald Reagan versus Barack Obama and the Campaign of 2012*. (Gadfly Publishing, 2012).

¹⁴¹ Reagan, Ronald. <http://reason.com/archives/1975/07/01/inside-ronald-reagan>
Reagan, Ronald. 1981. Inaugural Address. Available at <http://www.reagan.utexas.edu/archives/speeches/1981/12081a.htm>.

¹⁴² Prominent Republicans including Jeb Bush, Bob Dole, and William Kristol have acknowledged the increasing extremism of the party and expressed concern about its viability and wisdom. Thomas B. Edsall, “Has the GOP Gone Off the Deep End?” *The New York Times*, July 17, 2013, <http://opinionator.blogs.nytimes.com/2013/07/17/has-the-g-o-p-gone-off-the-deep-end/>

way¹⁴³ and argues vociferously against federal government programs to address social needs such as poverty reduction, housing expansion, and increased access to education.

We believe that the government has an important role to create the conditions that promote entrepreneurship, upward mobility, and individual responsibility. We believe, as our founders did, that "the pursuit of happiness" depends upon individual liberty; and individual liberty requires limited government.¹⁴⁴

Ryan attacks Democratic efforts to actualize greater equal opportunity, inaccurately depicting federal efforts as 'centralized solutions' when in fact many of the programs of the Great Society (some of which are still in place) were federally funded but with a great emphasis on local and state control and implementation and grassroots community development, as we will see in Chapter 5.

What was once a system of limited government has insidiously evolved into one with virtually no limits at all. From the New Deal through the Great Society and beyond, wherever a "national priority" arose--such as housing, education, or energy--we addressed the problem by centralizing solutions into new federal bureaucracies which are designed [to] steer and micro manage these priorities in our society.¹⁴⁵

Although Ryan acknowledges the importance of 'upward mobility' he provides no significant policy role for the government in enabling upward mobility nor does he provide evidence for how, in the absence of government, such mobility will be enabled. He makes general and unsupported claims about business growth, economic expansion,

¹⁴³ See also Ryan's 2012 Republican National Convention Speech. Extracts from State of the Union Republican Response 2011 and Republican National Convention, 2012.

Ryan, Paul. Website and related policy and political ideology statements.

<http://budget.house.gov/prosperity/truhtonmedicare.htm>

<http://budget.house.gov/prosperity/fy2013.htm>

Paul Ryan, http://www.ontheissues.org/2012_RNC.htm.

¹⁴⁴ Ryan, 2011

¹⁴⁵ Ryan, 2012.

and charitable and communal support – none of which can provide social goods such as affordable universal health insurance to all citizens.

2.5 Major Healthcare Reform Policy Milestones

Although Harry Truman was unable to achieve passage of legislation for universal health insurance, during his administration preliminary steps were made to expand healthcare provision across the nation. In particular, congressional legislation expanded hospital and clinic construction, increasing access to healthcare substantially across the country. The Hill-Burton Act - also known as the 1946 Hospital Survey and Construction Act established a federal program of financial assistance for the modernization and construction of hospital facilities. The program brought national standards and financing to local hospitals, and raised standards of medical care throughout the United States during the course of the fifties and sixties. While the legislation favored middle-class and wealthy communities because it required local financial contributions, it channeled federal funds to poor communities, thus raising hospital standards and equity in access to quality care. The program required hospitals assisted by federal funding to provide emergency treatment to the uninsured and a reasonable volume of free or reduced cost care to poor Americans – major policy achievements with far reaching effects for the indigent in need of medical care.¹⁴⁶

Perhaps the most significant historical moment in the history of healthcare reform, alongside Obama's Affordable Care Act, was the creation of Medicare and

¹⁴⁶See Altman and Shachtman, 111-121 for details on the Hill-Burton program. Despite its successes, many hospitals ignored the law's provisions which were often poorly enforced. This was particularly true in hospitals that followed formal or informal racist policies of admission and treatment, denying African-Americans care and/or segregating them once in hospital and often offering them lower quality care than that offered to whites. Beatriz Hoffman details the ways in which the promise of this law often went unmet. See pages 71-89 of Hoffman's *Health Care for Some*. Beatriz Hoffman, *Healthcare for Some: Rights and Rationing in the US Since 1930*, (Chicago: University of Chicago Press, 2012).

Medicaid in 1965 under Lyndon Baines Johnson which made healthcare affordable and accessible to tens of millions of Americans. Medicare guarantees healthcare to all Americans 65 and over and Medicaid provides health care to extremely indigent Americans, providing healthcare to tens of millions of Americans who would otherwise lack it. However, it excludes many disadvantaged Americans who, while technically less poor than Medicaid recipients, are deprived of health insurance because with their relatively minimal financial resources they cannot afford to buy themselves health insurance. Many such individuals work full time, earn minimum wage, and still struggle to meet their basic needs.¹⁴⁷ It also primarily serves indigent parents of children. Many disadvantaged adults who do not have children and/or are not disabled receive no Medicaid support.¹⁴⁸ Two years after Medicaid was created “only 40% of childhood chronic conditions were being treated in low income areas¹⁴⁹” and Medicaid has failed to teach tens of millions of impoverished Americans in need of subsidized or free medical care but unable to receive it due to the severe limitations placed on who qualifies for Medicaid and the parsimonious nature of most state’s Medicaid which reach a fraction of the poor who need it.¹⁵⁰ As Jonathan Engel writes,

Medicaid is a flawed program, and has always been. . . Medicaid has had systemic problems which have never been wholly corrected. For most of its history, the program did not reimburse providers at rates competitive with private insurance and Medicare; it never covered all the nation’s poor; and it failed to provide consistent standards between the different states’ Medicaid plans.¹⁵¹

¹⁴⁷These individuals form a major part of ‘working class’ and ‘economically disadvantaged’ Americans to which I refer throughout the thesis.

¹⁴⁸ <http://www.governing.com/topics/health-human-services/Enrolling-Child.html>

Some states, however, use their own funds to provide insurance and/or financial subsidies for insurance to indigent childless adults.

¹⁴⁹ Jonathan Engel, *Poor People’s Medicine: Medicaid and American Charity Care since 1965*, (Durham: Duke University Press, 2006.) 86.

¹⁵⁰ Jonathan Engel, *Poor People’s Medicine: Medicaid and American Charity Care Since 1965*.

¹⁵¹ Engel, 248. Laura Katz Olson similarly analyzes the failures of Medicaid to meet the needs of impoverished Americans. See Laura Katz Olson, *The Politics of Medicaid*, (New York: Columbia University Press, 2010.)

Medicare was influenced by the increasingly universal Canadian system of health insurance (by the mid 1970s Canada had established universal health insurance) but in the United States Medicare exclusively serves seniors. Also notable in the history of the provision of healthcare in the United States is the Indian Health Service which provides healthcare provision to Native Americans and the Veterans Health Administration, both of which are similar to centralized national healthcare programs such as Britain's National Health Service. The creation of Medicare and Medicaid marked the largest government interventions to guarantee healthcare to a substantial percentage of the American people. Several decades later, some states such as Hawaii¹⁵² and Massachusetts¹⁵³ created their own plans to expand health insurance coverage to their most disadvantaged residents on a near universal basis.

Another major advance in increasing healthcare provision in the United States to disadvantaged Americans was the creation of the CHIP program, the Children's Health Insurance Program which provides health insurance for over five million indigent children across the United States. It was recently renewed in 2009 with funding provided until 2013 to continue to enable disadvantaged children to receive health insurance. CHIP was initiated in 1997 and has disbursed over 40 billion dollars to fund insurance for uninsured American children.¹⁵⁴ Like Medicaid, it is a state administered program and every state has its own guidelines for services and benefits, with wide disparities amongst states in terms of effectiveness of their efforts to administer the program and ensure maximum participation. It has had great success in expanding insurance but

¹⁵² D Neubauer. "State Model: Hawaii. A Pioneer in Health System Reform." *Health Affairs* 12 (1993): 31-39. <http://content.healthaffairs.org/content/12/2/31.full.pdf>

¹⁵³ Massachusetts Healthcare Reform History. http://www.umassmed.edu/chle/expertise/ma_health_care_reform/history.aspx?linkidentifier=id&itemid=73036

¹⁵⁴ Website describing CHIP child health insurance program.

<http://www.cms.gov/NationalCHIPPolicy/>

<http://www.cms.gov/CHIPRA/>

http://www.cms.gov/NationalCHIPPolicy/06_CHIPAnnualReports.asp#TopOfPage

<http://www.cms.gov/NationalCHIPPolicy/downloads/CHIPFY2001ReportToCongress.pdf>

implementation challenges remain in reaching uninsured children who have the right to insurance but whose parents are not aware of this opportunity to enrol their children in a free healthcare program, have difficulty doing so, or choose not to initiate the process of enrolling their children in the CHIP program. 25% of Hispanic children, for example, lack coverage.¹⁵⁵ CHIP has received the support of Republicans and Democrats alike and while Republican support has been less enthusiastic and wide-scale than Democratic support, CHIP remains an unusual example of bipartisan legislation to expand access to healthcare to the most disadvantaged US citizens.¹⁵⁶ Orrin Hatch and Chuck Grassley, both Republican Senators, played a major role in initiating and advancing CHIP legislation.

Under Ronald Reagan's presidency, COBRA legislation was passed allowing for health insurance portability for a period of several years once an individual has left one job but is still in search of employment, which potentially increases healthcare security for millions of Americans changing jobs due to the fluidity of the American labor market although it does not address the problem of unduly high costs that many individuals cannot meet. So too was the Emergency Medical Treatment and Active Medical Labor Act, which gave individuals "an explicit right to emergency medical treatment by hospitals that participate in Medicare."¹⁵⁷

¹⁵⁵ Gulnur Scott and Hanyu Ni, "Access to Health Care Among Hispanic/Latino Children: United States, 1998-2001," *Advance Data from Vital Health Statistics* 344 (2004): 3.

¹⁵⁶ Government records of Legislators involved in creation and support of CHIP legislation.
http://hatch.senate.gov/public/index.cfm?FuseAction=PressReleases.Detail&PressRelease_id=19bbc7f-1b78-be3e-e037-5878ab10d5bf&Month=1&Year=2009
http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=111&session=1&vote=00031#top

<http://clerk.house.gov/evs/2009/roll016.xml>

¹⁵⁷ Paul Starr, *Remedy and Reaction*, 68.

2.6 American Exceptionalism: Why the US Did Not Guarantee Near Universal Health Insurance Until the Patient Protection and Affordable Care Act

There is an extensive literature on why the United States remains the only Western, industrialized country to lack universal health insurance and reasons provided are varied. First, there are structural reasons¹⁵⁸ why healthcare reform is always a challenge to pass. While other countries have faced similar challenges and succeeded to surmount these obstacles, in the United States the power and resources of medical associations and healthcare corporations, especially large pharmaceutical companies – many of which are headquartered in the US and earn the bulk of their profits in the US – are particularly great.¹⁵⁹ Furthermore, the structure of US government with its system of checks and balances, the large majority needed to break a filibuster in the Senate¹⁶⁰, and the decentralized powers of the state can make large-scale reform of federal law extremely difficult to pass because there are so many opportunities to stall, revise, and reject legislation.¹⁶¹

¹⁵⁸ For an analysis of structural forces that have hindered healthcare reform in the United States relating to how groups such as doctors, health insurers, businesses, and unions have each mobilized against healthcare reform and been major obstacles to healthcare reform and expansion see: Jill Quadagno, “Why the United States Has No National Health Insurance: Stakeholder Mobilization Against the Welfare States, 1945-1996,” *Journal of Health and Social Behavior*, 45 (2004).

¹⁵⁹ “Many political scientists have highlighted healthcare as a special case because of the relative political strength of the medical profession and the difficulties this can create for governments looking to push through reforms that challenge the interests of the profession.” John Hudson and Stuart Lowe. *The Short Guide to Social Policy*, (Bristol: Policy Press, 2008), 108.

¹⁶⁰ For more on the way the structure of Congress and the filibuster impact the willingness of Senators and Representatives to take political risks and vote for healthcare reform see David W. Brady and Daniel P. Kessler, “Why is Health Reform So Difficult?,” *Journal of Health Politics, Policy and Law* 35: 2012.

¹⁶¹ For the most comprehensive and rigorous analysis of the role of institutions and the structure of American government in impeding healthcare reform see Sven Steinmo and Jon Watts. “It’s the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America.” *Journal of Health Politics, Policy and Law* 20 (1995). James Morone also comments on the role of institutions in undermining healthcare reform but incorporates these in a holistic analysis that incorporates American political culture, the ambivalence of moderate and conservative Democrats to support Clinton’s reforms, the power of conservative rhetoric, and conservative and healthcare industry advocacy against the healthcare reforms. James A. Morone. “Nativism, Hollow Corporations, and Managed Competition: Why the Clinton Health Care Reform Failed.” *Journal of Health Politics, Policy and Law* 20 (1995): 394-395.

The healthcare reform experience under the Clinton administration demonstrates a series of obstacles that make major expansion of government activity difficult in this sector. Many citizens are skeptical of government intervention. Interest groups are able to mount public and private lobbying campaigns on behalf of their preferred policy positions so that reformers find it difficult to see their vision rise to [the] top of the systemic agenda unchallenged. The federal system dictates that policy can be made (and blocked) at multiple levels of government... the Clinton health care proposal did not fail in a Republican-controlled legislature. It failed to get a floor vote in a session in which the Democratic Party held majorities in both houses.¹⁶²

What we find throughout the history of attempts at passing universal healthcare is that almost every time a bill to create such a policy is presented there is initially strong support for it amongst a majority of Americans. But, this support is quickly eroded when the financial¹⁶³ and human resources of corporations – particularly private health insurers and medical associations but also at many junctures hospitals and unions as well - apply themselves to the task of undermining such legislation.¹⁶⁴

Doctors have become increasingly supportive or at least tolerant of the idea of universal health insurance – as reflected in the positive change in attitude of the American Medical Association which is now less resistant to universal health insurance than ever before - but only if there are very firm protections in place enabling them to charge fees with limited government regulation.¹⁶⁵ Historically, the fear that racist Southerners had of being forced to integrate segregated hospitals and clinics also led to support – including amongst Democrats – to block national healthcare reform efforts

¹⁶² Jessica R. Adolino and Charles H. Blake. *Comparing Public Policies: Issues and Choices in Six Industrialized Countries*. (Congressional Quarterly Publishing: Washington, D.C., 2001), 221.

¹⁶³ Daschle, *Critical*, 93. Opponents outspent supporters of the bill 100 million to 15 million.

¹⁶⁴ For a concise explanation of the various reasons why the United States lacks universal health insurance see, Jacob Hacker, *Health at Risk: America's Ailing Health System and How to Heal It*, (New York City: Columbia University Press, 2008) 106-137. Hacker cites similar points made by Skocpol, Daschle, Quadagno, Starr, and other scholars of healthcare reform: a lack of a strong socialist party/leftist party, relatively weak unions in comparison to unions in Europe, (particularly true from the 1970s onwards,) path dependence caused by a piecemeal provision of healthcare insurance via employers, Medicare, and Medicaid, and the healthcare industry and its heavy lobbying,

¹⁶⁵ Healthcare profession advocacy groups have grown in diversity, with the AMA no longer a monolith. This has the potential both to expand opportunities to gain support for healthcare reform or to stymie it, if splintered interest groups do not come together to support reforms. For more on this topic see Frank R. Baumgartner and Jeffery C. Talbert, "From Setting a National Agenda on Health Care to Making Decisions in Congress." *Journal of Health Politics, Policy, and Law* 20 (1995): 438-439.

which could force states to desegregate health facilities.¹⁶⁶ Indeed racism played a large and relatively little discussed role in the failure of healthcare reform in the United States. Colin Gordon argues that, in contrast to European welfare states where welfare programs were seen as provision for overwhelmingly racially and ethnically homogenous nations and thus were based on civic solidarity grounded in shared racial and ethnic identity, there was no such basis in the United States for solidarity amongst citizens.

In the United States, by contrast, deeply racialized contests over citizenship predate the welfare state and were reflected in it... The U.S. welfare state... combined deference to labor markets with decentralized administration in such a way as to exaggerate and perpetuate the racial distinctions inherent in each. All of this meant not only that African-Americans and Latinos would remain second-class citizens of the American welfare state, but that many white Americans came to count health care as a ‘wage of whiteness,’ to be defended against erosion by universal programs.”¹⁶⁷

Intense and overt racism which sought to deny healthcare to African-Americans was particularly salient an issue during the Truman and Johnson administrations, but less so, with regard to healthcare reform during the Clinton and Obama administrations. In the case of the Clinton administration, many analyses point to the bureaucratic processes that took up time and made the process of crafting legislation laborious – and increasingly suspect to a public faced with strong advocacy in the media against the legislation. So while the discursive element of efforts to advance healthcare necessitates examination because it undoubtedly impacts public attitudes, it is essential to acknowledge the structural issues that impact policy outcomes as well.

The limitations of discourse (even when accurate and communicated clearly) in informing public knowledge, sentiment, and perception also need to be acknowledged.

Recent polls conducted by Stanford University and the Robert Wood Johnson

¹⁶⁶ Quadagno, *One Nation Uninsured*, 33-34 & Daschle, *Critical*, 53. Also Mark A. Peterson. “Clinton’s Plan Goes to Congress – Now What?” *Journal of Health Politics, Policy and Law* 19 (1994): 263.

Derickson, *Health Security for All*, 106.

¹⁶⁷ Colin Gordon, *Dead on Arrival: The Politics of Health Care in Twentieth-Century America*, (Princeton: Princeton University Press, 2003), 176.

Foundation reveal that more than half of Americans believe that Obama's healthcare reforms will raise taxes for most people – this is incorrect. About a quarter believe it has provisions for panels of bureaucrats to make vital decisions about health care provision including end of life care – this too is wrong.¹⁶⁸ These are issues which Obama, Democrats, academics, journalists, and non-governmental organizations addressed and explained – but the information was lost in the cacophony of conservative rhetoric attacking the plan with often spurious and misleading accusations. As Joseph White of the Brookings Institution explains, “The system’ is biased against reform. But the system includes far more than the legislative process. It includes an entire structure of public debate, which favors simple ideas over complex ones and the status quo over change.”¹⁶⁹ And for many Americans, irrespective of whether they heard conservative rhetoric countering claims in support of Obama's healthcare plan they are simply incredulous that it can both provide an additional 50 million Americans with health insurance and bring down costs, which seems counterintuitive at first glance.

People were asked, for example, whether the Congressional Budget Office, (a non-partisan agency of Congress) had ruled that the legislation would probably increase the government's debt, or whether the nonpartisan budget analysts found that the health law would reduce red ink. [It concluded it would save tens of billions of dollars.] But 81 percent in the survey got the wrong answer, including majorities of both supporters and opponents – even though Obama seldom misses a chance to remind audiences of the CBO's favorable report.¹⁷⁰

Jon Kresnick, Stanford professor of political science who directed the poll summed up these findings stating, “Among Democrats and independents, the lack of knowledge is suppressing public approval of the bill. Although the president and others have done a

¹⁶⁸ Ricardo Alonso-Zaldivar and Trevor Thompson., “AP Poll: health care law making us muddle-minded,” *Associated Press*, <http://news.yahoo.com/ap-poll-health-care-law-making-us-muddle-2.html> September 21, 2010.

¹⁶⁹White, 382.

¹⁷⁰ Ricardo Alonso-Zaldivar and Trevor Thompson., “AP Poll: health care law making us muddle-minded,” *Associated Press*, http://news.yahoo.com/s/a/us_health_care_poll/print. September 22, 2010.

great deal to educate people about what is in this bill, the process has not been particularly successful.”¹⁷¹ There is not so much only a lack of knowledge or information but a lack of trust, understanding, and belief in the credibility of the information the American public has received. Other, non-discursive centered reasons for challenges in pursuing universal healthcare insurance include changing legislative priorities, current events and global crises, and bureaucratic rules that impact the timing of legislation, and in particular in Congress, that allow committee chairs to control the progress of legislation.¹⁷²

Path dependence is one significant, though by no means exclusive reason for the difficulty the United States has had in guaranteeing universal health insurance. David Wilsford explains,

In the path-dependent model, actors are hemmed in by existing institutions and structures that channel them along established policy paths. Therefore, in any system, big (non-incremental) change is unlikely... In path dependency, structural forces dominate, therefore policy movement is most likely to be incremental... While very early on a number of different paths may be equally plausible and probable, once a given path has been laid, perhaps as the result of quite random variables initially, each subsequent decision making episode at the individual level in this decentralized decision making network reinforces the path which characterizes collective decision outcomes.¹⁷³

In the context of healthcare reform, this creates major restrictions on how healthcare is likely to be expanded in terms of access and affordability in the United States.

Initial policy decisions narrow the menu of future options by forming self-reinforcing paths that become increasingly difficult to alter. Thus Social Security succeeded while national health insurance failed. Social Security was enacted before a private pension system developed. By contrast, the private health insurance system was solidly entrenched by the time reformers began to press for a government solution, crowding out the public alternative.¹⁷⁴

¹⁷¹ Ibid.

¹⁷² Quadagno, *One Nation Uninsured*, 14.

¹⁷³ David Wilsford, “Path Dependency or Why History Makes It Difficult but Not Impossible to Reform Health Care Systems in a Big Way,” *Journal of Public Policy* 14 (1994): 251-253.

¹⁷⁴ Quadagno, *One Nation Uninsured*, 15.

Once health insurers and health related corporations tapped into massive markets for health insurance and health products in which they had the freedom to set prices and maximize prices irrespective of the public good, they were and still are loathe to give up this monopoly on the healthcare market. Employer based insurance became the dominant form of healthcare insurance provision in the United States, later with Medicare serving the elderly. This patchwork form of health insurance provision made it hard to unite citizens in support of healthcare reform efforts because each depended on different programs and did not have an incentive to support reforms that would assist the uninsured and underinsured.¹⁷⁵

Additionally, other factors that are frequently cited in the academic literature as barriers to successful passage of universal/near universal healthcare legislation in the US include the general weakness of the labor movement and consequently of the social solidarity that it sustains and expands and the huge drop in union membership since the 1970s and the lack of a social-democratic and socialist tradition and political movement in the United States.¹⁷⁶

American political culture, which has long emphasized individual liberties at the expense of collective solidarity - in contrast to many Western European democracies - and which has looked upon the government with scepticism and even with fear has been an intrinsically infertile soil in which to plant the seeds of universal health insurance.¹⁷⁷ The deep fear of Communism and socialism and the belief that they are uniquely and intensely threatening to America has been a potent antagonist to healthcare reform. The conviction - often deeply felt and dogmatic within American political and popular

¹⁷⁵James A. Morone. "Nativism, Hollow Corporations, and Managed Competition: Why the Clinton Health Reform Failed." *Journal of Health Politics, Policy and Law* 20 (1995): 395-396.

¹⁷⁶For commentary on the significance of the lack of a labor party and social democratic/socialist party in the United States see, Milton Terris, "National Health Insurance in the United States: A Drama in Too Many Acts," *Journal of Public Health Policy* 20 (1999):18.

¹⁷⁷Lawrence Jacobs. *The Health of Nations: Public Opinion and the Making of American and British Health Policy*, (Ithaca: Cornell University Press, 1993.) See also, Lawrence Jacobs, "Health Reform Impasse: The Politics of American Ambivalence Toward Government," *Journal of Health Politics, Policy and Law* 18 (1993).

culture— that free markets always yield socially ideal consequences, suffer from no imperfections and market failures, nor asymmetries in information and power, are not unduly influenced by the vagaries of human emotions such as greed and fear and the negative impacts they can have on the economy, and that they always function more efficiently than centralized government¹⁷⁸ has also inhibited the advancement of universal healthcare in the United States.

Conservative politicians fan public fears about healthcare reforms, linking them to spurious charges of government violations of civil liberties and making unsubstantiated claims about how they will reduce the quality of healthcare coverage. Incremental reforms have been made which significantly extended insurance to disadvantaged Americans: as discussed earlier, most notably in the form of Medicare and Medicaid, and most recently the CHIP program to provide insurance to disadvantaged children. But these reforms still leave approximately 50 million Americans uninsured with tens of millions more underinsured and at great vulnerability for poverty due to high healthcare costs.

2.7 Conclusion

Democrats have been the primary advocates of expanding health insurance on a universal basis to all Americans, with Republicans generally rejecting the principle of universality and often presenting their own healthcare reform plans as less expensive and less expansive responses to Democratic initiatives. Still, Republicans such as Richard Nixon did support significant expansions of health insurance and at many proposals initiated by Democrats to expand healthcare there have been some Republicans who have joined in these efforts – though far less so since the Reagan era.

¹⁷⁸ Quadagno, *One Nation Uninsured*, 12.

Conservative rhetoric about the dangers of ‘socialized medicine’ that stoked fears of an encroaching government that would violate the liberties of Americans and that created harsh, negative associations between universal health insurance and authoritarian regimes has been prevalent since the 1910s and right through the passage of Barack Obama’s health care reforms. Undoubtedly, this rhetoric played a major role in increasing public antipathy towards universal health insurance as well as providing an excuse for members of Congress with strong ties to the healthcare sector to cloak their rejection of universal health insurance legislation under claims of concern for the freedom of Americans.

Although at every juncture of attempts to pass universal health insurance there have been campaigns against it the dynamics of power and interests have changed over the course of the twentieth and twenty-first centuries. While some organizations such as insurance companies have largely been hostile to these reforms consistently – with some time-bound exceptions when initial openness to reforms was quickly followed by rejection - there have also been numerous reconfigurations in alliances for and against healthcare reform with organizations such as the American Medical Association and American Hospital Association being ardently opposed to universal health insurance under Truman and to a lesser degree under Nixon, but becoming increasingly open to it under Clinton and Obama. In part, this is because they realized that with 50 million uninsured Americans there is a huge untapped market and earnings potential for healthcare providers and insurers, should all these Americans be provided with a decent standard of healthcare.¹⁷⁹ Furthermore, they recognized, like many corporations, that there is an inexorable movement towards providing universal health insurance because the number of uninsured Americans keeps growing and this is causing tremendous economic and social problems and will eventually become a political liability. All those in

¹⁷⁹ Paul Starr, *Remedy and Reaction*, 114-115.

the healthcare industry – from doctors and hospitals to health insurers and pharmaceutical companies - have the incentive to support universal health insurance on their *terms* – maximizing the compensation they receive from the government by participating in the process of drafting universal health insurance legislation and advocating vigorously for their own collective self-interest.¹⁸⁰ Corporations who expend huge sums on health insurance for their workers have similar interests in ensuring that their concerns and costs are addressed in healthcare reforms.

The interests of private sectarian groups have historically overpowered those legislators and organs of civil society seeking to advance universal health insurance that would guarantee health insurance to all Americans on the basis of equality irrespective of income. Barack Obama’s healthcare reforms came close to being defeated because of these same powers and much of the legislation he proposed was changed to be more sympathetic to their interests. Ultimately, however, in 2010 the pattern of healthcare insurance reform failure was broken and the public good asserted itself over sectarian interests.

¹⁸⁰ Ibid. See also Stuart Altman and David Shactman. *Power, Politics, and Universal Health Care*. 66-67. And yet, the business community including many insurers ultimately rejected Clinton’s healthcare reforms, proving that the status quo is powerfully attractive to businesses. “By mid-fall 1993 Clinton had lost the support of all the major business groups, not only the National Federation of Independent Business, but also the Chamber of Commerce, the Business Roundtable, and the National Association of Manufacturers.” Jill Quadagno. *One Nation, Uninsured*, 192.

Chapter 3: Theory: The Social Imaginary and its Moral Order

3.1 The Social Imaginary

Dilip Gaonkar characterizes the social imaginary as “an enabling but fully explicable symbolic matrix within which a people imagine and act as world-making collective agents¹⁸¹” – noting that this definition of the social imaginary was developed by Cornelius Castoriadis¹⁸² who eventually came to reject Marxist determinism and sought to establish a theoretical framework for understanding how individuals and collectives act in creative ways.¹⁸³ The place of freedom, autonomy, choice, and creative possibility as opposed to determinism within Castoriadis’ theorization of the social imaginary is central and my thesis reflects this.

The social imaginary is a dynamic field of continuous construction and contestation, although the various forms of political contestation in a mature democracy with a long democratic tradition are relatively stable. US Presidents both contribute to its construction and respond to it and are influenced and potentially constrained by it.

Charles Taylor defines the social imaginary as,

...the ways in which people imagine their social existence, how they fit it together with others, how things go on between them and their fellows, the expectations that are normally met, and the deeper normative notions and images that underlie these expectations.¹⁸⁴

¹⁸¹ Dilip Paraneswar Gaonkar, “Toward New Imaginaries: An Introduction,” *Public Culture* 14 (2002): 1.

¹⁸² Castoriadis’ theorization of the social imaginary evolved in large part as a reaction to Marxism. The concept of the ‘symbolic matrix’ which individuals draw upon as a resource for identity and action in the world is an important and useful one, and one which Taylor incorporates into his own theorization. However, I do not discuss Castoriadis’ theorization of the social imaginary in depth because it is embedded in a much larger ideological and theoretical debate vis-à-vis Marxism that is beyond the scope of this thesis and is dense in theoretical claims and often highly technical, rarefied, and abstruse argumentation.

Cornelius Castoriadis, *The Imaginary Institution of Society*, (Cambridge: MIT University Press, 1987).

¹⁸³ Ibid.

¹⁸⁴ Charles Taylor, “Modern Social Imaginaries,” *Public Culture* 12 (2002): 106.

For Taylor morality or the ‘moral order’ is a central component of the social imaginary and its progenitor, fundamental to it and integrated within it encompassing a broad constellation of values. In a Western (and by extension, American) context the social imaginary refers in large part to a market economy, democratic self-governance, basic principles of rights to security of person and property, and an open public sphere for reasoned deliberation in which differences of opinion can be examined peacefully. Equality is a central pre-condition for the viability of each of these components of the social imaginary.¹⁸⁵ Significantly, morality precedes politics and creates the framework for a political and legal system while simultaneously forming a central part of what the political and legal system debates and enforces.

The underlying idea of moral order stresses the rights and obligations which we have as individuals in regard to each other, even prior to or outside of the political bond. Political obligations are seen as an extension or application of these more fundamental moral ties.¹⁸⁶

In politics, the social imaginary is contested. Inherent in the democratic moral order are unsettled tensions between potentially incommensurable values such as liberty and justice, liberty and equality, individual well being and collective welfare. The obligations of individual citizens to one another and to government and the obligations of government to individual citizens is one of many potential areas of contestation and disagreement.

The American social imaginary exhorted in Republican conservative rhetoric of ‘limited government’ in relation to healthcare reform has distinct normative notions which it advocates, and my thesis illuminates how these normative notions are countered in liberal Democratic texts which reject this political and moral philosophy.

¹⁸⁵ Charles Taylor, “On Social Imaginary,” <http://blog.lib.umn.edu/swiss/archive/Taylor.pdf>.

¹⁸⁶ Ibid.

Taylor argues that social change is enabled by rhetoric which transforms the social imaginary, by recontextualizing the idea of foundation from an early mythical time to contemporary time as “something that people can do today...something that can be brought about by collective action in contemporary, purely secular time.”¹⁸⁷ Indeed this is exactly what the presidential rhetoric I analyze illustrates, how, through the invocation of moral ideals that are considered to transcend political divisions and to be timeless, such as equality of opportunity and communitarian solidarity, support can be generated for the expansion of health insurance.

The social imaginary changes on both individual and collective social levels. Candace Vogler theorizes it as the meeting of these two, the juncture at which individuals locate themselves emotionally and intellectually in relation to society, its expectations, their obligations to it, and the dynamic nature of that relationship which is characterized by a multiplicity of subjective experiences and the diversity inherent to them. But Vogler also notes that there is an impersonal element to the social imaginary in how it potentially informs human identity and behavior. Vogler writes,

It may be impossible to do ethics without engaging the individuating question, What should I do? Or, more generally, How should I live?... Crudely put, imaginaries are complex systems of presumption – patterns of forgetfulness and attentiveness – that enter subjective experience as the expectation that things will make sense generally (i.e. in terms not wholly idiosyncratic.)¹⁸⁸

The social imaginary, in this sense, alleviates a certain individual existential loneliness by linking the individual with society, by providing a context in which he/she can imagine himself as part of a larger collective, which aspires and expects and maintains a vision of

¹⁸⁷ Charles Taylor, "Modern Social Imaginaries," *Public Culture* 14 (2002): 117.

¹⁸⁸ Candace Vogler, "Social Imaginary, Ethics, and Methodological Individualism," *Public Culture* 14, (2002): 625.

life that by its social nature is larger than anything an individual alone can pursue.¹⁸⁹ For it to have significance and impact individual and collective life alike the social imaginary needs the individual to believe in it, contribute to it, engage with it dialogically and act upon its values, symbols, visions, and plans of action.

Of course, the solidarity and sense of belonging engendered by it is never complete. As we have discussed, the social imaginary can be inclusive or exclusive, and at any given time it exists on a spectrum between these two potential polarities.

Accordingly, the social imaginary – as we will see in the specific iterations of each president – makes demands of individuals, exhorting them to value, feel, reason, and act in a certain way and in the case of the presidential rhetoric I examine in an inclusive and universalistic way that emphasizes common values and shared obligations to one another.

Action-guiding, personal answers to ethical questions will turn on some mode of more general sense-making – What should *I* do? And How should *I* live? can be restated as What should *one* (in my circumstances) do? Or How should one (in my circumstances) live? “In my circumstances” becomes the point of contact between the personal question and the general, socially extended imaginary frame – that is, “my circumstances” both are and are not mine alone.¹⁹⁰

In this way the social imaginary invokes the identity of the individual as citizen, it creates the possibility of communitarian social solidarity, providing an ethical, affective, and ideational framework for the individual self-identifying, acting and being part of a civic project and society that is more than the sum of its aggregate individual parts, indeed one in which the individual is an essential constituent.¹⁹¹

¹⁸⁹ For commentary on how American presidents, specifically Barack Obama, use rhetoric to create a social imaginary and imagined community see Stefanie Hammer, “The Role of Narrative in Political Campaigning: An Analysis of Speeches by Barack Obama,” *National Identities*, 12 (2010): 269-290.

¹⁹⁰ Candace Vogler, “Social Imaginary, Ethics, and Methodological Individualism.”

¹⁹¹ There are some academic usages of the ‘social imaginary’ to signify something less civically oriented and more a product of forms of cultural transmission such as media and the creative arts. Indeed culture and all that it includes – artistic expression, religious and secular rituals and myths,

As is evident from this theorization and discussion, the social imaginary is an intrinsically complex entity, one which in virtue of the fluid nature of its conceptualization needs to be carefully defined and analyzed. I rely primarily on Taylor's theorization of the social imaginary. I explore the meaning of the 'social imaginary' and the way in which it is based in large part on the idea of a particular moral order and interpretation of principles of equality, liberty, justice, rights, and responsibilities. These are defined by a particular foundational logic, as a collective sensibility and attitude towards moral values as they relate to the nation¹⁹² to which liberal Democratic rhetoric contributes and which presidents seek to create, respond to, and challenge in their rhetoric.

The public realm or domain is the space in which politics is performed and in which political struggles take place, where social imaginaries and the moral orders they sustain are presupposed, expressed implicitly and explicitly, reproduced and challenged in the course of political struggles. This is an intrinsically dynamic and discursive space, where dialogue and polemic, appeals to emotions, ethics, and reason are employed and generate a range of emotions including fear, anxiety, disgust, rage, pride, and the euphoria that can accompany a shared sense of community and identity. The public realm or domain is an essential area for this study because political leaders and their rhetoric are embedded within it. They inform it through the act of presenting political arguments and inviting responses from civil society, opposing politicians, and the public and in so doing, linking the public realm to the discursive arena of political argument.¹⁹³

ethnicity, mass media, and norms of social interaction all contribute to the social imaginary alongside political and civic components of it. For a discussion of the social imaginary from a specifically cultural angle and the ways in which minority groups living in European societies respond to and create their own social imaginaries as they both integrate within and challenge dominant social imaginaries in the nations to which they immigrate see, Mette Anderson, "The Social Imaginary of First Generation Europeans," *Social Identities* 16 (2010): 3-4.

¹⁹² Charles Taylor, "Modern Social Imaginaries," *Public Culture* 14 (2002):92-95.

¹⁹³ Charles Taylor, "Modern Social Imaginaries," *Public Culture* 14 (2002): 107-110.

The social imaginary envisions a particular imagined national community which incorporates a range of collective narratives, moral values, memories, (both real and imagined) and beliefs. This imagined community may have one dominant overarching self-conception, but this is subject to revision. Other articulations of the imagined community may exist alongside it, either in competition or in synergy or as sub-genres of communities that do not necessarily reject the dominant definition of the imagined national community.¹⁹⁴ It has certain anchors that have withstood the test of time. For example, in the United States the Declaration of Independence, the Constitution, the Bill of Rights and the American flag, and other such universally respected and accepted legal documents and symbols which have particular resonances are tangible expressions of the imagined national community. These contribute to a shared understanding of the moral order of the nation, its aspirations, and the political and legal system to which it subscribes even as they are re-imagined and reinterpreted.

For example, the US civil rights movement invoked the US Constitution, Bill of Rights, and Declaration of Independence in its activities – all literal and stable documents, but urged that to fully realize their promise laws such as the Civil Rights Act and the Voters Rights Act needed to be passed to guarantee the rights of African-Americans and ensure equality. Thus the civil rights movement simultaneously embraced the vision of a national community present within these texts while demanding that political and legal changes be made to alter the actual social and political reality in the United States, which was highly unequal, segregated, and overtly racist at the time. It also battled with conservatives who insisted that whatever promises to equality in these

¹⁹⁴ In the United States the Native American experience has been appropriated by the American government in its coinage to associate values of valour and dignity with the American people. But Native Americans have been socially, economically, and politically marginalized. Their history and social experience presents a counter-narrative to the American social imaginary but is not necessarily considered to be, both by Native Americans and by other Americans, an active rejection of the American state and its social imaginary as a whole, although it does certainly challenge aspects of it, particularly its moral claims of justice, equality, and freedom extended to all citizens. Gretchen M. Bataille, *Native American Representations: First Encounters, Distorted Images, and Literary Appropriations*, (Lincoln: University of Nebraska Press, 2001).

founding documents, the rights of states to discriminate against minorities always took precedence. In this way the civil rights movement was able to strategically use universally accepted and respected texts and invigorate them with progressive meaning that advanced a new discourse of equality and a revised social imaginary inclusive of minorities. As Martin Luther King Junior states,

One day the South will know that when these disinherited children of God sat down at lunch counters they were in reality standing up for the best of the American dream and the most sacred values in our Judaeo-Christian heritage, and thus carrying our whole nation back to the great wells of democracy, which were dug deep by the founding fathers in the formulation of the Constitution and the Declaration of Independence.¹⁹⁵

By changing social understandings of justice – by altering in a progressive way what van Dijk describes as ‘social cognition,’¹⁹⁶ civil rights activists transformed a racist discourse of dominance and exploitation in the United States to an egalitarian discourse of equality, justice, and communitarian social solidarity. It is through discursive struggle over the social imaginary that public policies are influenced and changed and social norms and expectations evolve in ways that expand and contract the power, rights, and visibility of particular social and economic groups.¹⁹⁷

¹⁹⁵ Martin Luther King Junior, in Talal Asad, “What Do Human Rights Do? An Anthropological Enquiry, *Theory and Event* 4 (2000).

¹⁹⁶ Teun A van Dijk, “Principles of Critical Discourse Analysis,” *Discourse and Society* 4 (1993): 251.

¹⁹⁷ The women’s rights/feminist movement functioned similarly in transforming the American social imaginary regarding the place, rights, and obligations of American women to themselves as individuals, to one another as a community of women, and to their husbands/partners, children, families, and society at large. It expanded their rights and freedoms and made it more socially acceptable for women to pursue a professional career rather than primarily care for children and to enjoy greater equality in the workplace and legal protection of that increasingly socially acceptable equality. Like most social movements feminist/women’s rights activists and civil rights activists remain vigilant and socially engaged as their efforts have not been fully realized. Similarly, the gay rights movement is perhaps the most salient and embattled social movement active in the United States today seeking to prevent discrimination on the basis of sexual orientation and ensure equality for gay and lesbian Americans. The labor movement and anti-poverty activists continuously struggle in the face of increasing economic inequality and high rates of poverty and also seeks to transform the American social imaginary to demand greater protection of impoverished Americans and greater recognition of the structural and systemic injustices they face and to destigmatize them.

3.2 Discourse and Hegemonic Constructions of the Social Imaginary

Discourse consists of symbols and argumentative practices that constitute the social imaginary of a national public and is inherently related to the power relations of this public space and the role of language in expressing them. Discourse enables the setting of moral, social, and political boundaries which include and exclude particular groups, ideas, and moral values. Part of the power of discourse is to call up symbols, images, and values that create, rather than simply represent, communities of solidarity, identity, and aspiration.¹⁹⁸ Discourse both provides the resources for imagining community that affirms the participation and belonging of its constituent members and for rejecting individuals and groups from this community. Power within discourse is both directed from political elites to the general public and derives from the common language and norms that the public adopts, reiterates, and spreads.¹⁹⁹ As such, the power of discourse is often unconscious, invisible, and therefore largely unaccountable. This magnifies its power and enables its hegemony, extending and expanding its influence in ways that make it hard to attribute it to one particular source as it spreads and becomes integrated on a wide scale across society, assuring that what may begin as a discursive expression transparently representing the interests of a very particular group of people becomes so diffuse so as to insidiously become associated with the interests of all even if it is sometimes invidious to large sectors of citizenry.²⁰⁰

Samuel Taylor Coleridge reflects on this process which is a major concern of rhetoric analysts. “When this distinction has been so naturalized and of such general currency that the language itself does as it were think for us (like the sliding rule which is

¹⁹⁸ Lillie Chouliaraki, “Discourse Analysis” in *The Sage Handbook of Cultural Analysis*, ed. John Frow and Tony Bennett (Thousand Oaks: Sage, 2008), 674-675, 677.

¹⁹⁹ Lillie Chouliaraki, “Discourse Analysis” in *The Sage Handbook of Cultural Analysis*, ed. John Frow and Tony Bennett, 675, 677, 679, 680.

²⁰⁰ Norman Fairclough, *Discourse and Social Change*. (Polity: Cambridge, 1999), 92.

the mechanic's safe substitute for arithmetical knowledge) we can say that it is evident to common sense."²⁰¹ Words like 'freedom' and 'rights' are conceptual signifiers whose common sense meanings have evolved substantially as Democrats and Republicans have jockeyed for political power in the United States. They have undergone a continuous process of revision within this context of struggle to define their meaning.²⁰²

Rhetoric is the persuasive power of discourse, that aspect of discourse that courts and seeks to influence public opinion towards particular visions of community and morality and the frontiers they imply.²⁰³ Rhetoric refers to forms of discourse that are intentional and strategically executed in the images, symbols, arguments, and emotions they employ and entails consciousness on the part of speakers of the particular persuasive cognitive and affective outcomes they intend their rhetoric to yield. Aristotle explains that rhetoric contains three dimensions: moral, emotional, and logical (ethos, pathos, and logos) which are employed together to maximize the power and persuasiveness of language. Herbert Gottweis provides a helpful description of Aristotle's definition of these three dimensions of rhetoric,

Although a mode of argumentation dominated by logos is characterized by reasoning and the presentation of facts, evidence, and empirical proofs, pathos operates with empathy, sympathy, sensibilities, while ethos functions with trust, respect, authority, honesty, credibility and considerations of the desirable. Any communication or speech act combines elements of logos, pathos and ethos,

²⁰¹ Stephen Bygrave, *Kenneth Burke: Rhetoric and Ideology* (London: Routledge, 1993), 101.

²⁰² Geoffrey Nunberg, *Talking Right: How Conservatives Turned Liberalism into a Tax-Raising, Latte Drinking, Sushi-Eating, Volvo-Driving, New York Times-Reading, Body-Piercing, Hollywood-Loving, Left Wing Freak Show*, (New York: Public Affairs, 2006.)

Drew Westen, *The Political Brain: The Role of Emotion in Deciding the Fate of the Nation*. (New York: Public Affairs, 2008.)

²⁰³ George Lakoff, *Moral Politics: How Liberals and Conservatives Think*, (Chicago: University of Chicago Press, 2002.) Aristotle affirms that rhetoric is intrinsically linked to matters of ethics because it addresses social and political ideals and projects.

James Paul Gee, *Discourse Analysis: Theory and Method*. (London: Routledge, 2000), 82-83, 86, 120-124.

though different weight might be put by a speaker on these three elements of persuasion.²⁰⁴

These dimensions of rhetoric are expressed in texts in complex, sometimes overlapping, and relational ways in which context is often fundamental to matters of meaning and significance. “Pathos and ethos are tied to specific circumstances.”²⁰⁵ This informs the way in which my rhetoric analyses situate each text in its particular historical and political context, as well as in relation to the character and public expression of values for which each president is known. More broadly, Kenneth Burke provides a definition of rhetoric that I will use to orient my rhetoric analysis,

The basic function of rhetoric is the use of words by human agents to form attitudes or to induce actions in other human agents... It is rooted in an essential function of language itself, a function that is wholly realistic, and is continuously born anew; the use of language as symbolic means of inducing cooperation in beings that by nature respond to symbols.²⁰⁶

Rhetoric is a resource for all individuals and communities seeking to assert power and acquire resources and it can constitute the very visions of society to which it claims to aspire. It may then become the only reality, however nebulous, with which individuals identify and invest their energies, psychic and political alike. Sometimes the most influential forms of rhetoric are the kinds that are so emotionally compelling that they require very little basis in reality or truth to be convincing and serve as a rallying point – the more extreme their utopianism is and the less it reflects the realm of the possible the more attractive rhetoric can be to those who wish to submit to its sometimes unitary visions, collectively self-gratifying emotions and perceptions and uncompromising stance. In a society of shifting ethnic, sexual, religious, cultural, and political values and

²⁰⁴ Herbert Gottweis, “Rhetoric in Policy Making: Between Logos, Ethos, and Pathos,” in *Handbook of Public Policy Analysis: Theory, Politics and Methods*, ed. Frank Fischer and Gerald J. Miller, (Boca Raton: CRC Press/Taylor and Francis, 2007), 243.

²⁰⁵ Gottweis, 242.

²⁰⁶ Kenneth Burke, *A Rhetoric of Motives*. (New York: Prentice Hall, 1950.) 41-43.

identities rhetoric²⁰⁷ can represent the final frontier of a relatively static homogeneity, a comfortable place in which to seek respite from a society changing its moral order and social imaginary and therefore sometimes alienating those individuals and groups who no longer feel that they recognize it nor that they have the same power to define its values and membership as in the past.

The conceptualization of the social imaginary as a struggle of discourses can best be theorized through Laclau and Mouffe's view of power as hegemony. Laclau and Mouffe state that hegemony's: "...very condition is that a *particular* social force assumes the representation of a *totality* that is radically incommensurable with it."²⁰⁸ In examining the social imaginaries offered by Democratic political elites I pay particular attention to the ways in which they expand boundaries of social inclusion and outreach beyond the more constricted boundaries offered by Republicans and seek to continuously enlarge these to incorporate as broad a population of citizenry as possible. The idea of boundaries is central to the hegemonic function of a social imaginary, insofar as "there is no hegemonic articulation without the determination of a frontier, the definition of a 'them.'"²⁰⁹ These imaginaries exist in a dynamic state and are characterized by the need to constantly reassert themselves as desired outcomes of inclusion and exclusion change. As they are transformed to become conventional wisdom, "[they] may eventually become the taken-for-granted shape of things, too obvious to mention."²¹⁰

This concept of a commonly accepted and also largely unconscious 'common sense' can also be found in Gramsci's work on ideology. "For Gramsci... a popular identity is no longer something to be given, but has to be constructed – hence the

²⁰⁷ This observation of rhetoric refers to traditionally conservative uses of it as a bulwark against change, liberalism, and increasing social diversity.

²⁰⁸ Ernesto Laclau and Chantal Mouffe. *Hegemony and Socialist Strategy: Towards a Radical Democratic Politics*, (London: Verso, 2001), X.

²⁰⁹ Chantal Mouffe. *The Democratic Paradox*. (London: Verso, 2000), 56. However, this is not the case with regard to rhetoric and policy that aims to be universally applicable to all citizens of a given polity. In such cases, the boundary of the 'them' lies with those who do not hold citizenship, but it is not necessarily an invidious frontier.

²¹⁰ Charles Taylor, "Modern Social Imaginaries," 111.

articulatory logic of hegemony.”²¹¹ What is being articulated is a combination of discourses which include a set of ideas, emotions, and moral values about what is considered to be politically and socially right, an attribution of these to a particular social group which wishes to assert its dominance, and the consequent exclusion of other social groups who do not share the qualities and convictions by which it defines itself and seeks to monopolize the social imaginary as a whole. As van Dijk explains,

...dominant speakers control the access to public discourse and hence are indirectly able to manage the public mind. They may do so by making those structures and strategies that manipulate the mental models of the audience in such a way that ‘preferred’ social cognitions tend to be developed, that is, social cognitions (attitudes, ideologies, norms and values) that are ultimately in the interest of the dominant group.²¹²

In affirming a particular kind of socially and politically sanctioned identity the hegemonic discourse of the social imaginary is constructed and conflicting definitions of it jockey for discursive space and power. In the process of this hegemonic construction of a form of widely accepted ‘common sense,’ ideologies become naturalized, or automatized.²¹³

Gramsci theorizes ideologies as being in constant battle, shifting, undermining, overtaking, and transforming themselves and one another in the effort to assert hegemony. “This suggests a focus upon the processes whereby ideological complexes come to be structured and restructured, articulated and rearticulated.”²¹⁴ The pursuit of increasingly homogenous political and social groups enables the hegemony of one group, because it minimizes the potential for adversarial relations with diverse groups which may challenge its values, legitimacy, and actions and thus effectively neuters potential opposition.

²¹¹ Ernesto Laclau and Chantal Mouffe. *Hegemony and Socialist Strategy*. (London: Verso, 2001), 137.

²¹² Teun A van Dijk, “Principles of Critical Discourse Analysis,” *Discourse and Society*, 4 (2) 279-280.

²¹³ Norman Fairclough. *Discourse and Social Change*. (Polity: Cambridge, 1999), 91.

²¹⁴ Norman Fairclough. *Discourse and Social Chang*, 92.

For Gramsci, political subjects are not – strictly speaking – classes, but complex ‘collective wills...An historical act can only be performed by “collective man”, and this presupposes the attainment of a “cultural-social” unity which a multiplicity of dispersed wills with heterogeneous aims, are wielded together with a single aim.’²¹⁵

It is this ‘wielding together’ which is necessary for power to be able to assert itself with maximal influence and authority. As Linda Zerelli writes about this common sense or communal sensibility,

when we appeal to the *sensus communis*, we are not appealing to a fixed set of opinions but to what is communicable. Far from guaranteeing agreement in advance, *sensus communis* allows differences of perspective to emerge and become visible. *Sensus communis* is not a static concept grounded in eternal truths but a creative force that generates our sense of reality.²¹⁶

Thus the common sense of the social imaginary – while grounded in a common knowledge of symbols, ideas, values, and principles - is malleable and subject to contestation and change.

Accordingly, the function of a democratic public realm is best conceptualized as a ‘cultural-social’ and political system enabling struggle for particular values and visions of society and the power that enables and maintains them, what Mouffe calls ‘agonistic’ struggle. This struggle takes place largely in the context of and is limited by the communally and culturally determined rhetorical resources which Kenneth Burke affirms, “are possessed by a community”²¹⁷, whose competing interests are always

²¹⁵Ernesto Laclau and Chantal Mouffe. *Hegemony and Socialist Strategy*, 67.

²¹⁶As cited in Finlayson, 2012, 763.

²¹⁷Alan Finlayson writes that this concept of community is directly linked to ethos, “Ethos is fundamentally about what the American rhetorician Kenneth Burke thought the main function of rhetoric: the creation of community through forms of identification.” Finlayson, 2012, 760.

acknowledged.”²¹⁸ Indeed Kenneth Burke’s²¹⁹ writings on rhetoric reflect Mouffe’s claims. Mary Fortunato argues that,

When one identifies favorably with one group (audience) he/she inevitably isolates and alienates another audience. Burke states that the definition of rhetoric requires every ‘us’ to have a corresponding ‘them’ otherwise there occurs a lack of self awareness and personal definition.²²⁰

While this is often and probably generally the case it is by no means necessary and universal that rhetorical identification with one audience (such as the American people) implies denigration of another audience, domestic or international. While my rhetoric analysis will show how certain presidents such as Truman and Johnson openly and vigorously criticized particular sections of the American polity such as health insurance companies, pharmaceutical corporations, and hospitals, not all presidential rhetoric on healthcare reform orients itself to this antagonistic approach, or at least does not do so fully. Clinton and Obama’s rhetoric, as we will see, is oriented away from such antagonism and focuses on conciliation and unity even as it acknowledges (often gently and obliquely) the negative role the same aforementioned groups have played in preventing equitable access to quality healthcare.

This concept of ‘agonistic struggle’ is closely related to Gramsci’s theorizing of ideological contest and transformation between competing groups vying for the capacity to assert their particular values and vision through the power of the government. They may do so not necessarily primarily by means of reasoning but often through emotional

²¹⁸ Bygrave, 34. It should be noted, however, that some but not all competing interests are acknowledged in agonistic struggles and many may be left deliberately unsaid. It may often be strategic for a party or particular population not to acknowledge competing interests and instead to create an illusion of mutual interests which can then be used to co-opt and concentrate power over others, win their assent, and surreptitiously dominate them all under the subterfuge of pursuing purportedly common interests.

²¹⁹ Burke also refers to rhetoric as “agonistic.” Marie Hochmuth, “Kenneth Burke and the ‘New Rhetoric,’” *Quarterly Journal of Speech* 38 (1952): 135.

²²⁰ Mary Beth McMurray Fortunato. “Philip Morris Faces ‘the truth’: A Rhetorical Analysis of the Persuasiveness of Two teen-Targeted Anti-Smoking Advertising Campaigns,” MA Thesis, Brigham Young University, 2002. <http://contentdm.lib.byu.edu/ETD/image/etd150.pdf>

and irreconcilable rhetoric and aims.²²¹ Mouffe makes this claim as a normative judgment about how democracy best functions and argues that the political left can best achieve its aims by encouraging this agonistic model and participating in it.

My thesis does not take a stance on the normative value of her vision of agonistic democracy. However, it acknowledges that her characterization of the contestations of power that take place within a democracy and their impassioned and often contradictory tendencies are evident in the rhetoric of Democrats and Republicans in the United States as they relate to notions of the just parameters of government with regard to healthcare reform and conflict about them. It follows that creating a social imaginary and its underlying moral order is a process of competition and debate subject to diverse interpretations, claims, and aspirations.²²² Attempts to redefine and refine it are continuous²²³ and US Democratic Presidents use the power, prestige, and commanding attention of the presidency to guide the social imaginary and moral order in an emancipatory direction that prioritizes the values of equal opportunity and communitarian social solidarity. Their efforts, however, do not necessarily entail an exclusionary desire to assert dominance over others and exclude them. The civil rights movement, for example, was and remains motivated by a vision of justice and equality, not one of discrimination, dominance, exclusion, and exploitation as we will see in Chapter 6.

This struggle for hegemony happens domestically through appeals to the nation, what Benedict Anderson defines as

²²¹ Chantal Mouffe. *The Return of the Political*. (London: Verso, 2006.)

²²² Norman Fairclough. *Discourse and Social Change*, 93.

²²³ 'Hegemony is not sought and won once for all, it must be ongoingly sustained and struggled for under shifting circumstances and shifts in the competitive field of hegemonic projects.' Norman Fairclough, "Blair's Contribution to Elaborating a New 'Doctrine of International Community,'" in *The Soft Power of War*, ed. Lilie Chouliarakis, (Amsterdam: John Benjamins BV, 2007), 51.

an imagined political community — and imagined as both inherently limited and sovereign. It is imagined because the members of even the smallest nation will never know most of their fellow-members, meet them, or even hear of them, yet in the minds of each lives the image of their communion.²²⁴

Although Anderson refers primarily to the imagined community as a construct created in large part in relation to a collective relationship to external nations and societies, his concept of the imagined community can also be applied domestically, within a given society in which the role of the ‘other’ is typically played by domestic minority groups. In the case of liberal-democratic politics the frontier of legitimacy in the moral order and political community is an internal one, “and the ‘them’ is not a permanent outsider.”²²⁵ I will use the term social imaginary to include the concept of the imagined community because the ‘social imaginary’ encompasses the imagined community of the nation and allows for a more expansive inclusion of aspects of society and culture that are not necessarily obviously related to the ‘nation’ or perceived as forming part of its identity but nevertheless relate to its contemporary social reality.

For example, certain aspects of popular culture may form part of the social imaginary but may not be considered consciously both by political elites and by laypeople to be a component of the nation’s self-conception of its national community. Television programs and film in the United States have powerful symbolic meanings that relate to how the nation imagines itself. Westerns, for example, comment on the meaning of the great expanses of open land in the American West, human migration, the pursuit of freedom, the legitimate role of government in society, and the gender dynamics that exist in small towns in the West where men assume certain clearly defined roles as leaders and protectors or criminals that are largely unchangeable and women accompany them only

²²⁴ Benedict Anderson, *Imagined Communities: Reflections on the Origin and Spread of Nationalism*. (London: Verso, 2006).

²²⁵ Chantal Mouffe, *The Democratic Paradox*, (London: Verso, 2000), 56. In *The Return of the Political* Mouffe defines this opposition created by the frontier as the ‘enemy,’ 69.

tangentially and with an inferior status.²²⁶ But these media productions do not necessarily achieve formal recognition as symbols and discourses that contribute to the definition of the national community. Formal discourses and historical events related to politics and the military often take precedence in how the public interprets the imagined national community because it is politicians who seek to monopolize these imaginings and who prioritize military and political themes, even as they call upon a whole range of resources beyond those subject areas to do so.

Therefore, I argue that the social imaginary is more dynamic and less historically bound than the imagined national community. Contemporary culture contributes to the social imaginary but it takes a great deal of time before it becomes accepted and integrated into a commonly understood and agreed upon definition of the imagined national community. The struggle over the definition of the social imaginary and the moral order it advocates is, as I have explained, a discursive one which informs political debate and in so doing impacts on how particular public policies are characterized, advanced, and rejected by political leaders. While Mouffe focuses on conflict within the imaginary, and Anderson focuses on shared meanings and perceptions, these two poles of contestation and agreement, change and stability characterize the ongoing development and expression of the social imaginary.

3.3 The Middle Class in the American Social Imaginary

One of the key signifiers of the American social imaginary is the ‘middle-class’ – particularly in the post World War 2 era when increases in wealth and patterns of settlement and culture, such as suburbanization, associated with a middle-class lifestyle

²²⁶Richard Aquila, *Wanted Dead or Alive: The American West in Popular Culture*. (Urbana-Champaign:University of Illinois, 1996).

and standard of living, became accessible to ever growing numbers of Americans.²²⁷ This symbolic and practical category is extremely important, because it has become a major source of self-identification for Americans. Politicians across the political spectrum use it to appeal to a huge swathe of the American public and to advance their own particular notions of middle-class values and ideals, which they seek to depict as broadly representative of Americans as a whole even as they are often exclusive of major segments of US citizenry, including the working class and the economically disadvantaged²²⁸ whose economic and social realities cannot be subsumed into the middle class category because they are distinct.

Defining the category ‘middle class’ with specificity is difficult, because it has multiple definitions offered by academics, politicians, journalists, and the public; there is no widely accepted common definition.²²⁹ Its power rhetorically rests precisely in its protean nature. In the context of rhetoric analysis it is significant more as a symbolic archetype to which Americans aspire to belong than a practical, clearly delineated category based in large part – in the contemporary era - on income by which Americans with an income of roughly \$55,000 for a family of four are typically considered to be

²²⁷ For more on the impact of class on limiting the expansion of health insurance in the United States and the neglect of working class and economically disadvantaged Americans see David J. Rothman, “A Century of Failure: Class Barriers to Reform” in *The Politics of Health Care Reform: Lessons from the Past, Prospects for the Future*, ed. James Morone and Gary S. Belkin. (Durham: Duke University Press, 1994).

²²⁸ For a description of the working class and economically disadvantaged in the United States – particularly those who struggle with poverty but do not qualify for governmental assistance – see Katherine Newman and Victorn Tan Chen, *The Missing Class: Portraits of the Near Poor in America*. (Boston: Beacon University Press, 2008).

²²⁹ “There is no consensus definition of “middle class,” neither is there an official government definition. What constitutes the middle class is relative, subjective, and not easily defined.” Brian W Cashell. Specialist in Quantitative Economics, Government and Finance Division. *CRS Report for Congress*, October 22, 2008. http://assets.opencrs.com/rpts/RS22627_20081022.pdf 1. Based on income, however, Cashell states that the midpoint of income distribution in the United States in 2007 is the median, \$50,233. But he notes that, “How far above and below that amount the middle stretches remains an open question. The US Census Bureau has published figures for 2007 breaking the income distribution into quintiles, or fifths. The narrowest view of who might be considered middle class based on that presentation would include those in the middle quintile, which includes households with incomes between \$39,100 and \$62,000. A more generous definition might be based on the three middle quintiles, those households with income between \$20,291 and \$100,000. 1.

middle-class.²³⁰ It is important to note, however, that middle class in popular culture means far more than income level.²³¹ It relates to social class, the type of work someone has, their values and aspirations, the way they lead their lives, their patterns of recreation, consumption, and their social interactions and networks. A definition of it based strictly on income would be too reductive, however useful it may be in creating clarity and parameters for common understanding of a multifarious word. As a 2010 study on the middle class in America by the US Department of Commerce states,

Income levels alone do not define the middle class. Many very high and very low income persons report themselves as middle class. Social scientists have explained this by defining “middle class” as a combination of values, expectations, and aspirations, as well as income levels. Middle class families and those aspiring to be part of the middle class want economic stability, a home and a secure retirement. They want to protect their children’s health and to send them to college. They also want to own cars and take family vacations.²³²

Still, a minimum income is needed to access the constellation of resources and qualities that contribute to the ‘middle class’ in the American social imaginary – sufficient income, for example, to own a modest suburban home, take a yearly vacation, shop at certain types of stores, and have access to communities that offer reasonable quality schools and other social services.

The term ‘middle class’ – given its vague and malleable nature – can be used as a catch-all phrase that lacks meaningful specificity, and which masks real differences in income, assets, and resources as there is tremendous diversity and breadth amongst individuals and families that are considered to be ‘middle class.’ For example, Mitt

²³⁰ Eduardo Porter. “America’s Sinking Middle Class,” *The New York Times*, September 18, 2013. http://www.nytimes.com/2013/09/19/business/americas-sinking-middle-class.html?_r=0

²³¹ Arthur Vidich, *The New Middle Classes: Social, Psychological, and Political Issues*, (New York: NYU Press, 1994).

Charles B. Nam and Monica Boyd, “Occupation Status in 2000: Over a Century of Census-Based Measurement.” *Population Research and Policy Review*. 23: (2004) 327-358.

²³² US Department of Commerce. “Middle Class in America,” January, 2010, 6. <http://www.commerce.gov/sites/default/files/documents/migrated/Middle%20Class%20Report.pdf>

Romney and Barack Obama have both publicly stated that they view the upper end of the middle class to fall in the income range of \$200,000 - \$250,000 per household. Just how skewed this definition is becomes apparent when we consider that households with \$250,000 in annual income fall above the 96th percentile.²³³ ‘Middle class’ can therefore be used rhetorically as a phrase for strategic conflation between social and economic groups, in which slippage between categories of wealth and social capital is a defining feature of the term and contributes to its rhetorical utility while detracting from its empirical usefulness as a substantive descriptive category.²³⁴

The keyword ‘middle-class’ in American political rhetoric is the way of referring to the American everyman/woman, to a category of Americans that is considered to be deserving of respect, a category of Americans who - unlike the working and unemployed poor - have never been denigrated by disparaging and stigmatizing conservative rhetoric questioning their moral, intellectual, and social integrity and depicting them as parasitical in nature, dependent on government welfare programs, and unwilling to work sufficiently to earn a living that would enable them to be financially independent.²³⁵ ‘Middle-class’ is a category both real and imagined, aspirational as much as empirical, whose construction in American popular and political culture maintains the illusion of a near universal middle-class in which many Americans – aside from the wealthiest elite – desire to

²³³For definitions of the middle class and how Americans choose to define themselves see: Catherine Rampell, “Defining the Middle Class,” *The New York Times*, September 14, 2012. <http://economix.blogs.nytimes.com/2012/09/14/defining-middle-class/>
The use of the figure of \$55,000 offered by some economists and other social scientists is problematic, however. \$55,000 varies in purchasing power substantially, depending on where one lives in the United States. It may provide for a middle class lifestyle in Texas and much of the Midwest, but would be far less valuable in New York City and other expensive major American cities where costs of living are high.

²³⁴For a comprehensive sociology of class structure in the United States, poverty, inequality, and the changing dynamics of American social classes see Dennis L. Gilbert, *The American Class Structure in an Age of Growing Inequality*, (Thousand Oaks: Pine Forge Press, 2011).

²³⁵Angie-Marie Hancock, *The Politics of Disgust: The Public Identity of the Welfare Queen*. (New York: NYU Press, 2004).

Peter Edelman, “Welfare and the Politics of Race: Same Tune, New Lyrics,?” *Georgetown Journal on Poverty and Law Policy* 11 (2004).

Karen McCormack, “Resisting the Welfare Mother: The Power of Welfare Discourse and Tactics of Resistance,” *Critical Sociology*, 30 (2004).

belong and self-identify.²³⁶ It is this ‘middle-class’ which anchors the American social imaginary.

As the New York Times columnist and film critic A.O. Scott explains,

The idea of the universal middle class is a pervasive expression of American egalitarianism – and perhaps the only one left. In politics the middle has all but swallowed up the ends. Tax cuts aimed at the wealthy and social programs that largely benefit the poor must always be presented as, above all, good for the middle class, a group that seems to include nearly everyone. It is also a group that is, at least judging from the political rhetoric of the last 20 years, perennially in trouble: shrinking, forgotten, frustrated, afraid of falling down and scrambling to keep up.²³⁷

The ‘middle-class’ is perceived to encompass the majority of Americans, and thus because it includes such a large and intrinsically diverse population transcends partisanship and sectarian interest, thereby embodying inclusive civic values. It represents – in the popular imagination – the typical, decent, hard working, aspiring American seeking to lead a dignified and secure life for him and herself and his or her family. As our analysis progresses, we will see how the ‘middle-class’ becomes an increasingly prominent signifier in Democratic presidential healthcare reform rhetoric of Presidents Clinton and Obama,²³⁸ but plays a much smaller role in the rhetoric of Truman and

²³⁶Catherine Rampell, “Who Counts as Middle Class,” *The New York Times*, August 23, 2012.

<http://economix.blogs.nytimes.com/2012/08/23/who-counts-as-middle-class/>

Derek Thompson, “Is \$250,000 a Year Really ‘Middle – Income?’” *The Atlantic*, September 14, 2012.

<http://www.theatlantic.com/business/archive/2012/09/is-250-000-a-year-really-middle-income/262402/>

Dylan Matthews, “What is the Middle Class?” *Washington Post*, September 16, 2012.

<http://www.washingtonpost.com/blogs/ezra-klein/wp/2012/09/16/what-is-the-middle-class/>

Fiona Devine, *The Sociological Review. Social Identities, Class Identity, and Political Perspectives*. 40 (2008).

Mike Davis, *Prisoners of the American Dream: Politics and Economy in the History of the US Working Class*, (New York: Verso, 1986).

Rhonda F. Levine, *Social Class and Stratification*, (Lanham: Rowman and Littlefield, 2006).

²³⁷A.O. Scott, “Hollywood’s Class Warfare,” *The New York Times*, December 22, 2010.

<http://www.nytimes.com/2010/12/26/movies/26scott.html>

See also article by Gary Younge in the *Guardian*, February 27, 2011, “Wisconsin is making the Battle Lines Clear in America’s Hidden Class War.”

<http://www.guardian.co.uk/commentisfree/2011/feb/27/republican-attack-unions-class-wisconsin>

²³⁸Most recently, we can see Obama’s extensive, repetitive, and relentless focus on the ‘middle class’ in his first debate with Mitt Romney, held on October 3, 2012. Repeatedly Obama portrayed himself as

Johnson who more explicitly and vigorously champion the economically disadvantaged and the working class who often lack the financial means to afford and/or types of employment that provide health insurance coverage.

3.4 Discourse: An Evolving Theory from Foucault to Fairclough

Discourse is both a theoretical concept and a methodological approach. In its methodological use it refers to specific linguistic statements, images, and symbols that appear in the form of texts and can be analyzed as manifestations of various ideologies and points of view. In its theoretical dimension it refers to the resources of meaning making available in society that constitute the social imaginary and is deeply embedded in an understanding of the social context in which words exert meaning and power and construe both social perceptions and social realities.²³⁹ It refers to the emotions, conceptual frames, associations, and narratives that words create. In this abstract and conceptual sense, discourse consists of formations of meaning and sensibilities that can be seen as emerging from texts and that in some way define, comment on, and perceptually create social reality and social identities from particular vantage points and

protecting the middle class and having their interests as his paramount concern. Only once in his speaking did he acknowledge the working class and economically disadvantaged, towards the end of the speech, when he mentioned those *aspiring to join* the middle class alongside the middle class as the people whose interests he seeks to protect. But other than this one time in all his comments he referred to the middle class, fifteen times over the course of a ninety minute debate.

<http://www.cnn.com/2012/10/03/politics/debate-transcript/index.html>

Romney also appealed to middle class voters in the speech numerous, though not as frequently as Obama. He also made only one reference to low income Americans.

In this debate we also observed Obama's rhetorical focus on arguments based on pragmatism and efficiency rather than justice and morality. In speaking about government programs that are essential for disadvantaged Americans – such as grants for education – he spoke primarily about these as investments in human capital rather than as rights, entitlements, or reflections of the principles of equality of opportunity and communitarian social solidarity.

²³⁹James Paul Gee, *Discourse Analysis: Theory and Method*, (London: Routledge, 2000.) 82-83, 120-124.

George Lakoff, *Moral Politics: How Liberals and Conservatives Think*.

George Lakoff and Mark Johnson. *Metaphors We Live By*. Chicago: University of Chicago Press, 2003.

positions of power which exhibit diverse aspirations to power and aspirations to withhold and extend power to and from others.

Norman Fairclough draws upon Michel Foucault for certain aspects of his theory and methodology of critical discourse analysis, CDA. Although I do not apply CDA as my methodology, the theoretical definition of discourse it provides is a productive one in which the concept of the social imaginary can be fruitfully located. Fairclough draws an important distinction between his theoretical definition of discourse and Foucault's. According to Fairclough, Foucault's interest in discourse is focused on the general field of topics, ideas, morals, and their associated psychological and social assumptions that particular discourses entail and enable. For example, a discourse about mental illness may presuppose certain ideas of normality and abnormality, normative claims about ideals of mental health and definitions of pathology, and articulation of mental illness as something that the broader public needs to be protected against, and which may entail the creation of physical sites such as mental hospitals to separate the mentally unfit and unstable from the mentally healthy.

Fairclough's approach to CDA takes into account such ideational and ethical patterns within discourse, but it does so grounded in close readings of texts, rather than in Foucault's broader analysis of the spheres of knowledge, ethics, and actions that particular subject discourses, such as discourses of mental illness, allow. Fairclough states that Foucault was interested initially, primarily in the discourses of the human sciences: medicine, psychiatry, economics and grammar and how these inform our conception of what constitutes knowledge and truth. This was Foucault's way of attempting a new form of social scientific analysis, distinctive from structuralism and hermeneutics.²⁴⁰ Fairclough states, "His focus is upon the 'conditions of possibility' of discourse, upon rules of formation which define the possible 'objects', 'enunciative modalities', 'subjects',

²⁴⁰ Norman Fairclough. *Discourse and Social Change*. (Polity: Cambridge, 1999), 38.

‘concepts’ and ‘strategies’ of a particular type of discourse.’²⁴¹ In short, Fairclough and CDA integrate the application of social theory with close linguistic analysis of texts, whereas Foucault concerns himself primarily with social theory, and not with the particular texts that give expression to its claims. Rhetoric analysis, which I employ as my methodology, shares the orientation of CDA of close linguistic analysis of texts, but does not focus on how the language of texts relates to social theory.

Foucault’s theorizing of power and the way in which discourse reflects power struggles significantly informs CDA. Two insights in particular from Foucault’s early archaeological research which Fairclough integrates into CDA are:

1. the constitutive nature of discourse – discourse constitutes the social, including ‘objects’ and social subjects;
2. the primacy of interdiscursivity and intertextuality – any discursive practice is defined by its relations with others, and draws upon others in complex ways.

From Foucault’s genealogical work Fairclough highlights:

- 1 the political nature of discourse – power struggle occurs both in and over discourse;
- 2 the discursive nature of social change – changing discursive practices are an important element in social change.²⁴²

²⁴¹ Ibid

²⁴² Norman Fairclough. *Discourse and Social Change*, 55-56.

As I apply rhetoric analysis to my selected texts these will form a part of the analytical concepts that I will apply to analyze how discourse informs the social imaginary and the moral order it articulates and defends.

Norman Fairclough's definition of discourse captures the way in which the concept embodies the possibilities of power to exert itself through language and language's impact on social and political perception and communication.

Discourse as a political practice establishes, sustains and changes power relations and the collective entities (classes, blocs, communities, groups) between which power relations obtain. Discourse as an ideological practice constitutes, naturalizes, sustains, and changes significations of the world from diverse positions in power relations...²⁴³

Discourse then is a way of justifying, rationalizing, and defending political, social, and economic projects – doing so often in implicit ways which avoid acknowledging the real purposes of discourse which often is to legitimize particular patterns of dominance and exclusion. There are three aspects of discourse, what CDA calls the 'meta-functions of discourse', which are central in the construction of social reality and identities by discourse and in the ideologies, spheres of power, and relations they create and maintain.

These are:

1. Ideational – naming and representing the world: the categories, concepts, ideologies, and values within a given discourse.
2. Interpersonal – the social relationships and interactions that a discourse encourages and discourages, enables and denies.

²⁴³ Norman Fairclough. *Discourse and Social Change*, 67.

3. Textual – the internal coherence and patterns of reasoning and linguistic expression of a given discourse.²⁴⁴

Each of these elements is present in presidential depictions of the social imaginary with its ideational components in relation to democratic values and principles such as communitarian solidarity and equal opportunity, its interpersonal character in relation to arguments about the moral and political bonds and obligations that tie citizens to one another and the government to citizens, and textual in relation to the specific definitions presidents provide of the American social imaginary. I will address these three aspects of political discourse in my analysis of the selected texts addressing healthcare reform.

3.5 The Public Realm

Drawing on these theories of discourse and the social imaginary, it follows that power and hegemony can only be expressed and maintained on a sustainable basis in a liberal democracy through efforts to legitimize them in relation to the purported values, culture, and aspirations of the public. It is through the creation of a distinctly conservative social imaginary that the power and hegemony of conservative Republicans, and the exclusionary practices they advocate and maintain, can assert themselves and achieve popular legitimacy and the status of normalcy. There is a tension between the possibility of a social imaginary that is inclusive of economic and social diversity²⁴⁵ and empowers economic minorities and encourages freedom as Craig Calhoun and Martha

²⁴⁴ Lillie Chouliaraki, “Discourse Analysis” in *The Sage Handbook of Cultural Analysis*, ed. John Frow and Tony Bennett (Thousand Oaks: Sage, 2008), 691.

²⁴⁵ Although I focus on liberal and conservative rhetoric as it applies to the economically disadvantaged who cannot afford healthcare it is not always possible to separate out economic class and economic status from social class and social status. Rhetoric that overtly refers to the poor often carries connotations of meaning that relate to social status that transcend income and that may include ethnic background.

Nussbaum argue is a prerequisite for sustainable and credible democracy, and the possibility of a social imaginary that is exclusionary in nature, advocating and maintaining narrow and exclusive boundaries of community and solidarity. The two elements of exclusion/dominance over the economically and socially disadvantaged and empathy for out-groups and the maximization of their freedom coexist in the public realm. They pull the moral order of the social imaginary in different directions. Calhoun and Nussbaum present normative arguments for what the characteristics of the public realm ideally should consist of, although the public realm often falls prey to demagoguery and discrimination in reality.

The public realm is the space in which political and socio-cultural performance and struggle take place and where public opinion is formed. Alan Finlayson provides a description of this space of political contestation,

The place where these heterogeneous world-views and multifarious forms of expression meet is the place of politics... Here political actors present their interpretations of the situation, visions of the world and proposals for what we should do; they must find the arguments around which different peoples can form a common view and act in concert.²⁴⁶

The public realm consists of civil society, the media, intellectuals and individuals engaged in the creative arts, politicians, public servants, and the private sector. Discourse in the public realm may take on many forms, rational and irrational, cognitive and affective. Often the most influential forms of discourse in the public realm are those that are emotionally charged, simple, direct, and easily reproduced and internalized. The speeches of politicians are important rhetorically because they have a huge influence on and often set the agenda of political parties, (while also reflecting party preferences) of the issues that the media covers and debates, and consequently, of public dialogue generally and of

²⁴⁶ Alan Finlayson, "For the Sake of Argument: Re-imagining Political Communication," *Soundings*, 33 (2006): 36.

public perceptions of social and political realities. They serve as ways to channel public zeal in a particular direction and provide guidance to the content of communication, and the emotions that inspire both the content of the dialogue and the manner in which it takes place. In so doing they serve as a way to legitimize and delegitimize certain values, policies, and groups of people.²⁴⁷

To understand the character of the social imaginary and the context in which it is created and debated we need a theory of the public realm which explains the overlap and interaction between individuals, groups, and society at large, which Craig Calhoun provides. It is in the public realm where the social imaginary is subject to continuous change and development.

Publics are self-organizing fields of discourse in which participation is not based primarily on personal connections and is always in principle open to strangers. A public sphere comprises an indefinite number of more or less overlapping publics, some ephemeral, some enduring, and some shaped by struggle against the dominant organization of others... Communication in public also informs the sharing of social imaginaries, ways of understanding social life that are themselves constitutive of it.²⁴⁸

This is a practical description of the public realm, rather than a normative one. But the last sentence alludes to a normative one, because if the social imaginaries constructed in the public realm exclude minorities (including the impoverished) and undermine the egalitarian basis of democracy then the public realm actively undermines the possibility of genuine democracy that respects the rights of all its citizens alike.

²⁴⁷Van Dijk, "Principles of Critical Discourse Analysis," 255.

Political elites have "special access to discourse: they are literally the ones who have the most to say." They have extensive symbolic power because of the tremendous extent of their "discursive and communicative scope and resources."

²⁴⁸ Craig Calhoun, "Imagining Solidarity: Cosmopolitanism, Constitutional Patriotism and the Public Sphere," *Public Culture* 12 (2002): 162.

Indeed Calhoun argues that public realms that systematically exclude minority groups threaten and make impossible the maintenance of a democratic public - which he argues is predicated on the basis of universality, equality, and non-discrimination. As a consequence, he argues that in a democracy it is essential that individuals exercise their capacity for empathy, giving voice to the foundational discourse of liberalism and the social imaginary it champions. On this basis their ability to exercise democratic solidarity depends and on this basis they can change, expand, and develop their personal and collective identities and normative commitments. Thus Calhoun provides us with both a functional description of the public realm and a normative one without which the public realm amounts to little more than a public echo chamber of dissonant voices and opinions, without any shared sense of values and overarching commitment to a democratic social imaginary that acknowledges and respects the equality of all citizens.

Although the social imaginary has the positive potential of enabling a moral order that cultivates empathy for the marginalized, vulnerable, and impoverished it is a potential that may be rejected, accepted, or simply ignored, in favour of the status quo and the power structure it maintains. The centrality of the emotional state of empathy is also a major component of Martha Nussbaum's theory of the individual and collective civic traits needed in a democracy that respects human dignity, freedom, and equality. Nussbaum analyzes the role of empathy and emotional openness in enriching democracy. She argues that empathy enables moral thought and moral understanding that promotes tolerance; it helps individuals reach beyond the boundaries of their own identities and values to understand 'others' and appreciate human difference.²⁴⁹

According to Calhoun discourse in a democratic public realm cannot simply reiterate dominant and socially accepted identities and values; for it to be genuinely

²⁴⁹ Martha Nussbaum, *Upheavals of Thought: The Intelligence of Emotions*. (Cambridge: Cambridge University Press, 2003). See also, Martha Nussbaum, *Poetic Justice: The Literary Imagination and Public Life*. (Boston: Beacon Press, 1997.)

democratic in nature, that is, egalitarian and non-discriminatory, it needs to be characterized by openness and malleability that enables it to embrace difference and to evolve in ways that enable tolerance and new forms of social relationship and mutual understanding. In this regard the public realm depends upon rationality for its coherence. Calhoun explains that a public realm in a democracy must be able to accommodate diverse personal and group identities, including gender, class, and nationality/ethnic background. It also, “requires participants to be able - at least some of the time - to adopt perspectives distanced from their immediate circumstances, and thus carry on conversations that are not determined strictly by private interest or identity.”²⁵⁰ In advancing principles of equal opportunity and communitarian social solidarity in defense of their efforts to expand access to healthcare each Democratic president seeks to advance a social imaginary that is more expansive and inclusive and which invites Americans to think beyond their own immediate, narrow interests. But each president pursues this in distinct ways, with Truman and Johnson pushing the social imaginary in more dramatic and expansive ways to explicitly include the economically disadvantaged and working class, whereas Clinton and Obama, in their rhetorical emphases on the ‘middle class’ do not make as explicit a demand of US citizens to appreciate the perspectives, experiences, and needs of minority groups such as the economically disadvantaged.

In a democracy, Calhoun argues, this process of acknowledging and respecting diversity and offering recognition to diverse groups within society can only be considered genuinely inclusive if it does not compromise the identity of minority and/or marginalized groups, whereby in order to gain recognition they must downplay their own

²⁵⁰ Craig Calhoun, “Imagining Solidarity: Cosmopolitanism, Constitutional Patriotism and the Public Sphere,” 165.

identity, concerns, difference, and perspective. This is the social element of the public realm. Calhoun writes,

...Inclusiveness is also a matter of how the public sphere incorporates and recognizes the diversity of identities that people bring to it from their manifold involvement in civil society. It is a matter of whether, for example, to participate in such a public sphere, women must act in ways previously characteristic of men and avoid addressing certain topics defined as appropriate to the private realm...²⁵¹

Martha Nussbaum addresses the way in which conservative rhetoric can inspire shame amongst the minorities it targets by demeaning them and depicting them as deviants and/or suffering because of their own lack of initiative and incompetence, causing them to conceal aspects of their identities and, in some cases, to internalize stigmatization. In doing so it fails to generate the basic qualities of public and political discourse that Calhoun argues are necessary in a democracy.²⁵²

Charles Taylor theorizes how a theory or an ideology of the socially acceptable is introduced through public discourse and via this discourse impacts the reality of the social and political world, transforming it, the behavior of individuals, and the perception individuals have of it.

...people take up, improvise, or are inducted into new practices. These practices are made sense of by the new outlook, the one first articulated in the theory; this outlook is the context that gives sense to the practices... the new understanding... begins to define the contours of their world...²⁵³

²⁵¹ Craig Calhoun, "Imagining Solidarity: Cosmopolitanism, Constitutional Patriotism and the Public Sphere," 167.

²⁵² See Nussbaum, Martha. *Hiding from Humanity: Disgust, Shame and the Law*. (Princeton: Princeton University Press, 2006.) See also Yoshino, Kenji. *Covering: The Hidden Assault on Our Civil Rights*. (New York: Random House, 2007.)

²⁵³ Charles Taylor, "Modern Social Imaginaries," *Public Culture* 14 (2002): 111.

Calhoun further argues that the public realm is itself a form of social solidarity. What makes it distinctive, he argues, is that it is “created and reproduced through discourse.”²⁵⁴ He goes on to stress the importance of discourse’s constitutive role in the formation of the public realm, because, “It is not primarily a matter of unconscious inheritance, or power relations, or of the usually invisible relationships that are forged as a by-product of industrial production and market exchanges...”²⁵⁵ It is precisely the role of American liberal political rhetoric in discursively producing and reshaping the American social imaginary to yield an inclusive and expansive form of social and political solidarity that rejects the political philosophy of ‘limited government’ which I examine. By insisting upon guaranteed state provision of health insurance on the basis of equality, recognition of vulnerability, and amelioration of economic and social disadvantage Democratic presidents revise the moral order to embrace these principles. They challenge the tendency of conservative Republican discourse to depict those who are poor and cannot afford healthcare negatively and in contrast to positive conservative Republican depictions of those Americans who are wealthier and can afford health insurance.²⁵⁶

3.6 Conclusion

By analyzing presidential speeches on healthcare reform we are able to examine how presidents use their unique position of power and authority within the public realm

²⁵⁴ Craig Calhoun, "Imagining Solidarity: Cosmopolitanism, Constitutional Patriotism and the Public Sphere," 159.

²⁵⁵ Ibid

²⁵⁶ Teun A van Dijk. *Critical Discourse Analysis*. <http://www.hum.uva.nl/~teun/cda.htm>

“To appear in Deborah Tannen, Deborah Schiffrin & Heidi Hamilton (Eds.) *Handbook of Discourse Analysis*.

American political conservatism is not unusual in asserting dominance by stigmatizing and marginalizing the poor to enable the collective self-interest of wealthier Americans in maintaining low taxes,

Van Dijk argues that, “What we may conclude from many critical studies is the prominence of overall strategy of Positive Self-Presentation of the dominant ingroup, and Negative Other-Presentation of the dominated out groups. The polarization of Us and Them that characterizes shared social representations and their underlying ideologies is thus expressed and reproduced in all levels of text and talk.”

which commands the attention of the American public to both define and respond to the social imaginary. The American social imaginary continues to be fiercely contested discursive terrain, with Democratic presidents seeking both to initiate changes to it to expand it in ways that include economically and socially disadvantaged Americans and to respond to changes caused by Republican counterparts, such as Ronald Reagan, who have shifted the imaginary substantially in ways that are inimical to efforts to expand access to affordable healthcare because of Republican critiques of government spending and social welfare programs and their attacks on recipients of welfare spending.

Democratic presidents have shifted the content and tone of their arguments as the social imaginary has been contested and changed, with each advancing a distinctive balance of pragmatism and principle, rhetorical and moral caution and daring, seeking to maximize the extent to which citizens will relate to and identify with their efforts in a context which has become increasingly hostile to efforts to expand access to and affordability of healthcare. Consequently, ethos, pathos, and logos in each president's speech is distinctively articulated in relation to these different presidential orientations and emphases as to how much they wish to guide the social imaginary and to potentially challenge and revise it or to take a less active proactive role in its formation and instead reactively seek to contain the emerging limited government conservatism that undermines Democratic principles of equal opportunity and communitarian social solidarity.

To the extent that some Democratic presidents have chosen a more politically moderate and compromising stance, analysis of their speeches reveals how the American social imaginary has emerged in a way that incorporates elements of Republican limited government ideology not only as a result of Republican efforts but also of deliberate Democratic appropriation of elements of these ideas and ideals and incorporation into a new conciliatory centrist Democratic rhetoric which strives to appeal to as broad a

segment of the American population as possible. By critically analyzing these new constructions of the American social imaginary we are able to assess the extent to which they accurately reflect social and historical realities or if – in their efforts to maximize their appeal across party lines - they reflect elisions and marginalization of particular social groups such as the economically disadvantaged.

As the middle class has become a reference point for common American aspiration and achievement that is a stable aspect of the American social imaginary Democratic presidential healthcare reform rhetoric has increasingly oriented itself towards this both real and imagined constituency, making direct appeals to ‘middle class’ Americans and anchoring the social imaginary in their perceived needs. Analyzing the presidential rhetoric will reveal how this rhetorical shift has evolved over time and allow us to consider its potential social implications on those economically disadvantaged Americans increasingly excluded from the social imaginary Democratic presidents exhort. Having examined the definition of the social imaginary and its place within discourse and the changing nature of appeals to particular groups within the imaginary, we will now turn to the methodology of the thesis.

Chapter 4: Methodology: Rhetoric Analysis

4.1 Why I Use Rhetoric Analysis

Through the application of rhetoric analysis a researcher can reveal in detail the ways in which language produces constructions of reality, morality, identity and relationships – all of which are components of the social imaginary - and thereby, seeks to persuade publics to support categories of inclusion and exclusion, legitimacy and illegitimacy, and particular ideologies and principles of justice. This enables my original contribution to knowledge in allowing me to pursue a comparative history of rhetoric and to analyze the evolution of American Democratic presidential healthcare reform rhetoric.

I have chosen rhetoric analysis as a methodology because of its capacity to reveal nuanced and multi-layered and multi-dimensional forms of meaning and its holistic approach to revealing the potential meanings embedded in texts within an interdisciplinary context which acknowledges the political, social, and historical aspects and resonances of texts. It enables the researcher to reveal and consider symbolic meanings, which are plentiful in presidential speeches generally, and especially in the presidential speeches I examine with their numerous patriotic and historical references and narratives. In light of my research questions on the nature of the American social imaginary American presidents invoke and evoke, the place of emotions and ethics within it, the ways in which particular social and economic classes are depicted, and the intricate usage of specific rhetorical strategies to contribute to the persuasive aims of the presidential speeches, rhetoric analysis provides for me the most effective methodology

to explore and answer these queries.²⁵⁷ In particular, it acknowledges the central role that public speech has in defining and framing a range of political and social issues, and enables analysis of the intellectual and ethical-practical consequences of these frames and definitions and how they are used in conflicting ways by politicians with differing ideologies. Alan Finlayson's commentary on the ways in which poverty can be rhetorically framed, for example, has particular relevance to Democratic presidential rhetoric.

Phenomena can be problematised in different sort of ways... poverty may be understood as an economic problem or a moral one. It is a problem that may be understood to lie in the organisation of production or the idleness and fecklessness of the poor themselves (or it may not be conceived as a problem at all).²⁵⁸

My thesis concerns itself with 'thick description' and qualitative analysis for which rhetoric analysis and its capacity for descriptive and interpretive sensitivity and integration with historical analysis and contextualization in politics and history is a particularly appropriate methodology. For this reason I have chosen not to use content analysis as a methodology, because it will not enable me to examine the intricate meanings of the presidential speeches and to analyze them holistically and in the context of a comparative history of rhetoric.

To properly situate American presidential healthcare reform rhetoric in a political and historical context, in Chapters 1 and 2 I refer principally to the scholarship of political scientists, historians, and policy analysts, in particular: Stuart Altman, Jill Quadagno, Theda Skocpol, and Paul Starr. Each of these scholars as well as other historians, political scientists, and policy analysts address the role of rhetoric in healthcare reform efforts though only in a brief and generalized way, making observations about

²⁵⁷Brian Vickers, "In Defense of Rhetoric." (Oxford: Clarendon Press, 1989).

Bryan Garsten. *Saving Persuasion: A Defense of Rhetoric and Judgment*. (Boston: Harvard University Press, 2009).

²⁵⁸Finlayson, 2007, 555.

rhetorical themes and tropes, but not engaging in extensive close readings and analysis of texts. Their comments on the use of rhetoric in healthcare reform efforts enriches my own by providing a macro social and historical context in which to situate my focused analysis of particular presidential speeches. Their writings provide a critical linkage between the spoken word and the practicalities of power politics, patterns of culture and political ideas, and the intricacies of public policy.

Thematizing the importance of analyzing political speeches as the privileged terrain for the study of the symbolic power of discourse and, specifically, of the tactics and strategies of political persuasion, Ruth Wodak says that,

Language is not powerful on its own; it gains power by the use powerful people make of it... Texts are often seen as sites of struggle in that they show traces of differing discourses and ideologies contending with struggling for dominance...²⁵⁹

Illuminating strategies of persuasion in discourse constitutes rhetoric analysis. To analyze the values, ideas, and power matrices that texts and speeches confront, create, assert, deny, manipulate, obscure, and appropriate and how that process includes and excludes particular social groups is the main research goal of my methodology.

4.2 Rhetoric Analysis and Discourse Analysis: Similarities and Differences

Rhetoric Analysis is similar to CDA but is less explicitly and principally concerned with expressions of power within texts and how texts enable relations of power, dominance, and social inequality.²⁶⁰ Rhetoric analysis has a much older tradition and is more focused on examining the nature of arguments and illustrating the persuasive aspects of texts in relation to statecraft and diplomacy which is the context in which

²⁵⁹Ruth Wodak, *The Discourse of Politics in Action: Politics as Usual*, (London: Palgrave Macmillan, 2009), 35.

²⁶⁰Van Dijk, "Principles of Critical Discourse Analysis," 249.

Aristotle's theories of rhetoric developed. Rhetoric analysis also incorporates particular concern with situating speech in its historical and cultural context, as well as taking into account psychological aspects of speech through analyzing the themes and styles of texts.

Rhetoric analysis often takes a more macroscopic view of texts²⁶¹ – a philosophy and approach I share - than discourse analysis' often microscopic and grammatically and syntactically oriented one. It does, however – like CDA - address power with regard to the analysis of socially determined signifiers such as the phrase, 'middle-class' and does examine issues of power inequalities and injustice and how rhetoric reflects, espouses, and challenges them, though this is not necessarily its main aim and rhetoric analysis may eschew this subject all together.

Rhetoric analysis orients itself somewhat more than CDA to analyzing the internal coherence and aims of particular texts without necessarily using them to illustrate larger societal patterns of domination and without applying particular social theories to reveal these patterns of domination. As Alan Finlayson notes, "Critical discourse analysis generates interesting findings but seems to presume political oratory to be merely a cover for dubious interests and is fixated on exposing evasions and omissions rather than attending to argumentative content."²⁶² Rhetoric analysis reflects the expansive interests and definition of the field of communication, as defined by the National Communication Association in the United States as, "the discipline that studies all forms, modes, media, and consequences of communication through humanistic, social scientific and aesthetic inquiry."²⁶³ Rhetoric analysis particularly concerns itself with the humanistic and aesthetic inquiry which discourse analysis largely elides. Rhetoric analysis applies a less uniformly

²⁶¹For this holistic approach see, for example, the journals *Rhetoric and Public Affairs* and the *Quarterly Journal of Speech* for their analyses of presidential speeches, which I discuss later in this chapter.

²⁶² Finlayson, 2007, 552-553. See also Alan Finlayson, "Political Science, Political Ideas and Rhetoric," *Economy and Society* 33 (2004): 539.

²⁶³ Website of the National Communication Association. 'NCA's Mission.'
<http://www.natcom.org/Default.aspx?id=46>

agreed upon schema for analysis of texts than discourse analysis and affords greater individual freedom to the individual conducting the analysis to establish his own distinctive conceptual and analytical framework, major reasons I have chosen it as my primary methodology.

CDA, in contrast to rhetoric analysis has a more explicitly emancipatory and normative objective and its use is often more transparently political. Van Dijk offers several definitions of CDA which address not just its moral orientation but its intellectual-activist orientation as well. “CDA should deal primarily with the discourse dimensions of power abuse and the injustice and inequality that result from it.”²⁶⁴ CDA attempts to locate examples of prejudice, discrimination, and domination of disadvantaged and vulnerable groups that is expressed in language and texts, often in deliberately evasive ways which allow powerful individuals and groups to assert hegemony without having to take responsibility for it. Van Dijk characterizes the work of discourse analysts as “admittedly and ultimately political”²⁶⁵ and states that critical discourse scholars should be “social critics and activists”²⁶⁶ and that “CDA is unabashedly normative: any critique by definition presupposes an applied ethics.”²⁶⁷ For van Dijk the overall project of CDA is a moral-social one which permeates and unites its theory, methodology, and practice alike and should draw together critical discourse analysts from disparate fields and cultures with varying theoretical and methodological emphases and paradigms. “International, theoretical, and methodological integration would obviously benefit the realization of a common aim, namely to analyze, understand

²⁶⁴ Van Dijk, “Principles of Critical Discourse Analysis,” 252.

²⁶⁵ Ibid.

²⁶⁶ Ibid.

²⁶⁷ Van Dijk, “Principles of Critical Discourse Analysis,” 253.

²⁶⁷ Ibid.

and combat inequality and injustice.”²⁶⁸ Offering a comprehensive definition of CDA, van Dijk states,

Critical Discourse Analysis is a type of discourse analytical research that primarily studies the way social power abuse, dominance and inequality are enacted, reproduced and resisted by text and talk in the social and political context. With such dissident research, critical discourse analysts take explicit position, and thus want to understand, expose, and ultimately resist social inequality.²⁶⁹

I use the term ‘rhetoric analysis’ throughout in an expansive way which incorporates elements of discourse analysis and critical discourse analysis.²⁷⁰ However, because my analysis is less grounded in social theory and particular theories of power than those associated with critical discourse analysis, I use the term ‘rhetoric analysis’ to refer to my primary analytical tool and methodology. Furthermore, because I focus on liberal challenges to conservative discourse that has shown a marked historical tendency to disavow government responsibility to provide healthcare to impoverished and otherwise disadvantaged Americans, my analysis is less principally concerned with power abuse, dominance, and exploitation than it is with rejection of²⁷¹ these oppressive phenomena. Although I am sympathetic to the emancipatory normative orientation of CDA my use of rhetoric analysis and discourse analysis is not ideologically oriented towards an explicit

²⁶⁸Van Dijk, “Principles of Critical Discourse Analysis,” 279.

²⁶⁹ Teun A van Dijk. Critical Discourse Analysis. <http://www.hum.uva.nl/~teun/cda.htm>.

“To appear in Deborah Tannen, Deborah Schiffrin & Heidi Hamilton (Eds.) *Handbook of Discourse Analysis*.

²⁷⁰ I am sympathetic to Michael Billig’s assertion regarding the tendency of scholars to formally affiliate with CDA that “Young academics should not seek to identify themselves with a defined way of doing academic research, but should see themselves as engaged in the critical analysis of discourse.” Michael Billig, “The Rhetoric of Critique” in *Critical Discourse Analysis: Theory and Interdisciplinarity*, ed. Gilbert Weiss and Ruth Wodak (New York: Palgrave Macmillan, 2003), 44-45.

²⁷¹ Technically, enquiry into the phenomenon of ‘resistance’ to oppression is a major concern of CDA as well, as van Dijk notes in his aforementioned definition of CDA. Nevertheless, the bulk of CDA research focuses on illustrating and analyzing hegemony rather than examining forms of resistance to it.

emancipatory end goal although it concentrates on the way in which Democratic presidents have tried to use rhetoric to advance emancipatory healthcare policies.

4.3 Aristotle's Theory of Rhetoric: Appeals to Ethos, Pathos and Logos

I use Aristotle's tripartite conceptual framework of ethos, pathos, and logos to analyze how presidential speakers unite ethical values and their purported ethical qualities of character,²⁷² generate emotions for audiences, and develop a particular logic of ideas and arguments – moral and otherwise which impels their listeners to be persuaded of the veracity and value of their claims. In so doing, rhetoric analysis reveals the ways in which presidential political texts seek to defend particular policy prerogatives and inspire citizen support for them and understanding for their rationale, aims, and the larger civic, ethical, and cultural context in which presidents situate them.

In undertaking rhetoric analysis of key presidential speeches I am able both to analyze each speech as a discrete and unique entity and to examine it in a comparative perspective, noting the different ways in which each speech applies ethos, pathos, and logos and the extent to which it emphasizes each one. The historical comparative perspective I apply is well served by the methodology of rhetoric analysis which facilitates exploration of the evolution of rhetoric, its changes and continuities across time. I examine how each president employs different rhetorical strategies and emphases, contextualizing them in relation to the dominant social imaginary and moral order of the time period in which they address the nation and attempt to shift that social imaginary and moral order in a more egalitarian and communitarian direction.

²⁷² Although Aristotle uses the term 'ethos' to refer primarily to the character of the speaker I use it – by extension – to refer to the ethical values the speaker espouses which are integral to the character that he projects rhetorically.

Kenneth Burke emphasizes the close reading at the heart of rhetoric analysis which he argues is necessary to reveal the often intricate and multiple meanings embedded in texts, their dramatic qualities, symbolic resonance, and the way in which they come together as a whole, “the modes of rhetorical appeal can be stated in highly generalized terms, yet any given exhortation arises out of a context so immediately urgent as to be unique.”²⁷³ My rhetorical analysis draws principally from Aristotle and is informed by Burke’s general theories of rhetoric. I also draw upon the contemporary tradition of political rhetoric analysis exemplified by the relatively young journal, *Rhetoric and Public Affairs*²⁷⁴ and the older journal of rhetoric studies which has been and remains a major address for rhetorical analyses of political speeches, the *Quarterly Journal of Speech*.²⁷⁵ These journals have proved invaluable in providing a broad context for analyzing presidential rhetoric beyond healthcare reform, particularly as much of their recent scholarship analyzes how Barack Obama has depicted the American social imaginary.²⁷⁶

For Aristotle, projecting positive character is essential to render rhetoric persuasive. Aristotle cites three qualities as necessary for demonstrating ethos: good will, practical wisdom, (phronesis) and virtue.²⁷⁷ Kenneth Burke presents a similar idea in his concept of ‘identification’ and Burke’s theories of rhetoric builds closely on Aristotle’s. In ‘Rhetoric of Motives’ he explains that the audience identifies with the speaker when they perceive shared interests, qualities, and beliefs: “You persuade a man only insofar as

²⁷³ Burke, p. 38.

²⁷⁴ David A. Frank and Mark Lawrence McPhail, “Barack Obama’s Address to the 2004 Democratic National Convention: Trauma, Compromise, Consilience, and the Impossibility of Racial Reconciliation” *Rhetoric and Public Affairs* 8 (2005).

Robert C. Rowland and John M. Jones, “One Dream: Barack Obama, Race, and the American Dream.” *Rhetoric and Public Affairs*. 14 (2011).

Martin Carcasson, “Ending Welfare as we Know It: President Clinton and the Rhetorical Transformation of the Anti-Welfare Culture” *Rhetoric and Public Affairs*, 9 (2006).

²⁷⁵ Robert C. Rowland and John M. Jones. “Recasting the American Dream and American Politics: Barack Obama’s Keynote Address to the 2004 Democratic National Convention” *Quarterly Journal of Speech* 93 (2007).

Robert E. Terrill. “Unity and Duality in Barack Obama’s ‘A More Perfect Union’” *Quarterly Journal of Speech* 95 (2009).

²⁷⁶ Ibid. See also footnote 273 above.

²⁷⁷ Aristotle. *On Rhetoric: A Theory of Civic Discourse*. (Oxford: Oxford University Press, 2006.)

you can talk his language by speech, gesture, tonality, order, image, attitude, idea, identifying your ways with his.”²⁷⁸ Burke refers to style as a form of “ingratiation”²⁷⁹ and rhetoric as an attempt “to gain favour by the hypnotic or suggestive process of ‘saying the right thing.’”²⁸⁰ Burke builds on Aristotle by acknowledging that while persuasion is at the heart of rhetoric, his introduction of the concept of ‘identification’ allows for the more complex psychological and dramatic modes of expression that rhetoric strives for and achieves which are not limited to matters of the rational and logical. Burke writes,

When we come upon such aspects of persuasion as are found in ‘mystification,’ courtship, and the ‘magic’ of class relationships, the reader will see why the classical notion of clear persuasive intent is not an accurate fit, for describing the ways in which the members of a group promote social cohesion by acting rhetorically upon themselves and one another.²⁸¹

He goes on to acknowledge that the concepts and terms of persuasion and identification cannot be neatly divided and ultimately act together rhetorically in an integrated and holistic way.

We might well keep it in mind that a speaker persuades an audience by the use of stylistic identification; his act of persuasion may be for the purpose of causing the audience to identify itself with the speaker’s interest; and the speaker draws on identification of interests to establish rapport between himself and his audience. So there is no chance of our keeping apart the meanings of persuasion, identification, and communication.²⁸²

Similarly, as we will see, the Aristotelian tripartite conceptual paradigm of ethos, pathos, and logos operationalizes itself in an interdependent and holistic way in texts.²⁸³

²⁷⁸ Martha S. Cheng, “Ethos and Narrative in Online Educational Chat” in *Rhetoric in Detail*, ed. Barbara Johnstone and Christopher Eisenhart, (Amsterdam: John Benjamins, 2008), 196.

²⁷⁹ Kenneth Burke, *Permanence and Change*, (New York City: New Republic, 1935), 71.

²⁸⁰ *Ibid.* In another work he explains that ‘doing the right thing’ entails in part pleasing the audience by ‘arousing and fulfillment of desires.’

Kenneth Burke, *Counter-Statement*, (New York: New Republic, 1931), 38-57.

²⁸¹ Kenneth Burke, *A Rhetoric of Motives*. (New York: Prentice Hall, 1950), xiv.

²⁸² *Ibid.* 46.

²⁸³ Martha Cheng argues that it is difficult to justify a clear separation between these concepts.

Burke's analyses of rhetoric place emphasis on the ability and aim of rhetoric to change attitudes because, "An attitude contains an implicit program of action."²⁸⁴ According to Burke, "the symbolic act is the dancing of an attitude."²⁸⁵ This cultivation of particular attitudes is essential for politicians who want political support to pass particular pieces of legislation. Thus when Burke states that 'An attitude is an 'incipient act'²⁸⁶ he understands that in a democracy politicians cannot undertake major policy acts without the consent and ongoing support of the public. Burke theorizes a pentad in 'Grammar of Motives' "act, scene, agent, agency, purpose – which correspond respectively to the what, the where and when, the who, the how, and why of utterances,"²⁸⁷ for which a rhetoric analysis must account. He sets out the subtle distinction between poetic, scientific, and rhetorical language emphasizing the centrality of persuasive effort to change attitude to rhetorical language. "Whereas poetic language is a kind of symbolic action, for itself and in itself, and whereas scientific action is a preparation for action, rhetorical language is inducement to action (or to attitude, attitude being an incipient act.)"²⁸⁸

The division between ethos, pathos, and logos is often not obvious and sharp, they overlap. "Garver's study of Aristotle's Rhetoric focuses on practical wisdom and character. He uses practical wisdom to argue that the separation of logos and ethos is superficial, not substantive. He claims that the reasoning in rhetoric, which is always concerned with contingent matters, only persuades when it is also a sign of practical wisdom. And, at times, reasoning does not persuade when it is not also a sign of character. When an audience witnesses a rhetor's reasoning and judges it to be good reasoning, they are also judging the character of the speaker – that the ends and values guiding that reasoning are signs of practical wisdom." Martha S. Cheng, "Ethos and Narrative in Online Educational Chat" in *Rhetoric in Detail*, 197.

²⁸⁴ Kenneth Burke, *A Grammar of Motives*. (New York City: Prentice Hall, 1945), 57.

²⁸⁵ Stephen Bygrave, *Kenneth Burke: Rhetoric and Ideology*. (New York: Routledge, 1993), 24.

²⁸⁶ Kenneth Burke, *A Rhetoric of Motives*, 42.

²⁸⁷ Stephen Bygrave, *Kenneth Burke: Rhetoric and Ideology*, 85.

²⁸⁸ Stephen Bygrave, *Kenneth Burke: Rhetoric and Ideology*, 85.

4.4 Rhetoric Analysis in Practice: Mapping Rhetorical Strategies and their Rhetorical Effects

A rhetorical strategy is a tool of persuasive communication that enables the advancement of a particular argument and/or idea on a micro level while framing it on a macro level within the broader persuasive aims of the speech as a whole. Framing an issue strategically in a public address involves the selective highlighting of issues that will effectively convince an audience to support the speaker's proposed policy.²⁸⁹ In pursuing rhetoric analysis I will carefully examine both micro and macro strategies of rhetorical expression and persuasion. These include the following rhetorical strategies which discourse analysts and rhetoric analysts alike have noted to be frequent features of political rhetoric and which are prominent in the presidential rhetoric I examine.

Because presidents are both rhetorically creating socially imaginaries and responding to them, both inductive and deductive approaches are needed to analyze the texts effectively. I examine when and how particular rhetorical strategies are used in the corpus I have selected and how they contribute to the broader persuasive aims of the rhetoric. I take care to consider how these strategies are applied within the very particular context of the speeches I examine and in relation to the broader political, historical, and social contexts in which the speeches were given.

Analyzing how these strategies are implemented enables me to answer my research questions as to what type of social imaginary and moral order each president strives to articulate and/or revise and shift and to what moral and practical ends; what does it have in common with and how does it differ from conservative Republican

²⁸⁹ Jennifer Jerit, "Issue Framing and Engagement: Rhetorical Strategy in Public Policy Debates." *Political Behavior* 30 (2008).

For more on rhetorical strategies see: Helene A. Shugart, "Counterhegemonic Acts: Appropriation as a Feminist Rhetorical Strategy." *Quarterly Journal of Speech* 83 (1997).

Joanne P. Sharp, "Hegemony, popular culture, and politics: the Reader's Digest and the Construction of Danger," *Political Geography*, 6-7: (1996).

healthcare reform rhetoric; and finally, if and how the rhetorics exclude particular social groups and obfuscate, minimize, obscure, and/or deny aspects of history which may undermine the overall argument and tone each president hopes to achieve to advance his particular policy agenda. We will now turn to the rhetorical strategies.

4.5 Rhetorical Strategies

1. Epideictic rhetoric based on convincing audiences that the president has integrity and should be trusted, shares their experiences, identity, challenges, and concerns, that he understands them, and that he identifies with them and cares about them.²⁹⁰
2. The use of implicit and explicit rhetoric, also known as enthymematic²⁹¹ rhetoric in which the premise or conclusion is not clearly delineated. Sometimes this is used as a strategy to avoid conflict and as a strategy to maintain a position of neutrality which elides matters of moral agency and accountability. It is also involved in creating a notion of common sense which is meant to be accepted by the audience rather than questioned critically.²⁹²
3. Narratives that are grounded in patriotism, history, and a linear temporal orientation seeking to create a coherent and inspiring link between past, present, and future in which change and tradition are melded together meaningfully and in a daring but non-threatening way striking a careful balance between old and new, maintenance and change. The concept of the future, for example, can be used in specifically persuasive ways and is not a neutral signifier of time beyond the present. Patricia Dunmire states that, “The Future, I contend, is a discursive construct that rhetors embed within and project through the linguistic design of their texts, and, which, thereby, functions as a means of persuasion... I see representations of the future in policy documents as a type of legitimation device (van Dijk, 1998) used in institutional contexts to shore up an institution’s call for

²⁹⁰ Dale Sullivan, “The Ethos of Epideictic Encounter,” *Philosophy and Rhetoric*, (1993):118.

²⁹¹ James H. McBurney, “The Place of the Enthymeme in Rhetorical Theory,” *Communication Monographs*, 1 (1936).

²⁹²“The enthymeme is an attempt to bring together ‘reality’ and commonly accepted premises – what ‘everyone’ knows to be the case. It involves ‘showing’ how things are, inviting people to consider things and to see them ‘like this’ rather than ‘like that.’” Finlayson, 2012, 761.

particular near-term policies and actions.”²⁹³ (83) She further states that, “Bitzer (1968) argues that exigence, that is, an ‘imperfection marked by urgency’ is a necessary element of rhetorical situations. The responsibility of the rhetor is to observe this exigence and remedy it through her rhetorical act.” In Aristotle’s theory of rhetoric, in contrast, “The future is understood to be the terminus of deliberation, rather than a means of persuasion within deliberative rhetoric.”²⁹⁴ In my analysis of the speeches I both trace how their use of ethos, pathos, and logos evolves as well as how each speech makes reference to the past and the future.

4. Individualization and personalization – the use of anecdotes and narratives of individual people to illustrate broader systemic and structural challenges and injustices.
5. Pragmatism and prudential arguments based on efficiency rather than morality and solidarity.²⁹⁵
6. Moralizing and moral muting – the strategic use of morality to advance a particular policy goal by sometimes emphasizing morality when seeking to build assent for a progressive policy that requires changes in moral norms and the silencing or downplaying of morality in efforts to create unity and agreement and to avoid castigating any one particular group or institution for acting immorally. As Douglas V. Porpora and Alexander Nikolaev explain, “Moral muting occurs when a message either blunts the moral considerations involved in a case or presents an equivocal moral meaning.”²⁹⁶ This “...often produces a *blurred frame*

²⁹³Patricia L. Dunmire, “The Rhetoric of Temporality: The Future as Linguistic Construct and Rhetorical Resource” in *Rhetoric in Detail*, ed. Barbara Johnstone and Christopher Eisenhart. (Amsterdam: John Benjamins, 2008), 85.

On the importance of constructing stories and narratives see, Martha Chang.

Martha S. Cheng, “Ethos and Narrative in Online Educational Chat” in *Rhetoric in Detail*, 197-198.

Martha Cheng writes that, “Many contemporary scholars have rediscovered practical wisdom in their explorations of narrative rationality. Within rhetoric, Walter Fisher... argues that the fundamental way humans make meaning is through placing specific events, people, and objects into narratives, rather than processing information through analytical logical models. In other fields, scholars such as Ricoeur, MacIntyre, and Bruner make similar claims about narrative, particularly in regard to identity formation and self-understanding. In ‘Life in Quest of Narrative’ Ricoeur states, ‘It is therefore by means of the imaginative variations of our own ego that we attempt to obtain a narrative understanding of ourselves, the only kind that escapes the apparent choice between sheer change and absolute identity. Between the two lies narrative identity.’ Thus, it is through the narrative of our lives that we maintain a sense of continuity or stability but also negotiate the events of our lives and social and cultural influences. Narrative is the nexus of identity.”

²⁹⁴ Ibid.

²⁹⁵ See footnote below.

²⁹⁶ Douglas V. Porpora and Alexander Nikolaev. “Moral Muting in US Newspaper Op-Eds Debating the Attack on Iraq,” *Discourse and Communication* 2 (2008), 165.

that dampens or distances moral reasoning.”²⁹⁷ This downplaying of attribution of agency is often expressed through nominalization. Van Dijk further states, “We may examine the style, rhetoric or meaning of texts for strategies that aim at the concealment of social power relations, for instance by playing down, leaving implicit or understating responsible agency of powerful social actors in the events represented in the text.”²⁹⁸ (See also #2 on implicit/explicit rhetoric.)

7. Depoliticization, conciliation, and bipartisanship – the effort to generate assent through transcending obvious and sharp political differences often aided by moral and patriotic appeals that cross partisan divides.²⁹⁹
8. Hedging or wilful equivocation and the calculated use of linguistic modality to show an appreciation of complexity, lack of dogmatism, and broad-mindedness, legitimize one’s political and personal qualities by appearing humble and not overconfident in one’s convictions, and to avoid appearing overtly political and intolerant of dissent.³⁰⁰
9. Linkage, whereby affective, logical, and ethical connections are made between various sub-sections of society including peoples of different economic, racial, and geographic backgrounds to inspire communitarian social solidarity.

As is evident from the list, there is considerable overlap amongst these rhetorical strategies. They are generally employed in an integrated manner such that patriotic appeals often coincide with moralizing appeals and may be grounded in individual anecdotes, for example, about the challenges facing an individual American citizen

²⁹⁷ Porpora and Nikolaev, 166.

²⁹⁸ Van Dijk, “Principles of Critical Discourse Analysis,” 250.

T Luckmann. “The Moral Order of Modern Societies, Moral Communication, and Indirect Moralizing”, paper delivered at Collegium Budapest, Institute for Advanced Study. 1997.

Caffi, “On Mitigation,” *Journal of Pragmatic* 31 (2000):881-909.

B. Fraser. “Conversational Mitigation,” *Journal of Pragmatics* 4 (1980): 341-550.

T.A. Van Dijk, *Ideology: A Multidisciplinary Approach*. (Los Angeles: SAGE, 2000.)

²⁹⁹ Frank and McPhail, “Barack Obama’s Address to the 2004 Democratic National Convention: Trauma, Compromise, Consilience and the (Im)possibility of Racial Reconciliation”: 589.

³⁰⁰ Andrea Deciu Ritivoi, “Talking the Political Talk: Cold War Refugees and Their Political Legitimation through Style in *Rhetoric in Detail*, edited by Barbara Johnstone and Christopher Eisenhart, (Amsterdam: John Benjamins, 2008,)34. For more on rhetorical means of establishing political legitimacy see Jaworski and Galsinski, 2000.

Jaworski, A., & Galasinski, D. (2000). “Vocative address forms and ideological legitimization in political debates,” *Discourse Studies* 2 (2000).

Ritivoi paraphrases their main argument stating, “An important tool in achieving legitimacy is the reliance upon well-established ideologies – those beliefs and representations that are shared by the members of a community and that act as providers of meaning for their everyday practices.”

lacking healthcare insurance. As I describe and analyze how these strategies work and when and how they are employed in speeches I will illustrate the relationships between the aim of persuading the American public of the legitimacy and necessity of healthcare reform, the rhetorical summoning and transformation of the American social imaginary and moral order, and the particular rhetorical strategies used to enable the political goal of support for healthcare reform which cannot be achieved without successful rhetorical persuasion.

4.6 Critique of Rhetoric Analysis and Researcher's Reflexivity

Rhetoric analysis can be impressionistic³⁰¹ and suffer from a lack of analytical rigor if employed in an ideological manner. Kenneth Burke is sometimes considered as an 'intuitionist' in intellectual orientation, for even though he delineates a general methodology in the form of the pentad, many of his arguments and the manner in which he undertakes rhetoric analysis relies upon intuition. There is much value in his approach and I incorporate it into my analysis. Importantly, Burke is transparent about his intuitionist orientation and does not attempt to create a false sense of objectivity or a universal mechanical linguistic toolkit which he advocates, favoring a more case-by-case, qualitative, context specific approach to the analysis of texts, which I adopt as well. He has stated that he was "strongly influenced by anthropological inquiries."³⁰²

A potential flaw that can impact both rhetoric and discourse analysis as research methods is the fact that the person undertaking the analysis may inject his/her own biases and convictions into the analysis in a way that renders it less of an analysis, and more of a projection of their own beliefs onto a text which may not genuinely reflect

Burke has also alternatively characterized himself as a pragmatist and a sociological critic. Marie Hochmuth, "Kenneth Burke and the 'New Rhetoric,'" *Quarterly Journal of Speech*, 38 (1952): 133.
³⁰²Kenneth Burke. *A Rhetoric of Motives*, 40.

whatever the analyst claims. Discourse analysis is intrinsically challenged by the fact that, as Michael Billig writes, “We cannot... rigidly separate the objects of our analyses from the means by which we conduct analyses”³⁰³ because to investigate language discourse analysts must use language itself. For critical discourse analysts, the potential for injecting ideology inappropriately into the process of analyzing discourse is particularly acute.

Billig argues,

We seek to analyze language critically, exposing the workings of power and ideology within the use of language... How can we be sure that our own use of language is not marked, even corrupted, by those ideological factors that we seek to identify in others.³⁰⁴

In light of this, researchers have no alternative but to be as reflexive as possible, as self-aware of our ideological interests and commitments and how they impact our interpretive styles and strategies and the arguments that we consequently make.³⁰⁵

Beyond this self awareness, researchers need to acknowledge their own sympathies transparently such that they enable readers of their research to appreciate the particular perspective that informs their work.

The discourse or rhetoric analyst may also over determine the extent to which the meanings which he/she draws from the text are apparent to intended audiences, and overestimate the extent to which audiences accept the texts without challenging them, probing them, and interpreting them in ways that differ from the particular reading which the analyst makes. As Norman Fairclough cautions, “A danger in focusing on the language of New Labour is that its social power tends to be overstated, because the ways

³⁰³ Michael Billig, “The Language of Critical Discourse Analysis: The Case of Nominalization,” *Discourse and Society* 19 (2008): 783.

³⁰⁴ *Ibid*

³⁰⁵ Michael Billig, “Nominalizing and De-Nominalizing: A Reply.” *Discourse and Society*, 19 (2008): 836-837.

in which it is taken up, resisted, or just ignored are not in focus.”³⁰⁶ Van Dijk also argues that discourse analysts must take care not to project ideology where it may not exist and to acknowledge that speech and texts do more than assert relations of power. “Most importantly, also theoretically, is to realize that discourse is not just to express or reproduce ideologies. People do many other things with words at the same time.”³⁰⁷ They have, he argues, cognitive, interactional, and social functions which are more than merely ideological in nature and motivation. In the same vein, he emphasizes the importance of taking into account context when undertaking discourse analysis, “who is speaking to whom, when, and with what intention.”³⁰⁸ Consequently, researchers need to exercise humility in accepting that texts cannot be reduced to expressions of ideology and instrumentalized for the sake of the pursuit of discourse analysis. Sometimes a text is a matter of fact expression of information, desire, emotion, or query – neither rich in potential critical interpretations nor characterized by insidious ideology, complex power matrices, and invidious attempts at control and dominance.

My use of rhetoric analysis which tends to avoid the aforementioned ideologically charged arguments will mitigate some of the concerns raised here. However, some of the ones regarding bias, impressionism, selective attention, and selective interpretation remain as salient for rhetoric analysis as for discourse analysis as potential methodological vulnerabilities. However, any analysis of language entails selection of modes of interpretation and the creation of a particular narrative which has its own frame, logic, and assumptions. Consequently, the cautions Billig raises regarding discourse analysis have value in raising my consciousness of how to employ rhetoric analysis in a way that is not one dimensional and implicitly ideological but that genuinely strives to take into account a multiplicity of perspectives, the compromises and lack of

³⁰⁶ Norman Fairclough, *New Labour, New Language?* (London: Routledge, 2000), 62.

³⁰⁷ Teun Van Dijk, “Critical Discourse Analysis and Nominalization: A Problem or Pseudo-Problem?” *Discourse and Society* 19 (2008): 824.

³⁰⁸ *Ibid*

clarity intrinsic to language, and that is aware of and acknowledges its logic and assumptions.

4.7 Conclusion

In choosing rhetoric analysis as my methodology I will best be able to analyze presidential speeches in a comparative way that is sensitive to their historical and cultural contexts and how rhetoric both creates and responds to a dynamic social imaginary. Rhetoric analysis allows me to address some of the concerns of discourse analysis with revealing how texts can be used in ways that marginalize, disempower, and systematically ignore particular individuals and peoples and their rights and needs which informs my research questions. Simultaneously, it enables me to explore the substantive arguments of the presidential speeches and to focus on examining these arguments, their potential meanings and implications. Rhetoric analysis allows me to study the persuasive aspects of the presidential speeches through the use of ethos, pathos, and logos and to examine how various rhetorical strategies are used to create different rhetorical effects. It takes care to address symbolic meanings in speeches and allows for a holistic approach to the study of public address that analyzes each speech with an aim towards a ‘thick description’ of the speech that is descriptively sensitive and characterized by in depth interpretation.

Chapter 5: Harry Truman's November 19, 1945 Address to Congress on Healthcare Reform

I have had some bitter disappointments as president, but the one that has troubled me most, in a personal way, has been the failure to defeat the organized opposition to a national compulsory health insurance program.³⁰⁹ – Harry Truman

5.1 A First Attempt at Comprehensive National Health Insurance

Harry Truman's proposals to Congress to create universal government guaranteed health insurance for all American citizens was the first such sustained attempt initiated by a US president.³¹⁰ As such, Truman's effort has particular significance. It built on Franklin Delano Roosevelt's New Deal and provided an essential stepping stone to Lyndon Baines Johnson's creation of Medicare and Medicaid. When Johnson invited Truman to attend the signing of that legislation in 1965 it was not merely a symbolic act, but recognition of Truman's role in beginning the long policy road to expanding healthcare access and quality in the United States.³¹¹ As Johnson said, "It all started really with the man from Independence."³¹²

Truman carefully built upon Roosevelt's successful New Deal legacy, insisting upon the same principles of government responsibility to guarantee the social and economic rights of citizens as part of the new moral order and social imaginary that Roosevelt's New Deal had begun but had not completed. Truman's arguments for healthcare reform were extremely sensitive to the historical moment: the conclusion of World War 2 with victory for the United States, the return to economic growth and the

³⁰⁹James Morone. "Seven Consequences of the Health Care Ruling," *The New York Times*, June 28, 2012. <http://campaignstops.blogs.nytimes.com/2012/06/28/seven-consequences-of-the-health-care-ruling/?ref=healthcarereform>

³¹⁰Theodore Roosevelt's healthcare reform efforts, as mentioned earlier, were briefer and less intensive in nature.

³¹¹Theda Skocpol, "From Social Security to Health Security? Opinion and Rhetoric in US Social Policy Making." *PS: Political Science and Politics* 27: (1994.)

³¹²President Truman's Proposed Health Program, <http://www.trumanlibrary.org/anniversaries/healthprogram.htm>

end of the Depression, and a spirit of possibility enabled by both in which the American people were at a historical juncture where the change that Roosevelt had initiated could become more comprehensive and fully actualized in both law and government policy. Although Truman's proposed healthcare reforms never took shape as legislation presented to Congress, Truman did succeed in winning passage of reforms that expanded healthcare considerably across the United States and improved quality of care and access to healthcare to middle-class and economically disadvantaged Americans.

This rhetoric analysis examines Harry Truman's November 19, 1945 speech to Congress on healthcare reform. I analyze this speech because it was the defining speech of Truman's presidency on healthcare reform in which he addressed the nation to advocate for a groundbreaking plan that would dramatically expand healthcare access and quality and extend it to all Americans.³¹³

5.2 Dimensions of Rhetoric

The Aristotelian rhetorical concepts of logos, ethos, and pathos – examined in Chapter 4 of the thesis provide a conceptual framework for understanding the speech. Logos refers to the reasoning structure, logic, and technical arguments made in a speech. In Truman's speech the logos dimension is dominant and centers upon the principle of universal healthcare provision without discrimination on the basis of economic resources and the resulting healthcare reform policy explication and justification. Ethos refers to the values and moral principles espoused in a text and in turn, associated with the character of the speaker. Ethos manifests itself as a vision of government as a fundamental provider of maximal equal opportunity and well being for all American

³¹³ There is relatively little academic literature addressing Truman's healthcare reform efforts in depth. For an overview of them from the perspective of the medical profession see Robert D. Schremmer and Jane F. Knapp's "Harry Truman and Health Care Reform: The Debate Started Here," *Pediatrics* 127 (2011).

citizens and protector of their social and economic rights and the principle of collective national solidarity.³¹⁴ I use the phrase ‘social and economic rights’ rather than ‘human rights’ because Truman situates these rights in an American context and depicts them as the social and economic rights of US citizens, rather than universal human rights.³¹⁵ Pathos refers to emotions. Pathos plays a small role in Truman’s speech, but it is most pronounced in his depictions of the structural injustice that economically disadvantaged Americans face because they cannot secure healthcare. Consequently, this chapter will discuss how logos and ethos are applied in the speech and how they contribute to its persuasive power and its articulation of a progressive moral order and social imaginary.

To articulate ethos and logos Truman relies principally on four rhetorical strategies which each contribute to the overarching goal of legitimizing his healthcare reform efforts. These strategies – which will be examined in the forthcoming sections of the chapter – are:

- Moralization highlighting the need for government guarantee of social welfare and of healthcare provision and depicting the negative consequences that result from failing to do so. (Ethos)
- Historical temporality – Truman refers primarily to the immediate past of Franklin Delano Roosevelt’s New Deal and his desire to build upon the New Deal’s commitment to social and economic rights. Truman also refers to the historical experience of World War 2. He builds upon both as reasons for his healthcare reforms. Truman also links the immediate

³¹⁴Though communitarianism in its contemporary form was not formally theorized by political and social philosophers at Truman’s time, in retrospect many of the arguments he presents for universal health insurance revolve around communitarian principles of care, mutual obligation, and partnership across all economic and social classes to uplift American citizens as a whole.

³¹⁵ However, in a number of his speeches he alludes to a broader notion of human rights needed to guarantee the welfare of persons, irrespective of their particular nationality. In this regard he mimics Roosevelt’s rhetoric which championed social and economic rights as rights that all people have and merit, not only Americans. It should be noted that the legal codification of human rights through the creation of the United Nations during Truman’s era was still at its nascent state and consequently when Truman refers to rights he is positing them more as transcendent moral principles than as legal rights guaranteed by an international legal body.

past to a timeline for urgent action, for example, in relation to his concern that discharged army doctors be encouraged by the government to settle and work in underserved communities. (Ethos and Logos)

- Anticipatory and defensive rhetoric (prolepsis) pre-empting conservative arguments against healthcare reform and government guarantee of social welfare, conveying the effect of conferring legitimacy on his healthcare reform plans amongst independents and conservatives. Sometimes this features affirmations of conservative concerns such as local control of government initiatives. (Logos)
- Linking individual welfare and the welfare of particular communities and national sub-groups with collective national welfare and portraying the two as inextricably and intrinsically bound. This conveys the effect of solidarity and national unity. In Truman's rhetoric this takes the form of linking public health efforts to individual health quality and promoting expanded research on and treatment for illnesses that impact all Americans of diverse economic and social backgrounds, such as cancer. It is also reflected in Truman's use of the health status of soldiers to argue for healthcare for all US citizens. (Ethos and Logos)

We will now consider the historical and political context of Truman's healthcare address.

5.3 Post World War 2 Political and Historical Context

In analyzing Harry Truman's healthcare reform rhetoric it is essential to contextualize the time in which Truman addressed healthcare reform. As discussed in Chapters 1 and 2, in the years immediately following World War 2, nations across Europe strengthened existing healthcare programs and expanded healthcare access to realize the vision of universal healthcare provision, often with the support of Marshall

Plan funds.³¹⁶ This took place alongside larger reforms they undertook to expand the welfare state in which the government guaranteed its citizens a range of essential services, from schooling to housing and child care. Although Franklin Delano Roosevelt had left healthcare out of his New Deal, the New Deal itself entailed the passing of a series of progressive social policies and a radical revision of the American social imaginary and its underlying moral order. These moved the United States closer in the direction of a state that comprehensively guarantees the welfare of its citizens, although, as noted earlier, it never reached the level of comprehensiveness achieved in Western Europe, particularly but not exclusively because universal health insurance never came into law.

There are a number of reasons why the United States was less receptive to the type of comprehensive social welfare system that was created in the post World War 2 years in much of Western Europe. Many relate to subjects discussed in the Introduction and Chapter 2 on American political culture and the American social imaginary and its skepticism towards social and economic rights. Structural and institutional factors relating to the role of the private sector in the United States, especially in healthcare provision and the particularly negative attitude American unions had towards universal health insurance are relevant as well. But it may also be significant that France and Britain, for example, were able to pass comprehensive social welfare reforms – including universal health insurance – because World War 2 had such a profound impact on their societies (and a far more direct and traumatizing one than the United States’ war experience) and allowed them to envision a new socio-political compact between government and citizen.

³¹⁶Laurie Garrett, “The US Promotes Universal Health Care, But Only in Other Countries,” *The Atlantic*, June 29, 2012.
<http://www.theatlantic.com/international/archive/2012/06/the-us-promotes-universal-health-care-but-only-in-other-countries/259160/>

5.3.1 Truman's Ethos in Context: An Era of Faith in Government Action

Truman applied the rhetoric of rights to his social welfare plans and they were central to their ethos, having released a statement of 21 Points in September of 1945 that comprehensively addressed the government's responsibility to provide for the welfare of its citizens and defined this responsibility as directly reflecting the social and economic rights of American citizens. It would come to be known as the 'Fair Deal' – with the use of the word 'deal' building deliberately on Roosevelt's popular 'New Deal' and the concept of fairness alluding to a progressive definition of the parameters of a just society in which maximal equality of opportunity is assured and no one suffers vulnerability to poverty and its related deprivations, reflecting an ethos of communitarian solidarity.

Thus Truman's rhetoric about healthcare reform is situated in a political context in which social and economic rights as key parts of the American social imaginary were considered mainstream because Roosevelt had rapidly and dramatically normalized them during his New Deal and created legal entitlements to them through programs like Social Security. 'Limited government' as a conservative philosophy was in its nascent stages and was by no means dominant as a political philosophy in the United States, with the New Deal remembered favourably and Roosevelt widely hailed as a President who applied government resources effectively to successfully tackle the depression. Americans were willing to accept a high degree of government social welfare programming because in the context of the Depression the government was the only organization with sufficient power, resources, and a mandate to help all US citizens. As Theda Skocpol writes,

Back in the 1930s, outcries against 'government bureaucracy' and 'creeping socialism' were not as effective as they usually are in US politics. Amidst the Depression, the American public could no longer believe that business magnates

had all the answers, and the New Deal was a time of unusual openness to governmentally sponsored reforms and the expansion of federal power.³¹⁷

Thus the popular expression of the American social imaginary was welcoming of government action to ensure citizen welfare and positive liberty. Additionally, because the government was primarily responsible for the US military and its victory in World War 2 it had credibility on account of its military success. Truman tapped into the spirit of collective sacrifice that the war had generated and necessitated and argued deliberately in relation to the needs of the military and returning soldiers for the universalization of health insurance. But this context should not lead one to underestimate the dramatic nature of his proposed healthcare reforms. As Alan Derickson writes about Truman's insistence on a universal healthcare insurance program that would end discrimination on the basis of class, gender, and race, "...this was a breathtaking departure. Truman dared to seek a seamless system of protection."³¹⁸

In his 21 points address Truman quotes Roosevelt affirming the ethical principles of equality and universality stating, "We have accepted, so to speak, a second bill of rights under which a new basis of security and prosperity can be established for all-- regardless of station, race, or creed."³¹⁹ In so doing he reflects strategies of moralization and historical temporality, using social and economic rights as a moral framework to continue to advance the principles and aims of Roosevelt's New Deal and its transformative moral order. Truman states,

The objectives for our domestic economy which we seek in our long-range plans were summarized by the late President Franklin D. Roosevelt over a year and a

³¹⁷Skocpol, *Social Policy in the United States*, 295.

³¹⁸ Derickson, *Health Security for All*, 93.

³¹⁹ The Economic Bill of Rights, http://www.fdrheritage.org/bill_of_rights.htm

half ago in the form of an economic bill of rights. Let us make the attainment of those rights the essence of post-war American economic life.³²⁰

To appreciate the legacy which Truman is building upon it is helpful to turn to Roosevelt's January 11, 1944 State of the Union Address which introduced the idea of an economic bill of rights and the principle of government guarantee of social and economic rights alongside civil and political rights.

These were radical ideals and at odds with the traditional American emphasis both in law and in political culture on civil and political rights rather than social and economic ones. Roosevelt's insistence that the realization of social and economic rights is necessary for the maintenance of democracy represents a wholesale redefinition of the American social imaginary and its underlying moral order. It provides an expansive definition of communitarian solidarity by charging the government with the responsibility to guarantee the positive liberty of all citizens irrespective of their economic and social status.

It is our duty now to begin to lay the plans and determine the strategy for the winning of a lasting peace and the establishment of an American standard of living higher than ever before known. We cannot be content, no matter how high that general standard of living may be, if some fraction of our people whether it be one-third or one – fifth or one tenth is ill-fed, ill clothed, ill housed, and insecure. This Republic had its beginning, and grew to its present strength, under the protection of certain inalienable political rights among them the right of free speech, free press, free worship, trial by jury, freedom from unreasonable searches and seizures. They were our rights to life and liberty. As our nation has grown in size and stature, however, as our industrial economy has expanded, these political rights proved inadequate to assure us equality in the pursuit of happiness. We have come to a clear realization of the fact that true individual freedom cannot exist without economic security and independence. Necessitous men are not free men. People who are hungry and out of a job are the stuff of which dictatorships are made.³²¹

³²⁰Special Message to the Congress Presenting a 21 Point Program for the Reconversion Period. September 6, 1945.

<http://www.presidency.ucsb.edu/ws/index.php?pid=12359#axzz1i5Jaak8q>

³²¹State of the Union Message to Congress, January 11, 1944,
http://www.fdrlibrary.marist.edu/archives/address_text.html

Roosevelt's insistence that civil and political rights lack meaning and operability if they are not accompanied concurrently by social and economic rights creates both the moral and logical framework in which Truman advances his healthcare reform plans. It provides the basis for Truman's rights-based framework for government guaranteed healthcare provision as but one component of government guarantee of an extensive body of rights.

This is significant because although the American public was receptive to Roosevelt his actions were vigorously contested by the Republican minority in Congress and they were radical in nature. As the Depression ended and World War 2 came to a close it was quite possible that the window of opportunity for social reform would begin to narrow as an exceptional era came to an end. Indeed, as we will see, with regard to creating universal health insurance in fact it slammed shut on Truman and much of his Fair Deal failed to win passage. The social imaginary that Roosevelt had created – much as Truman tried to generate it rhetorically in a similar way – was not a foregone conclusion. Its power to inspire Americans to support a new political and social compact largely waned under Truman despite his best intentions to consolidate and expand Roosevelt's politics and policies.

To understand just how all-encompassing this rhetoric of rights was we need to consider the rights that Truman presented in the 21 Points, in which he restated verbatim Roosevelt's Economic Bill of Rights and committed himself to their realization.

- The right to a useful and remunerative job in the industries, or shops or farms or mines of the Nation.
- The right to earn enough to provide adequate food and clothing and recreation.
- The right of every farmer to raise and sell his products at a return which will give him and his family a decent living.

- The right of every businessman, large and small, to trade in an atmosphere of freedom from unfair competition and domination by monopolies at home or abroad.
- The right of every family to a decent home.
- The right to adequate medical care and the opportunity to achieve and enjoy good health.
- The right to adequate protection from the economic fears of old age, sickness, accident, and unemployment.
- The right to a good education.
- All of these rights spell security. And after this war is won we must be prepared to move forward, in the implementation of these rights, to new goals of human happiness and well-being.³²²

These rights are concerned principally with the social and economic welfare of American citizens and particularly at combating poverty through employment provision and government guarantee of all essential human needs: food, clothing, housing, healthcare, education, and insurance from catastrophic loss.

The wording of these points is significant because it provides an absolute government guarantee of citizen welfare and maximal positive liberty in contrast to the philosophy of limited government that becomes its antithesis. It illustrates the distinctive American social imaginary and moral order dominant during the Roosevelt and Truman eras and which extended into the Johnson era and achieved its most expansive policy

³²²Special Message to the Congress Presenting a 21 Point Program for the Reconversion Period. September 6, 1945.

<http://www.presidency.ucsb.edu/ws/index.php?pid=12359#axzz1i5Jaak8q> and The Economic Bill of Rights, http://www.fdrheritage.org/bill_of_rights.htm

expression in the programs of the War on Poverty and Great Society. We will now discuss the speech structure of Truman's Special Message to Congress on Healthcare Reform.

5.4 Speech Structure of the Special Message to Congress on Healthcare Reform

Truman's 'Special Message to the Congress Recommending a Comprehensive Health Program' delivered on November 19, 1945 begins by setting the context of the speech, referring to Roosevelt's Economic Bill of Rights which informed Truman's 21 Points and examines their role in guaranteeing every American healthcare and freedom from the insecurity that emerges from lack of health insurance.³²³ It illustrates the lack of quality healthcare provision in the United States by referring to the large percentage of soldiers called up to the military who failed health exams or showed serious illness and injury, many of which were treatable.³²⁴ It goes on to describe the advances of modern medicine and presents public health statistics about the reduction of death rates. It then addresses inequality of healthcare provision, noting that the poor and middle class suffer from poor quality healthcare and less access to healthcare than those with greater economic means and that people living in the countryside have poorer quality healthcare and less access to healthcare than those living in cities.³²⁵

Forming the bulk of the speech, Truman asserts that there are five problems his healthcare reform seeks to address, which we will discuss when analyzing the logos of the

³²³ All references to the presidential addresses I analyze refer to the name of the president followed by the page number from the appendix from where the quote/reference originates. The observations I make about the organization of the speech are intended to provide a concise overview of its thematic development and are not rigidly demarcated. Neither Truman's speech nor the other speeches I examine explicitly organize themselves with clearly delineated introductions, main arguments, and conclusions. Truman, exceptionally, does list topic headings that divide the speech, but they do not organize the entire speech and only refer to parts of it. As such, when I refer to speech sections in Truman's speech and in the other presidential speeches I analyze I am doing so in a descriptive way to aid in understanding how the speech is structured and functions as a whole. Truman, 345.

³²⁴ Truman, 345.

³²⁵ Truman, 346.

speech; they center on concerns with equity and access to healthcare, the social costs of work absence due to illness, and the need for increased funding for medical research³²⁶ and Truman discusses each in turn offering solutions to them³²⁷ He concludes the speech by urging adequate care for veterans of war and arguing that passing the healthcare reform he proposes will enable freedom from want and minimize the social and economic problems that health insecurity exacerbates.³²⁸ We will now turn to the rhetoric analysis of Truman's Special Message to Congress Concerning Healthcare Reform.

5.5 Rhetoric Analysis of Truman's Special Message to Congress Concerning Healthcare Reform

5.5.1 The Ethos of Healthcare Reform: Strategies of Moralization and Historical Temporality to Defend Healthcare as a Right

Truman's rhetoric displays a bold confidence of conviction and normative assurance regarding ethos. This is often expressed through the rhetorical strategy of moralization and the assertion of healthcare as a right. Truman begins the speech by situating healthcare reform within the context of a broad vision of social welfare based on the principle that American citizens have a wide range of rights which the government must actualize. By beginning the speech this way Truman applies the rhetorical strategy of moralization, creating a simple and powerful rights-based ethical framework centered upon two normative principles: every American has the right to healthcare irrespective of economic means and to freedom from fear of impoverishment due to illness and it is the government's obligation to guarantee these rights.

³²⁶Truman, 346-349.

³²⁷Truman, 349-354.

³²⁸ Truman, 355.

In my message to the Congress of September 6, 1945, there were enumerated in a proposed Economic Bill of Rights certain rights which ought to be assured to every American citizen. One of them was: "The right to adequate medical care and the opportunity to achieve and enjoy good health." Another was the "right to adequate protection from the economic fears of sickness"³²⁹

After reaffirming these two principles Truman illustrates the gap between these rights and the current American social reality, creating a sense of urgency and linking the ethos of rights with the logos of his healthcare reforms and arguing for healthcare reform on the basis of the ethical principle of equal opportunity.

Millions of our citizens do not now have a full measure of opportunity to achieve and enjoy good health. Millions do not now have protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection.³³⁰

Truman's emphasis on "security against the economic effects of sickness" is significant because by framing the argument for universal health insurance this way he builds upon an already widely accepted ethos and history of legislation passed by Roosevelt and embeds universal health insurance within the larger ethical argument about economic rights, social security, and the struggle to defeat poverty he earlier presented in other speeches, including in his 21 points. This reflects the rhetorical strategy of historical temporality. Thus while he begins the speech with an affirmation of the specific right to healthcare he simultaneously notes that this right forms part of a larger collection of economic rights which together form a liberal social imaginary and moral order of expansive, activist government actualizing citizen welfare and thus, positive liberty.

³²⁹ Truman, 345.

³³⁰ Ibid.

Truman affirms the ethos of his speech by succinctly establishing its normative parameters with an impassioned series of staccato denunciations of deprivation of healthcare across the nation, reflecting the strategy of moralization.

No area in the Nation should continue to be without the services of a full-time health officer and other essential personnel. No area should be without essential public health services or sanitation facilities. No area should be without community health services such as maternal and child health care.³³¹

The normative thrust of his argument on the basis of equality and government responsibility for the welfare of all citizens alike is interwoven throughout the speech. It appears again in the speech's conclusion, where Truman reasserts the ethical principles that motivate his healthcare reforms.

Throughout the speech a statement about equality of opportunity appears in similar forms but with slightly different iterations, each time reinforcing the principles of maximal equality of opportunity and communitarian solidarity and a right to healthcare with a slightly different wording and emphasis. Thus the following statement is similar in content to the one I have just considered, the primary difference being its linguistic construction which affirms provision of services rather than criticizing deprivation of services. Emphasizing the collective, universal, and non-discriminatory principles of his healthcare reforms Truman states,

Hospitals, clinics and health centers must be built to meet the needs of the total population, and must make adequate provision for the safe birth of every baby, and for the health protection of infants and children...³³² Everyone should have ready access to all necessary medical, hospital and related services...³³³

Similarly, the following passage - also employing a strategy of moralization - incorporates a fervent statement of ethos asserting the paramount value of equality; the

³³¹ Truman, 350.

³³² Ibid.

³³³ Truman, 350.

necessity of government action to guarantee health insurance that meets the needs of the poor for better access to healthcare and better quality healthcare, and the principle of non-discrimination in healthcare provision. This final principle is a particularly radical revision of the American social imaginary as it undermines social norms given segregation in the American South³³⁴ and informal but still powerful forms of racism prevalent in northern parts of the United States during the Truman era. As we discussed in Chapters 1 and 2, segregationists (especially many Democrats) had been vociferous antagonists to the expansion of healthcare well into the 1960s and 1970s.

In the past, the benefits of modern medical science have not been enjoyed by our citizens with any degree of equality. Nor are they today. Nor will they be in the future--unless government is bold enough to do something about it. People with low or moderate incomes do not get the same medical attention as those with high incomes. The poor have more sickness, but they get less medical care. People who live in rural areas do not get the same amount or quality of medical attention as those who live in our cities. Our new Economic Bill of Rights should mean health security for all, regardless of residence, station, or race--everywhere in the United States. We should resolve now that the health of this Nation is a national concern; that financial barriers in the way of attaining health shall be removed; that the health of all its citizens deserves the help of all the Nation.³³⁵

The final sentence affirms the principle of communitarian solidarity and this passage condenses the overarching ethos of Truman's speech with its emphasis on equality and universality and the conviction that government programming is a legitimate and necessary tool to strengthen public welfare and social solidarity.

Truman squarely places the burden explicitly on the government to address the injustices of healthcare inequality and deprivation repeatedly in this passage and at numerous junctures throughout the speech, as we will see. For example, when articulating the need for children to have better healthcare Truman affirms that the government has a fundamental role to play in assuring that their health needs are met.

³³⁴ Indeed the prevalence of racism in the United States, especially in the South, is one of the reasons why Truman's proposed reforms for universal healthcare failed to gain traction.

³³⁵ Truman, 346.

Truman states, “The health of American children, like their education, should be recognized as a definite public responsibility.”³³⁶ His argument for universal healthcare then is inseparable from his argument for government responsibility and capacity for ensuring citizen welfare. We shall now proceed to examine the logos of Truman’s speech.

5.6 Logos: Illustrating Deprivation with Data and Presenting his Healthcare Reforms

The statements of ethos we have discussed speak in general terms and illustrate problems of inequality and insufficiency without providing detailed data to back up the claims. But throughout the speech Truman assiduously details with statistics the gap between the ethos of his plan and the current social reality, stating for example,

Inequalities in the distribution of medical personnel are matched by inequalities in hospitals and other health facilities. Moreover, there are just too few hospitals, clinics and health centers to take proper care of the people of the United States. About 1,200 counties, 40 percent of the total in the country, with some 15,000,000 people, have either no local hospital, or none that meets even the minimum standards of national professional associations.³³⁷

Although we will see such use of statistics as a central element in the logos of each of the presidents we are examining, Truman’s rhetoric is the most impersonal, lacking the humanizing, individual examples that are major rhetorical features of the logos of Clinton and Obama’s speeches on healthcare reform. In the logos of his speech Truman reveals the policy details that actualize the principles of ethos that provide the normative impetus for the plan. Setting the parameters of universality Truman defines its terms

³³⁶ To appreciate just how significant this statement is we need to consider that it was not until the 1990s, when Bill Clinton and Edward Kennedy worked together to develop and pass the SCHIP, State Children’s Health Insurance Program (now known as CHIP, Children’s Health Insurance Program) healthcare insurance program for economically disadvantaged children that America’s children achieved anything close to resembling Truman’s vision of guaranteeing the healthcare needs of American children.

³³⁷Truman, 347.

incorporating every type of American – first delineating the different types of workers who will benefit from the healthcare insurance and then explaining that it will also provide coverage to the economically disadvantaged, including the unemployed.

Significantly, Truman makes direct reference to the most impoverished – rather than appealing to the ‘middle-class’ category, a strategy we will see that Clinton and Obama favor and who render the working class and economically disadvantaged largely invisible in their rhetoric. In part this is because during Truman’s era the middle-class had not yet expanded greatly, and many Americans confidently self-identified as working class. However, a post World-War 2 shift in patterns of settlement including suburbanization and increased economic growth began to consolidate the notion of an expanding middle-class to which most Americans aspire.³³⁸ Still, his explicit advocacy for the most economically disadvantaged contrasts with that of Clinton and Obama. Truman could have chosen to emphasize the middle class at the exclusion of the working class and most economically disadvantaged, given its enormous expansion in the years immediately following World War 2. But he insisted upon asserting the rights of the most economically disadvantaged.

I am in favor of the broadest possible coverage for this insurance system. I believe that all persons who work for a living and their dependents should be covered under such an insurance plan. This would include wage and salary earners, those in business for themselves, professional persons, farmers, agricultural labor, domestic employees, government employees and employees of non-profit institutions and their families. In addition, needy persons and other groups should be covered through appropriate premiums paid for them by public agencies.³³⁹

³³⁸ Robert A. Margo. “Explaining the Postwar Suburbanization of Population in the United States: The Role of Income,.” *Journal of Urban Economics* 31 (1992).

Kenneth T. Jackson. *Crabgrass Frontier: The Suburbanization of the United States*. (New York: Oxford University Press, 1985.)

³³⁹Truman, 353-354.

He explains that to meet these needs the federal government will provide funding for the construction of hospitals, health clinics, and associated health facilities and that additional funding will be given to hospitals and health clinics already in existence, but lacking sufficient funds to expand services in an inclusive way to meet the needs of all Americans. Justifying the feasibility of implementing the values expressed in his ethos Truman explains that the United States spends only 4% of its GNP on healthcare and states, “We can afford to spend more for health” because this amount of spending leaves so many Americans uninsured.

But four percent is only an average. It is cold comfort in individual cases. Individual families pay their individual costs, and not average costs. They may be hit by sickness that calls for many times the average cost--in extreme cases for more than their annual income. When this happens they may come face to face with economic disaster. Many families, fearful of expense, delay calling the doctor long beyond the time when medical care would do the most good.³⁴⁰

Truman notes that the US government already provides some healthcare services to the poor – allowing himself to relate his healthcare reforms with one aspect of policy already in place which he wishes to substantially expand. This argument enables Truman to downplay the impression that his healthcare reforms necessitate a dramatic change in government programming and expenditure. In fact, they do, but by anchoring them in pre-existing programs which are familiar to some Americans he seeks to deemphasize this and make them less threatening to those audience members, including but not exclusively limited to those with conservative sympathies and concerns about excessive government programming and changes to the extant healthcare system. Still, he robustly articulates the nature of the poverty of the economically disadvantaged and the need for their healthcare deprivation to be addressed by the government.

³⁴⁰Truman, 349.

For some persons with very low income or no income at all we now use taxpayers' money in the form of free services, free clinics, and public hospitals. Tax-supported, free medical care for needy persons, however, is insufficient in most of our cities and in nearly all of our rural areas. This deficiency cannot be met by private charity or the kindness of individual physicians.³⁴¹

This last sentence is extremely important in its explicit rejection of the preference of advocates of limited government for charity as the basis for healthcare provision to the economically disadvantaged and insistence that the current state of medical care for the poor is wholly inadequate and demands remedy. It provides a justification for his comprehensive healthcare reform plans and the liberal philosophy of government provision for social services.

Truman rejected charity as a basis for essential social services because of its demeaning impact on recipients. When he spoke at Johnson's signing of the Social Security amendments that established Medicare and Medicaid, twenty years after his own healthcare reform efforts, he stated, reflecting the values which informed his own earlier attempts at expanding healthcare provision, "Not one of these, our citizens, should ever be abandoned to the indignity of charity. Charity is indignity when you have to have it. But we don't want these people to have anything to do with charity and we don't want them to have any idea of hopeless despair."³⁴²

5.6.1 The Logos of Policy Expertise and Technical Excellence: Applying Rhetorical Strategies of Anticipatory and Defensive Rhetoric

Applying a rhetorical strategy of anticipatory and defensive rhetoric Truman emphasizes that the healthcare plan will not detract from or change the healthcare currently available to Americans, it will only expand access and quality.

³⁴¹ Ibid.

³⁴² President Lyndon B. Johnson's remarks with President Truman at the Signing of the Medicare Bill, July 30, 1965.
<http://www.lbjlib.utexas.edu/johnson/archives.hom/speeches.hom/650730.asp>

Truman stresses his desire to expand the ‘existing compulsory social insurance system’ that is in place to all Americans because “Only about 3% or 4% of our population now have insurance providing comprehensive medical care,”³⁴³ providing the rationale for government expansion of health insurance provision.

Under the plan I suggest, our people would continue to get medical and hospital services just as they do now--on the basis of their own *voluntary* decisions and choices. Our doctors and hospitals would continue to deal with disease with the same professional *freedom* as now. There would, however, be this all-important difference: whether or not patients get the services they need would not depend on how much they can afford to pay at the time.³⁴⁴

The keywords ‘voluntary,’ and ‘freedom’ are signifiers to reassure conservatives and their sympathizers that Truman’s healthcare plan will not undermine their values. Truman similarly applies the rhetorical strategy of anticipatory defense in his vigorous rejection of conservative characterizations of his healthcare reform plans as socialist in nature. “This is not socialized medicine,³⁴⁵” he states, because it is not an attempt to do away with private sector healthcare and insurance providers and because it is a voluntary insurance plan which will allow Americans who are happy with their current health insurance to stay with their current insurance providers. Truman uses the concept of insurance with which all Americans are familiar, is ideologically uncontested and uncontroversial, and which is provided in various domains largely by the private sector to illustrate the logic of his healthcare reforms.³⁴⁶

Everyone who carries fire insurance knows how the law of averages is made to work so as to spread the risk, and to benefit the insured who actually suffers the loss. If instead of the costs of sickness being paid only by those who get sick, all the people--sick and well--were required to pay premiums into an insurance fund, the pool of funds thus created would enable all who do fall sick to be adequately

³⁴³Truman, 352.

³⁴⁴Truman, 353.

³⁴⁵*Ibid.*

³⁴⁶We will see that Bill Clinton and Barack Obama employ the same strategy in their addresses on healthcare reform, referring to commonly accepted and legally required forms of insurance, such as auto insurance.

served without overburdening anyone. That is the principle upon which all forms of insurance are based.³⁴⁷

Using the technical explanation of how insurance works to illustrate the logos of his healthcare reforms Truman also simultaneously expresses a central component of its ethos: communitarian solidarity.

Truman details the logos of his plan: it requires prepayment in the form of universal health insurance which spreads medical costs more equitably and makes them more affordable to everyone. Health insurers would have an incentive to encourage Americans to go to the doctor before illness has become serious, potentially saving on overall healthcare expenditures. Increased healthcare will lower the prevalence of diseases in society and hospital and laboratory services which until now have only been available to some Americans will become available to all. Truman proposes that this insurance system should be comprehensive, covering medical, hospital, nursing, and laboratory services. He justifies the need for a national health insurance fund by explaining that it will allow people to know, when they are well, that in time of sickness they will be reliably and adequately cared for. He insists on the national character of the health insurance plan because it is the only way practically speaking to maximize cost savings and cross-subsidize Americans and to ensure quality hospital and medical care services across the nation. But, as we shall shortly see, his policy maximizes the individual state role in *implementation* of the plan.³⁴⁸ Finally, in a rebuttal against those who show preference for health insurance programs offered on a state basis he explains that this would take far too long to set up – leaving many Americans without health insurance for too many years, coverage would be inadequate, and disease would cross state lines. These

³⁴⁷Truman, 352.

³⁴⁸ Significantly, however, unlike with Medicaid, where states can offer relatively low benefits to economically disadvantaged residents, Truman's plan demanded that all states meet a high bar of healthcare provision to economically disadvantaged residents.

are practical arguments related to effectiveness and feasibility of implementation, rather than moral or ideological critique although it is clear that Truman's insistence on a federal program stemmed in part from concern that not all states would agree to universal health insurance – particularly not those states in the segregationist South. All of these key arguments of Truman's logos in defense of healthcare reform feature in those of Clinton and Obama as well – they are the most consistent element of each of these president's rhetoric on healthcare reform and the nature of these particular arguments change little over the course of the more than sixty years that divide Truman's presidency from Obama's.

Further applying a strategy of anticipatory and defensive rhetoric, Truman outlines the ways in which his healthcare reform plan protects private markets and insurers and, especially, the freedom of doctors and the ease with which they carry out their work.

The plan which I have suggested would be sufficient to pay most doctors more than the best they have received in peacetime years. The payments of the doctors' bills would be guaranteed, and the doctors would be spared the annoyance and uncertainty of collecting fees from individual patients. The same assurance would apply to hospitals, dentists and nurses for the services they render.³⁴⁹

Although Truman's healthcare policies do not reflect a compromise on liberal principles of universality and government responsibility for welfare of citizens, the logos of his healthcare reform plans contains many elements which conservatives will find reassuring. These include its emphasis on local and state control over healthcare provision and maximal freedom for doctors to determine the parameters of patient care without invasive government regulation and limitation of treatments and with respect for the priorities and preferences of state and local government.

³⁴⁹Truman, 354.

Medical services are personal. Therefore the nation-wide system must be highly decentralized in administration. The local administrative unit must be the keystone of the system so as to provide for local services and adaptation to local needs and conditions. Locally as well as nationally, policy and administration should be guided by advisory committees in which the public and the medical professions are represented.³⁵⁰

Although he calls for ‘national standards’ he also stresses that methods and rates of pay for doctors and hospitals should be ‘adjusted locally’ – striking a balance between concern for national standards and flexibility to meet local needs and communal dynamics. This reflects respect for conservative concerns with states rights. In particular, Truman shows how his health insurance reforms, rather than minimizing choice and harming the private market, will embrace the democratic values of freedom and choice and respect the market. The intense frequency of the words free and freedom drive this message home unambiguously and forcefully.

People should remain *free to choose* their own physicians and hospitals. The removal of financial barriers between patient and doctor would enlarge the present *freedom of choice*. The legal requirement on the population to contribute involves *no compulsion* over the *doctor's freedom* to decide what services his patient needs. People will remain *free* to obtain and pay for medical service outside of the health insurance system if they desire, even though they are members of the system; just as they are *free* to send their children to private instead of to public schools, although they must pay taxes for public schools.³⁵¹

He also argues that physicians should be able to accept or reject patients, choose if they wish to participate in the health insurance system and to what extent, and explains that Americans will not be required to use the system if they prefer private healthcare and so the public insurance system will not cause a narrowing of healthcare options and will only expand healthcare options, especially to those who cannot afford healthcare now. To demonstrate that there’s nothing radical about his plan – except for its enabling

³⁵⁰Truman, 352.

³⁵¹ Truman, 353.

universal health insurance - Truman depicts it conservatively as something that does not represent a major social change aside from increasing access and quality and makes vigorous and repeated statements denying that it has any relationship to socialism.

None of this is really new. The American people are the most insurance-minded people in the world. They will not be frightened off from health insurance because some people have misnamed it "socialized medicine." I repeat--what I am recommending is not socialized medicine. Socialized medicine means that all doctors work as employees of government. The American people want no such system. No such system is here proposed.³⁵²

As discussed earlier, many of the key themes and arguments within Truman's logos can be found in Clinton and Obama's rhetoric who also rebut conservative characterizations of their healthcare reforms. There is, however, one major component of Truman's logos that is unique to his speech and does not repeat itself in Johnson, Clinton and Obama's rhetoric. This is the way in which he relates healthcare reform and universal healthcare provision to military preparedness and the welfare of American soldiers. We will now proceed to examine this distinctive strand of Truman's speech.

5.6.2 Military Preparedness in Truman's Logos: The Rhetorical Strategy of Linkage to Advance Social Solidarity

The relationship between healthcare reform and the US military is fundamental for Truman's logos. According to Truman, universal health insurance and improvement in healthcare services in the United States are necessary to maintain America's military preparedness which, he argues, has been undermined by the lack of quality, accessible, and affordable healthcare for all Americans. Reflecting rhetorical strategies of linkage and historical temporality, Truman states,

³⁵²Truman, 353.

The people of the United States received a shock when the medical examinations conducted by the Selective Service System revealed the widespread physical and mental incapacity among the young people of our nation. We had had prior warnings from eminent medical authorities and from investigating committees. The statistics of the last war had shown the same condition. But the Selective Service System has brought it forcibly to our attention recently--in terms which all of us can understand.³⁵³

Truman explains that a million and a half men were discharged from the Army and Navy for physical and mental disabilities and that the same number needed to be treated for physical and mental illness while in the armed forces. These facts provide strong supporting evidence for Truman's argument that the government must provide all Americans with healthcare not only because it violates their rights not to do so but because the lack of universally accessible and affordable healthcare severely impinges upon the quality of the American military and its ability to protect the American people.

Building on the pragmatism of his argument about the need to improve healthcare provision in order to improve the health of the men and women inducted into the US armed forces, Truman goes on to make a practical note that the illnesses and disabilities from which a large number of soldiers suffer will make their life more difficult and possibly more economically strained and that, therefore, "It is... important to resolve now that no American child shall come to adult life with diseases or defects which can be prevented or corrected at an early age."³⁵⁴ Thus Truman uses the particular concern for the health and welfare of prospective and former US military servicemen and women as a pivot point to argue for the health and welfare of the American people as a whole, applying a strategy of linkage between the needs of one particular group of Americans with the American people at large. He treats this as one integrated topic rather than two discrete ones, and this gives his argument power because the desire for

³⁵³Truman, 345.

³⁵⁴Ibid.

healthy soldiers is universal and uncontested, whereas universal health insurance is contested and there is no collective agreement on it. Truman explains that maintaining a healthy citizenry will maximize the economic output of the United States, strengthening the pragmatic line of reasoning of his logos to relate to overall economic efficiency which is a theme that is marginal to his speech, and, as we shall see, to Johnson's, but dominant in Clinton and Obama's, reflecting changes in the American social imaginary.

This line of reasoning allows Truman to implicitly convey the idea that antagonists to his healthcare reform plan are by definition antagonists to America's military preparedness and to the peace and security of the American people – a subject on which no politician would ever be willing to compromise and appear to be on the side of American military weakness. This is particularly true in the context of Truman's time: immediately after the conclusion of World War 2 in which America's participation in the war was needed to defend democracy and the physical integrity of the United States, which was attacked at Pearl Harbor. Immediately after World War 2, as Communism became the new enemy of the United States, the need for a ready and capable military force continued to be of great importance as the US projected power globally in defense of its interests. Traditionally conservatives have maintained the closest ties with the military and in emphasizing the military – which is a conservative priority – Truman is also strongly inoculating his healthcare reform plan from attacks by conservatives. It is a powerful addition to the logos of his speech and injects the pragmatic argument of the need to ensure a nation's capacity for self-defense with the ethos of government guarantee of citizen welfare and government responsibility to ameliorate poverty and other social injustices.

Continuing on the theme of soldiers and the military Truman links the widespread sorrow in the face of military deaths by virtually all Americans to argue that the tragedy of death is even greater in the United States amongst civilians where it is

avoidable but because of a lack of government resolve millions of Americans are not receiving the life preserving care that they need and deserve. “In spite of great scientific progress, however, each year we lose many more persons from preventable and premature deaths than we lost in battle or from war injuries during the entire war.” Building on the respect that Americans have for returning war veterans he also argues that many war veterans will not have adequate healthcare upon completing their service and that only those with disabilities will have guaranteed access to quality care.

Many millions of our veterans, accustomed in the armed forces to the best of medical and hospital care, will no longer be eligible for such care as a matter of right except for their service-connected disabilities. They deserve continued adequate and comprehensive health service. And their dependents deserve it too.³⁵⁵

Based on the need to provide veterans with follow-up healthcare upon completing their military service Truman builds his argument that the government must guarantee healthcare to *all* Americans. In so doing, returning veterans who should be entitled to such care will also be able to avail themselves of it, he argues. Thus a central thrust of Truman’s logoi is the instrumentalization of the topic of military preparedness and the health of prospective and current American soldiers to advance his healthcare reforms to expand health insurance to all Americans. We will now proceed to examine how Truman applies the rhetorical strategy of linkage in the logoi of his healthcare reforms in relation to public health.

³⁵⁵Truman, 355.

5.6.3 Public Health and the Rhetorical Strategy of Linking Individual and Collective Welfare: Transcending Class Division

One of the ways in which Truman's rhetoric is distinctive is how it incorporates public health issues alongside healthcare service provision. This linkage is not a way to avoid highlighting the particular needs of economically disadvantaged Americans, rather, it is a practical argument for communitarian solidarity and national unity that reflects the health vulnerabilities all Americans have in common and which need to be recognized as shared national challenges which cannot be addressed if healthcare provision is largely limited to the wealthy and upper middle class. Because public health issues such as adequate sanitation and clean air and water affect rich and poor alike this a component of his healthcare reforms that transcends many social divisions and links particular needs with collective, universal ones. Consequently, it is a useful argument to rally support for healthcare reform because it does not concentrate on helping one particular section of the American population such as rural Americans or economically disadvantaged Americans exclusively. It appeals to the self-interest of every American and in so doing unites diverse and sometimes contradictory interests and concerns of rich and poor, urban and rural, black and white under one unifying banner of improving the health quality of all Americans in relation to the land, air, and water that they share and the communities which they inhabit together.

Truman's extensive incorporation of broad public health goals further provides him with the opportunity to embed the priority of his healthcare reform plans to assist the economically disadvantaged with broader goals to improve the welfare of all Americans, including the wealthy. In so doing he applies the rhetorical strategy of linking individual and collective welfare, rich and poor alike.

If we agree that the national health must be improved, our cities, towns and farming communities must be made healthful places in which to live through provision of safe water systems, sewage disposal plants and sanitary facilities. Our streams and rivers must be safeguarded against pollution. In addition to building a sanitary environment for ourselves and for our children, we must provide those services which prevent disease and promote health.³⁵⁶

This argument will easily win the assent of most Americans because clean air, water, and sanitation needs are universal human needs. Truman then pivots from the universal back to the particular, returning to address the needs of the most disadvantaged Americans.

Services for expectant mothers and for infants, care of crippled or otherwise physically handicapped children and inoculation for the prevention of communicable diseases are accepted public health functions. So too are many kinds of personal services such as the diagnosis and treatment of widespread infections like tuberculosis and venereal disease. A large part of the population today lacks many or all of these services.³⁵⁷

Here Truman creates a direct link between the needs of disadvantaged Americans and the needs of all Americans as a whole. Infectious disease may be generally higher amongst the economically disadvantaged, but its impact is not isolated to them. By providing the economically disadvantaged with better medical care to limit infectious disease all Americans benefit, and this line of reasoning enables Truman once again to present his healthcare reform plan not only as a project that will benefit the marginalized but that will benefit all Americans, of all backgrounds and classes. He then follows with a passage that refers to eradicating diseases in general which cannot easily be ascribed to one sect of society but which potentially impacts all Americans.

Our success in the traditional public health sphere is made plain by the conquest over many communicable diseases. Typhoid fever, smallpox, and diphtheria--diseases for which there are effective controls--have become comparatively rare. We must make the same gains in reducing our maternal and infant mortality, in controlling tuberculosis, venereal disease, malaria, and other major threats to life

³⁵⁶Truman, 347.

³⁵⁷Ibid.

and health. We are only beginning to realize our potentialities in achieving physical well-being for all our people.³⁵⁸

As in several other passages of the speech we have discussed, in this passage Truman emphasizes continuity with healthcare programs that are already in place, thus depicting his healthcare reforms as being based on programs that have already proven their success and are familiar to Americans and have won their trust.

Following the logos of expanding healthcare reforms that will improve the health of all Americans, Truman continues to apply the rhetorical strategy of linkage. He calls for increased funding and programs to treat cancer, an illness which strikes rich and poor across the nation. He argues similarly about the need to expand programs to address mental illness, an area of healthcare that has been marginalized historically and from which all Americans, irrespective of economic status and geographic location suffer from insufficient access to health services.

There is also special need for research on mental diseases and abnormalities. We have done pitifully little about mental illnesses... We need more mental-disease hospitals, more out-patient clinics. We need more services for early diagnosis, and especially we need much more research to learn how to prevent mental breakdown. Also, we must have many more trained and qualified doctors in this field.³⁵⁹

His comments on the value of medical research also focus on its universal benefits and relate to the research and development output that World War 2 enabled.

It is clear that we have not done enough in peace-time for medical research and education in view of our enormous resources and our national interest in health progress. The money invested in research pays enormous dividends. If any one doubts this, let him think of penicillin, plasma, DDT powder, and new rehabilitation techniques.³⁶⁰

³⁵⁸Truman, 348.

³⁵⁹Ibid.

³⁶⁰Truman, 348.

In the section addressing how to curb healthcare costs Truman notes that both the economically disadvantaged and those who are generally able to meet their life needs have difficulty meeting the costs of healthcare, again maintaining his strategy of linking different economic and social classes of Americans, in this case the needs of middle-class Americans with those of the economically disadvantaged.

The principal reason why people do not receive the care they need is that they cannot afford to pay for it on an individual basis at the time they need it. This is true not only for needy persons. It is also true for a large proportion of normally self-supporting persons.³⁶¹

In referring to “normally self-supporting persons” Truman is not idealizing this category or casting aspersions on the poor and unemployed, rather he is making an empirical observation.

All of these arguments by Truman transcend divisions of economic status. By so vigorously employing his strategy of linkage Truman powerfully illustrates that because government guarantee of healthcare will not only help the economically disadvantaged but will help all Americans it therefore merits the support of all Americans. Having already discussed some of the distinctive features of Truman’s rhetoric – including his use of the rhetorical strategy of linkage, his bridging of diverse economic and social classes and thus his reimagining the social imaginary in a more egalitarian and inclusive way, and his invocation of the military and soldiers in defense of his healthcare reforms we will further examine what makes Truman’s rhetoric distinctive in relation to the rhetoric of Johnson, Clinton, and Obama.

³⁶¹Truman, 348.

5.7 Truman in a Comparative Perspective: The Uniqueness of His Rhetoric and the Place of the Poor Within It

As we have seen, Truman contextualizes a right to healthcare by defining it as but one component of a constellation of social and economic rights whose defence is essential to the realization of an American social imaginary and moral order based on the aforementioned principles of Truman's ethos. Truman situates healthcare reform as one component of a broader effort to alleviate poverty and its social consequences, which he depicts as an affront to the American social imaginary and moral order. Truman states, "By meeting that demand [for healthcare reform] we shall strengthen the Nation to meet future economic and social problems; and we shall make a most important contribution toward freedom from want in our land."³⁶²

Truman's plan includes a provision designed to prevent the onset of poverty due to extended absence as a result of illness and employs no language of compromise. Only a small section of Truman's speech is devoted to addressing complaints of critics that his healthcare reform plan is 'socialized medicine' that will lead to a government takeover of healthcare. Truman robustly addresses the rights, needs, and vulnerabilities of the most economically disadvantaged, and does not focus on the needs of the middle-class nor does he use the middle class as an idealized signifier. He does not efface the working class and poor from public discourse – on the contrary – he explicitly recognizes their dignity and rights, and demands that they be defended. As our discussion of his strategy of linkage illustrates, Truman needs to attract the support of a diverse group of Americans rather than exclusively the most disadvantaged ones to help win passage of his healthcare reforms. So while he does not focus on the middle class or elide the needs and vulnerabilities of the working class and the most economically disadvantaged, he

³⁶²Truman, 355.

does appeal to the widest American audience possible, including wealthy Americans and those with adequate health insurance.

As campaigning for his healthcare reforms progressed, however, Truman began to employ the rhetorical trope of the idealized middle class American in ways that we do not find in his main address to Congress on healthcare reform. In his 1948 Healthcare Assembly Address, for example, Truman heaps praise on the middle class and explicitly orients his healthcare reform rhetoric towards them and lionizes them.

You know the things in which I am vitally interested... to arrange things so that those hospitals may be available to the people who need them most, the people who are not the very rich and who are not the very poor, but who are the backbone of the population of this great Nation of ours, the very people who make this Nation great. The fact that we have a well-informed so-called middle class in this country, is what makes it the greatest republic the sun has ever shone upon, or ever will shine upon again. And I want to keep that republic going, just as it has done in the past, by any small or great contribution that I can make to that end.³⁶³

This reflects a shift in his rhetoric – and perhaps a realization on his part that, increasingly, the most effective way of addressing Americans was by referring to the middle class because it was perceived as being ever more accessible to Americans. The ‘middle class’ was becoming a focal point of the American social imaginary and the identity to which many Americans would *aspire* during the period of economic growth, increased consumer spending, and suburbanization that followed World War 2.³⁶⁴

This turn in appeal to the middle class may have been a function of Truman realizing the limits of his rhetoric to motivate Americans to support a program that would have as a major concern the rights and welfare of the most economically disadvantaged. The memory of the Great Depression was still powerful in 1948, but in the post World War Two years, as we discussed earlier, as the economy grew and more

³⁶³Harry Truman. “Remarks at the National Health Assembly Dinner,” May 1, 1948. <http://www.trumanlibrary.org/publicpapers/viewpapers.php?pid=1612>

³⁶⁴See page 148, footnote # 337.

Americans received healthcare through their employment³⁶⁵ many Americans may have been less receptive to arguments for universal health insurance because as many did better economically and benefited from employer provided health insurance they did not perceive themselves as vulnerable in the same way as during and after the Great Depression and during Roosevelt's presidency.³⁶⁶

5.8 Conclusion

By making social and economic rights the heart of the ethos of his healthcare reform Truman maintains the immediate historical link with Franklin Delano Roosevelt's New Deal and its emphasis on the integration of social and economic rights with civil and political ones and its consequent revision of the American moral order and social imaginary. This reflects a strategy of historical temporality which links the immediate past with the present and future. Truman also employs it when discussing the necessity of improving healthcare across the nation so as to improve the health and welfare of prospective and former American soldiers. Moralizing rhetoric which passionately decries the injustices of healthcare inequalities is often anchored to rights based arguments for government guarantee of healthcare provision. Because rights are asserted as being self-evident and incontrovertible normative values Truman – while providing careful reasoning for why healthcare is a right the government should respect – also establishes rhetorical power that follows from the force of conviction and faith which is imbued in rights based moral arguments.

Truman applies a rhetorical strategy of linkage between particular groups of Americans – specifically, military service people, to advance a social imaginary in which

³⁶⁵ Quadagno, 46-47 & 50-52.

³⁶⁶ Derickson, 101.

the welfare of all Americans is provided by the government. Indeed the military was a potent signifier for trans-class solidarity and trans-ethnic and racial solidarity because the draft reached rich and poor, black and white, and Americans of all cultures, backgrounds, and identities.³⁶⁷ As another expression of this rhetorical strategy which strives to link individual and collective national welfare he emphasizes public health projects which are necessary to maintain the health and welfare of all Americans, rich and poor, irrespective of their background and resources. This enables Truman to advocate for healthcare which benefits the most economically disadvantaged without alienating the middle class and the wealthy and rhetorically advances communitarian solidarity and national unity.

To strengthen the social imaginary Roosevelt's rhetoric and policies seeded, Truman depicts his healthcare reforms as an expression of Roosevelt's ideals and plans and applies a strategy of moralizing with a focus on equal opportunity, social and economic rights, and communitarian solidarity. Truman employs anticipatory rhetoric but rather minimally – it is not defensive in tone as we will see in Clinton and Obama's rhetoric - such that the overall tone of Truman's speech is confident and uncompromising and unapologetic – especially in its rejection of conservative characterizations of his healthcare reforms as socialist.

What additionally makes Truman's healthcare rhetoric different from Clinton and Obama's - but evidencing continuities with Johnson's - is its progressive liberalism in which Truman situates healthcare provision as one component of a broader government responsibility for actualizing positive liberty of citizens and securing their welfare.

Truman shows no deference to the ideology of limited government – on the contrary –

³⁶⁷ However, wealthier Americans had more options to avoid the draft because of their economic resources and educational background. In contrast today, in an all voluntary armed forces, the US armed forces skew heavily towards the working class and economically disadvantaged. Ethnic and racial minorities are overrepresented, with wealthier Americans and wealthy whites in particular substantially underrepresented.

David M. Halbfinger and Steven A. Holmes. "Military Mirrors Working Class America." Originally published in *The New York Times*, March 20, 2003.
<http://www.cwalocal4250.org/news/binarydata/Military%20Mirrors%20Working-Class%20America.pdf>

he robustly asserts that his healthcare reforms are the logical next step in realizing Roosevelt's progressive vision of an expansive role for the government whose responsibility is to ensure the welfare of its citizens.

Although Truman did not succeed in realizing this vision – and indeed the massive expansion of government social programming that Roosevelt launched in the New Deal was never to repeat itself in American history – with Johnson's Great Society efforts to defeat poverty and creation of Medicare and Medicaid the only comparable such expansions - no other American president save for Johnson offered the American people an alternative to the ideology of limited government regarding healthcare reform from an unabashedly liberal orientation as Truman's. Although Clinton and Obama barely tapped into this rhetoric it remains a touchstone in presidential rhetoric about healthcare reform and an alternative to the defenses of healthcare reform provided by Clinton and Obama with their emphasis on economics and efficiency rather than the primacy of the rights and welfare of citizens and government responsibility to honor them.

Chapter 6: Lyndon Baines Johnson's Remarks at the Signing of the Medicare Bill, July 30, 1965 and Related Speeches

And if I am ever to be remembered by any of you here, I want to be remembered as one who spent his whole life trying to get more people more to eat and more to wear, to live longer, to have medicine and have attention, nursing, hospital and doctors' care when they need it, and to have their children have a chance to go to school and carry out really what the Declaration of Independence says, 'All men are created equal.'³⁶⁸

- Lyndon Baines Johnson

6.1 Introduction

Incremental improvements in healthcare quality and provision that began under Truman such as the Hill-Burton Act to expand hospital construction, as discussed in Chapter 1, continued under Johnson. However, from a policy perspective Johnson was able to deliver far more consequential legislation which expanded healthcare provision massively, through the Medicare and Medicaid programs and related healthcare programs such as the expansion of community health clinics. Unlike Presidents Truman and later Clinton and Obama, these policies were not initiated by a major public address to Congress that focused specifically and primarily on healthcare reform. Instead, they formed one component of an extensive and diverse program of social change to be financed by the federal government which Johnson dubbed 'The Great Society' and in which he incorporated efforts to increase employment and reduce poverty in his 'War on Poverty.'³⁶⁹

Johnson addressed the Great Society and War on Poverty extensively in his State of the Union addresses and in other speeches both to Congress and at public events. I

³⁶⁸Remarks in San Antonio at the Signing of the Medicare Extension Bill, <http://www.presidency.ucsb.edu/ws/index.php?pid=27535>

³⁶⁹This was the term he used to describe both his vision for eliminating poverty and the actual programs intended to meet those goals.

draw from a diverse selection of these speeches, taking care to analyze the speeches that were landmarks in Johnson's public definition and defense of the Great Society and War on Poverty. Healthcare reform for Johnson then was, similar to Truman's framing of it, but one component of a larger effort to advance equal opportunity and positive liberty to all American citizens. It was one part of a larger rhetorical and practical revision of the American social imaginary and its underlying moral order to include an extensive government guarantee of citizen welfare.

Moralization is the dominant rhetorical strategy in Johnson's speeches, both on healthcare reform and on the War on Poverty and Great Society generally. Linkage also plays a key role as a rhetorical strategy in his speeches on the War on Poverty and Great Society, as Johnson seeks to redefine the American social imaginary and moral order to include African-Americans and economically disadvantaged Americans as equals and to unite disparate aspects of American society, city dwellers and rural inhabitants, young and old, the affluent and the impoverished. Historical temporality plays a prominent role as a rhetorical strategy in Johnson's healthcare reform rhetoric as well, where he ties Medicare and Medicaid to the unfinished work of Truman's Fair Deal. Johnson championed the economically disadvantaged vigorously in both his rhetoric and policy, placing them at the heart of his government programming and insisting that it is the role of government to protect the most vulnerable and marginalized.

Like Truman, Johnson defined healthcare as a social and economic right (though he stated this less explicitly than Truman) and characterized the creation of Medicare and Medicaid as the realization of that right (albeit only a partial one as Truman's reforms called for universal healthcare, rather than expansion of coverage to seniors and the most indigent, as Medicare and Medicaid respectively provide.) Because healthcare reform was but one major legislative achievement in the context of Johnson's Great Society and War

on Poverty,³⁷⁰ I initially address the policies born of the War on Poverty and Great Society programs. I then analyze the social imaginary and moral order Johnson constructs in his speeches in defense of these programs³⁷¹ examining their ethos. I follow this with an analysis of the logos of these programs, critically examining Republican critiques of the Great Society as entailing massive and increased government expenditures. I then analyze Johnson's speech at the signing ceremony of Medicare and Medicaid in 1965 (signed as amendments to the Social Security Act of 1935.)

Of the three rhetorical domains of ethos, pathos, and logos Johnson's rhetoric is heavily dominated by ethos – like Truman's. However, Johnson's rhetoric is substantially more emotive than Truman's. Johnson's depictions of pathos reflecting moral indignation in the face of injustice span the corpus of his speeches and in addition to being expressed forcefully they often play a central role in the structure of his addresses and are their dominant rhetorical feature and make him unique amongst the four presidents.

6.2 Government Programs of the War on Poverty and Great Society

As part of the War on Poverty, The Economic Opportunity Act of 1964 created an Office of Economic Opportunity which oversaw a range of government support for community based programs to improve employment skills and alleviate poverty. Major highlights of these programs include the creation and expansion of community health clinics to serve disadvantaged communities, investments in education, combating urban

³⁷⁰ The War on Poverty formed part of the Great Society. Though I often refer to the two as distinct visions/government programs, as Johnson often did, any reference to the Great Society alone implies the War on Poverty as one of its fundamental components. The War on Poverty generally referred more to the specific policy programs that sought to realize the overarching vision of the Great Society as it related to expanding economic opportunity and increasing social mobility.

³⁷¹ For more on Medicare as an integral component of the War on Poverty and Great Society see Edward Berkowitz, "Medicare: The Great Society's Enduring National Health Insurance Program," in *The Great Society and the High Tide of Liberalism* ed. Sidney M. Milkis and Jerome M. Mileur, (Amherst: University of Massachusetts Press, 2005).

and rural decay and fostering communal revitalization, and investment in transport infrastructure. Food stamps expansion, consumer protection, environmental protection, public health safeguards through government regulation of food production and other industries, and funding for affordable housing all were components of the War on Poverty and Great Society.

Community Development Districts were established to foster local, collective efforts to reduce poverty through job and skills training³⁷² and a Teacher Corps was created to reach schools that were understaffed. Johnson increased unemployment insurance payments, raised the minimum wage, and empowered working class Americans by supporting labor in calling for the repeal of section 14b of the Taft-Hartley Act, ensuring that in every state unions would not face ‘right to work’ measures which make it increasingly difficult to organize workers and negotiate fair wages, benefits, and working conditions. Programs included a National Service Corps to apply the principles of service of Kennedy’s Peace Corps serving abroad domestically, mandating federal minimum wage laws to reach all American workers, construction of libraries, hospitals and nursing homes, and increased funding for training teachers and nurses.³⁷³ Head Start, a pre-school program for disadvantaged children that also addressed their nutritional needs, increases in Social Security benefits for disadvantaged individuals, and increased financial aid to indigent mothers and families all were significant legislative achievements.³⁷⁴

³⁷² For a comprehensive description of these programs, their aims, finance, and content see Robert F. Clark, “The War on Poverty: History, Selected Programs and Ongoing Impact (Lanham: University Press of America, 2002.) See also James MacGregor, Part 2 : The Great Society Today and Part 3, The Frontiers of Excellence in *To Heal and to Build: The Programs of President Lyndon B. Johnson*, (McGraw-Hill, New York, 1968).

³⁷³ Ibid.

³⁷⁴ It is beyond the scope of this thesis to evaluate the efficacy of this spending, on which there is substantial debate amongst scholars and much of which is informed by their particular political sympathies. Undoubtedly the record was mixed, but data does indicate a decline in poverty and an improvement in quality of life indicators during the years when the War on Poverty was fully funded. The War on Poverty itself fell far short of Johnson’s aim to eradicate poverty completely but that may be less of an indictment of the War on Poverty than a commentary on the unrealistic and overly idealistic goals which Johnson set out for it. As Johnson stated in his 1969 State of the Union Address, “This is the richest nation in the world. The antipoverty program has had many achievements. It also

Many of Johnson's achievements were limited in time to his presidency and did not receive funding beyond that under successive presidencies. So their impact on poverty reduction and empowerment of disadvantaged minorities did not necessarily extend many years beyond the Johnson presidency.³⁷⁵ Johnson's Great Society and War on Poverty came into being just before the expansive expectations of government in insuring citizen welfare that were dominant during the Roosevelt and Truman eras (despite Truman's failure to pass healthcare reform and the growing public suspicion of it) began shifting towards scepticism towards the capacity and appropriateness of wide-scale government provision of social services.

Some of Johnson's programs also had mixed records of success and the focus on local control and implementation was no guarantee of success. However, in addition to Medicare and Medicaid there were a host of social programs positively impacting the economically disadvantaged that Johnson passed which were lasting achievements that remain government policy to this day: food stamps³⁷⁶ to increase food security to

has some failures. But we must not cripple it after only 3 years of trying to solve the human problems that have been with us and have been building up among us for generations."

<http://www.pbs.org/wgbh/americanexperience/features/primary-resources/lbj-union69/?flavour=mobile>

One of Johnson's aides, Joseph A. Califano, Jr., has defended the War on Poverty vigorously stating that "From 1963 when Lyndon Johnson took office until 1970 as the impact of his Great Society programs were felt, the portion of Americans living below the poverty line dropped from 22.2 percent to 12.6 percent, the most dramatic decline over such a brief period in this century." The percentage of African Americans below the poverty line dropped from 55 percent in 1960 to 27 percent in 1968.

Joseph Califano, "What Was Really Great About the Great Society," *The Washington Monthly*, October, 1999.

<http://www.washingtonmonthly.com/features/1999/9910.califano.html>

³⁷⁵ Prominent exceptions to this are the Voting Rights Act and Civil Rights Act which we will discuss later in the chapter. The legacy of the War on Poverty is much debated.

See Attiat F. Ott and Paul Hughes-Cromwick, "The War on Poverty: Two Decades Later" in *Lyndon Baines Johnson and the Uses of Power*, ed. Bernard J. Firestone and Robert C. Vogt (Westport: Praeger, 1988), for an assessment of the efficacy of the War on Poverty and its impact beyond the Johnson years.

³⁷⁶ The United States currently spends over 75 billion dollars a year on food stamps, one of the primary sources of government support for the most impoverished Americans. Currently 46 million Americans receive foodstamps. After Medicaid, the food stamps program, known as SNAP – Supplementary Nutrition Assistance Program, is the second largest government welfare expenditure.

Peter Edelman, "Poverty in America: Why Can't We End It?" *The New York Times*, July 28, 2012.

<http://www.nytimes.com/2012/07/29/opinion/sunday/why-cant-we-end-poverty-in-america.html?pagewanted=all>

indigent and disabled Americans, federal aid to schools, the continuous expansion of health clinics in rural and urban impoverished areas, and the increase in Social Security benefits for all Americans but especially the poor and disabled to help meet rises in costs of living.

6.3 Patriotism and Possibility: Moral Idealism in Johnson's Social Imaginary and the Ethos of the Great Society

The social imaginary which Johnson rhetorically constructs has an almost utopian vision regarding its expectation of the extent to which it could eliminate poverty, its primary moral and practical aim. “Our aim is not only to relieve the symptom of poverty, but to cure it and, above all, to prevent it.”³⁷⁷ It offers a vision of limitless potential for Americans and of massive correction of egregious injustices and inequalities and its use of the metaphor of war conveys its sense of total commitment, urgency, and shared sacrifice. On the urban blight of slums, for example, Johnson states, “I recommend to you a program to rebuild completely, on a scale never before attempted, entire central and slum areas of several of our cities in America.” This emphasis on social transformation on a massive scale is present in the language that Johnson uses when describing the Great Society and War on Poverty which rarely looks to ‘improve’, ‘expand’, or otherwise achieve incremental change, rather, its hallmark is its epic scale and scope and its conviction that total societal transformation is possible within the short time frame of the Johnson presidency. Johnson listed among his policy aims,

Jordan Weissman, “Why Are Republicans Waging War on Foodstamps Now?” *The Atlantic*, June 21, 2012.

<http://www.theatlantic.com/business/archive/2012/06/why-are-republicans-waging-war-on-food-stamps-now/258794/>

For an assessment of how Community Services Block Grants, initiated under Truman, continued to impact disadvantaged Americans decades later see Michael Givel, *The War on Poverty Revisited: The Community Services Block Grant Program in the Reagan Years*, (Lanham: University Press of America 1991.)

³⁷⁷January 8, 1964 State of the Union Address.

<http://www.lbjlib.utexas.edu/johnson/archives.hom/speeches.hom/640108.asp>

- I recommend that you attack the wasteful and degrading poisoning of our rivers, and, as the cornerstone of this effort, clean completely entire large river basins.
- I recommend that you meet the growing menace of crime in the streets by building up law enforcement and by revitalizing the entire Federal system from prevention to probation.
- I recommend that you take additional steps to insure equal justice to all of our people by effectively enforcing nondiscrimination in Federal and State jury selection, by making it a serious Federal crime to obstruct public and private efforts to secure civil rights, and by outlawing discrimination in the sale and rental of housing.³⁷⁸

Virtually no major area of government social policy was left untouched by the depth and breadth of Johnson's vision for social change.

Johnson's Great Society offered a comprehensive and explicit expansion of the American social imaginary. It built on Roosevelt and Truman's New Deal and Fair Deal. But it also moved beyond a language of social and economic rights and social solidarity towards one more spiritual in nature, concerned with particular ethical values such as ending citizen isolation and improving communities and protecting the natural environment and enabling citizens to appreciate and enjoy its beauty. It questioned values such as materialism and demanded a greater commitment to communitarianism, invoking a liberal patriotic quest that was as much about citizen involvement in building a new type of society as a series of government guaranteed rights and entitlements which were a defining feature of the New Deal and the Fair Deal.

Johnson gave one of his most significant speeches on the Great Society at the University of Michigan in a commencement speech there on May 22, 1964 where he was replacing President Kennedy who was originally to have addressed the graduating students but who had been assassinated seven months earlier. In this speech³⁷⁹ Johnson

³⁷⁸State of the Union Address, January 12, 1966.
<http://millercenter.org/president/speeches/detail/4035>

³⁷⁹President Johnson's Remarks at the University of Michigan,
<http://www.lbjlib.utexas.edu/johnson/archives.hom/speeches.hom/640522.asp> -
 For more on the social imaginary of the Great Society and the War on Poverty see Marvin E. Gettleman and David Mermelstein, editors, *The Great Society Reader: The Failure of American*

describes three major areas of concern of the Great Society: improving quality of life and reducing poverty in the city, improving quality of life and reducing poverty in the countryside as well as protecting the integrity of nature and protecting it in a spirit of stewardship, and greater funding for schooling to ensure educational success and higher graduation rates for American primary and secondary school students and increased college enrolment. The speech is explicitly communitarian in its vision of a thriving American society in which citizens enjoy bonds of close relationship in the context of a generally high quality of life defined by freedom, unblighted by poverty, and protected by equality before the law. The rhetorical strategies used are moralization and linkage.

The Great Society rests on abundance and liberty for all. It demands an end to poverty and racial injustice, to which we are totally committed in our time...The Great Society is a place where every child can find knowledge to enrich his mind and to enlarge his talents... It is a place where the city of man serves not only the needs of the body and the demands of commerce but the desire for beauty and the hunger for community. It is a place where man can renew contact with nature. It is a place which honors creation for its own sake and for what it adds to the understanding of the race. It is a place where men are more concerned with the quality of their goals than the quantity of their goods. But most of all, the Great Society is not a safe harbor, a resting place, a final objective, a finished work. It is a challenge constantly renewed, beckoning us toward a destiny where the meaning of our lives matches the marvelous products of our labor.³⁸⁰

There are two interweaving strands within this passage and within the University of Michigan Great Society speech as a whole which elucidate Johnson's distinct articulation of a new American social imaginary and its underlying moral order. The first concerns itself with practical matters of alleviating material deprivation, maximizing human development through education, and eliminating the structural barriers of racism that hinder the actualization of the former two social goals as well as the full and equal

Liberalism, (New York: Random House, 1967.) See also David Zarefsky, *President Johnson's War on Poverty: Rhetoric and History*. (Tuscaloosa: University of Alabama Press), 1986.

³⁸⁰President Johnson's Remarks at the University of Michigan,
<http://www.lbjlib.utexas.edu/johnson/archives.hom/speeches.hom/640522.asp>

political and civil participation of African-Americans and other minorities and economically disadvantaged Americans in the life of the country. The second strand concerns a more intangible spiritual and social vision of Americans engaging in creative activities that give meaning to their lives, participating in interpersonal exchange and the creation of community, enjoying the beauty and bounty of nature,³⁸¹ and rejecting the values of selfish materialism. It favors a dynamic vision of social renewal that is as oriented to the purpose and pleasures of social processes and relationships and intellectual and artistic engagement as to material production and work. Thus Johnson's vision of the new American social imaginary is both ethical and emotional. We see the prominence of ethos and pathos in his rhetoric which is attuned to a particular understanding of human well being with the heavy use of moralization to defend paramount moral values of equality and justice and an Aristotelian conception of the good life, with an integrated individual and collective vision of its characteristics.

Johnson defines the term 'greatness' in moral and practical terms referring to it as a form of "liberation" which would

use our success for the fulfillment of our lives. A great nation is one which breeds a great people. A great people flower not from wealth and power, but from a society which spurs them to the fullness of their genius. That alone is a Great Society.³⁸²

In other words, Johnson's vision is one of maximizing a citizen's positive liberties, a subject which he addresses directly in many of his speeches as we have already discussed and in his calls for government programs which will make real the promise of the

³⁸¹ Environmental protection and nature conservation were key components of the Great Society, both as practical policy commitments and in relation to their role in realizing a vision of improving the relationship American citizens have with nature.

³⁸² Johnson's State of the Union Address January 12, 1966, <http://www.let.rug.nl/usa/presidents/lyndon-baines-johnson/state-of-the-union-1966.php>

American Declaration of Independence to enhance the ability of American citizens to pursue happiness.³⁸³

Imploring the graduating seniors to join in the fashioning of a new America, Johnson calls upon them to embrace his vision of community, service, individual and collective self-expression, and the pursuit of justice which links together disparate sectors of American society with different backgrounds and resources, but with a common cause.

You can help build a society where the demands of morality, and the needs of the spirit, can be realized in the life of the Nation. So, will you join in the battle to give every citizen the full equality which God enjoins and the law requires, whatever his belief, or race, or the color of his skin? Will you join in the battle to give every citizen an escape from the crushing weight of poverty? Will you join in the battle to make it possible for all nations to live in enduring peace--as neighbors and not as mortal enemies? Will you join in the battle to build the Great Society, to prove that our material progress is only the foundation on which we will build a richer life of mind and spirit?³⁸⁴

Here again we see the intertwining of the themes of ethics and spirituality, the rejection of a dry materialism concerned with economic expansion without providing a broader sense of intellectual, moral, and spiritual purposes grounded in the principle of equality and communitarian obligation and solidarity. Johnson decries the loss of community which the War on Poverty and Great Society seek to restore. He says, “worst of all expansion is eroding the precious and time honored values of community with neighbors and communion with nature. The loss of these values breeds loneliness and boredom and indifference.”³⁸⁵ Here Johnson is speaking of both low density housing that is spread

³⁸³ For the speech in which Johnson’s refers to the Declaration of Independence see the conclusion of this chapter.

³⁸⁴The Great Society, University of Michigan Ann Arbor, May 22, 1964, http://www.lbjlib.utexas.edu/johnson/lbjforkids/gociety_read.shtm

³⁸⁵ In other speeches on the Great Society Johnson would emphasize these same values of communitarianism and the need to end the alienation and fragmentation caused by urban decay and low quality housing projects and the degradation of nature and disconnect between American citizens and

out and disconnected from community centers and urban housing that is so dense as to separate people from nature and create unpleasantly crowded conditions that inhibit healthy social interaction and instead raise tension. Out of concern with addressing these conditions which were undermining the communal geography of American life and the social interactions of Americans the War on Poverty included programs to improve housing and clear slums and promote nature conservation.

6.4 Healthcare Reform in the Great Society

Describing the programs of the War on Poverty and Great Society Johnson employs a strategy of linkage between the welfare of economically disadvantaged Americans including seniors who will benefit from Medicare and the poor below age 65, who will benefit from Medicaid, and all Americans at large. Johnson states.

These programs are obviously not for the poor or the underprivileged alone. *Every* American will benefit by the extension of social security to cover the hospital costs of their aged parents. *Every* American community will benefit from the construction or modernization of schools, libraries, hospitals, and nursing homes, from the training of more nurses and from the improvement of urban renewal in public transit. And *every* individual American taxpayer and every corporate taxpayer will benefit from the earliest possible passage of the pending tax bill from both the new investment it will create and the new jobs that it will create.³⁸⁶

Johnson's emphasis is on the universal nature of Medicare and the improvement in health – with its concurrent positive social consequences – enabled by Medicare and

their natural environment. "In our urban areas the central problem today is to protect and restore man's satisfaction in belonging to a community where he can find security and significance."

State of the Union Address, January 4, 1965,
<http://www.presidency.ucsb.edu/ws/index.php?pid=26907>

³⁸⁶State of the Union Address, January 8, 1964.
<http://millercenter.org/president/speeches/detail/3382>

Medicaid. The benefits Johnson depicts are cross-generational and transcend social and economic divisions of class and of geography.

In this vein, Johnson argues that Medicare, in insisting upon equal treatment of all Americans irrespective of race, is a prime example of the government enabling the disadvantaged and discriminated against to realize their right to equal treatment.

It used to be, in many places in our land, that a sick man whose skin was dark was not only a second-class citizen, but a second-class patient. He went to the other door, he went to the other waiting room, he even went to the other hospital. But tonight that old blot of racial discrimination in health is being erased in this land we love. Under this administration's Medicare program, the hospital has only one waiting room; it has only one standard for black and white and brown, for all races, for all religions, for all faiths, for all regions. And I think that is a victory for all of us; that is a victory for America. The day of the second-class treatment, the day of the second-class patients is gone. And that means that we are reaching a new day of good health for the people of America.

Thus Medicare gives policy expression to Johnson's dual legal and moral commitment to non-discrimination with an active provision of services to the impoverished and racial minorities who had previously not been entitled to such healthcare provision.

It also affirms the ethical value of human dignity. Johnson argues that programs such as Medicare are valuable not only because of the practical services they offer entitling everyone 65 and over - including many impoverished and low income Americans who formed a very large percentage of the population of American seniors - to adequate medical care. But also because they prevent people from falling into poverty because of medical costs and they do so in a way that respects the dignity of these individuals, obviating the need for them to be dependent on and have to request aid from family members, religious organizations, and charities.

Like Truman, who criticized the notion that disadvantaged citizens should have to depend on charity for their healthcare because of its negative impact on their dignity and lack of comprehensiveness and assuredness, as we have discussed in the previous

chapter, Johnson echoes these sentiments. Acknowledging that prior to Medicare many Americans received medical care as charity in an often incomplete way he contrasted this with the effects of Medicare, stating that now “they receive care on a private patient basis, with the dignity and freedom of choice that goes with the ability to pay provided by Medicare.”³⁸⁷ Similarly, he states in another speech,

So I think that we must have hope and we must recognize that there is in the place of charity now dignity, and where the children, the kinfolks, and the public agencies were the sole reliance just a few months ago, you now can have self-respect and realize that the machinery of government and the methods that we have evolved, the contributions of the individuals and the Government altogether--you can now have self-respect and still provide for your medical bills and your medicine, your nursing care, and things of that kind.³⁸⁸

The importance of the dignity and health security afforded by Medicare and the freedom it provides both senior citizens and their family members were major concerns for Johnson which he commented upon frequently. In his Statement to Congress on July 9, 1965 after the Senate passed Medicare Johnson stated,

When the conference has completed its work, a great burden will be lifted from the shoulders of all Americans. Older citizens will no longer have to fear that illness will wipe out their savings, eat up their income, and destroy lifelong hope of dignity and independence. For every family with older members it will mean relief from the often--crushing responsibilities of care. For the Nation it will bring the necessary satisfaction of having fulfilled the obligations of justice to those who have given a lifetime of service and labor to their country.³⁸⁹

We see the centrality here of ethos: Johnson’s argument relies principally on conceptions of matters of justice and fairness and communitarian social solidarity.

³⁸⁷Statement by the President on the First Anniversary of Medicare, July 1, 1967.

<http://www.presidency.ucsb.edu/ws/?pid=28336>

³⁸⁸Remarks in San Antonio at the Signing of the Medicare Extension Bill, April 8, 1966

<http://www.presidency.ucsb.edu/ws/index.php?pid=27535>

³⁸⁹Center for Medicare and Medicaid Services, <https://www.cms.gov/About-CMS/Agency-Information/History/Downloads/CMSPresidentsSpeeches.pdf>

6.5 Defending Positive Liberty and Championing the Disadvantaged in the Great Society

Equal opportunity was the overriding principle of Johnson's ethos that permeated his social legislation, including healthcare reform. He also complemented it with a vision of a minimum standard of actualization of positive liberty to enable human development and well being and dignity for all America's citizens, for him a fundamental principle of justice. One of the aims of the War on Poverty was to lift the most impoverished Americans towards the kind of quality of life and security middle-class Americans enjoyed. Its very title indicates its concern with addressing the needs of the poor and transforming their economic and social situation away from deprivation and neglect to opportunity and equal participation.

What is so exceptional about Johnson's rhetoric in contrast to Clinton and Obama – as we shall soon see - is his explicit and extensive focus on affirming the well being of the very poorest Americans and assuring their dignity. Describing the logos of the War on Poverty Johnson states, "The program I shall propose will emphasize this cooperative approach to help that one-fifth of all American families with incomes too small to even meet their basic needs." In his 1965 State of the Union address Johnson said,

We must open opportunity to all our people. Most Americans enjoy a good life. But far too many are still trapped in poverty and idleness and fear. Let a just nation throw open to them the city of promise:

- to the poor and the unfortunate, through doubling the war against poverty this year;

- to Negro Americans, through enforcement of the civil rights law and elimination of barriers to the right to vote;³⁹⁰

We can see this concern with both elements of barriers to equality expressed most clearly in Johnson's address to Howard University where he employs the rhetorical strategy of moralization decisively. There he argues that both legal barriers to equal participation in politics, society, and economy *and* correcting systemic and historical underinvestment in social services and poverty reduction are required to genuinely enable equal opportunity. He defines freedom as composed in large part by positive liberty requiring government programming to capacitate citizens rather than negative liberty to protect them from government interference in their choices and lives. Regarding the former he states, "Freedom is the right to share, share fully and equally, in American society--to vote, to hold a job, to enter a public place, to go to school. It is the right to be treated in every part of our national life as a person equal in dignity and promise to all others." Regarding the latter Johnson cautions,

But freedom is not enough. You do not wipe away the scars of centuries by saying: Now you are free to go where you want, and do as you desire, and choose the leaders you please. You do not take a person who, for years, has been hobbled by chains and liberate him, bring him up to the starting line of a race and then say, "you are free to compete with all the others," and still justly believe that you have been completely fair. Thus it is not enough just to open the gates of opportunity. All our citizens must have the ability to walk through those gates. This is the next and the more profound stage of the battle for civil rights. We seek not just freedom but opportunity. We seek not just legal equity but human ability, not just equality as a right and a theory but equality as a fact and equality as a result.³⁹¹

³⁹⁰State of the Union Address, January 4, 1965,
<http://www.presidency.ucsb.edu/ws/index.php?pid=26907>

³⁹¹Eyes on the Prize, America's Civil Rights Movement, 1954-1985,
http://www.pbs.org/wgbh/amex/eyesontheprize/sources/ps_bakke.html

Johnson further explains that poverty and community and familial decay and dysfunction need to be addressed through government programs to actualize equal opportunity for all Americans. This passage gives clearest expression to the link between the ethos of the Great Society and its moral order and the logos that it is the government – through the consent and participation of citizens – that is required to play an active role in creating basic conditions of justice in society and to correct an enormous and challenging legacy of inequality and government sanctioned disadvantage directed to racial minorities and the most economically disadvantaged.

Johnson also has a strong message of expectation that the wealthy assist the poor as a matter of justice and a clear expression of communitarian concern. The explicitness of his redistributive demands of the wealthy is unique, and contrasts powerfully with the lack of such statements in defense of healthcare reform and other government programs in the rhetoric of Clinton and Obama.

I have not come here tonight to ask for pleasant luxuries or for idle pleasures. I have come here to recommend that you, the representatives of the richest Nation on earth, you, the elected servants of a people who live in abundance unmatched on this globe, you bring the most urgent decencies of life to all of your fellow Americans. There are men who cry out: We must sacrifice. Well, let us rather ask them: Who will they sacrifice? Are they going to sacrifice the children who seek the learning, or the sick who need medical care, or the families who dwell in squalor now brightened by the hope of home? Will they sacrifice opportunity for the distressed, the beauty of our land, the hope of our poor? Time may require further sacrifices. And if it does, then we will make them. But we will not heed those who wring it from the hopes of the unfortunate here in a land of plenty. I believe that we can continue the Great Society while we fight in Vietnam. But if there are some who do not believe this, then, in the name of justice, let them call for the contribution of those who live in the fullness of our blessing, rather than try to strip it from the hands of those that are most in need. And let no one think that the unfortunate and the oppressed of this land sit stifled and alone in their hope tonight. Hundreds of their servants and their protectors sit before me tonight here in this great Chamber. For that other nation within a Nation--the poor--whose distress has now captured the conscience of America, I will ask the Congress not only to continue, but to speed up the war on poverty.³⁹²

³⁹²State of the Union Address, January 12, 1966,
<http://www.lbjlib.utexas.edu/johnson/archives.hom/speeches.hom/660112.asp>

In Johnson's speeches addressing poverty the poor are never a distant, abstract, or marginal entity and Johnson depicts himself as their most ardent guardian. About Medicare, for example, Johnson says, "But under this plan all Americans, *not just the rich and affluent Americans*, all Americans can face the autumn of life with dignity and security."³⁹³ Embedded in the use of the word "all" are working class and middle class Americans, from the poorest Americans who are jobless or living in poverty despite working to middle class Americans who despite a reasonable level of income lack health insurance and would be left economically devastated if they or family members were to suffer a major illness with its attending high medical costs.

With regard to expanding healthcare through Medicare and Medicaid Johnson is equally emphatic that the economically disadvantaged have access to the same quality healthcare, irrespective of income. In his Special Message to the Congress on the Nation's Health, on February 10, 1964, he states,

The American people are not satisfied with better-than-average health. As a Nation, they want, they need, and they can afford the best of health:--not just for those of comfortable means.--but for *all* our citizens, old and young, rich and poor. In America, --There is no need and no room for second-class health services. --There is no need and no room for denying, to any of our people the wonders of modern medicine.--There is no need and no room for elderly people to suffer the personal economic disaster to which major illness all too commonly exposes them. Clearly, too many Americans still are cut off by low incomes from adequate health services. Too many older people are still deprived of hope and dignity by prolonged and costly illness. The linkage between ill-health and poverty in America is still all too plain.³⁹⁴

Repeatedly in his many speeches on the War on Poverty and the Great Society Johnson dignifies the poor by empathically relating the structural barriers to their full economic

³⁹³ Remarks in New York City Before the 50th Anniversary Convention of the Amalgamated Clothing Workers , <http://www.presidency.ucsb.edu/ws/index.php?pid=26237>

³⁹⁴ Social Security History, Lyndon Baines Johnson, <http://www.ssa.gov/history/lbjstmts.html#healthmsg>

and social equality. He commits himself and invites the American people to join together to defeat poverty and include those marginalized Americans living in poverty in the vision of the United States as a land of promise and opportunity for all its citizens.

Very often a lack of jobs and money is not the cause of poverty, but the symptom. The cause may lie deeper in our failure to give our fellow citizens a fair chance to develop their own capacities, in a lack of education and training, in a lack of medical care and housing, in a lack of decent communities in which to live and bring up their children.³⁹⁵

Equally significant is the way in which the Great Society and War on Poverty envision social change that crosses every conceivable boundary in the American polity, from race to class to color to geographic location – a project for all Americans to pursue on behalf of and in partnership with all Americans, not an act of charity towards the poor but a shared effort at promoting justice.

Our joint Federal-local effort must pursue poverty, pursue it wherever it exists-- in city slums and small towns, in sharecropper shacks or in migrant worker camps, on Indian Reservations, among whites as well as Negroes, among the young as well as the aged, in the boom towns and in the depressed areas.³⁹⁶

In addressing structural causes of poverty, Johnson emphasizes that poverty is largely a function of government failure to provide disadvantaged Americans with a quality education which the Great Society aims to rectify.

Today, 8 million adult Americans, more than the entire population of Michigan, have not finished 5 years of school. Nearly 20 million have not finished 8 years of school. Nearly 54 million--more than one-quarter of all America--have not even

³⁹⁵Margaret Talbot, "Is it Dangerous to Talk About the Middle Class?," *The New Yorker*, July 26, 2012. <http://www.newyorker.com/online/blogs/comment/2012/07/obama-and-the-middle-class.html>

³⁹⁶LBJ's State of the Union Address, January 8, 1964, <http://ows.edb.utexas.edu/site/jad2793edc370s/speeches-and-legislation>

finished high school. Each year more than 100,000 high school graduates, with proved ability, do not enter college because they cannot afford it.³⁹⁷

He explains the vicious cycle that is perpetuated when primary and secondary schools are inadequate because of a lack of funding and individuals fall into a poverty trap because without access to quality education they cannot develop their knowledge and skills sufficiently to find a place in the labor force, nor can they afford a college education.

In many places, classrooms are overcrowded and curricula are outdated. Most of our qualified teachers are underpaid, and many of our paid teachers are unqualified. So we must give every child a place to sit and a teacher to learn from. Poverty must not be a bar to learning, and learning must offer an escape from poverty.³⁹⁸

Indeed education (along with job and skills training) was one of the major areas of government expenditure in the War on Poverty and Great Society because it is so fundamental to positive liberty and a key tool of government to decrease poverty by enhancing citizen employability.

Johnson also links the welfare of the economically disadvantaged Americans with that of all Americans as a whole, which we have seen was a prominent feature of Harry Truman's rhetoric and which we will see does not feature as centrally in the rhetorics of Clinton and Obama. This linkage served two purposes: one is to convey to Americans that social programs that target the poor are in the interests of society as a whole and thus should receive the support of all Americans – including and especially wealthier

³⁹⁷The Elementary and Secondary Education Act, which Johnson signed on April 11, 1965 included massive new investments in education for the construction of libraries, the purchase of 30 million books to be distributed to schools in need, and programs for teacher training. Remarks in Johnson City, Texas Upon Signing the Elementary and Secondary Education Bill, April 11, 1965, <http://www.lbjlib.utexas.edu/johnson/archives.hom/speeches.hom/650411.asp>

³⁹⁸LBJ Launches the Great Society, <http://www.heritage.org/initiatives/first-principles/primary-sources/lbj-launches-the-great-society>

Americans. The second purpose is to contribute to the redefining of the American social imaginary in an inclusive way whereby Americans would come to perceive themselves in a more cohesive way across boundaries of race, class, and geography united by shared civic values of communitarian solidarity and a moral order based on equality and solidarity. We will now examine two of the most important pieces of legislation that advanced these principles of equality.

6.6 Civil Rights Act and Voting Rights Act

Two major pieces of legislation that informed the values of the Great Society and legally codified the place of equality in the American moral order and social imaginary needed to make the social and economic promises of the Great Society tangible are the Civil Rights Act of 1964³⁹⁹ and the Voting Rights Act of 1965. The Civil Rights Act barred discrimination against African-Americans and women in places such as schools and any form of ‘public accommodation’ such as hotels, restaurants, cinemas, parks, and theatres, and crucially, in the workplace. The Voting Rights Act⁴⁰⁰ ensured that African-Americans would not be discriminated against at the polls and have their right to vote violated. In 1968 the Housing Act was passed which banned racial discrimination in housing and included subsidies for low income housing, which would in large part

³⁹⁹ The Civil Rights Act of 1964 and the Equal Employment Opportunity Commission, <http://www.archives.gov/education/lessons/civil-rights-act/> and Transcript of Civil Rights Act, <http://www.ourdocuments.gov/doc.php?flash=true&doc=97&page=transcript>

⁴⁰⁰ The Voting Rights Act of 1965, http://www.justice.gov/crt/about/vot/intro/intro_b.php and Voting Rights Act of 1965, <http://www.ourdocuments.gov/doc.php?flash=true&doc=100>
The Voting Rights Act and Civil Rights Act remain legally binding and include provisions that detail how the government must rigorously guard the rights of minorities and the steps it must take if certain standards of equality are not being maintained to correct discriminatory trends. These are a particularly potent legacy of the Great Society, although the Voting Rights Act was recently challenged in the Supreme Court which ruled on June 25, 2013 – controversially - that sections of it no longer needed to be enforced due to the Court’s belief that they were no longer warranted as a result of declining levels of racism and improved law enforcement.

Adam Liptak, “Supreme Court Invalidates Key Part of Voting Rights Act,” *The New York Times*, June 25, 2013. <http://www.nytimes.com/2013/06/26/us/supreme-court-ruling.html?pagewanted=all>

benefit minorities, reflecting Johnson's consistent approach of addressing both legal barriers to equality and providing the economic means needed to surmount poverty that itself was largely the result of decades of invidiously discriminatory government practices.

In explaining why legislative changes were needed to overturn formal, legal government discrimination against African-Americans and other ethnic minorities Johnson did not mince words on the moral motivation for these changes.

Let me make one principle of this administration abundantly clear: All of these increased opportunities--in employment, in education, in housing, and in every field--must be open to Americans of every color. As far as the writ of Federal law will run, we must abolish not some, but all racial discrimination. For this is not merely an economic issue, or a social, political, or international issue. It is a moral issue, and it must be met by the passage this session of the bill now pending in the House.⁴⁰¹

As we have discussed, Truman had initiated this process of purging government programs and laws of racism and requiring enforcement of equality laws. He addressed it in his address on healthcare reform, insisting that returning soldiers of all colors and races and backgrounds should have access to the same quality of healthcare, and that indeed all Americans irrespective of race and background should be assured of the same opportunities. But it was Johnson who addressed this issue repeatedly both in his oratory and in his policy with the greatest investment of energy, an uncompromising stance, and a relentlessly explicit commitment to equal opportunity across every social and political domain (not just healthcare) that he would reaffirm throughout his presidency and that he was able to incorporate into government policy with far reaching impact.

⁴⁰¹ American Experience, <http://www.pbs.org/wgbh/americanexperience/features/primary-resources/lbj-union64/?flavour=mobile>

6.7 The Logos of the Great Society and War on Poverty – Prioritizing Social Needs While Reducing Overall Government Spending

Though Johnson had no need to show deference to conservative concerns with the size of government and government expenditure given the extent of the Democratic majority in Congress⁴⁰² and the overall strength of the American economy - and in the mid 1960s the conservative concern with reduced government spending was not a salient political issue - it is interesting to note that Johnson's social programs were part of *reductions* in government employment and expenditure as a whole. Johnson proudly noted that despite large increases in social spending his budget was the "smallest since 1951."⁴⁰³ He emphasized the relative frugality of the budget,

It will call for a substantial reduction in Federal employment, a feat accomplished only once before in the last 10 years. While maintaining the full strength of our combat defenses, it will call for the lowest number of civilian personnel in the Department of Defense since 1950. It will call for total expenditures of \$97,900 million--compared to \$98,400 million for the current year, a reduction of more than \$500 million.⁴⁰⁴

Despite these cuts Johnson's social expenditures were significant. His budget was possible, likely, partially, because overall tax rates were substantially higher at that time than today and more progressive, providing the government with greater revenue than what is available today at a time when costs for social programs - particularly healthcare – were much lower.⁴⁰⁵

⁴⁰²Immediately following Johnson's election in 1964 28 Democratic Senators were elected or re-elected and there were 295 Democratic members of the House. The Senate was almost 70% Democratic by 1965 and had a filibuster proof majority in 1964 and 1965.

<http://www.pbs.org/wgbh/americanexperience/features/general-article/lbj-politics/>

<http://www.brendan-nyhan.com/blog/2010/03/obama-versus-fdr-and-lbj.html>

⁴⁰³ Ibid.

⁴⁰⁴ January 8, 1964, State of the Union Address,

<http://www.lbjlib.utexas.edu/johnson/archives.hom/speeches.hom/640108.asp>

⁴⁰⁵Thomas Piketty & Emmanuel Saez, "How Progressive is the U.S. Federal Tax System? A Historical and International Perspective," *Journal of Economic Perspectives* 21 (2007): 3-24.

Although this extensive array of government programs necessitated large capital expenditures, Johnson also passed a massive tax cut of 11 billion dollars, “to create new jobs and new markets in every area of this land” by freeing up funds for private investors and entrepreneurs. This demonstrates that the dichotomized ‘limited government’ vs. ‘big government’ framing of conservative and liberal philosophies of governance which was introduced by Reagan and vigorously championed by Republicans since his era was not always the dividing line in American politics, despite being so powerfully prevalent in the past three decades and today.

Johnson’s tax cuts and reductions in the deficit were not aimed at winning over conservatives and appropriating their values and rhetoric, promoting political moderation, or laying the foundations for bipartisan policy consensus in part because of the scope of Democratic majorities in Congress.⁴⁰⁶ While we will see similar rhetoric of efficiency in Clinton and Obama’s rhetoric the context is a very different one where Clinton and Obama’s rhetoric is deferential to and apologetic towards specifically conservative concerns with limited government, rather than the universal value which transcends political ideology of avoiding wasteful expenditures. But they demonstrate that a president who championed extensive redistribution of wealth through progressive taxation and a powerful and a comprehensive social welfare safety net guaranteed by government was far more concerned with restraining government spending than how he has been depicted by conservative Republicans who find the Great Society so threatening to their ideology of limited government.

As we have seen, The Great Society represents – alongside Roosevelt’s New Deal and Truman’s Fair Deal – the antithesis to the conservative ideology of limited government in its concern for government provision of social services and recognition of

⁴⁰⁶See footnote 384.

social and economic rights. Johnson's efforts reflect a continuation of Roosevelt and Truman's promise to advance the human security of all Americans through government programs to realize their social and economic rights and to enable them to achieve their fullest potential and actualize positive liberty. However, despite greatly increasing government expenditures on social programs, Johnson did not intend to establish a large, centralized government bureaucracy. In many of his speeches he calls for safeguards to limit waste and maximize efficiency with regard to Medicare in particular, but also to all the programs of the Great Society. He cautions that the federal government cannot provide the answer alone to addressing educational inequalities and insufficiencies and the injustice of poverty; it would need to do so through partnership with states and municipalities.

The solution to these problems does not rest on a massive program in Washington, nor can it rely solely on the strained resources of local authority. They require us to create new concepts of cooperation, a creative federalism, between the National Capital and the leaders of local communities.⁴⁰⁷

In his 1964 State of the Union Address Johnson emphasizes the same, "Poverty is a national problem, requiring improved national organization and support. But this attack, to be effective, must also be organized at the State and the local level and must be supported and directed by State and local efforts."⁴⁰⁸ As we discussed in Chapters 1 and 2, these concerns with state rights and local control have traditionally been conservative priorities, priorities which Richard Nixon, for example, articulated in his proposed healthcare reforms.

⁴⁰⁷ LBJ, University of Michigan Great Society Speech,

<http://www.pbs.org/wgbh/americanexperience/features/primary-resources/lbj-michigan/>

⁴⁰⁸ State of the Union Address, January 8, 1964, <http://millercenter.org/president/speeches/detail/3382>

Although the funding for social programs stemmed largely from the federal government, Johnson never depicts the Great Society and War on Poverty as government centric programs of aid.⁴⁰⁹ On the contrary, he depicts them as citizen movements necessitating extensive citizen participation taking place on a grassroots and local level, enabled but not limited by the prerogatives of the federal government. “For the war against poverty will not be won here in Washington. It must be won in the field, in every private home, in every public office, from the courthouse to the White House.”⁴¹⁰ Beyond this rhetoric, the policies themselves also placed emphasis on local control and programming delivery. Although Johnson’s rhetoric places great emphasis on communitarian solidarity, he also defends the importance of citizens not becoming dependent on each other if such dependency undermines dignity. In setting out his vision for the War on Poverty Johnson states,

Our chief weapons in a more pinpointed attack will be better schools, and better health, and better homes, and better training, and better job opportunities to help

⁴⁰⁹Significantly, one of the core expenditures of Great Society programs was on job training, which appeals equally to liberals and conservatives as a means to lift the indigent out of poverty, presuming that the economy has quality, well paying jobs to offer the suitably skilled. Many of Johnson’s programs that sought to limit poverty did not encourage dependency on the government, but emphasized instead the responsibility of employers to offer fair wages, government responsibility to assist the disabled who cannot work and to fund vocational rehabilitation for those who are disabled but can still work with proper training, and, as noted earlier, job training programs generally. “First are those who, in the midst of our great wealth, cannot find work, and those whose work does not bring them the reward of a decent living. Our new Unemployment Compensation Act has provided \$769 million to 3.5 million men and women out of work. Through federally supported programs, we have provided more than a million new jobs. Our Manpower Development and Training has taken hundreds of thousands of men and women thrown out of work by new machines or new techniques of production and given them new skills. Minimum wage extensions have given basic protection to 3.5 million more Americans under the Democratic administration...”

President Johnson’s Remarks to the 1964 Campaign Conference for Democratic Women.
<http://www.presidency.ucsb.edu/ws/index.php?pid=26205>

⁴¹⁰January 8, 1964 State of the Union Address,

<http://www.lbjlib.utexas.edu/johnson/archives.hom/speeches.hom/640108.asp>

In supporting increased funding for education Johnson similarly emphasized the importance of the federal government providing increased resources to states and cities to implement educational reform. In signing the Elementary and Secondary Education Bill, April 11, 1965 Johnson stated, “We strengthen State and local agencies which bear the burden and the challenge of better education, and we rekindle the revolution – the revolution of the spirit against the tyranny of ignorance.”

President Johnson’s Remarks on Signing the Elementary and Secondary Education Act, April 11, 1965,
<http://www.nea.org/grants/40182.htm>

more Americans, especially young Americans, escape from squalor and misery and unemployment roles where other citizens help to carry them.⁴¹¹

It is particularly noteworthy that although Johnson increased spending on social programming his budget reflected concerns with lowering the deficit and lowering taxes. In his 1964 State of the Union Address he promised to cut the deficit in half and to offer the smallest budget since 1951. He also called for cuts in government employment, primarily in the Defense Department and promised that,

by cutting back where cutting back seems to be wise, by insisting on a dollar's worth for a dollar spent, I am able to recommend in this reduced budget the most Federal support in history for education, for health, for retraining the unemployed, and for helping the economically and the physically handicapped.⁴¹²

Thus the Great Society and War on Poverty do not reflect a massive increase either in taxes or in government expenditure overall. Instead, they reflect reductions in other forms of government spending and large increases in spending on social programs.⁴¹³ Having discussed the ethos and logos of The Great Society overall we will now turn to analyze Johnson's defense of Medicare and Medicaid in particular.

⁴¹¹ January 8, 1964 State of the Union Address, <http://www.lbjlib.utexas.edu/johnson/archives.hom/speeches.hom/640108.asp>

For more on the role of local and grassroots empowerment in the Great Society see Herbert Marcuse and Norton E. Long in chapters 3 and 4, "The Individual in the Great Society" and "Local and Private Initiative in the Great Society" in *A Great Society?* ed. Bertram M. Ross, (New York: BasicBooks, 1968). See also Chapter 1, *The President's Questions – And Some Answers.*"

⁴¹² Johnson emphasized the importance of efficiency and cost saving in many of his speeches. "For government to serve these goals it must be modern in structure, efficient in action, and ready for any emergency... Wherever waste is found, I will eliminate it. Last year we saved almost \$3,500 million by eliminating waste in the National Government. And I intend to do better this year." State of the Union Address, January 4, 1965,

<http://www.lbjlib.utexas.edu/johnson/archives.hom/speeches.hom/650104.asp>

⁴¹³ Johnson on his proposed cuts to government spending: State of the Union Address, January 8, 1964, <http://www.lbjlib.utexas.edu/johnson/archives.hom/speeches.hom/640108.asp>

6.8 Rhetoric Analysis of Johnson's Remarks with President Truman at the Signing of the Medicare/Medicaid Bill, July 30, 1965

6.8.1 Ethos and Pathos

With regard to Medicare and healthcare reform Johnson depicts the ethos of Medicare in relation to the principle of security that we saw is so dominant in Truman's rhetoric and that we will see returning again in that of Clinton and Obama. Indeed personal security is the unifying moral principle and conceptual thread of each of the four presidents in their addresses on healthcare reform and a core principle of Truman's Fair Deal and Johnson's Great Society. "Every older American must have the opportunity to live out his life in *security* without the fear that serious illness will be accompanied by a financial ruin,⁴¹⁴" Johnson states in one of his commentaries on the aims of Medicare. He defends this ethos in relation to the pathos of anxiety generated by the insecurity caused by a lack of health insurance.

That is what Medicare is all about. What to do? How to live? Who will pay the doctor? Who will pay the hospital? Who will pay for the medicine? Who will pay the rent? Well, these are questions. that older Americans that I have known all of my life have dreaded to answer. Now Medicare is changing a lot of that.⁴¹⁵

Let us now turn specifically to Johnson's defense of Medicare at the signing ceremony which established it.

The main rhetorical strategies that Johnson employs at the signing ceremony of Medicare and Medicaid are moralization and historical temporality. Notably absent are strategies of anticipatory and defensive rhetoric (prolepsis) and appropriation of conservatism. Johnson's rhetoric emphasizes the principle of equality of opportunity and a communitarian vision of social solidarity. Its ethos is impassioned and explicit in its call

⁴¹⁴Remarks in San Antonio at the signing of the Medicare Extension Bill, <http://www.presidency.ucsb.edu/ws/index.php?pid=27535>

⁴¹⁵Remarks Upon Extending the Medicare Program, http://glifos.lbjf.org/gsm/index.php/WHCA_411-1

for justice and in the principle of security from poverty caused by excessive medical costs and/or a lack of health insurance. On the passage of Medicare and its implementation Johnson states,

No longer will older Americans be *denied* the healing miracle of modern medicine. No longer will illness *crush* and *destroy* the savings that they have so carefully put away over a lifetime so that they might enjoy *dignity* in their later years. No longer will young families see their own incomes, and their own *hopes*, eaten away simply because they are carrying out their *deep moral obligations* to their parents, to their uncles, and their aunts. And no longer will this Nation refuse the hand of *justice* to those who have given a lifetime of service and wisdom and labor to the *progress* of this *progressive* country.⁴¹⁶

In this way Johnson's healthcare reforms revise the social imaginary to become one of greater equality, justice, and personal security. The keywords of justice and progress indicate the direction of the social imaginary Johnson envisions and articulate the moral order his healthcare reforms will realize. They contrast fundamentally with the denials of dignity and of hope that have so marred the lives of many economically disadvantaged Americans until this time.

In addressing Harry Truman, who joined Johnson at the signing ceremony, Johnson exemplifies the strategy of moralization that is so prevalent in his speeches and the heightened usage of emotionally stirring images and words to convey an ethical message. Praising Truman for Truman's many efforts to create universal healthcare and for his concern with the disadvantaged who lack it Johnson says,

Many men can make many proposals. Many men can draft many laws. But few have the piercing and humane eye which can see beyond the words to the people that they touch. Few can see past the speeches and the political battles to the doctor over there that is tending the infirm, and to the hospital that is receiving

⁴¹⁶Johnson, 357.

those in anguish, or feel in their heart painful wrath at the injustice which denies the miracle of healing to the old and to the poor.⁴¹⁷

The link between the pathos of empathy and compassion and indignation in the face of the suffering of the poor and the ethical imperative of expanded healthcare provision is fundamental to this passage. Applying a strategy of historical temporality,⁴¹⁸ Johnson harkens back to Truman's first efforts to create universal health insurance, and quotes from Truman's address to Congress on healthcare reform that we have discussed in the previous chapter.

Millions of our citizens do not now have a full measure of opportunity to achieve and to enjoy good health. Millions do not now have protection or security against the economic effects of sickness. And the time has now arrived for action to help them attain that opportunity and to help them get that protection.⁴¹⁹

Significantly, although his speech frames the issue as particular to the United States and to the obligations of the United States government to its citizens, Johnson also applies a strategy of moralization in his appeals to principles rooted in the Bible. This gives his speech a moral anchor that transcends nationality and party; depicting Medicare and Medicaid as the embodiment of a universal human aspiration and moral ideal. Speaking on why Americans can come together to support expanded healthcare he states,

And this is not just our tradition or the tradition of the Democratic Party or even the tradition of the nation. It is as old as the day it was first commanded: "Thou

⁴¹⁷Ibid.

⁴¹⁸ Johnson uses the rhetorical strategy of historical temporality in many of speeches on Medicare. See for instance,

Statement by the President Following Passage of the Medicare Bill by the Senate, July 9, 1965, "The 22-year fight to protect the health of older Americans is now certain of swift and historic victory. For these long decades bill after bill has been introduced to help older citizens meet the often crushing and always rising costs of disease and crippling illness. Each time, until today, the battle has been lost.

Each time the forces of compassion and justice have returned from defeat to begin the battle anew."

⁴¹⁹Johnson, 357.

shalt open thine hand wide unto thy brother, to thy poor, to thy needy, in thy land.⁴²⁰

This shares similarities with Truman's Fair Deal enumeration of rights which as discussed in the previous chapter – though referring only to US citizens – Truman describes as fundamental to all humanity, because the rights reflect basic human needs.

Johnson applies the strategy of historical temporality repeatedly throughout the speech, defining Medicare and Medicaid as the (partial) realization of Truman's healthcare reform plans but harkening back further, to Roosevelt's New Deal. Johnson speaking to Truman, states that,

In 1935 when the man that both of us loved so much, Franklin Delano Roosevelt, signed the Social Security Act, he said it was, and I quote him, "a cornerstone in a structure which is being built but it is by no means complete."⁴²¹

Johnson goes on to say that Medicare and Medicaid is "the most important addition that has been made in three decades" creating a seamless historical link between past and present. He positions himself and the policies he has shepherded through Congress as the completion of a historical project that has been long in the making. Johnson is explicit and repetitive in his references to history, stating,

History shapes men, but it is a necessary faith of leadership that men can help shape history. There are many who led us to this historic day. Not out of courtesy or deference, but from the gratitude and remembrance which is our country's debt.⁴²²

He links history directly to the ethos of Medicare and Medicaid, noting that there is a distinct moral significance to Medicare and Medicaid that complements their significant practical achievements which reflect the vision and will of previous American presidents.

⁴²⁰Johnson, 359.

⁴²¹Johnson, 358.

⁴²²Ibid.

But there is another tradition that we share today. It calls upon us never to be indifferent toward despair. It commands us never to turn away from helplessness. It directs us never to ignore or to spurn those who suffer untended in a land that is bursting with abundance.⁴²³

Thus moralization returns as a strategy that dovetails with historical temporality and Johnson reaffirms it explicitly and reemphasizes an ethos of communitarian solidarity and care.

The promise of tangible and immediate benefit to Americans was particularly important to Johnson because only if Medicare would have a decisive transformative impact on Americans would they come to appreciate the legislation and make its repeal less likely. The sooner a government policy that universally guarantees a benefit is codified into law and enforced it becomes normalized and the harder it becomes for political opposition to challenge it, as the typical American citizen comes to perceive it as a non-negotiable right or at least an entitlement they would not want taken away from them. Johnson promises that the positive effects of Medicare will be felt speedily.

Because of this document... there are men and women in *pain* who will now find ease. There are those, alone in *suffering* who will now hear the sound of some approaching *footsteps* coming to help. There are those fearing the terrible darkness of despairing poverty despite their long years of *labor* and expectation who will now look up to see the light of *hope* and realization.⁴²⁴

In this passage by illustrating the plight of individuals lacking health insurance in such strong terms Johnson generates pathos about the hope and deliverance that Medicare and Medicaid will offer individuals who have experienced suffering and pain because of a lack of access to healthcare. This is a depiction of solidarity – and the solidarity it expresses is not abstract. Although Johnson does not refer to any particular individuals

⁴²³Johnson, 359.

⁴²⁴Ibid.

by name – the usual way in which the strategy of personalization manifests itself in the rhetoric of Clinton and Obama and in Republican rhetoric of their eras as well - Johnson chooses to personify the care and support that the elderly and most impoverished will receive with a literal representation of an individual coming to them and offering assistance. This reflects a move away from moral arguments based on aggregate observations of how Medicare and Medicaid will improve health outcomes overall, to their immediate effect practically and emotionally on individual Americans. He also returns to linking pathos and ethos, the historical past and the present by affirming the moral values that inform Medicare and Medicaid and the practical and emotional outcomes of health security and freedom from fear of impoverishment that give these moral values tangible expression. “I am so proud that this has come to pass in the Johnson administration. But it was really Harry Truman of Missouri who planted the seeds of compassion and duty which have today flowered into care for the sick, and serenity for the fearful.”

6.8.2 Logos

Johnson defines the problem by providing aggregate data on the number of Americans who are senior citizens who lack the economic means to purchase health insurance and explains that Medicare will guarantee that these Americans will no longer have to forego health insurance because of their limited economic resources and that it will offer comprehensive coverage, including hospital stays, skilled nursing home provision, home healthcare, and regular coverage to see a doctor for check-ups and outpatient treatment.

There are more than 18 million Americans over the age of 65. Most of them have low incomes. Most of them are threatened by illness and medical expenses that they cannot afford.⁴²⁵

Speaking directly to the American people, he states, “Now here is how the plan will affect you,”

During your working years, the people of America--you--will contribute through the social security program a small amount each payday for hospital insurance protection. For example, the average worker in 1966 will contribute about \$1.50 per month. The employer will contribute a similar amount. And this will provide the funds to pay up to 90 days of hospital care for each illness, plus diagnostic care, and up to 100 home health visits after you are 65. And beginning in 1967, you will also be covered for up to 100 days of care in a skilled nursing home after a period of hospital care.⁴²⁶

He also explains the mechanism by which Medicare coverage will provide outpatient care for senior citizens, stating that until the age of 65 American workers will contribute a Medicare tax of \$3 per month which the government will match, providing enough Medicare funds to cover the outpatient care needs of Americans over age 65.

As discussed earlier, Medicare and Medicaid were signed into law as amendments to the Social Security Act as part of one comprehensive reform bill. Johnson focused overwhelmingly on Medicare at the signing ceremony of Medicare and Medicaid and emphasized Medicare’s promise to all Americans irrespective of economic status. As a social entitlement program for senior citizens, rather than an exclusively means tested program of social welfare for the most economically disadvantaged – which was the remit of the Medicaid program – Medicare would have much broader appeal to all Americans across all divisions of class, race, and geography. Johnson’s choice not to speak explicitly and extensively about Medicaid at the signing ceremony represents a sharp break from his repeated championing of the poor and from his emphasis on the

⁴²⁵Johnson, 357.

⁴²⁶Ibid.

way which Medicare would help a large number of impoverished senior citizens. Despite this rhetorical choice, it is important to note that Medicaid was designed and continues to serve the healthcare needs of some of the most indigent Americans.⁴²⁷

6.9 Conclusion

As we have seen, Johnson's rhetoric on the programs and services government should provide citizens in the service of the moral order and social imaginary of the Great Society is characterized by these qualities:

- It is highly emotive and simultaneously vigorously moralizing, applying the rhetorical strategy of moralization with frequency.
- It is centered upon the principles of equality of opportunity, communitarian solidarity, and a desire to maximize human capabilities and frames these as matters of justice and the realization of positive liberty.
- It explicitly articulates the vulnerabilities, rights, and needs of the poor with confidence and addresses the structural barriers to access to healthcare they face and dignifies the poor. Healthcare reform is integral to the larger social programs of the War on Poverty and Great Society and is always linked to these efforts to improve citizen welfare, as in Truman's Fair Deal.
- It calls for a central and significant role for government while insisting on the importance of maximizing local control and program administration on the state and city level.

⁴²⁷ Still, as has been discussed in Chapters 1 and 2, Medicaid excludes large portions of very poor and poor Americans because of their marital status and particular state residency and that state's definitions of poverty, which can often undermine Medicaid's purpose to reach the poor. For a critique of the injustices and inequities of the Medicaid program see *Health Care for Some* by Beatrix Hoffman, 134-142.

- In the speech at the signing ceremony of Medicare and Medicaid Johnson mainly applies strategies of historical temporality and moralization to reveal his ethos. Although ethos, pathos, and logos all play a role in Johnson's speeches, ethos and pathos generally dominate, with the ethos being confident and uncompromising and the pathos passionate and very central to the rhetoric in a way that's distinct from Truman and even more so from Clinton and Obama.
- Unique to Johnson, setting him apart from Truman and the other Presidents as well, is the place of a transcendent spiritual vision in his social imaginary with its focus on environmental protection and conservation, citizen interaction, and grassroots community empowerment across boundaries of race and class.

Although the War on Poverty and Great Society did not achieve equality they did equalize American society in deep and expansive ways – some of which (particularly the legacies of the Voting Rights Act and Civil Rights Act, Medicare and Medicaid, community health clinics, and food stamps) remain as fundamental components of a social safety net which Johnson constructed and tirelessly championed. Arguably, without Medicare and Medicaid the healthcare reforms that Clinton and Obama tried to advance and that Obama realized would have faced even greater opposition without there being an entitlement to healthcare insurance that was universal for those 65 and older and almost universally accepted and expected as an essential government program in the interest of the public good.

Chapter 7: Bill Clinton's September 22, 1993 Address on Healthcare Reform to Congress

“The whole idea was to divide the American electorate in ways that worked to their [Republicans] advantage and then make the people deeply suspicious of anything the government did. So then what I tried to do was take the rhetoric they had used and flip it... that we could actually have a smaller, more efficient, but far more active government that dealt with the problems of the late twentieth century. And I tried to promote a vision of reconciliation and community that would go behind their politics of division... So I was essentially trying to launch a new progressive era by reigniting government activism tailored to the realities of the late twentieth century.”⁴²⁸

Bill Clinton, September 4, 2009

7.1 Introduction and Political Context: Healthcare Reform as Limited Government Conservatism is Hegemonic

President Clinton's proposed healthcare reform was the first major presidential attempt to create universal health insurance since Harry Truman's efforts to advance a government guarantee of healthcare in the 1940s. Although Clinton had a formidable Democratic majority in Congress his presidency took place in the context of an increasingly assertive and hegemonic conservatism that sought to limit government spending and programming. The moral order and social imaginary dominant during Clinton's presidency was not a malleable one sympathetic to liberalism – it was already a well entrenched conservative philosophy of limited government and scepticism towards government that Ronald Reagan cultivated as president and that was built by grassroots and decentralized approaches to conservative activism and organization through networks of conservative think tanks, and conservative media – especially talk radio, social organizations, and churches.⁴²⁹ There was no such parallel liberal network with

⁴²⁸Mark Warren, “Bill Clinton then and Now: The Esquire Interview,” *Esquire*, September 8, 2009. <http://www.esquire.com/features/bill-clinton-interview-1009-2>

⁴²⁹Skocpol, *Boomerang*, 86-89.

Significantly, this is in contrast to the increasingly professionalized liberal activist groups which counted hundreds of thousands of members nationally, but few of these members had any social interaction, according to Skocpol. Their ‘membership’ typically consisted of sending in annual

the same reach, scope, and resources.⁴³⁰ The growth of these sectors had begun during Reagan's presidency between 1980 and 1988, but the fruits of their labors and the maturity of their capacity to organize and mobilize large numbers of people, extensive financial resources, and community organizations such as churches peaked in the 1990s and early 2000s.⁴³¹ Their anti-government rhetoric gained prominence in public debate on healthcare reform.⁴³²

Under Ronald Reagan's leadership and followed by George H. W. Bush, conservatives radically altered the tax code to lower taxes on the rich, initiated cuts in social welfare programs, and advanced at every turn the principle of limited government and the primacy of markets. Poverty rates increased as did inequality and a steady assault on organized labor and extensive deregulation further defined the political and policy landscape.⁴³³

Unlike Truman and Johnson, in his healthcare reform speech Clinton does not seek to revise the American moral order and social imaginary in a comprehensive and radical way, grounded in a firmly liberal understanding of government responsibility to

donations, reading direct mail, and receiving a newsletter or magazine in the mail. Moreover at a time when conservative advocacy organizations were growing in membership and activism, union membership, a pillar of liberal activism and no longer hostile to universal healthcare provision was declining, weakening the overall political strength of Democrats and their capacity to advance new and socially progressive legislation. There was also increased fragmentation and atomization amongst organizations addressing similar issues, making it hard to harness their resources effectively and to mobilize coalitions to advance the cause of healthcare reform.

⁴³⁰ Skocpol,

⁴³¹ John Micklethwait and Adrian Wooldridge. *The Right Nation: Conservative Power in America*, 109-113.

⁴³² Milton Terris characterizes the election of Ronald Reagan as a major blow to healthcare reform efforts and the beginning of a conservative turn for Democrats and Republicans. "The Republicans moved further to the right, from conservative to reactionary, and the Democrats moved from quasi-liberal to conservative, from national health insurance to mandated care through private health insurance and to 'managed care.' Despite the noble rhetoric, President Clinton's health plan was conceived and developed primarily by the large private insurers such as Aetna, Cigna, Metropolitan Life, and Travelers, who wished to manage the delivery of care, not just pay for it, and by the largest US corporations such as the General Electric Company, General Motors Corporation, and Caterpillar, who wanted not only to reduce costs through managed care, but also to shift part of the burden of costs through mandating coverage by smaller companies." Terris, 18.

⁴³³ Martin Schuldes, *Retrenchment in the American Welfare State: The Reagan and Clinton Administrations in Comparative Perspective*, (London: LIT Verlag, 2012).

Sandra Morgen, Joan Acker & Jill Weigt *Stretched Thin: Poor Families, Welfare Work, and Welfare Reform*, (Ithaca: Cornell University Press, 2009).

secure the rights and welfare of citizens. Instead, Clinton depicts the American social imaginary and moral order as characterized by slow, ongoing, incremental change in the pursuit of increasing equality of opportunity and freedom for all American citizens. This account has little resonance in prevalent American incarnations of political conservatism, although it reflects one close to Burkean conservatism which substantially informs the British Conservative party.⁴³⁴ The social imaginary Clinton offers is centered not on government obligations to citizens but on an increasing sense of social solidarity which prompts periodic changes in government programs to better reflect citizen needs. It is, essentially, a cautious vision of social progress that fuses the liberal value of equality of opportunity with conservative ones of slow and deliberate progress marked not by massive and sudden changes and expansions in government programming as Truman and Johnson sought, but by an organic and long term process of evolving government social programming.

In 1995 Republicans won control of Congress with a sweeping victory, with Speaker of the House Newt Gingrich offering a 'Contract with America' that built upon Reagan's philosophy of limited government and further sought to cut back on government welfare programming.⁴³⁵ The Act called for major tax cuts which were regressive in nature as they principally benefited the wealthy and were devoted to capital gains tax cuts, tax penalties for non-traditional families who were receiving government benefits which sought to demonstrate government endorsement for traditional marriage, reforms to criminal law to make punishments for crimes harsher, the construction of

⁴³⁴ In the United States, perhaps the most well known proponent of this type of conservatism is David Brooks, an opinion writer for the New York Times.

⁴³⁵ Jeffrey B. Gayner, *The Contract with America: Implementing New Ideas in the US*, <http://www.heritage.org/research/lecture/the-contract-with-america-implementing-new-ideas-in-the-us> For a full listing and description of the Contract with America see James Fallows, *Washington and the Contract with America*, <http://www.theatlantic.com/past/docs/unbound/jfnpr/jfreview.htm>

more prisons, and limiting the rights of appeal of criminals.⁴³⁶ There were several laws that would potentially help middle class families but only fairly marginally, such as savings accounts to encourage greater retirement savings. The overwhelming focus of the contract was on dismantling and limiting government welfare programming, cutting taxes on the wealthy, increasing military spending, cutting Social Security - which is a particularly crucial safety net for the economically disadvantaged, working class, and middle class Americans - and overall advancing a morally, socially and economically conservative policy agenda. As a Democratic President Clinton disagreed with many of these policies and principles, but the political context in which he governed was uncompromising in its conservatism and hostile to even the moderate 'third way' he would advance.

This rhetoric analysis examines Bill Clinton's September 22, 1993 Address on Healthcare Reform to Congress. I analyze this speech because it is the major address Bill Clinton gave introducing his proposed healthcare reforms. The speech provides Clinton's most detailed account of the policies and principles that inform his healthcare reforms. At the time that Clinton gave the speech there was a strong sense of possibility and optimism, and conservative antagonism to healthcare reform had not yet crystallized and reached its zenith. Nevertheless, it is clear from the content of the speech and its careful calibration of a mixture of liberal and conservative ideas in defense of healthcare reform that Clinton understood that selling healthcare reform required reaching out to at best very sceptical conservatives and at worst, outrightly hostile ones.

<http://www.heritage.org/research/lecture/the-contract-with-america-implementing-new-ideas-in-the-us>

7.2 The Working Class and Economically Disadvantaged – Increasing Invisibility

Clinton's rhetoric offers a departure from Truman and Johnson's. It does not situate healthcare reform within a vision of social and economic rights as Truman does in his Fair Deal. Nor does it situate universal health insurance as one component of broader government efforts to alleviate poverty and pursue social and economic justice as Johnson does in his War on Poverty and Great Society programs. Although it does not focus on the needs of the working class and most economically disadvantaged as Truman and Johnson do, Clinton does directly address the vulnerabilities and needs of impoverished Americans who do not qualify for Medicaid but remain unable to afford healthcare. His rhetorical emphasis, however, is on securing the well being of the middle class; the working class and most economically disadvantaged play only a marginal role in his rhetoric and he makes few direct appeals to their rights and welfare, in sharp contrast to the rhetoric of Johnson we have just discussed. Lisa Disch explains that Clinton chose to frame healthcare reform, "to appeal to middle-class concerns about security while minimizing the problem of access, which is more of an issue for the poor."⁴³⁷ Alan Derickson comments on Clinton's decisive emphasis on the middle class and evasion of addressing the needs of the working class.

The speech reflected the shifting terms of social-policy discourse in a regressive time... For the next several months, the president and his advisors emphasized not the extension of security to the exposed working poor but rather the guarantee of continued protection for a middle class worried about losing the benefits they already possessed.⁴³⁸

⁴³⁷Lisa Disch, "Publicity-Stunt Participation and Sound Bite Polemics: The Health Care Debate 1993-1994," *Journal of Health Politics, Policy and Law* 21 (1996): 4. Disch, 8. Disch here cites Paul Starr. Paul Starr, "What Happened to Health Care Reform?" *The American Prospect*, 20:20-21.

⁴³⁸ Derickson, *Health Security for All*, 162.

This turn away from explicit concern for the working class and economically disadvantaged in Clinton's rhetoric was not limited to healthcare reform.

Due to his campaigning for welfare reform in 1992 and continuing to press for welfare reform legislation as President, Clinton had already associated himself with an antagonistic orientation towards the economically disadvantaged. He positioned himself primarily as a champion of middle-class Americans who are valorized in the American social imaginary as hard working and deserving of the benefits of government social programming.⁴³⁹ Clinton's calls for greater 'personal responsibility' in many campaign and presidential speeches were also appropriations of conservative rhetoric and thinly veiled critiques of economically disadvantaged Americans who – since the Reagan era – were depicted as lacking the desire to act responsibly, maintain a job, and be self-sufficient.

Clinton ultimately named his welfare reform which received Republican support the "Personal Responsibility and Work Opportunity Reconciliation Act"⁴⁴⁰ – insinuating that the primary problem the economically disadvantaged faced in the United States was not a lack of quality education, adequately remunerated jobs, and discrimination in provision of government social services - as Johnson had argued - but their own defects of character and effort.⁴⁴¹ Welfare reform as Clinton pursued it gave his 'third way' philosophy of government some credibility for conservatives. Though it did not go nearly as far as many conservatives desired, in both rhetoric and policy it reflected many of their key concerns and broke decisively with both the rhetoric and policy of Johnson.

⁴³⁹ Ann Devroy, "President Insists Congress Enact Reforms in Welfare, Health Care," *The Washington Post*, January 26, 1994. <http://www.washingtonpost.com/wp-srv/politics/special/states/stories/sou012694.htm>

⁴⁴⁰ Martin Carcasson. "Ending Welfare as We Know It: President Clinton and the Rhetorical Transformation of the Anti-Welfare Culture." *Rhetoric and Public Affairs* 9 (2006).

⁴⁴¹ Bill Clinton, "How We Ended Welfare Together," *The New York Times*, August 22, 2006. <http://www.nytimes.com/2006/08/22/opinion/22clinton.html>

7.3 Clinton's Third Way

As president, Clinton portrayed himself as a centrist who advanced a 'third way'⁴⁴² which was neither conservative nor liberal but somewhere between the two: above all not only politically moderate but also non-ideological, concerned with maximizing positive outcomes at minimal cost and without an ideological commitment *either* to comprehensive and generous state centered welfare programs or a drastically truncated welfare state with few social safety nets inspired by principles of limited government. The American judge, Richard Posner, characterizes the 'third way' in an American context as follows, building on the writings of political scientist Stephen Skowronek and defining it as a 'pragmatic centrism.'

Obama resembles Presidents such as Nixon and Clinton in the following respect. They are what the political scientist Stephen Skowronek calls practitioners of "third way" politics (Tony Blair was another), who undermine the opposition by borrowing policies from it in an effort to seize the middle and with it to achieve political dominance.⁴⁴³

As Clinton articulates in this speech, his policies stem from pragmatic concern with the ways in which globalization necessitates changes in how government relates to citizens and enables them to be competitive in a global economy that demands new levels of education, skills and infrastructure to sustain economic growth. It also places an emphasis on individual citizen responsibility and effort and seeks to reduce dependency

⁴⁴² For more on Clinton's 'Third Way' see, William Clinton and Albert Gore, *Putting People First: How We Can All Change America* (New York: Three Rivers Press, 1992). Jane Lewis and Rebecca Surender, *Welfare State Change: Towards a Third Way?* (New York: Oxford University Press, 2004).

⁴⁴³ Posner, Richard (July 17, 2011). "The Federal Deficit Mess". *The Becker-Posner Blog*. Skowronek reflects on the term 'the third way' in the conclusion to his book, *The Politics Presidents Make: Leadership from John Adams to Bill Clinton*. Stephen Skowronek. *The Politics Presidents Make: Leadership from John Adams to Bill Clinton*. (Boston: Harvard University Press, 1997).

on government, a key component of Clinton's welfare reforms, which we will soon discuss.

Clinton's 'third way' philosophy of governance often tilted further towards conservative concerns with limited government, low taxes, and minimizing government expenditure rather than liberal concerns with egalitarianism and social and economic justice.⁴⁴⁴ Many of the arguments Clinton makes in his healthcare reform speech reflect concerns with economic efficiency and growth. British sociologist Anthony Giddens articulated a definition of the 'third way' which was more concerned with egalitarianism, social justice, and positive liberty than the one that Clinton would ultimately adopt in his policies and that Posner and Skowronek use to characterize the 'third way' in the United States. Indeed the term and concept as Giddens defines it applies more to Tony Blair and British politics than to Bill Clinton and American politics, despite Blair being in part inspired by Clinton's own revising of liberal-left politics in a pragmatic, centrist, compromising vein.

In the case of Clinton's healthcare reforms the 'third way' reflected the politically moderate policy core of the reforms: universal guarantee of health insurance with quality and cost controls based on government regulation (reflecting liberal values) while maximizing the freedom of private healthcare insurers to continue to provide healthcare insurance on a for profit basis, and maximizing consumer choice to pick amongst a wide range of health insurance plans (reflecting conservative values.) Thus Clinton's healthcare reforms and his speech advance a liberal goal of universal health insurance via moderately conservative means. Before we turn to Clinton's healthcare reform address we will consider the political character of his healthcare reform efforts and examine several possible causes of their failure.

See Anthony Giddens, *The Third Way: The Renewal of Social Democracy*, (Malden: Polity Press, 1999). See also, Anthony Giddens, *The Third Way and its Critics*, (Malden: Polity Press, 2000).

7.4 Bill Clinton's Healthcare Reforms: Policy History and Causes of Reform Failure

Bill Clinton's⁴⁴⁵ efforts to create universal health insurance in 1993 and 1994 were the most focused and advanced since Nixon's and Truman's although there were various health reform bills before Congress when Bill Clinton attempted to pass his reforms.⁴⁴⁶ The Clinton proposal called for managed competition with federal budget controls under an employer-mandate plan.⁴⁴⁷

The discursive strategy conservatives used to defeat Clinton's legislation nested comfortably with the dominant conservative discourse of 'socialized medicine' as the bogeyman of American politics and society, threatening the civil liberties of Americans, their freedom to pick health insurance (or freedom to abstain from being insured) and allegedly bringing down the quality of care for all Americans. As with prior conservative efforts to defeat universal health insurance legislation during the Truman era the rhetoric employed was emotive, impressionistic, short on facts and analysis and high on innuendo, fear mongering, and misrepresentation.⁴⁴⁸

⁴⁴⁵ There is a very extensive literature commenting on the failure of Clinton's healthcare reforms. In addition to Quadagno, Skocpol, and Reid's commentary which we will address in this section see the chapter 'Clinton Chooses Wrong: The Colossal Defeat of Managed Competition' in Altman and Shactman's *Power, Politics, and Universal Health Care*, 62-96. Also see pages 79-128 which offer a detailed description of the Clinton reform plans and their failure in Paul Starr's *Remedy and Reaction*.

The *Journal of Healthcare, Politics, and Law* devoted a special edition to analyzing the Clinton reforms and a second one to analyzing the causes of their failure. See Volume 19, Issue 1, (1994) and Volume 20, Issue 2, (1995), "The Clinton Reform Plan" and "The Failure of Health Care Reform," respectively.

⁴⁴⁶ These included the liberal Wellstone-McDermott bill based on a single-payer model; the Cooper-Grandy bill which called for a less comprehensive managed competition plan driven by employer-mandate insurance and was backed moderates centered in the House. The Moynihan bill expanded access to most citizens through various initiatives. The Chafee bill called for a diluted managed competition plan with a more limited employer mandate that drew the support of some moderates and conservatives. Joseph White argues that Chafee was against regulatory cost controls and Cooper's plan was untenable, but conservative Democrats insisted upon it because of strong ideological convictions against government regulation. White, 381.

Skocpol, *Boomerang*, 98, 103, 105

⁴⁴⁷ Adolino, *Comparing Public Policies*, 220.

⁴⁴⁸ The Annenberg Policy Center at the University of Pennsylvania concluded that many of the commercials the insurance industry and its allies used to attack Clinton's healthcare reforms were deceptive, characterizing them as, "unfair, misleading, or false." Mark A. Peterson. *The Health Care*

Although the bulk of the energy and resources devoted to its rejection came from conservative Republicans and businesses fearful of revenue loss, Democrats also played a role in the defeat of the legislation.

The health insurance industry committed tens of millions of dollars to... TV ads, which began denouncing the 'Hillarycare' plan months before it was completed. The hospital industry, the drug industry, and many physicians' groups joined the insurers in opposition. Business support began to crumble. Organized labor, angry at the Clinton White House because of the NAFTA free-trade agreement, was lukewarm at best. Liberal backing was tepid, because the compromise plan the Clintons came up with fell short of the single-payer universal-coverage plan that the left had expected from a Democratic president...⁴⁴⁹

After 12 years of Republican control of the White House, and Ronald Reagan's consistently anti-government rhetoric, Democrats faced a public and political culture that was almost intrinsically sceptical of the government, its value, efficacy, and capacity to promote genuine positive social change.⁴⁵⁰

... the Clinton proposals come at a juncture when government is held in general disrepute. Taxes are not the only issue... more so are the public's worries about

Debate: All Heat and No Light." *Journal of Health Politics, Policy, and Law* 20 (1995): 428. See also the books and articles in footnote 414.

⁴⁴⁹ Reid, *The Healing of America*, 183.

⁴⁵⁰ Additionally, the American public became increasingly risk averse and afraid of healthcare reform and the changes it implied as healthcare reform efforts were delayed in Congress. When Clinton initiated healthcare reform efforts the public was largely supportive of them in general and to his proposed reforms in particular. But, over the course of approximately a year and a half attitudes sharply changed in part because of successful conservative attacks on the healthcare reforms on the part of insurers and Republicans in particular. "By the end of this debate, the middle class became more worried about the possible negative effect of health care reform than they were about the problem itself. By June 1994, more Americans were worried that a health care bill would jeopardize quality and cost more (37%) than were worried that universal control and cost control would not be achieved. (29%) At the same time, most Americans believed that under the Clinton plan their costs would increase, they would have fewer choices of physicians, and that the quality of health care they received would decrease rather than improve. The status quo seemed more desirable than any major reform. In fact, almost one-half of the public said they were relieved that Congress did not enact any reform... The initial public support for the Clinton plan at 59% decreased over time, and by July 1994 public support stood at only 40%."

Mollyann Brodie and Robert J. Blendon. "The Public's Contribution to Congressional Gridlock on Health Care Reform." *Journal of Health Politics, Policy and Law* 20 (1995): 406.

governmental effectiveness. Many Americans believe, or are quite ready to be convinced, that governmental ‘bureaucracies’ bungle everything they touch.⁴⁵¹

Public attitude surveys since the 1950s showed an almost continuous drop in faith in the competence and integrity of government and in its trustworthiness. In 1958 over 70% of Americans expressed trust in “the government in Washington to do what is right” always or most of the time. The figure kept declining to a low of roughly 25% in 1980. By 1992 it was even lower at 22% and by 1994 it had dipped to 20%.⁴⁵²

Cognizant of these tendencies, part of Clinton’s rhetorical strategy was to downplay the role of government in the healthcare plan. For example, Clinton was sensitive to public scepticism of government. Campaign posters advocating Clinton’s Health Security Act listed three options: Government Insurance, Guaranteed Private Insurance, and No Guarantee of Coverage. ‘Guaranteed Private Insurance’ was placed in the middle in bold, seeking to focus on the private component of Clinton’s universal health insurance plan rather than invoking the government role in its implementation.⁴⁵³ But such rhetorical shifts were not enough to allay the public’s anxieties about the government’s ability to implement universal health insurance reform fairly and successfully, especially given the intensity of conservative attacks on the very notion of the government having any role to play in healthcare reform.

Clinton and Democrats had an uphill battle to face given the political, cultural, and media climate – but there was nothing inevitable about their failure to pass healthcare reform. The urgency to pass universal insurance reform was lost amidst the competing healthcare insurance plans, infighting amongst Democrats and the lack of support of conservative and moderate-conservative Democrats⁴⁵⁴ who shared

⁴⁵¹ Theda Skocpol, *Social Policy in the United States*, 295.

⁴⁵² Skocpol, *Boomerang*, 108.

⁴⁵³ Skocpol, *Boomerang*, 112.

⁴⁵⁴ David W. Brady and Kara M. Buckley. “Health Care Reform in the 103d Congress: A Predictable Failure.” *Journal of Health Politics, Policy and Law* 20 (1995).

conservative scepticism of a major government role in healthcare reform, and the vigorous advocacy of many insurers and their political allies against Clinton's reforms. Finally, the Clintons faced the same institutional and structural challenges of American government we discussed in Chapters 1 and 2, with its highly decentralized organization, system of checks and balances, competing interest groups and sub-sections of the population already enjoying health insurance, such as the elderly, and often sclerotic character that has long impeded the efforts of social reformers.

Discursively too, the Clintons and the Democrats may have undermined their reform efforts by choosing not to adopt the kind of rhetoric with a strong dimension of ethos and pathos with the potential to move and unite Americans in support of reform. It is only with robust and sustained public support that the massive obstacles to healthcare reform can be overcome.⁴⁵⁵

By early 1994, when the Clintons abandoned their plan, the central ethical argument for universal health care coverage – the notion that a wealthy country ought to provide medical treatment for all who need it – was nowhere to be heard. The moral issue... never got moving in the USA...⁴⁵⁶

The moral issue and the concurrent emotions it inspires of solidarity with the vulnerable and indignation in the face of injustice and discrimination was the most potent issue in terms of its potential to breach the conservative obstructionism to healthcare reform which was overwhelmingly ideological, rather than concerned with the most effective way to provide quality healthcare to America's citizens.

Conservative rhetoric is meant to frighten middle-class Americans – especially those who still enjoy relatively good benefits through private insurance – dissuading them from supporting any kind of comprehensive reform. In short, during the 1990s, just as in the 1910s and the 1940s, the opponents of any sort of

⁴⁵⁵ Skocpol states that although the Clintons invested heavily in developing their Health Security proposal they neglected to organize sufficient political support for it. Skocpol, *Boomerang*, 90.

⁴⁵⁶ Reid, *The Healing of America*, 183.

national health insurance have quickly undertaken to create ideological metaphors. They aim to fuel fears of reform among the citizenry and bring together the worries about change of stakeholders in the health economy as it is presently structured. Meanwhile, very little is being done by advocates of fundamental reform to create their own positive ideological metaphors for wide public dissemination.⁴⁵⁷

Such conservative ideological attacks on healthcare reform are about more than a desire to maintain the interests of insurance companies and the healthcare industry. They are part of a larger conservative ideological battle against liberal efforts to advance justice and equality of opportunity through government programs.⁴⁵⁸ As William Kristol, a major figure within the conservative movement openly acknowledged, “We at the Project for the Republican Future want to use the health care debate as a model for routing contemporary liberalism and advancing an aggressive conservative activist agenda.”⁴⁵⁹ But the Clintons largely neglected ethos which would have potentially mitigated at least some of the hostility generated by conservative attacks on the healthcare reforms. In focusing so much on the logos and the practical aspects of their healthcare reforms their appeals for healthcare reform were emotionally flat – failing to inspire and energize Americans. They were unable to generate sufficient support on the part of both politicians and laypeople for the motivating ethical principle of universal health insurance: that American citizens are entitled to health insurance, irrespective of their economic status and income. Because of the complex nature of the reforms the public

⁴⁵⁷ Skocpol, *Social Policy*, 287.

⁴⁵⁸ Vicente Navarro argues more explicitly in terms of class, that conservatives and the business interests they represent are threatened by the transfer in power that would occur were working class and middle class Americans no longer dependent on employers for healthcare. “As employers, members of the corporate or capitalist class, they most value control over their own labor force, and employment-based health benefits coverage gives them enormous power over their employees. The United States is the only country where the welfare state is, for the most part, privatized. Consequently, when workers lose their jobs, health care benefits for themselves and their families are lost. In no other country does this occur. This is why the corporate class and its instruments in the United States oppose establishing government-guaranteed universal entitlements: They strengthen the working class and weaken the capitalist class.”

Vicente Navarro. “Why Congress Did Not Enact Health Care Reform.” *Journal of Health Politics, Policy and Law* 20 (1995): 458.

⁴⁵⁹ Skocpol, *Boomerang*, 146.

was turned off by what many perceived as an overly bureaucratic and convoluted restructuring of health insurance with excess government involvement. Despite the best efforts of the Clintons to focus on the way in which the reforms encouraged the private sector to provide health insurance and healthcare services this message failed to convince the public which was powerfully influenced by the emotive Republican and health insurance industry rhetoric attacking the reforms. Iwan Morgan characterizes the failure of his healthcare reforms as Clinton's "greatest defeat" as president. "More than just a failed proposal, the fiasco was a political disaster for Clinton... It obliterated his 'New Democrat' image that had helped to elect him in 1992 and made him look like just another big-government liberal."⁴⁶⁰ We will now turn to the speech itself.

7.5 Dimensions of Rhetoric

Ethos in the speech manifests itself as a call for government guarantee of security, echoing the use of the word 'security' from the time of Franklin Delano Roosevelt and his Social Security program through Truman and Johnson who, as we have discussed, made similar references to the concept. Clinton makes no direct appeals to human rights or any rights based arguments. Instead, he favors appeals to equal opportunity and communitarian social solidarity to enable a common standard of universal well being, grounding this in civic references to the values found in the Declaration of Independence, a strategy that all four presidents use when seeking to support healthcare reform in relation to national texts for which there is universal, apolitical reverence and shared agreement as to their central place in the American social imaginary. Clinton uses pathos to illustrate injustices and inequalities in the current

⁴⁶⁰Iwan Morgan, "A New Democrat's New Economics" in *The Presidency of Bill Clinton: The Legacy of a New Domestic and Foreign Policy*, ed. Mark White. (New York: IB Tauris, 2012), 70.

healthcare system and to advance the ethos of solidarity, bipartisanship, and equal opportunity to healthcare irrespective of income. The logos dimension of rhetoric in Clinton's speech is predicated on the principle of equal access to healthcare irrespective of economic resources based on the individual mandate requiring all Americans to be insured. As such, it dovetails with the principle of security. The bulk of the speech is devoted to detailing policy and explaining its reasoning.

To articulate ethos, pathos, and logos Clinton relies principally on the following four rhetorical strategies.

- Historical temporality – Primarily concerned with the ending of the Cold War but also to public policies from the past such as Social Security and an intangible generalized historical sensibility. This refers not to specific events and moments in time but to broad historical aspirations for equal opportunity grounded in founding national legal texts such as the Constitution and the Bill of Rights to justify Clinton's healthcare reforms to provide a sense of continuity and legitimacy to the healthcare reforms. (Ethos)
- Moralization emphasizing the need for immediate healthcare policy change to guarantee quality healthcare that is dependable and accessible to all Americans, irrespective of their income to communicate legitimacy and urgency of the proposed healthcare reforms. Moral muting, often seen when practical and pragmatic arguments dovetail with moral ones is the corollary of moralization, and conveys ideological moderation and conciliation. (Ethos)
- Personalization through references to individuals experiencing economic loss and psychological suffering due to a lack of adequate health insurance to cultivate social solidarity. Personalization enables a rhetoric that minimizes ideology and abstract political and moral arguments and instead argues for healthcare reform by illustrating healthcare injustices facing individuals. (Logos, ethos, pathos)

- Selective appropriation of conservative values and ideas and anticipatory and defensive rhetoric (prolepsis) acknowledging conservative concerns particularly as they relate to cost saving, minimizing government bureaucracy, maximizing individual choice, and supporting free markets so as to find favor with conservatives. (Logos)

We will now examine the structure of the speech.

7.6 Speech Structure

The speech follows a logical, linear structure. It begins by grounding the speech in the progressive values of the Declaration of Independence, ‘life, liberty and the pursuit of happiness’ and establishes them as guiding values for Clinton’s ethos and which situates healthcare reform historically at the end of the Cold War, at a time of great possibility while linking it to past historical achievements of the American people – from sending a man to the moon to settling the United States during the country’s westward expansion. Clinton emphasizes the importance of the courage to change, and defines the healthcare system as broken and in urgent need of fixing.⁴⁶¹

Clinton then turns to six guiding principles that inform the “journey” towards the successful implementation of the healthcare reforms: security, simplicity, savings, choice, quality, and responsibility. Clinton provides an overview of what is wrong with the healthcare system both practically and morally and invokes the story of an individual American to illustrate this in an emotive way. Clinton emphasizes the bipartisan nature of his reform plans and the importance of uniting around the principle of universality of healthcare provision. He reviews each of the six principles, making the case for each one and explaining how they interact and support one another.⁴⁶² His arguments focus on logos and incorporate ethos, addressing the principles of mutual responsibility and

⁴⁶¹Clinton, 361.

⁴⁶²Clinton 361-368.

solidarity extensively, showing how healthcare cannot be made universal in a sustainable way unless every US citizen is mandated to carry health insurance, such that the healthy and young subsidize the elderly and the sick and all are guaranteed healthcare at any and all points in life, and especially when they are most vulnerable and in greatest need of it.⁴⁶³ As the speech approaches its conclusion, Clinton focuses intensely on pathos and ethos, urging members of Congress to prioritize the suffering and the vulnerable, and to look beyond narrow economic arguments that may prioritize the needs of the few in the form of businesses and some members of the healthcare industry rather than the American people as a whole.⁴⁶⁴ Clinton returns to history and the possibility of change, the need for courage, and the harnessing of a spirit of bipartisanship and openness to achieve universal healthcare. He anchors the final paragraphs of the speech in the values of freedom and solidarity, returns to the metaphor of a journey, and urges Congress and the American people to continue and complete the journey and to culminate in a program of affordable, accessible universal health insurance for all Americans.

I begin by analyzing the ethos of the speech and the role of pathos within ethos. I begin with ethos because – although logos is quantitatively dominant in the speech – Clinton uses ethos to justify his healthcare reforms and to frame the logos of the speech. Clinton opens the speech with an emphasis on values. “We know the cost of going forward with this system is far greater than the cost of change. Both sides, I think, understand the literal ethical imperative of doing something about the system we have now.”⁴⁶⁵ Clinton’s use of the phrase ‘ethical imperative’ is significant because in its explicitness it defines the entire healthcare reform effort and corresponding debates as being primarily one about realigning public policy to reflect the American ethos; in making this argument Clinton is affirming that however intricate the arguments he makes

⁴⁶³ Clinton, 368-371.

⁴⁶⁴ Clinton, 371-372.

⁴⁶⁵ Clinton, 363.

may be in their technical details there is an overarching ethical motivation that propels them. I incorporate pathos within ethos because Clinton uses pathos to illustrate his ethos and it almost always appears embedded within ethos. The section on examining ethos is divided into four sub-sections, followed by a bridging section which links ethos and logos. The section on logos is also divided into four sections and is followed by the conclusion. Before beginning the analysis of the distinct strands of ethos, pathos, and logos in the speech we will examine the principle that incorporates all three as a common thread of the speech: security.

7.7 The Cardinal Principle of Clinton's Speech that Incorporates Ethos, Pathos and Logos: Security

The principle of 'security' is the foundational principle of Clinton's ethos and it is centered on the principle of universality of health insurance for all Americans, at all times.

First and most important, security. This principle speaks to the human misery, to the costs, to the anxiety we hear about every day, all of us, when people talk about their problems with the present system. Security means that those who do not now have health care coverage will have it, and for those who have it, it will never be taken away. We must achieve that security as soon as possible.⁴⁶⁶

As we have already explored, 'security' is critical to the ethos of the speech because it refers to the guarantee of health insurance to all Americans, irrespective of income on an equal and universal basis. It is also fundamental to the logos of the speech and the principle of responsibility because the individual mandate which requires all Americans to be insured is the practical policy mechanism which ensures security for all Americans, irrespective of income as it ensures the financial viability of insuring all people, including the sick and those with pre-existing conditions, as the young and healthy in effect

⁴⁶⁶Clinton, 363.

subsidize the sick and the elderly and those prone to illness and disability. Finally, security also refers to pathos in that it provides emotional security and freedom from fear. Addressing the miseries and anxieties he argues the healthcare reforms will do away with, Clinton explains with repetition and detail the absolute guarantee of healthcare security that his reforms provide.

With this card, if you lose your job or you switch jobs, you're *covered*. If you leave your job to start a small business, you're *covered*. If you're an early retiree, you're *covered*. If someone in your family has unfortunately had an illness that qualifies as a pre-existing condition, you're still *covered*. If you get sick or a member of your family gets sick, even if it's a life-threatening illness, you're *covered*. And if an insurance company tries to drop you for any reason, you will still be *covered*, because that will be illegal. This card will give comprehensive *coverage*. It will *cover* people for hospital care, doctor visits, emergency and lab services, diagnostic services like Pap smears and mammograms and cholesterol tests, substance abuse, and mental health treatment.⁴⁶⁷

Clinton uses the word 'covered' or 'coverage' eight times in this paragraph to stress how dependable coverage will be and to emotionally reassure the audience that they will never be abandoned without healthcare or with inadequate healthcare, as so many are now. Thus 'security' is the unifying principle of ethos, pathos, and logos and is the core signifier and value of the speech which informs the sub-arguments made and the rhetorical strategies used to advance them in each of the three rhetorical domains.

7.8 Ethos and the Rhetorical Strategies of Historical Temporality and Moralization to Convey the Urgency of Change

Reflecting a strategy of historical temporality, Clinton harkens back to reforms that were once controversial but are now considered entitlements with an overwhelming majority of Americans not only supporting them but considering them essential. In so

⁴⁶⁷Clinton, 363-364.

doing, he links the policy successes of the past with the present moment and the future, illustrating how just as a fundamental change was possible when Social Security was created – change that reflected an ethos of communitarian solidarity and care, so too can such change and a reinvigorated commitment to that ethos be made today. In so doing, Clinton implies that his healthcare reforms which are contested now will one day have the common acceptance of Social Security.

It's hard to believe that there was once a time in this century when that kind of fear gripped old age, when retirement was nearly synonymous with poverty and older Americans died in the street. That's unthinkable today because over half a century ago Americans had the *courage to change*, to create a Social Security system that ensures that no Americans will be forgotten in their later years. Forty years from now, our grandchildren will also find it unthinkable that there was a time in this country when hard-working families lost their homes, their savings, their businesses, lost everything, simply because their children got sick or because they had to change jobs. Our grandchildren will find such things unthinkable tomorrow if we have the *courage to change today*.⁴⁶⁸

Thus history contains an ethical lesson that Clinton is imparting by interpreting the passage of Social Security as a function of civic courage – civic courage which he asks Americans to emulate and which he needs to inspire in order to advance his healthcare reforms. Clinton also applies the strategy of historical temporality to invoke patriotism by insisting that,

Our history and our heritage tell us that we can meet this challenge. Everything about America's past tells us we will do it. So I say to you, let us write that new chapter in the American story. Let us guarantee every American comprehensive health benefits that can never be taken away.⁴⁶⁹

Thus Clinton summons the perceived greatness of the American past to inspire a commitment to healthcare reform today.

As with each presidential speech on healthcare reform which seeks to spur policy change and to do so in a tightly fixed time frame, Clinton creates a clear and immediate

⁴⁶⁸Clinton, 372.

⁴⁶⁹Clinton, 371.

linkage between the claim that the healthcare system in the United States is failing and that in order to achieve an ethical vision of solidarity and security it needs to be fixed. Reflecting a strategy of moralization, he illustrates the problems facing Americans and the ethically unacceptable deprivations and injustices caused as a result. “There are thousands of elderly people in every State who are not poor enough to be on Medicaid but just above that line and on Medicare, who desperately need medicine, who make decisions every week between medicine and food.”⁴⁷⁰ He immediately follows this moral point with the practical argument that the elderly who don’t take the right medicine get sicker and sicker and drain money from the healthcare system by using its services once their health problems have become increasingly complex and difficult to treat efficiently and affordably.⁴⁷¹ Such ‘tandem arguments’ in which an ethical argument is immediately followed by a practical one focused on economic efficiency are a hallmark of the speech, in which ethos and logos often immediately follow one after the other or are deliberately embedded in the same passage. It is particularly effective at integrating principle and pragmatism and at removing sharp ideological differences from arguments. As such, it is a prominent feature of Clinton’s ‘third way’ rhetoric and is an exemplar of the way in which Democratic presidents have contested hegemonic conservative ideas and principles of limited government not in a frontal and ideologically aggressive manner but through a deliberate use of moral muting that often relies in large part on practical arguments to buttress ethical ones.

Clinton summons the value of freedom in defense of healthcare reform and asks Americans to “strike a blow for freedom in this country, the freedom of Americans to live without fear that their own nation’s health care system won’t be there for them when they need it.”⁴⁷² As we have discussed in earlier chapters in the American social imaginary

⁴⁷⁰Clinton, 364.

⁴⁷¹Ibid

⁴⁷²Clinton, 372.

‘freedom’ is generally conceived of as referring to negative rather than positive liberty. But here Clinton is characterizing it as positive liberty that requires active government intervention in the form of healthcare reform.

‘Responsibility’ is one of the six principles that has a substantial ethical component and which Clinton uses to create a united appeal to all Americans. Reflecting a strategy of moralization, Clinton states,

We need to restore a sense that we're all in this together and that we all have a responsibility to be a part of the solution. Responsibility has to start with those who profit from the current system. Responsibility means insurance companies should no longer be allowed to cast people aside when they get sick. It should apply to laboratories that submit fraudulent bills, to lawyers who abuse malpractice claims, to doctors who order unnecessary procedures. It means drug companies should no longer charge 3 times more per prescription drugs, made in America here in the United States, than they charge for the same drugs overseas.⁴⁷³

The significance of this passage lies in the holistic way in which Clinton ascribes moral responsibility to *multiple* sectors of American society, strengthening the non ideological and unpartisan orientation of his arguments and emphasizing communitarian collective obligation. No one subgroup is singled out for criticism. In so doing, Clinton depoliticizes his reforms and maintains himself as a neutral expert arbiter, above the fray, seeking out the common good and maintaining a balance of criticism to all parties.

Clinton anchors the ethos of the speech in the narrative of the American dream with an implicit reference to the Declaration of Independence. This reflects rhetorical strategies of historical temporality and an overarching narrative structure which tells the tale of the American social imaginary as an unfolding story in which individuals – acting both alone and together as citizens in society are able to actualize their fullest potential and lead lives of dignity and security that are characterized by access to freedom and

⁴⁷³Clinton, 368.

social progress. It is through partnership – between citizens and government – that individual and collective welfare can both be best assured, Clinton argues, and so invites all Americans to join him to pursue healthcare reform.

My fellow Americans, tonight, we've come together to write a new chapter in the American story. Our forebears enshrined the American dream of life, liberty and the pursuit of happiness. Every generation of Americans has worked to strengthen that legacy, to make our country a place of freedom and opportunity, a place where people who work hard can rise to their full potential, a place where their children could have a better future.⁴⁷⁴

Here Clinton speaks of the principle of equal opportunity in an implicit way but nonetheless it is paramount to his anchoring of healthcare reform within the ethical context of maximizing opportunity for all Americans and enabling them to reach their fullest capabilities. The Declaration of Independence's articulation of the American dream, 'life, liberty and the pursuit of happiness' is presented here by Clinton as the pillar and pinnacle of the American social imaginary which Clinton anchors to the moment of first union of the United States and to which we will recall Johnson also referred as the ultimate inspiration for his War on Poverty and Great Society programs, including Medicare and Medicaid. It also reflects the rhetorical strategy of moralization, in that Clinton uses the aforementioned core moral values of the Declaration of Independence to provide the normative basis for his reforms and the ethos of the speech and to defend the government's role in these efforts.

Clinton's rhetoric is one of optimism grounded in history which fuses patriotism and positive visions of an American social imaginary in a constant state of transformation and growth, that is moving linearly towards greater realization of communitarian social solidarity alongside increased access to freedom. Clinton states,

⁴⁷⁴Clinton, 361.

From the settling of the frontier to the landing on the Moon, ours has been a continuous story with challenges defined, obstacles overcome, new horizons secured. That is what makes America what it is and Americans what we are.⁴⁷⁵

While Clinton illustrates much of his ethos in the speech by demonstrating the failure of the United States to provide its citizens with adequate healthcare – and thus the failure of Americans to make real the American social imaginary and its ideal moral order based on equality and freedom – by grounding the ethos in an American social imaginary of energy, expansion, and national achievement Clinton softens some of the inevitably unpleasant emotions and harsh ethical judgments that follow from depicting American healthcare failures and offers an optimistic rhetoric of hope and new possibility.

7.9 A Counterpoint to Values of Equality of Opportunity and Solidarity: Rhetoric of Neutral Change and Economic Efficiency

Further applying a strategy of historic temporality Clinton situates healthcare reform within the immediate past – a time of flux which he presents as leading to the contemporary era that demands a break with the past.

The end of the cold war, the information age, the global economy have brought us both opportunity and hope and strife and uncertainty. Our purpose in this dynamic age must be to make change our friend and not our enemy.⁴⁷⁶

This need for ‘change’ places Clinton’s rhetoric in a historical context that upends political and economic norms. This allows him to present his healthcare reform plans as stemming not from a particular political ideology, (and thus as not easily politically contestable nor easily derided as partisan and overtly liberal) rather as a necessary response to changes in the global economy. In so doing Clinton offers a deliberately neutral vision of government activity that is neither liberal nor conservative – it has no

⁴⁷⁵Clinton, 361.

⁴⁷⁶Ibid.

clear ideological basis, although it does insinuate respect for conservative values in its emphasis on changing the way government functions and reducing citizen dependency on government.

...We must face all our challenges with confidence, with faith, and with discipline, whether we're reducing the deficit, creating tomorrow's jobs and training our people to fill them, converting from a high-tech defense to a high-tech domestic economy, expanding trade, reinventing government, making our streets safer, or rewarding work over idleness. All these challenges require us to change.⁴⁷⁷

Healthcare reform then – although not rhetorically situated by Clinton within the context of a social justice centered redefinition of government - is here one component of a larger society in transition, not motivated by liberal values of justice and fairness per se as Johnson and Truman's rhetoric was, but by impersonal economic forces. Clinton depicts these as having an inexorable force of their own to which Americans and American government must respond or face economic marginalization in the context of global economic and political changes taking place on a large scale. The politically neutral phrase, 'reinventing government' – which evinces neither an obviously liberal nor conservative ideological proclivity, and instead reflects his centrist and managerial approach that favors conservative principles of limited government while protecting a scaled back welfare state that Clinton championed and succeeding in winning with the passage of his welfare reforms – is part of a larger primarily technocratic pragmatic process of transformation which Clinton describes and encourages and which serves as the implementing force of the ethical values Clinton calls to realize.

“Change” is a word that Clinton uses with two different insinuations in the speech: the implication of a moderate progressive liberalism leading towards a vision of greater equality of opportunity and communitarian solidarity and, in a second way, as a

⁴⁷⁷Clinton, 361.

pragmatically necessary category less concerned with ethics and justice than with economic efficiency. In the aforementioned list of social and economic issues that Clinton implies demand change none have an explicitly progressive social agenda in terms of addressing the needs of the marginalized. Here, ‘change’ is a signifier of a morally neutral managerial language. Further, by stating ‘rewarding work over idleness’ in reference to his welfare reforms Clinton is appropriating conservative values which see social problems as stemming primarily from individual and/or collective laziness and other character flaws rather than taking into account structural and systemic causes of poverty and related social injustice. What we find in the speech then is a combination of a particular vision of ethos centered on equal opportunity and communitarian social solidarity which is intertwined uneasily and inconsistently with a logos of management and appropriation of conservative ideas and ideals. We will now examine the place of pathos in the ethos of the speech.

7.10 Pathos in Support of Ethos: The Strategy of Personalization

The main rhetorical strategy Clinton uses to advance pathos is personalization. Clinton does not use personalization to explicitly address the vulnerabilities and injustices facing the most economically disadvantaged Americans – because he does not address them as such and acknowledge their existence as a group of individuals facing common structural economic and social injustices. Personalization allows Clinton to address their needs and realities by calling upon individual stories that exemplify broader issues and in arguing that middle class Americans suffer from healthcare insecurity Clinton is also able to *indirectly* address the healthcare challenges facing the most economically disadvantaged Americans. This obviates the need to make overtly ideological arguments in support of working class and economically disadvantaged Americans as collective populations that might undermine the ideologically moderate and non-confrontational approach Clinton

takes to try to generate bipartisan support for his healthcare reforms and appeal to conservatives.

Towards the end of the speech, as he delivers one final call for change Clinton warns against the arguments of individuals who have an interest in maintaining the status quo, such as insurers who profit from the current healthcare system. He plays powerfully on the linkage between the emotional and the moral, asking members of the House to look beyond the cold logos of businesses into the individual eyes of the ailing and to empathize with their plight and respond to their needs. Reflecting a strategy of moralization he states,

I want also to say to the Representatives in Congress, you have a special duty to look beyond these arguments. I ask you instead to look into the eyes of the sick child who needs care, to think of the face of the woman who's been told not only that her condition is malignant but not covered by her insurance, to look at the bottom lines of the businesses driven to bankruptcy by health care costs, to look at the "for sale" signs in front of the homes of families who have lost everything because of their health care costs.⁴⁷⁸

Here Clinton is using pathos to bypass logos – not the logos of his healthcare reforms but the logos of the healthcare industry and private insurers whose profit priorities may weigh heavily upon Congressmen and whose preference for inertia and maintaining the current healthcare system can easily win over Representatives afraid to take on the risks of change, even if they are necessary. Here Clinton is not invoking pathos in the context of a reasoned moral argument as much as summoning images of vulnerability, suffering, and injustice and empathically imagining an interaction between the individuals experiencing such vulnerability and suffering and Representatives in Congress. This act of empathic imagination ruptures the chain of facts and logic than can conceivably rationalize a refusal to embrace Clinton's healthcare reforms and without directly projecting guilt forces a confrontation of conscience.

⁴⁷⁸Clinton, 371.

Clinton continues to apply the strategy of personalization to evoke pathos in the context of a series of individual injustices facing Americans struggling to meet the costs of healthcare he recounts,

I ask you to remember the kind of people I met over the last year and a half: the elderly couple in New Hampshire that broke down and cried because of their shame at having an empty refrigerator to pay for their drugs; a woman who lost a \$50,000 job that she used to support her six children because her youngest child was so ill that she couldn't keep health insurance, and the only way to get care for the child was to get public assistance; a young couple that had a sick child and could only get insurance from one of the parents' employers that was a nonprofit corporation with 20 employees, and so they had to face the question of whether to let this poor person with a sick child go or raise the premiums of every employee in the firm by \$200; and on and on and on.⁴⁷⁹

One of the ways in which pathos has distinctive rhetorical power is a function of its relative incontestability. Whatever one thinks about Clinton's healthcare reforms these individual experiences – as exemplars of what is wrong with healthcare provision in the United States – describe the tormented emotions of individuals struggling to reconcile their healthcare needs with their limited financial means and do so in a way that rather than inviting dialogue and multiplicity of perspective assert one overarching claim: the sorrow and injustice which these individuals experience is a result of the failure to reform healthcare. Emotions do not invite reasoned argument and alternative viewpoints – they have intrinsic power and are self-justifying simply by virtue of being felt and described. As such, they are potent rhetorical tools which buttress reason and logos in support of healthcare reform by making potential arguments against healthcare reform unappealing in virtue of the emotional distress depicted of individuals who lack healthcare.

Clinton's invocation of a child's treatment in hospital – and the way in which the current healthcare system fails to reach many sick children in need similarly creates a powerful expression of pathos in the service of ethos. Discussing his visit to the Children's Hospital in Washington, DC Clinton states,

⁴⁷⁹Ibid.

A nurse named Debbie Freiberg told us that she was in the cancer and bone marrow unit. The other day a little boy asked her just to stay at his side during his chemotherapy. And she had to walk away from that child because she had been instructed to go to yet another class to learn how to fill out another form for something that didn't have a lick to do with the health care of the children she was helping. That is wrong, and we can stop it, and we ought to do it.⁴⁸⁰

The juxtaposition that Clinton establishes between the image of a vulnerable and needy sick child and the dehumanizing and stifling bureaucracy that results from the current system of health insurance in the United States - that prevents the child from receiving the support he needs during an anxiety provoking treatment - provides an emotionally resonant image and individual narrative that buttresses the ethos of Clinton's speech.

There is one other way in which Clinton uses pathos to advance the ethos of his speech, and that is with regard to advancing the value of bipartisanship. In this context, in contrast, Clinton uses pathos to invite dialogue and constructive debate on healthcare reform *implementation* and to affirm the moderate and malleable nature of his healthcare reforms which are open to the perspectives of a broad cross section of Americans, of all political persuasions, but which are uncompromising on the *principle of universality*.

7.10.1 Pathos and Bipartisanship

At the close of the speech Clinton links pathos with the ethos of bipartisanship. To invoke positive feelings in association with his proposed healthcare reforms, Clinton emphasizes the bipartisan nature of the efforts to reform healthcare and acknowledges that "... we have differences of opinion"⁴⁸¹ but affirms that despite these differences if we "look into our heart"⁴⁸² Congress will find a way to address healthcare insecurity and insufficiency. Using words such as 'magical,' 'moved', and 'proud' Clinton generates a

⁴⁸⁰Clinton, 365.

⁴⁸¹Clinton, 371.

⁴⁸²Ibid.

sense of patriotic shared mission and communitarian obligation in which whatever obstacles remain can be overcome because of unity of purpose and transcendence of partisan division and political acrimony. This is, of course, a highly idealized presentation of the political reality at the time – as indeed Clinton’s efforts failed in part because although the façade of substantial agreement may have existed it had rickety foundations and there was no consensus on healthcare reform.

The proposal that I describe tonight borrows many of the principles and ideas that have been embraced in plans introduced by both Republicans and Democrats in this Congress. For the first time in this century, leaders of both political parties have joined together around the principle of providing universal comprehensive health care. It is a magic moment, and we must seize it. I want to say to all of you, I have been deeply moved by the spirit of this debate, by the openness of all people to new ideas and argument and information. The American people would be proud to know that earlier this week, when a health care university was held for members of Congress just to try to give everybody the same amount of information, over 320 Republicans and Democrats signed up and showed up for two days just to learn the basic facts of the complicated problem before us.⁴⁸³

Clinton’s depiction of the bipartisanship of healthcare reform efforts is essential to maintain a rhetoric of urgency, moment, and even of inevitability and to link the political project of healthcare reform with a more universalistic social imaginary that incorporates all Americans and transcends party politics. By referring to bipartisanship in a way which makes it very hard for Republicans to back down from healthcare reform efforts – because doing so would imply that they have spoiled the magic and failed to listen and respect the wishes of the American people and the positive character of bipartisanship - Clinton creates a rhetorical trap whereby having set the terms of the debate any substantive objection to his healthcare reforms becomes an act of destructiveness and disrespect, rather than one of potentially principled dissent.

⁴⁸³ Clinton, 363.

Clinton goes on to make bipartisanship a necessary precondition for the realization of an ethos of solidarity and care which he alludes to by saying that, “rising above these difficulties and our past differences to solve this problem will go a long way toward defining who we are and who we intend to be as a people in this difficult and challenging era.”⁴⁸⁴ Although he does not describe bipartisanship as being necessarily constitutive of the ethos he advocates – as we will see is central to Obama’s rhetoric - he nevertheless salutes sustained bipartisanship as a prerequisite for achieving public policy that reflects the ethos of communitarian solidarity which he advocates. This necessitates transcending ideological division and coming together in support of his healthcare reforms which he depicts as being ideologically neutral but infused with moral values of communitarian solidarity and care. This represents a sharp departure from the rhetoric of Truman and Johnson, in which bipartisanship and political compromise do not feature centrally because the prevailing social imaginary at the time was more sympathetic to robustly liberal efforts to secure positive liberty through government programs and because of the strength of Johnson’s Democratic congressional majority.

Having examined the rhetorical dimensions of ethos and pathos in the speech we will now examine how Clinton applies various rhetorical strategies to illustrate the logos of the speech which outlines how Clinton envisions fixing healthcare provision in the United States and in so doing making a still unachieved American social imaginary a new American social reality.

⁴⁸⁴Clinton, 363.

7.11 Logos: Problems and Principles

The core problems with American healthcare according to Clinton are:

- The high costs of healthcare and the risks of bankruptcy for those without health insurance or insufficient health insurance.
- Discrimination against individuals with pre-existing conditions by insurers.
- 37 million uninsured Americans, most of whom are working but still do not receive health insurance. Tens of millions of other Americans who are underinsured or whose insurance state is precarious and are vulnerable to losing it.
- Rising medical bills that are forcing Americans to spend too much on health care, far more than other nations, and undermining American economic competitiveness as a result.

In addressing these problems, Clinton sets the parameters of the logos of his speech by referring to six principles: security, simplicity, savings, choice, quality, and responsibility. At the heart of the logos is the need for a universal mandate whereby by all Americans are required to be insured or guaranteed subsidies or free insurance provided by the government if they cannot afford it. Clinton states, “Unless everybody is covered—and this is a very important thing—unless everybody is covered, we will never be able to fully put the brakes on health care inflation.”⁴⁸⁵ Reflecting on the current insecurity regarding healthcare provision he states that, “our health care is too uncertain and too expensive”⁴⁸⁶ and regarding simplicity and savings, “too bureaucratic and too

⁴⁸⁵Clinton, 366.

⁴⁸⁶Clinton, 361.

wasteful.”⁴⁸⁷ On the subject of quality and responsibility he states, “It has too much fraud and too much greed.”⁴⁸⁸ Having established the core principles that guide his logos and defined the current problems which are preventing their actualization he reaffirms the ultimate overarching priority of his healthcare reform, healthcare security. This is the paramount principle which reflects both the ethos and logos of the reforms and he argues that it can only be actualized with a government guarantee of universal health insurance, “We must make this our most urgent priority, giving every American health security — health care that can never be taken away, health care that is always there.”⁴⁸⁹

7.11.1 Logos and the Rhetorical Strategy of Personalization

The rhetorical strategy of personalization humanizes large, often abstract matters of public policy relating to the six principles Clinton refers to and conveys their urgency in a way to which audiences can relate. Indeed, in references to Americans who represent a common or typical American citizen – rather than one with a particularly high rank in government or industry – this humanization is the major effect of personalization. But Clinton also uses personalization to call upon individuals with expertise who share his convictions about healthcare reform. In so doing, by naming these individuals he expands the circle of trusted authority and burnishes his own credentials.

So, for example, early in the speech he references his wife, Hillary Clinton as having conducted a wide ranging program of research on healthcare reform. In so doing, the Clintons become a synecdoche for the American people, a conduit whereby small business owners, the underinsured and the uninsured are all given voice. In the following passage we see the way in which speaking to individual Americans and learning about

⁴⁸⁷ Ibid.

⁴⁸⁸ Clinton, 361.

⁴⁸⁹ Ibid.

their stories and experiences of healthcare takes central stage and also epideictically demonstrates Clinton's openness, intellectual and policy rigor, and desire to be inclusive of all Americans in the efforts to improve and expand healthcare provision.

Over the last eight months, Hillary and those working with her have talked to literally thousands of Americans to understand the strengths and the frailties of this system of ours. They met with over 1,100 health care organizations. They talked with doctors and nurses, pharmacists and drug company representatives, hospital administrators, insurance company executives and small and large business. They spoke with self-employed people. They talked to people who had insurance and people who didn't. They talked with union members and older Americans and advocates for our children.⁴⁹⁰

Later in the speech he references the Surgeon General, marshalling him as an individual in a position of authority to help support his case for healthcare reform.

Now, nobody has to take my word for this. You can ask Dr. Koop. He's up here with us tonight, and I thank him for being here. Since he left his distinguished tenure as our Surgeon General, he has spent an enormous amount of time studying our health care system, how it operates, what's right and wrong with it. He says we could spend \$200 billion every year, more than 20 percent of the total budget, without sacrificing the high quality of American medicine.⁴⁹¹

Illustrating the problems with waste and inefficiency in current healthcare policy Clinton depicts his recent visit to a hospital - where doctors spend far too much time filling out papers rather than attending to the needs of their patients. He notes that two million dollars a year are spent at one hospital, Washington Children's Hospital, by hospital administrators. Clinton invokes a doctor he spoke to during a visit to the hospital.

We met a very compelling doctor named Lillian Beard, a pediatrician, who said that she didn't get into her profession to spend hours and hours—some doctors up to 25 hours a week—just filling out forms. She told us she became a doctor to

⁴⁹⁰Clinton, 362.

⁴⁹¹Clinton, 367.

keep children well and to help save those who got sick. We can relieve people like her of this burden.⁴⁹²

To illustrate just how significant this waste is Clinton recounts that he was told by hospital staff that if a system was in place that wouldn't require endless amounts of paperwork each doctor on staff - and there are 200 of them - could see another 500 children a year, for a total of 10,000 more children receiving healthcare. These examples then, in addition to humanizing by telling stories about individuals also humanize by insisting that healthcare reform will prioritize the individual welfare of Americans which is now so compromised by a highly bureaucratized system which constrains patient centered care and depersonalizes the experience of healthcare.

Finally, Clinton employs the strategy of personalization when he tells the story of Kerry Kennedy.

Kerry Kennedy owns a small furniture store that employees seven people in Titusville, Fla... over the last several years — again, like most small-business owners — he's seen his health care premium skyrocket, even in years when no claims were made. And last year, he painfully discovered he could no longer afford to provide coverage for all his workers because his insurance company told him that two of his workers had become high risks because of their advanced age. The problem was that those two people were his mother and father, the people who founded the business and still worked in the store.⁴⁹³

By invoking a small business owner – an idealized category of middle class Americans and a glorified middle class image of self-reliance and hard work that conservatives typically champion to illustrate the problem of health insurance discrimination and excessive costs, Clinton renders more immediate and dramatic these larger injustices. Although in this passage Clinton does *implicitly* address the healthcare injustices facing working class and economically disadvantaged Americans its focus and primary concern is not on them but on their middle class manager who employees them. Employing a

⁴⁹² Clinton, 365.

⁴⁹³ Clinton, 362.

strategy of anticipatory and defensive rhetoric, Clinton notes that organizations which have previously vociferously challenged universal healthcare efforts in past years out of concern for potential detrimental impact on small business owners now support the employer mandate at the heart of the healthcare reforms. “The Chamber of Commerce has said that, [the need for an employer mandate] and they're not in the business of hurting small business. The American Medical Association has said that.⁴⁹⁴” Thus Clinton invokes two of the most historically stalwart critics of universal health insurance and one pillar of conservative power and policy – the Chamber of Commerce – in defense of his healthcare reforms to assuage conservative critiques of them. We will now further examine how Clinton applies the strategy of appropriating conservative values in his healthcare reform rhetoric.

7.11.2 Logos and the Rhetorical Strategy of Appropriating Conservative Values and Anticipatory and Defensive Rhetoric to Convey Moderation: Clinton's Third Way

In the previously discussed passage about the Washington Children's Hospital Clinton uses the anti-bureaucratic trope that so dominates conservative Republican rhetoric. In much of the logos of the speech Clinton adopts conservative values and ideas in his arguments. In addressing how to actualize the principle of savings, for example, Clinton actively criticizes government regulation while simultaneously insisting that it is necessary in a mild form.

Rather than looking at price control or looking away as the price spiral continues, rather than using the heavy hand of Government to try to control what's happening or continuing to ignore what's happening, we believe there is a third way to achieve these savings.⁴⁹⁵

⁴⁹⁴Clinton, 369.

⁴⁹⁵Clinton, 366.

Clinton defines this third way which balances liberal concerns with access and affordability with conservative concerns with protecting the free market and maximizing choice and competition as follows:

- By giving groups of consumers and small businesses the same market bargaining power that large corporations and large groups of public employees now have.
- By using the law to force healthcare plans to compete and by making it illegal for them to profit by turning away the sick and the old or by providing excessive coverage for costly and medically unnecessary procedures.
- By establishing strict limits on the prices of healthcare plans, so that companies do not overcharge individuals and make healthcare prohibitively expensive.⁴⁹⁶

In order to depict these government regulations as being in the public interest – rather than smothering free markets and business initiative - Clinton offers the example of government regulation of airplanes to demonstrate the importance and broad acceptance of government regulation of matters of public safety. Clinton explains that it will be the government's responsibility to ensure that Americans receive quality healthcare.

Our proposal will create report cards on health plans, so that consumers can choose the highest quality health care providers and reward them with their business. At the same time, our plan will track quality indicators, so that doctors can make better and smarter choices of the kind of care they provide. We have evidence that more efficient delivery of health care doesn't decrease quality. In fact, it may enhance it.⁴⁹⁷

He provides a combination of examples from the private and the public sector to illustrate the effectiveness of cost savings and how they can be done in a way that improves healthcare rather than undermining it.

⁴⁹⁶ Clinton, 366.

⁴⁹⁷ Clinton, 368.

Ask the public employees in California, who've held their own premiums down by adopting the same strategy that I want every American to be able to adopt, bargaining within the limits of a strict budget. Ask Xerox, which saved an estimated \$1,000 per worker on their health insurance premium. Ask the staff of the Mayo Clinic, who we all agree provides some of the finest health care in the world. They are holding their cost increases to less than half the national average. Ask the people of Hawaii, the only State that covers virtually all of their citizens and has still been able to keep costs below the national average.⁴⁹⁸

Although Clinton criticizes the current healthcare system for many of the policies that stem from its lack of regulation he maintains a careful balance between criticizing the current lack of government regulation and cautiously calling for more regulation while simultaneously applying conservative rhetoric that finds problems not primarily in the functioning of the private sector but in excess government regulation.

This is a delicate rhetorical juggling act. In this sense Clinton is calling for a recalibration of the role of government and the private sector rather than championing one and denouncing the other. This nuanced approach enables him to advance his healthcare reforms in a way that is less likely to meet the rejection of conservatives.

Under our proposal there would be one standard insurance form, not hundreds of them. We will simplify also—and we must—the Government's rules and regulations, because they are a big part of this problem. This is one of those cases where the physician should heal thyself. We have to reinvent the way we relate to the health care system, along with reinventing Government. A doctor should not have to check with a bureaucrat in an office thousands of miles away before ordering a simple blood test.⁴⁹⁹

Indeed the language Clinton employs here is typically conservative in its critique of government and government tendency to over regulate and expand authority over areas that conservatives argue should be left to citizens and medical professionals to determine without government interference. But it is also critical of markets, acknowledging that they can be inefficient and wasteful and that having a large number of private health

⁴⁹⁸ Clinton, 367.

⁴⁹⁹ Clinton, 365.

insurers while superficially seeming to increase patient choice in fact undermines healthcare quality and affordability because of the huge bureaucracies created to process health insurance that distract from a focus on quality healthcare delivery above all.

Another way in which Clinton's rhetoric reflects the rhetorical strategy of appropriation and defensive rhetoric is his insistence on the centrality of individual choice to his healthcare reforms. In so doing he echoes Truman who similarly prioritized this principle and demonstrates a policy continuity that is manifest in Obama's healthcare reform rhetoric where it also features as a central component of his healthcare reform logos.

Americans believe they ought to be able to choose their own health care plan and keep their own doctors. And I think all of us agree. Under any plan we pass, they ought to have that right...⁵⁰⁰ We propose to give every American a choice among high quality plans. You can stay with your current doctor, join a network of doctors and hospitals, or join a health maintenance organization. If you don't like your plan, every year you'll have a chance to choose a new one. The choice will be left to the American citizen, the worker, not the boss and certainly not some Government bureaucrat.⁵⁰¹

The last sentence evokes populist feelings in its championing of the worker⁵⁰² - and especially in its explicit emphasis on the worker's rights as paramount and taking precedence to the authority of his higher ups at work and the government itself. This reflects a hybrid synthetic argument which incorporates liberal scepticism of intentions of corporate management and the profit bottom lines of business, and conservative scepticism of the competence and intentions of government and government's potential violations of citizen liberties.

⁵⁰⁰ Clinton, 367.

⁵⁰¹ Clinton, 367-368.

⁵⁰² 'The worker' here, however, is not being used to refer to a member of the working class, but rather to refer to an employee. The term is being employed here as a neutral term describing employment, and not as an expression of solidarity with a certain class of workers.

7.11.3 How High Healthcare Costs Harm Other Government Expenditure

As discussed earlier, Clinton does not directly link healthcare reform to a vision of government – like Truman’s and Johnson’s – in which the primary responsibility of government is assuring citizen welfare in a holistic way that realizes social and economic rights. However, he acknowledges that because the government performs a wide range of roles needed to maintain a functioning society if healthcare costs are not kept under control they will undermine the capacity of government to meet other social needs. Clinton’s focus is on managing the economy efficiently and he only obliquely addresses other social needs in the speech by emphasizing that if healthcare costs are not restrained and the healthcare system reformed then American ‘living standards’ will go down.

Rampant medical inflation is eating away at our wages, our savings, our investment capital, our ability to create new jobs in the private sector, and this public Treasury. Our competitiveness, our whole economy, the integrity of the way the Government works, and ultimately, our living standards depend upon our ability to achieve savings without harming the quality of health care.⁵⁰³

Clinton explains that until costs are brought down workers will lose \$655 a year in income because of increasing healthcare premium costs, small businesses will be forced to drop health insurance coverage because they will not be able to afford it, and American corporations will be at a disadvantage when competing in global markets with corporations which do not need to spend huge amounts of their own funds to cover their employees. “State and local government will continue to cut back on everything from education to law enforcement to pay more and more for the same healthcare.”⁵⁰⁴

Thus without appealing directly to the necessity of government programming to provide for social welfare Clinton links government expenditure on healthcare with

⁵⁰³ Clinton, 365.

⁵⁰⁴ Clinton, 366.

government programming in the areas of public safety and education. This allows him to bypass the need to ideologically engage conservatives in the debate about the appropriate size of government and to refer instead to two widely accepted areas of government programming that most Americans believe the government ought to provide and do not want to see cut. But Clinton also uses this same conservative trope bemoaning government bureaucracy to criticize the bloated insurance sector, with the excess of insurance plans provided by 1500 insurers which forces doctors to spend massive amounts of time and energy to fill out insurance paperwork. This ultimately diverts funds from healthcare provision to insurance administration.

The medical care industry is literally drowning in paperwork. In recent years, the number of administrators in our hospitals has grown by 4 times the rate that the number of doctors has grown. A hospital ought to be a house of healing, not a monument to paperwork and bureaucracy.⁵⁰⁵

Other issues Clinton raises in justification of his healthcare reforms are the need to cut down on fraud and abuse and to use funds earned from this to insure the uninsured as well as the problem of cost shifting, whereby everyone pays higher hospital bills because of the excessive use of emergency rooms for treatment which would be much less expensive and more efficacious to provide in a non-emergency clinical setting.

Although Clinton makes little mention of public health and does not use it rhetorically as Truman does to bridge divisions of class and geography, he does raise the issue in a way that appeals to conservatives and appropriates conservatism: with a focus on the need for greater individual responsibility not to engage in self-destructive behaviors. Here his strategy of moralization – which is linked in the logos of the speech to the principle of responsibility and the individual mandate - extends to demanding different behavior from citizens that reflects concern for maintaining their health, putting

⁵⁰⁵Clinton, 364.

some of the onus for improvement in health outcomes on citizens and their individual life choices. Comparing the United States to other Western countries, Clinton states,

We also have higher rates of AIDS, of smoking and excessive drinking, of teen pregnancy, of low birth weight babies... We have to change our ways if we ever really want to be healthy as a people and have an affordable health care system. And no one can deny that.⁵⁰⁶

What we have seen in the analysis of the logos of the speech is that the practical implementation of the healthcare reform plans is dominated by conservative values and ideas of limited government, protecting private provision of healthcare and health insurance, and maximizing individual choice while also appropriating conservative anti-bureaucratic tropes to criticize waste in the private insurance sector. The ethos of the speech, in contrast, puts greater emphasis on liberal concerns with equality of opportunity and communitarian social solidarity.

7.12 Conclusion

We have seen how Clinton's rhetoric diverges substantially from Truman and Johnson's. Like them, he advances healthcare reform in pursuit of the principle of 'security' but unlike Truman and Johnson he does this outside of a context of a broader effort to realize the social and economic rights of Americans. While Truman and Johnson squarely address the needs of the most impoverished Americans - with Johnson putting particular and major emphasis on this, Clinton focuses primarily on the middle class - (which we will see in the next chapter Obama does as well, but much more explicitly and intensely.) This reflects a shift in the American social imaginary which avoids explicitly addressing the realities and needs facing the most economically disadvantaged Americans.

⁵⁰⁶Clinton, 369.

Articulating his centrist ‘third way’ political philosophy, Clinton extensively anticipates potential conservative critiques of his healthcare reforms and appropriates both from conservative rhetoric and conservative values throughout the speech, applying anti-bureaucracy tropes, focusing on the importance of maximizing economic growth and business productivity, and enabling choice both for doctors and American citizens seeking healthcare. This does not appear as a rhetorical strategy or a concern in the rhetoric of Johnson and appears only minimally in Truman’s rhetoric.

To recap, the main characteristics of Clinton’s rhetoric are:

- The cross-cutting principle of ‘security’ which features in the ethos, pathos and logos of the speech and which unites all three elements in support for his healthcare reforms.
- Historical temporality as a strategy in logos that builds upon social policy successes such as Medicare and Social Security and creates a link between them and his proposed healthcare reforms.
- Moralization as a way to demonstrate the urgency of healthcare reform, discuss the human costs and injustices of the current healthcare system, and establish normative power.
- Personalization as a strategy that makes abstract issues more immediate and graspable and which add pathos to the ethos of communitarian solidarity and care and enables the strategic avoidance of explicit acknowledgment of structural inequalities and injustices facing disadvantaged Americans.
- The introduction of the ‘third way’ approach to healthcare reform which Clinton advances through strategies of defensive rhetoric and appropriation and through which he seeks to downplay ideological differences with conservatives and present himself and his policies as centrist and moderate, which is not present in Truman and Johnson’s rhetoric.

We will shortly see how Barack Obama expands on this ‘third way’ approach making bipartisanship and moderation even more central to his rhetoric than Clinton does.

Clinton's rhetoric is a marked departure from Truman and Johnson's. Markets are honored and deferred to more than government despite also being critiqued, and moral values such as justice, equality of opportunity, and communitarianism play a more muted role than in the rhetoric of Truman and Johnson, and especially that of Johnson. Clinton's rhetoric introduces a trope of pragmatic economic efficiency which dominates the speech and which we will shortly see is one of the most salient continuities – amongst several – between the rhetorics of Clinton and Obama which share so much in common both in persuasive style and in the moderate, mildly conservative policy implementation which they defend. Where Truman and Johnson pursued bold efforts to revise the moral order and social imaginary in a progressive way building upon the reforms of Roosevelt, Clinton and Obama chose to adjust the moral order and social imaginary incrementally, cautiously, and without liberal normative zeal. They reacted to the dominance of conservatism not with an equally impassioned and uncompromising liberal vision pursued antagonistically as an alternative to conservatism but with an appropriation of aspects of conservatism integrated alongside now somewhat weakened traditional liberal commitments to equal opportunity and communitarian social solidarity.

Chapter 8: Barack Obama's September 9, 2009 Healthcare Speech to Congress

Today, after almost a century of trying; today, after over a year of debate; today, after all the votes have been tallied, health insurance reform becomes law in the United States of America -- today...

I'm signing this bill for all the leaders who took up this cause through the generations, from Teddy Roosevelt to Franklin Roosevelt, from Harry Truman to Lyndon Johnson, from Bill and Hillary Clinton to one of the deans who's been fighting this long, John Dingell -- to Senator Ted Kennedy...

And we have now just enshrined -- as soon as I sign this bill -- the core principle that everybody should have some basic security when it comes to their health care. Today, I'm signing this reform bill into law on behalf of my mother, who argued with insurance companies even as she battled cancer in her final days.

I'm signing it for Ryan Smith, who's here today. He runs a small business with five employees. He's trying to do the right thing, paying half the cost of coverage for his workers. This bill will help him afford that coverage.

I'm signing it for 11-year-old Marcelas Owens, who's also here. Marcelas -- Marcelas -- Marcelas lost his mom to an illness, and she didn't have insurance and couldn't afford the care that she needed. So in her memory, he has told her story across America so that no other children have to go through what his family's experienced...⁵⁰⁷

8.1 Introduction

A primary objective of Obama's September 9 2009 speech to Congress on healthcare reform is to redefine the ethical and civic obligations of the American people to one another and of the American government to the American people, proposing a communitarian ethos of solidarity and care that includes all Americans – irrespective of income - and in so doing to legitimize his healthcare plan and its universal reach and guarantee.⁵⁰⁸ With this particular political emphasis Obama's speech reflects the “common and nearly universal function of rhetoric to rededicate common values as mutual commitment to each other's fortunes.”⁵⁰⁹ Obama's speech therefore seeks to transform excluded ‘others,’ into equals who become part of the American collective ‘us,’

⁵⁰⁷“Obama's Remarks at the Health Care Bill Signing,” *The New York Times*, March 23, 2010.

http://www.nytimes.com/2010/03/24/us/politics/24health-text.html?pagewanted=1&_r=0&ref=policy

⁵⁰⁸ For more on how Obama's rhetoric advances empathy in pursuit of solidarity see Robert E. Terril, “Unity and Duality in Barack Obama's ‘A More Perfect Union,’” *Quarterly Journal of Speech* 95 (2009): 365.

⁵⁰⁹ Stephen H. Browne, “The Circle of Our Felicities’: Thomas Jefferson's First Inaugural Address and the Rhetoric of Nationhood,” *Rhetoric & Public Affairs* 5 (2002): 415.

to propose a policy that transforms exclusion to inclusion, well-being, and equal dignity and in so doing revises the American moral order and social imaginary in an emancipatory way.

His speech is anti-agonistic, in the sense of focusing on creating unity and consensus and constituting a new political community with a shared ethical orientation. The speech shares this quality with the previous three speeches by Truman, Johnson, and Clinton we have analyzed, having noted, however, the willingness of Johnson to be more critical of antagonists to his healthcare and social reforms generally. Rather than highlighting the needs and realities of the most economically disadvantaged Americans who still cannot access healthcare as Truman and Johnson do, however, Obama defends healthcare reforms, which, as a matter of *policy*, are designed to include the most economically disadvantaged Americans, by *rhetorically* focusing on and giving voice to the American middle class and its healthcare vulnerabilities. This reflects continuity with Clinton's rhetoric, although Obama places even greater emphasis on the middle class.

The intended audience for this speech is the entire nation. Although it is an address to Congress, because it was broadcast nationally and widely reported in newspapers and throughout the media, it was one of Obama's most decisive moments to address the entire American people on the subject of healthcare reform. Unlike in the day long summit on healthcare with Republicans on February 25, 2010, in this speech Obama had no other interlocutors and commanded the full attention of the audience. He had complete control over the framing and discussion of healthcare because the speech was not a dialogue or negotiation, but a carefully constructed and highly self-conscious form of political address.⁵¹⁰ I analyze it because it is the most comprehensive speech Obama gave on healthcare reform at a critical juncture in his efforts to pass healthcare

⁵¹⁰ For more on the significance of the addressees of a presidential speech see, Sam Meyer, "The John F. Kennedy Inauguration Speech: Function and Importance of its 'Address System,'" *Rhetoric Society Quarterly* 12 (1982).

reform legislation in Congress that sets out in its entirety his detailed vision for the reforms and in so doing synthesizes politics and policy, in a paradigmatic way.

Obama's speech touches upon a great diversity of moral, economic and social issues – from the high financial costs of healthcare to the social costs that stem from bankruptcy due to healthcare costs and lack of universal guarantee of healthcare to all Americans. It also uses epideictic rhetoric, in that it actively champions Obama's virtues and depicts him as a leader of integrity who is worthy of the public's support, and who can be trusted to advance a politics of conciliation that defends the well being of all Americans. The ethos of bipartisanship and conciliation that he advances is grounded in a linguistic style and tone that is accommodating and affirming of differences of opinion,⁵¹¹ at a time when objective measures of political polarization in the United States amongst both citizens and members of Congress is at its highest since such data began to be collected.⁵¹²

Obama's epideictic rhetoric illustrates Sullivan's commentary on the way in which praise and blame can be used to influence an audience's commitment to a specific set of proposed values.

A successful epideictic encounter is one in which the rhetor, as a mature member of the culture, creates an aesthetic vision of orthodox values, an example of virtue intended to create feelings of emulation, leading to imitation. As such, epideictic rhetoric instructs the auditors and invites them to participate in a celebration of the tradition, creating a sense of communion.⁵¹³

⁵¹¹ Isabel Alonso Belmonte, Anna McBabe, and Daniel Chornet-Roses, "In Their Own Words: The Construction of the Image of the Immigrant in Peninsular Spanish Broadsheets and Freesheets," *Discourse and Communication* 4 (2010): 227, 230.

⁵¹² James Moody and Peter J. Mucha, "Portrait of Political Party Polarization," *Network Science*, 1 (2013).

Bipartisan Policy Center, "National Survey of Registered Voters Regarding Political Polarization," <http://bipartisanpolicy.org/library/research/national-survey-registered-voters-regarding-political-polarization>

Alan Abramowitz and Kyle L. Saunders, "Why Can't We All Just Get Along? The Reality of a Polarized America," *The Forum*, Manuscript 1076.

<http://www.dartmouth.edu/~govt/docs/Abramowitz.pdf>

⁵¹³ Dale Sullivan, "The Ethos of Epideictic Encounter," *Philosophy and Rhetoric* 26 (1993):118.

In so doing, the rhetor imagines a community and invites participation in it through support for his proposed policies. As we have discussed earlier, this community forms part of the social imaginary. The moral order, which is both informed by and constituent of the social imaginary has transitioned from one focused on the role of the government in realizing the social and economic rights that ensure the well being of citizens across a wide range of social domains to meet basic human needs to one that is narrower, focused on negative rather than positive liberty, predisposed to limiting government social programs rather than strengthening and expanding them and favoring the needs of the middle class over the most economically disadvantaged and marginalizing them within the social imaginary.

8.2 Dimensions of Rhetoric

In Obama's speech the logos dimension centers upon the principle of universal health insurance provision⁵¹⁴ without discrimination on the basis of economic resources (a guarantee of maximal equal opportunity to healthcare) and the resulting healthcare reform policy explication and justification. Ethos manifests itself as a communitarian call for solidarity with Americans who cannot afford healthcare and pragmatic morality to assist them, and a spirit of bipartisanship and conciliation.⁵¹⁵ Pathos manifests itself in the speech as emotions of personalized compassion which are predominantly generated through individual narratives that illustrate communitarian obligations to vulnerable and

⁵¹⁴Although the Affordable Care Act will not lead to completely universal coverage as explained earlier in the thesis, because it attempts to make coverage affordable and accessible to *all* Americans Obama argues for it and depicts it as a plan for guaranteed universal health insurance. Some Americans will choose to opt out of it, but have the possibility of coverage should they so desire.

⁵¹⁵On Obama's rhetoric of conciliation see David A. Frank and Mark Lawrence McPhail, "Barack Obama's Address to the 2004 Democratic National Convention: Trauma, Compromise, Consilience and the (Im)possibility of Racial Reconciliation," *Rhetoric and Public Affairs* 8 (2005): 589. For more on the rhetoric of recognition see Barack Obama's Speech on Race. http://www.nytimes.com/interactive/2008/03/18/us/politics/20080318_OBAMA_GRAPHIC. See also Robert C. Rowland and John M. Jones, "Recasting the American Dream and American Politics: Barack Obama's Keynote Address to the 2004 Democratic National Convention," *Quarterly Journal of Speech* 93 (2007).

disadvantaged citizens. Other emotions Obama evokes consist of indignation in the face of suffering and injustice and feelings of anxiety related to healthcare insecurity and emotions of comfort and calm resulting from Obama's promise to address healthcare insecurity. This chapter will discuss how logos, ethos, and pathos, are applied in the speech and analyze the way in which they highlight the signifier of the middle class, analyze how they are situated and interact with one another and where they overlap, and examine the overall effect their usage has on the persuasive power of the speech and its revision of the moral order and American social imaginary.

To articulate the three strands of logos, ethos, and pathos Obama relies principally on five rhetorical strategies which each contribute to the overarching goal of legitimizing his healthcare reform efforts. These strategies are used with particular ends: to summon the middle class as the focal point of the social imaginary and to create communitarian social solidarity. These strategies – which will be examined in the forthcoming sections of the chapter – are:

- moralization and moral muting highlighting the need for greater social solidarity to enable healthcare reform and downplaying conservative disavowals of such solidarity with associated use of implicit and explicit language. (Ethos)
- historical temporality in which history is used as a way of framing aspirations for social change and greater social solidarity. (Ethos and Logos.)
- recognition of conservative values and their selective appropriation which conveys values of moderation, conciliation, and bipartisanship. (Logos.)
- anticipatory and defensive rhetoric pre-empting well known conservative arguments which enable Obama to depict his healthcare reforms plans as respecting conservative values rather than undermining them. (Logos.)

- personalization in which narratives of individuals are used to illustrate the importance and urgency of healthcare reform and to generate empathy and social solidarity. (Pathos.)

Three of these five rhetorical strategies are applied to generate the symbolic apparatus to appeal to the middle class by both invoking them and directly appealing to them.

Moralizing and moral muting enable Obama to call for social solidarity grounded primarily in concern for the welfare of middle class Americans by highlighting their vulnerabilities and disadvantage while acknowledging that many middle class Americans support conservative priorities of maximizing individual choice and preserving free markets with minimal government interference. Historical temporality invokes social policies such as Social Security and Medicare which have become staples of middle-class American life and guarantors of middle-class quality of life, preventing Americans from falling into poverty and guaranteeing them economic and health security.⁵¹⁶ Finally, personalization enables Obama to tell the stories of middle class Americans and their struggles to make ends meet financially while maintaining their health and some form of health insurance.

Some of these strategies are directly linked or intertwined. Historical temporality, for example, is often accompanied by and/or incorporates anticipatory rhetoric. Recognition of conservative values is often accompanied by moral muting that downplays the role of conservatives in rejecting the principle of universality of health insurance. Some of the strategies can be found applied across the domains of logos/ethos/pathos and are not limited to only one of them. Historical temporality has a

⁵¹⁶ Laura Katz Olson describes Social Security and Medicare as ‘national safety net programs for the middle class...’ Laura Katz Olson, “Medicaid, the States, and Health Care Reform.” *New Political Science* 34 (2012): 38.

It should be noted, however, that both programs also help the economically disadvantaged and are critical social safety nets for them.

central role to play in the logos of the speech which depicts Obama's healthcare reform as a logical follow-up to Social Security and Medicare. But it is equally essential to Obama's illustration of the historical policy actualization of increasing social solidarity which addresses ethos. Personalization is applied in expressions of ethos and pathos but not found in logos. Before examining how each of these strategies is employed in the speech we will consider the speech's political context.

8.3 Political Context

Obama campaigned vigorously as a presidential candidate on a platform that highlighted the importance of expanding access to healthcare and making it more affordable. In the first year of his presidency healthcare reform was the first major political policy struggle he faced. Republicans were overwhelmingly hostile to both its aims and content, rejecting the principle of near-universality and the extension of health insurance to the overwhelming majority of Americans and opposing a government role in implementing this effort. This was primarily a result of a combination of political ideology that had grown extreme and rigidly dogmatic and out of political strategy to minimize the ability of Democrats to pass legislation,⁵¹⁷ a recurring Republican response to healthcare reform efforts since the Reagan era, as we explored in Chapters 1 and 2. Consequently, this speech, while focused on the specific policy matter of healthcare reform also speaks to larger moral and philosophical differences between Democrats and Republicans which were crystallized and came to a head in the healthcare reform debate and reflected differences in the liberal and conservative iterations of the American social imaginary and its underlying moral order.

⁵¹⁷ For more on gridlock, ideological intransigence, and dysfunction in American politics and government during the Obama administration see Iwan Morgan and Philip John Davies, *Broken Government? American Politics in the Obama Era*, (London: Institute for the Study of the Americas, 2012.)

Obama's efforts came at an important historical juncture of over 60 years of failed efforts to expand healthcare to cover the vast majority of Americans. Although Bill Clinton had prioritized healthcare reform, his plan failed to win passage. Since that failure, the number of Americans without health insurance and with insufficient insurance continued to climb at a high rate, with rising bankruptcies as a result of increasing healthcare costs.⁵¹⁸ Healthcare costs continued to outpace inflation and were demanding larger and increasingly unsustainable spending on the part of both the government and American citizens.⁵¹⁹ As Chapter 1 of the thesis illustrated, the social costs of inadequate healthcare are tremendously high, leading to increases in premature death, disease, poverty, and family dysfunction.⁵²⁰ Obama was determined to address these issues which were getting increasingly grave with the passage of a single and comprehensive healthcare reform bill. It would address the need for affordable and/or subsidized healthcare for all Americans irrespective of income, and in so doing begin to ameliorate the aforementioned social deterioration that resulted from the lack of such healthcare provision.

8.4 Speech Structure: Overview

Throughout the speech there is a strong effort to disentangle healthcare reform from ideology, to depoliticize the issue and address it from a pragmatic perspective that is morally informed but that presents itself as unsectarian. Although Obama's political and rhetorical strategy can be compared with Clinton and Blair's 'third way' it is also unique and quite unlike it in the way it champions compromise as a political and moral value itself rather than merely a concession to pragmatism and bridging political divisions. The speech never settles on one central rhetorical thread, instead weaving a

⁵¹⁸ See Chapter 1.

⁵¹⁹ Ibid.

⁵²⁰ See Dean E. Robinson. "US Health and Health Care: Does Political Inequality Make Us Sick?" *New Political Science* 29 (2007): 529-534.

multidimensional narrative with imbricated language that circles back on itself rather than pursuing a discreet linear thematic progression.⁵²¹

Structurally, the speech can be divided roughly into four parts in which certain themes overlap and repeat themselves, developing in tandem. The first part discusses the difficult economic position of the United States, preparing the groundwork for the major place economic savings and efficiency will have in the speech – one of the key components of the *logos* of the speech and the place of deideologization within it.⁵²² Anecdotes about individuals experiencing the injustice of inequitable access to healthcare are used, invoking *pathos* and reflecting a strategy of personalization. Short statements of moral judgment on these injustices are made, establishing *ethos*. There is a brief historical commentary on previous failed attempts to pass healthcare reform, reflecting a strategy of historical temporality. Its *logos* develops as a series of arguments in favour of healthcare reform and universal health security based on an implied moral argument that it is wrong to leave tens of millions of Americans uninsured and underinsured, an explicit pragmatic argument about the unsustainability of rising healthcare costs which make healthcare prohibitively expensive for vast numbers of Americans, and finally, pragmatically notes the unsustainability of the gap between tax revenue and government expenditure on healthcare in which expenditure keeps climbing while tax revenue fails to keep up.

The speech then turns – having established a tripartite definition of the problem – in the second section, to how to address these difficulties.⁵²³ Here Obama provides

⁵²¹ Obama's rhetorical style can also be classified as 'contrapuntal' – in that it produces persuasive effects through its combinations of arguments and the way in which it synthesizes differing principles and ideas.

Frank Myers, "Harold Macmillan's 'Winds of Change' Speech: A Case Study in the Rhetoric of Policy Change," *Rhetoric and Public Affairs* 3 (2000): 558.

⁵²² Obama, 373-374

⁵²³ Obama, 374-376.

descriptions of single-payer systems like Canada's and a comprehensive market-based system in which all Americans would buy health insurance on a market. These are two extremes offered by the left and right, respectively and Obama uses them as polarized arguments to knock down to establish his credibility as a moderate. Rejecting both, Obama advances his distinctive ethos of moderation, describing the perils of partisanship and sectarianism. This section focuses intensely on *logos*, addressing the practical details of Obama's healthcare plan, how it will impact Americans, the changes it will require and the systems that will remain unchanged.

The third section returns to the subject of partisanship but in this section Obama confronts political adversaries more directly and seeks to hold them accountable for their false accusations against his healthcare plan, employing a strategy of moralization.⁵²⁴ He then explains why his plan incorporates both liberal and conservative values, is intrinsically moderate, and will not harm the interests of the American people, reflecting a strategy of recognition and selective appropriation of conservative values. He focuses on policy details and justifying why his healthcare reform plan is economically viable, will not raise the deficit, will not harm seniors, is affordable, and will protect both Medicare and Medicaid, reflecting a strategy of anticipatory and defensive rhetoric. In this section Obama emphasizes *logos*. *Pathos* however is briefly employed in his attacks on conservative opponents.

The fourth and final section achieves a moral and emotional apex in which *pathos* and *ethos* take center stage and in which each of the five rhetorical strategies are employed.⁵²⁵ Obama comprehensively and explicitly addresses the American social imaginary and its moral order, presenting his vision for healthcare reform as the

⁵²⁴ Obama, 377-380.

⁵²⁵ Obama, 380-382.

fulfilment of a more just and inclusive social imaginary and moral order than has been achieved by the United States prior to this time. Obama speaks about Edward Kennedy's concern for healthcare reform reflecting a strategy of personalization and moralization. He emphasizes the moral demands of democratic citizenship and the importance of communitarian social solidarity while continuing to weave into his arguments messages of bipartisanship and conciliation to reaffirm his ethos. As in the very beginning of the speech Obama employs a strategy of historical temporality, saluting the earlier social policy successes of Medicare and Social Security. The logos of this section positions Obama as a leader who will enable Americans to come together to create a healthcare system that advances an American ethos of freedom, equality, and justice while respecting American preferences for maximizing free markets and individual choice, reflecting a strategy of recognition and appropriation as well as anticipatory and defensive rhetoric. It defends a legitimate role for government but not an excessive one and urges respect for the responsibility the government has to advance these values and preferences. Obama calls on Americans to show empathy for their co-citizens and to support healthcare reform that will ensure all Americans security and dignity and in so doing revise the social imaginary to be more inclusive. The speech concludes on a hopeful and confident note, urging unity of vision and purpose to enable a more just system of healthcare and culminating in the pathos of patriotic fulfilment of shared identity and concurrent mutual obligation.

We will turn to the text to examine Obama's logos and the rhetorical strategies he uses to advance it. I begin my analysis with logos because of the three categories of logos, ethos, and pathos logos is the most prominent in Obama's speech. I consider the role of logos in the speech because it provides the overarching argument for healthcare reform on the basis of universal provision and it sets the groundwork for the ethos and

pathos of the speech in which defense of the principle of universal healthcare security is associated with discourses of social solidarity and conciliation. I follow my analysis of the logos of the speech with an analysis of its ethos because it articulates the key moral argument that frames logos: the communitarian argument for social solidarity and the principle of equal opportunity. I regard pathos as subordinate to ethos, in that Obama invokes personalized compassion for individuals lacking sufficient health insurance so as to support his communitarian argument for social solidarity. The two key sections on logos and ethos, therefore, are each divided into three and four sub-sections, respectively. The first sub-section in logos addresses the place of the signifier 'middle class' within the rhetoric and how this relates to the logos of the speech and to the intrinsic moral and social compromise that the speech advances in which the economically disadvantaged are largely rhetorically marginalized. This is then followed by further sub-sections which address particular rhetorical strategies, their aims, and effects. The first two sub-sections in ethos address the rhetorical strategies Obama applies to illustrate his ethos. The third sub-section focuses on the role of pathos within Obama's evocation of ethos. This is followed by a fourth sub-section discussion which synthesizes observations of how ethos manifests itself in the speech, its focus on middle class well being, and its expansion of the American social imaginary to encompass Americans lacking health insurance.

8.5 The Logos of Healthcare Reform: Protecting the 'Middle Class' and Promoting the Principle of Universality

The 'middle class' is a signifier Obama uses to advance the principle of universal health insurance for all Americans, (including the poor) which stands in contrast to the Republican usage of the 'middle class' in which no entitlement to health insurance is

implied and from which the needs of the poor are excluded as a result of the common conservative argument that casts aspersions on the poor and depicts as wasteful government programming that addresses their needs. This pejorative discourse was not prevalent amongst Republicans until the Reagan era, when Reagan introduced character assassination against individuals receiving welfare support from the government, and in particular African-American women, who receive welfare benefits depicting them as lazy, dependent, unlawful, immoral, and unworthy of government assistance.⁵²⁶ We will shortly examine the specific rhetorical strategies Obama applies in relation to logos to use the middle class signifier as a way to articulate a defense of healthcare for *all* Americans.⁵²⁷

The focal point of Obama's logos is the need for security⁵²⁸ for all Americans, but especially middle-class Americans. Because 'middle-class' is the most benign and universally respected signifier in American political discourse considered a common sense term of intuitive understanding that does not require a fixed, explicit definition – as discussed earlier in the thesis - Obama frequently wields it to justify his healthcare reform and establish credibility with the overwhelming majority of Americans who perceive themselves and publicly identify as being 'middle-class.' Describing his healthcare reform plan Obama states,

⁵²⁶For Reagan's comments see pages 63-65 of the thesis.

⁵²⁷ A recent *New York Times* editorial, entitled, "The Untouchables" notes how profoundly the poor have been effaced from presidential discourse.

"The Untouchables," *New York Times* Editorial, *The New York Times*, October 3, 2012.

http://www.nytimes.com/2012/10/04/opinion/the-untouchables-on-the-campaign-trail.html?partner=rssnyt&emc=rss&_r=0

⁵²⁸ By which Obama means a combination of health security – the knowledge that one will receive sufficient and high quality medical treatment if one gets sick and economic security – the knowledge that receiving such treatment will not lead to impoverishment.

It will provide more *security and stability* to those who have health insurance. It will provide insurance to those who don't. And it will slow the growth of health care costs for our families, our businesses, and our government.⁵²⁹

'Security and stability' are key references entailing both pragmatic and moral arguments and are fundamental to the overall logos of the speech. As discussed in the chapters on Truman and Clinton's speech, 'security' has long been a signifier in political rhetoric for government guarantee of citizen welfare since Roosevelt created the Social Security program, a major guarantor of middle class economic achievement and stability.

The commitment to provide insurance to those who cannot afford it because they are economically disadvantaged – including the poor and not only the middle class - is fundamental to the logos of Obama's healthcare reform. Although Obama never explicitly defends a *right* to healthcare as Truman does as an anchoring moral argument for his logos – by providing government guarantee of it Obama's healthcare reform enables a policy consequence that in practice simulates the claims of a legally recognized right but that rhetorically obviates the need to argue with conservatives over the legitimacy of government provision for the economically disadvantaged. The promise to lower healthcare costs is significant in that Obama shows concern for diverse constituents in American society by delineating 'families, businesses, and our government,' rhetorically balancing concern for families (a liberal priority) with concern for business and for limiting government expenditure (conservative concerns.) This is a pragmatic argument which also reflects Obama's ethos and its insistence that all Americans, from every sector of society, have a stake in and a role to fulfil in the context of healthcare reform.

It's a plan that asks *everyone* to take responsibility for meeting this challenge – not just government and insurance companies, but employers and individuals. And it's a plan that incorporates ideas from Senators and Congressmen; from

⁵²⁹Obama, 375.

Democrats *and* Republicans – and yes, from some of my opponents in both the primary and general election.⁵³⁰

The use of the word ‘everyone’ has two major effects: it demonstrates Obama’s position as a leader who does not take a sectarian position in this debate but who holds all individuals and groups equally accountable and who reconciles political differences.

Obama’s emphasis on incorporating the perspectives of diverse American constituents allows him to implicitly convey epideictic self-congratulation for his own open-mindedness and willingness to compromise by crediting political opponents with contributions to his healthcare reform bill. It also enables Obama to legitimize the principle of universality by advancing a parallel argument about how the healthcare reforms he proposes will not only practically benefit all Americans but will incorporate the perspectives, concerns, and responsibilities of all Americans. By showing respect for different types of Americans this allows Obama to normalize the principle of universality which is central to the logos of his reforms. Such pre-emptive normalization seeks to undermine conservative Republican efforts to create wedges between Americans of different economic backgrounds and to denigrate those economically disadvantaged Americans without access to health insurance or with access to low quality and insufficient health insurance and deny them healthcare coverage, reflecting a strategy of anticipation and defence.

Obama illustrates the need for his healthcare plan by depicting the challenges some Americans currently face acquiring sufficient health insurance.

But the problem that plagues the health care system is not just a problem of the uninsured. Those who do have insurance have never had less *security and stability*

⁵³⁰Ibid.

than they do today. More and more Americans *worry* that if you move, lose your job, or change your job, you'll lose your health insurance too. More and more Americans pay their premiums, only to discover that their insurance company has dropped their coverage when they get sick, or won't pay the full cost of care. *It happens every day.*⁵³¹

This passage refers primarily to middle-class Americans who generally have jobs which offer sufficient compensation to provide health insurance as one component of work benefits. (Something which many working class Americans, in the retail and food service industry for example, often lack because their employers would rather not provide costly health insurance benefits.⁵³²) Obama's use of the word 'worry' and other negative words such as 'lose' which he states twice and 'sick' and his explanation for why Americans worry introduces emotions of fear, anxiety, and insecurity to his logos – emotions which any audience finds hard and unpleasant to sustain without promise of release and relief. This is exactly what Obama seeks to provide by arguing that his healthcare reform policy will do away with the conditions that cause worry, insecurity, and anxiety in relation to healthcare insurance and provision – especially as these are commonly experienced by middle class Americans.

Because Americans tend to migrate for work purposes within the boundaries of the United States much more frequently than citizens of other industrialized countries migrate domestically,⁵³³ the concern Obama raises of becoming uninsured as a result of moving or changing jobs is likely to resonate for many Americans, particularly the middle

⁵³¹Obama, 374.

⁵³² Small businesses, unlike large fast food chains and other large businesses have genuine concerns about the extremely high cost of purchasing health insurance for their employees. This is because small businesses do not have the same bargaining power with insurers as large companies, which can negotiate with insurers to provide them with health insurance for their employees that is reasonably priced and unlikely to harm the company's sustainability and profits.

⁵³³ "The Road Not Taken," *The Economist*, March 19, 2009.

<http://www.economist.com/node/13331109>

'History of Labor Turnover in the US.' <http://eh.net/encyclopedia/article/owen.turnover>

European Foundation for the Improvement of Living and Working Conditions. "Labour Mobility in a Transatlantic Perspective: Conference Report, Dublin, 30-31 October, 2000."

<http://www.eurofound.europa.eu/pubdocs/2008/26/en/1/ef0826en.pdf>

class who participate in this employment driven mobility. The final sentence, “It happens every day” serves to affirm that what Obama is describing is not unusual and abstract but a common reality. The use of the phrases “It can happen to anyone” and “It happens everyday” convey a sense of urgency, universal significance, and shared vulnerability which must be addressed to ensure the welfare of Americans as a whole, and not merely to ensure the welfare of the most economically disadvantaged Americans who are uninsured or underinsured. Providing further exposition of the need for his healthcare reforms Obama states,

There are now more than thirty million American citizens who cannot get coverage. In just a two year period, one in every three Americans goes without health care coverage at some point. And every day, 14,000 Americans lose their coverage. *In other words, it can happen to anyone.*⁵³⁴

Obama has distilled the importance of healthcare reform to common vulnerability: because it can happen to anyone it is in the interest of every American to support it.⁵³⁵ In so doing, Obama has once again affirmed the principle of universality which is fundamental to his reforms. The logos of his speech creates the framing of the term ‘middle class’ to have a universal connotation both in its practical and ethical appeal and in the expansiveness of the audience which it seeks to address. It transcends party and ideology, avoids articulating the needs and realities of stigmatized disadvantaged Americans, and provides a strong pragmatic basis for healthcare reform which, though to soon be accompanied by an ethical one, is logically sufficient to make the case for Obama’s proposed healthcare reforms. We will now consider the specific rhetorical strategies Obama uses to advance the logos of his speech.

⁵³⁴ Obama, 373.

⁵³⁵ As a prudential argument, however, this need not be interpreted as a narrow appeal to selfishness. Obama spent several years as a community organizer and one of the techniques for creating community solidarity and organization is encouraging individuals to come together in pursuit of their self-interest. When individual self-interest merges and becomes collective self-interest community organizing often is able to create power and social change.

8.5.1 Logos: Conveying Concern for the Middle Class with Strategies of Moralizing/Moral Muting and Historical Temporality

In the logos of the speech Obama applies strategies of moralizing and moral muting, historical temporality, anticipatory and defensive rhetoric, and appropriation, which we will discuss in turn. A very large portion of the speech is devoted to the details of Obama's policy and to explaining its rationale, method of functioning, and the ways in which it will meet the needs of a diverse range of constituents so as to defend its value and necessity to the American public and how it provides equal healthcare opportunity for all. A key example of this is Obama's illustration of how the only feasible way to make healthcare affordable is by pooling risk and having a diverse and large group of people covered by insurance so that, in effect, the healthy subsidize the sick and in time, when the healthy suffer from sickness they can count on affordability of healthcare because of this system of mutual support. Commenting on individuals who choose not to buy health insurance – many of whom are young and generally healthy – Obama applies a strategy of moralizing into his policy explication.

The problem is, such *irresponsible* behavior costs all the rest of us money. If there are affordable options and people still don't sign up for health insurance, it means we pay for those people's expensive emergency room visits. If some businesses don't provide workers health care, it forces the rest of us to pick up the tab when their workers get sick, and gives those businesses an *unfair* advantage over their competitors.⁵³⁶

These words, “irresponsible” and “unfair” reflect the strategic use of moralization in an otherwise mechanistic policy explication. These moral signifiers give normative power to Obama's healthcare reform efforts. But, even as Obama applies a strategy of moralization, he anchors it within a pragmatic rhetorical strategy. He explains that in his plan, all Americans will be required to buy health insurance, because that is the only way

⁵³⁶Obama, 376.

to insure all Americans, and, consequently, ensure fairness so that all Americans, irrespective of income, have access to healthcare. He illustrates this by pointing out its common-sense and better known counterpart – the legal requirement that most states enforce for all drivers, that they must carry auto insurance. And he explains that businesses will be required to offer health insurance to their workers or at least contribute to the costs of healthcare. For individuals who cannot afford to purchase healthcare the government will subsidize it, a key component of the universalistic ethos of the plan. Gentle moral critique and establishment of parameters of ethical decency and practical necessity take centre stage, “...we cannot have large businesses and individuals who can afford coverage game the system by avoiding *responsibility* to themselves or their employees. Improving our health care system only works if *everybody* does their part.”⁵³⁷ The keyword of ethical critique, ‘responsible’ appears here highlighting the ethical component of Obama’s logos and warning against abdication of responsibility which harms society as a whole and creates obstacles to decent healthcare coverage for tens of millions of Americans.

There are several vital policy components to the logos of the healthcare plan which Obama carefully delineates applying a strategy of moralization as these reflect the principle of universality and concern for the most disadvantaged and they address current injustices plaguing the healthcare system around issues of discrimination, access, and affordability. These are the prohibition on insurance companies on denying coverage to individuals with pre-existing conditions, dropping coverage when individuals get sick, and the placing of arbitrary caps on the amount of healthcare coverage an individual can enjoy over his lifetime. Obama reflects concern for the high costs of healthcare by affirming that, “We will place a limit on how much you can be charged for out-of-pocket

⁵³⁷Ibid.

expenses.”⁵³⁸ Finally, after this list of policies he makes an emotionally passionate and uncompromising statement of high modality and normative firmness, stating, “because in the United States of America, no one should go broke because they get sick.”⁵³⁹ This yields the effect of conveying rhetorical power and justifying the logos of healthcare reform through a revision of the moral order of the American social imaginary.

Like Johnson and Clinton, Obama uses a rhetorical strategy of historical temporality to situate his argument in the historical context of failed attempts to reform healthcare to extend it to all Americans – but especially and explicitly to the middle class - and to underline the urgency of finally addressing the issue in the face of the Republican preference to maintain the status quo. His argument for why it is a breaking point is primarily pragmatic.

Our collective failure to meet this challenge – year after year, decade after decade – has led us to a breaking point. Everyone understands the extraordinary hardships that are placed on the uninsured, who live every day just one accident or illness away⁵⁴⁰ from bankruptcy. These are not primarily people on welfare. These are middle-class Americans. Some can't get insurance on the job. Others are self-employed, and can't afford it, since buying insurance on your own costs you three times as much as the coverage you get from your employer.⁵⁴¹

To convey the long history of attempts to pass healthcare reform and situate himself as the President who will decisively break with a history of failure, Obama notes that the first such effort was initiated by Theodore Roosevelt, almost 100 years ago and that since 1943 a comprehensive healthcare reform bill has been introduced, but never passed, in each congressional session. Obama employs implicit and explicit rhetoric to strike a

⁵³⁸ Obama, 375.

⁵³⁹ Ibid.

⁵⁴⁰ This passage includes extensive language that evokes pathos in the sense of emotional anxiety in the face of vulnerability faced by uninsured, underinsured, and impoverished Americans who cannot afford healthcare. Although Obama is focusing here on their practical problems in so doing he is also emotionally evoking sentiments of vulnerability and inspiring the possibility of compassion and solidarity. We will explore this further as we discuss the role of ethos and pathos in the speech.

⁵⁴¹ Obama, 373.

balance between generating moral normative force and dissipating any of the potential harshness and partisanship it may trigger. He goes on to berate politicians, in which he implicitly includes himself, for this lack of traction and he then illustrates the resulting harsh social consequences. Here Obama employs a logos of exposition which builds on the notion of an error which *all* have made, irrespective of party and political philosophy, which needs to be urgently corrected.

Obama's use of the words 'our' and 'collective' reflects the strategy of moral muting and his bipartisan rhetorical style which strives not to place moral responsibility with any one particular political party/actor as this – if not offset with equal criticism of the opposing party/actor for balance – upsets his rhetoric of conciliation. Historically, however, the failure has not been a collective one in which both parties share equal or even similar responsibility, as was examined in Chapters 1 and 2. It has been a failure primarily of one party, the Republican Party, which has largely been antagonistic to healthcare reform committed to the principle of universality or near-universality. With his use of the word 'collective,' Obama rhetorically revises political history in a way that enables him to avoid confrontation with the asymmetry between Democratic efforts to create universal health insurance and Republican rejections of such attempts. In downplaying Republican efforts against universal health insurance to support his ethos of bipartisanship and conciliation which often strategically overlooks real policy and ethical disagreements between Democrats and Republicans, Obama sacrifices historical accuracy and undermines political accountability.

The two thematic focal points for the logic of the argument in the aforementioned passage are economic and social and relate to the vulnerability of Americans citizens without quality, comprehensive, affordable healthcare. Obama has chosen to open his speech with a criticism of how insufficient health insurance leads

many Americans to bankruptcy. This is indeed one major motivator for healthcare reform but it is not the primary one. Those Americans who have some health insurance – however lacking in quality and affordability – are surely better off than those with none at all. But those with some health insurance are likely to be perceived as middle-class, and, as discussed earlier, more sympathetic to the average American listener to Obama’s speech. Furthermore, he explains a major problem that sick Americans and Americans with a pre-existing condition face. “Many other Americans who are willing and able to pay are still denied insurance due to previous illnesses or conditions that insurance companies decide are too risky or expensive to cover.”⁵⁴² The next sentence is significant because although it is a statement of fact, “These are not primarily people on welfare”⁵⁴³ it also has immense rhetorical power and is an attempt to undermine the psychological and rhetorical framing of the healthcare debate. It reclassifies efforts to expand healthcare away from the image in the popular imagination of providing subsidized care for the popularly perceived ‘undeserving poor’⁵⁴⁴ and instead emphasizes the fact that lack of access to healthcare is primarily a problem for middle-class Americans.

By taking up this argument and characterizing Americans lacking health insurance as middle-class Obama has introduced a new logic separate from one based on justice: it is wrong that middle-class people should be barred from the standards of middle-class life. Here Obama is making a practical argument based on popular conceptions in the American social imaginary of entitlement rather than communitarian solidarity with and concern for those with moderate incomes. While a substantial portion of Americans may not consider the poor or lower-middle class to be ‘deserving’ of

⁵⁴²Obama, 373.

⁵⁴³ Ibid.

⁵⁴⁴ For more on the marginalization of the poor and their stigmatization in American political rhetoric and public policy see James A. Morone, “Enemies of the People: The Moral Dimension to Public Health,” *Journal of Health Politics, Policy and Law* 22 (1997). Also see, Bob Herbert, “Misery with Plenty of Company,” *New York Times*, January 7, 2011. <http://www.nytimes.com/2011/01/08/opinion/08herbert.html?hp>

government guaranteed access to affordable healthcare,⁵⁴⁵ there is little disagreement that the very basic and near universal aspiration to achieve at least middle-class status in America comes with an accompanying promise of social security which intuitively includes access to healthcare.

Obama's rhetoric of conciliation, however, comes at a cost both in the quality and totality of its truth telling about America's social reality and the history of efforts to expand healthcare insurance provision. It reflects the moral logic of a reformist political project that is constrained by dominant social norms such as the near effacement of the working class and poor from the American social imaginary and the insistence on framing moral values and social solidarity in relation to the needs of an imagined and idealized middle-class. In this regard Obama's rhetoric does not overtly and explicitly champion the most disadvantaged. Rather, it does so obliquely and without affording them the dignity of full acknowledgment and articulation. Moral muting enables Obama to gingerly address tangentially the depth of structural injustices faced by specifically working class and economically disadvantaged Americans in securing quality, accessible, affordable health insurance. Recognition of conservative values and anticipatory and defensive rhetoric pre-empting conservative arguments also play an important role in advancing the marginalization of the working class and economically disadvantaged from the speech as they align themselves with conservative concerns with addressing the needs of the middle-class and often the wealthiest of the middle class. This reflects the conciliatory compromise which informs the content of the speech as a whole and

⁵⁴⁵ For more on Medicaid and other social welfare and healthcare support programs for the most economically disadvantaged Americans, and their underfunding, see David G. Smith, "Entitlement Politics: Medicare and Medicaid 1995-2001," (New Jersey: Aldine Transaction, 2002.) Also see Laura Katz Olson, *The Politics of Medicaid*, (New York: Columbia University Press, 2010.) See also David G. Smith and Judith D. Moore, *Medicaid: Politics and Policy, 1965-2007*, (New Jersey: Transaction Publishers, 2010).

maintains a tightly calibrated balance between liberal and conservative values. We will now proceed to examine the role of conservatism in Obama's logos.

8.5.2 Logos: Conveying Moderation through Strategies of Anticipatory and Defensive Rhetoric and Appropriation of Conservatism

Obama anticipates accusations that he is 'anti-business' and antagonistic to free markets by tempering his criticism of the unsustainability of the health insurance system which discriminates against the sick by qualifying his critique and depicting and rationalizing the problem mechanistically, as the reasonable pursuit of profit.

Insurance executives don't do this [discriminate against the sick and people with pre-existing conditions which may predispose them to disease and disability] because they are bad people. They do it because it's profitable. As one former insurance executive testified before Congress, insurance companies are not only encouraged to find reasons to drop the seriously ill; they are rewarded for it. All of this is in service of meeting what this former executive called 'Wall Street's relentless profit expectations.'⁵⁴⁶

Here Obama applies the strategy of moral muting by neutrally explaining the logic of such predatory and exclusionary pricing and defending the individuals who carry it out and yet – implicitly – he is simultaneously critiquing the perverse incentives unregulated capitalism incentivizes and enables which inspire insurance executives to discriminate against the sick and those predisposed to illness. Thus he is able to separate out moral and economic logic and to say two contradictory things simultaneously – one of which is the inversion of the other. *Explicitly*, he expresses sympathy for insurance executives and defends them as being decent people just trying to reasonably profit and make a living. *Implicitly*, however, he is morally critiquing these actions, their justness, and their practical consequences. In so doing he espouses a logic that annihilates moral agency and moral responsibility on the part of the insurance executives. This prevents him from appearing

⁵⁴⁶Obama, 377.

to be antagonistic to free markets. Obama has strategically removed the pathos of indignation in the face of injustice in order to advance conciliation and moderation. But by rendering insurance executives and businesspeople blameless Obama's rhetoric betrays a certain logical coherence and ethical integrity.

The most potent criticism in Republican conservative rhetoric against Obama's healthcare plan is the claim that it entails government overreach in the provision of healthcare and determination of its quality. Anticipating these criticisms and appropriating conservative values, Obama affirms his commitment to the principle of maximizing the diversity of healthcare insurance plans available to the public – a value strongly held by conservatives but one that Truman similarly espoused: “My guiding principle is, and always has been, that consumers do better when there is choice and competition.”⁵⁴⁷ Obama goes on to offer justifications of his plan – clarifying that it will actually use the power of government regulation to open markets and break monopolies – an aim to which conservatives will be sympathetic because monopolies harm free market competition. He explains the logic behind his healthcare policy, noting that there is a severe shortage of competition amongst private insurers in the US with 75% of the insurance market controlled by only five companies and in some states, such as Alabama, just one company controls 90% of the market – driving up the cost of healthcare and lowering its quality. It also, he notes, enables health insurers to systematically discriminate against the sick and people with pre-existing conditions and to over charge them.⁵⁴⁸ He further adopts a rhetoric of recognition and appropriation - stressing cost-consciousness associated with the conservative philosophy of limited government⁵⁴⁹ and its disdain for government waste. He notes that his healthcare reform plan will reduce

⁵⁴⁷ Ibid.

⁵⁴⁸ Obama, 377.

⁵⁴⁹ Though, to be sure, this is a concern of liberals as well although rhetorically and in policy conservatives generally place a greater emphasis on reducing government waste. Since the Reagan era what was initially a largely a Republican conservative trope has been firmly adopted by Democrats.

waste and inefficiency in Medicare and Medicaid, raise revenue from insurance companies who will now insure tens of millions of more people, and raise revenue by charging insurance companies a fee for their most expensive policies.

Beyond the adoption of conservative philosophy in defense of the specifics of his healthcare reform, Obama also appropriates it in the final section of his speech that focuses on patriotism and solidarity.

One of the *unique* and *wonderful* things about America has always been our *self-reliance*, our *rugged individualism*, our *fierce defense of freedom* and our *healthy scepticism* of government. And figuring out the appropriate size and role of government has always been a source of *rigorous* and sometimes angry debate.⁵⁵⁰

By referring to self-reliance, individualism, freedom, and scepticism of government as positive things Obama vigorously praises values often associated with conservatism, and in so doing, presents himself as sympathetic to these values and frames them not only as conservative values but as transcendent, American ones fundamental to the American social imaginary. This ultimate rhetorical act of Obama's at the end of his speech is the culmination of the logos of appropriation and moderate revision of conservatism that permeates the entire speech. We will now examine the role of ethos in the speech.

8.6 Ethos: Communicating Conciliation through Moral Muting and Conveying Leadership and Integrity by Moralizing

To advance his ethos of bipartisanship and conciliation and neutralize opposition Obama advances justification of his healthcare reform through the rhetorical strategy of moral muting which downplays moral issues and therefore blurs the distinction between moral and pragmatic⁵⁵¹ arguments and the principles that inform them, a discursive

⁵⁵⁰Obama, 380.

⁵⁵¹See Chapter 1 on theory for more on pragmatic/prudential arguments.

enthymematic style.⁵⁵² Eliding matters of agency and responsibility obviates the need to ‘take sides’ and name and hold to account the violators of moral principles which his speech champions which could create political tension and potentially invite ideological division which would undermine the chances of passing his healthcare reforms. This allows him to maintain an overall tone of conciliation, with occasional and significant ruptures in that tone – strategically situated at specific moments when Obama speaks in a more confrontational manner to make uncompromising moral arguments with high modality.

To aid in this effort, Obama uses a mixture of transitive and intransitive language, particularly when discussing morally charged issues. One consistent and fairly uniform linguistic aspect of his rhetoric, however, is the rhetorical strategy of moralizing which is expressed through high modality when discussing matters of ethos: the importance of bipartisanship, honesty, and civility - topics on which Obama is uncompromising and consistent.⁵⁵³ Obama uses hedging and low modality in the context of acknowledging differences of opinion about practical ways of *implementing* universal health insurance and thus demonstrating his pragmatism and accommodating orientation. However he maintains high modality on the subject of the *moral principle of the universality* of health insurance provision to include the disadvantaged on which he is unyielding and which is fundamental both to the ethos of the speech and its logoi. We also see this in his discussion of the public option, where he strikes a middle ground emphasizing that while most Americans support it – as does he – he is more concerned with the principle of universality than the policy mechanism of a public option. Obama

⁵⁵² See Chapter 4 for more on the enthymematic rhetorical style.

⁵⁵³ See Ritivoi and Fairclough in Chapter 4 for more on modality and transitivity.

states, “The public option is only a means to that end – and we should remain open to other ideas that accomplish our *ultimate goal*.”⁵⁵⁴

In the following passage, Obama’s gives expression to this uncompromising high modality, taking aim at partisanship, its rigidity, political corruption, and myopia – all of which are counter to the ethos he advocates.

But what we have also seen in these last months is the same *partisan* spectacle that only hardens the disdain many Americans have toward their own government. Instead of *honest* debate, we have seen *scare* tactics. Some have dug into *unyielding ideological* camps that offer no hope of *compromise*. Too many have used this as an opportunity to score short-term political points, even if it robs the country of our opportunity to solve a long-term challenge. And out of this *blizzard* of charges and counter-charges, *confusion* has reigned.⁵⁵⁵

Here Obama makes an important link between the conservative ideology of limited government and partisanship. He argues that one of the reasons why Americans show scepticism of the efficacy of the government is because of the spectacle of partisanship and its prevention of the politics of moderation – in this passage signified by the word ‘compromise.’ This logic allows him to recast ideological scepticism towards government as popular exhaustion and exasperation with the corruption of politics as usual, obviating the need for him to directly rebut conservative ideology on moral grounds and run the risk of alienating conservatives. In so doing Obama has evacuated ideological differences from the healthcare debate. By describing the current political climate as a ‘blizzard’ filled with ‘confusion’ and by implying that politicians have been dishonest he asserts his own capacity to stand in contrast to mendacity and deceit and to clear the mess – both the ethical and the discursive one – which he claims the politicians who he so castigates have created.

⁵⁵⁴ Obama, 378.

⁵⁵⁵ Obama, 375.

Well the time for *bickering* is over. The time for *games* has passed. *Now* is the season for action. *Now* is when we must bring the best ideas of *both* parties together, and show the American people that we can still do what we were sent here to do. *Now* is the time to deliver on health care.⁵⁵⁶

Here the infantilizing keywords of ‘bickering’ and ‘games’ are signifiers for politicization and the moral corruption of politics and generate emotions of disgust and moral opprobrium at the narrowness and selfishness which impedes healthcare reform and undermines the idealized social imaginary of bipartisanship and reconciliation Obama so fervently champions. His repetition of the word ‘Now’ at the beginning of three sentences evokes urgency and Obama’s command as a leader demanding immediate action who will work in a bipartisan way, transcending rigid party ideologies. We will now proceed to examine the other rhetorical strategies Obama uses to advance an ethos of conciliation and bipartisanship.

8.6.1 Ethos: Constructing Social Solidarity through Rhetorical Strategies of Appropriation, Anticipatory and Defensive Rhetoric, and Historical Temporality

Obama applies ethos to advance a conciliatory new form of American political community committed to bipartisanship and common aspirations. Employing a strategy of recognition of political opposition Obama states, “I know that many in this country are deeply sceptical that government is looking out for them.”⁵⁵⁷ By tackling the ideology of limited government directly and sympathetically through a rhetoric of recognition – by acknowledging the integrity of its concerns and the need to balance concern with government intervention in individual freedom with the desire to use the government to advance positive liberty and the cause of justice, Obama’s rhetoric seeks to neutralize much of the power of conservative critiques of his healthcare plan.

⁵⁵⁶ Obama, 375.

⁵⁵⁷ Obama, 381-382.

To justify his ethos, Obama uses the rhetorical strategy of anticipatory and defensive rhetoric which predicts the ideological and practical queries and criticisms his healthcare reforms will face and pre-empts them. This manifests itself in part through apologetics in which Obama disavows allegiance to the more liberal wing of the Democratic party by implicitly including all politicians – Democrats and Republicans alike – in his criticism for their failure to come to consensus on healthcare reform and by berating liberals for their own tendencies towards uncompromising dogmatism, thereby having the effect of reinforcing his image as a moderate who is not beholden to ideology nor to party politics and who wishes to depolarize political debate. This strategic use of apology,⁵⁵⁸ however, should not be misconstrued as a form of capitulation. It contains a central tension: on the one hand it acknowledges the fallibility of liberalism and its adherents; on the other hand, it does the exact same for conservatism and its adherents.

The following passage illustrates Obama's use of recognition/appropriation and anticipatory and defensive rhetoric, establishing a delicate balance of applying both liberal and conservative attitudes towards government and its responsibility to citizens.

You see, our predecessors understood that government could not, and should not, solve every problem. They understood that there are instances when the gains in security from government action are not worth the added constraints on our *freedom*. But they also understood that the danger of *too much* government is matched by the perils of *too little*; that without the leavening hand of wise policy, markets can crash, monopolies can stifle competition, and the vulnerable can be *exploited*.⁵⁵⁹

By locating this in the past Obama is able to ground his argument in an empirical account of history rather than ideologically charged abstraction. His second sentence affirms the conservative conviction that often liberty trumps 'security' or justice as a

⁵⁵⁸ For more on the phenomenon of apology in political rhetoric see Triadafilos Triadafilopoulos. "Politics, Speech, and the Art of Persuasion: Toward an Aristotelian Conception of the Public Sphere," *The Journal of Politics* 61(1999).

See also, Sandra Harris, Karen Grainger, and Louise Mullany, "The Pragmatics of Political Apologies," *Discourse and Society* 17 (2006).

⁵⁵⁹ Obama, 381.

paramount value. In this passage Obama depicts this centrist understanding of the legitimate aims and scope of government as fundamental to a morally and socially sound vision of ethos which rejects the exploitation of the vulnerable and demands government regulation of markets to ensure fairness while insisting on conservative values that citizens should not be overly dependent on the government for their well being. Reaching out to conservatives, however, does not preclude Obama delivering a stinging rebuttal of ideological conservatism. Speaking of “the history of our progress” Obama uses the rhetorical strategy of historical temporality to try to build support for his reforms and the principle of extending healthcare provision to more Americans and to highlight the two policies that have become essential to maintaining a middle class quality of life, Social Security and Medicare, and which are overwhelmingly favored by a majority of Americans.

In 1933, when over half of our seniors could not support themselves and millions had seen their savings wiped away, there were those who argued that Social Security *would lead to socialism*. But the men and women of Congress stood fast, and *we are all the better for it*. In 1965, when some argued that Medicare represented a *government takeover* of health care, members of Congress, Democrats and Republicans, did not back down. They joined together so that all of us could enter our golden years with some *basic peace of mind*.⁵⁶⁰

He rebuts the claims of conservative ideologues that hampered healthcare reform for decades, showing how accusations of socialism and violations of liberty had no basis in fact and uses high modality to categorically assert that Social Security and Medicare were programs that impacted all Americans in a positive way, stating, “we are all the better for it”⁵⁶¹ regarding their passage.

These passages reflect two strands in Obama’s rhetoric: highly accommodating theoretical defenses of the legitimacy of the ethos of conservatism and empirical and

⁵⁶⁰ Ibid.

⁵⁶¹ Obama, 381.

historically based defenses of liberal efforts to expand social welfare and healthcare, which characterize conservative critiques of these efforts as inflammatory, hysterical, and simply wrong. Returning to other aspects of ethos, Obama emphasizes the bipartisan nature of Social Security and Medicare and uses the phrase ‘peace of mind’ which closely parallels the phrase ‘security and stability’ which appears more frequently in the speech and reinforces the overarching principle of universality and Obama’s argument that all Americans stand to benefit from his healthcare reforms and that he is defending the interests of middle class Americans. We will now examine the role of pathos within the ethos of the speech, for it is pathos which provides the persuasive power of the ethos, illustrating abstract moral principles in a humanizing, personal way.

8.6.2 Affirming Ethos through Pathos with Rhetorical Strategies of Personalization with Moralization/Moral Muting

Obama’s ethos is often steeped in the language and examples of pathos. Obama builds pathos in large part through the rhetorical strategy of personalization, exemplified in short personalized narratives.⁵⁶² These narratives describe healthcare injustices from an individual perspective, humanizing larger structural problems and systemic failures, advancing his argument for healthcare reform in relation to the consequences it will have for individuals who have suffered as a result of a lack of healthcare. They also allow Obama to develop his theme of concern for vulnerable middle class Americans, as several of the individuals he describes have a typically middle class background in terms of economic resources and work background.

⁵⁶² This rhetorical style was employed with particular frequency and success by Ronald Reagan and has since become a thoroughly bipartisan rhetorical style.

Obama uses the figure of Edward Kennedy to illustrate how the drive to expand healthcare and to universalize it is not motivated by an aim to expand government – as conservatives fear and as they depict his healthcare plan – rather, it reflects an as yet unfulfilled work in progress of a moral vision for American society and a social compact rooted in a communitarian ethos of care and enabled by emotions of empathy and compassion. By invoking Kennedy - an archetypal figure for liberalism - Obama is able to argue that Republican hostility to healthcare reforms misunderstands and politicizes something that even for as fundamentally political and potentially polarizing a figure as Kennedy is about much more than partisan politics and ideological conviction. This contributes to Obama’s arguments that his healthcare reforms should not be seen as stemming from dogmatic ideology but from common ethical values and shared sentiments of communitarian solidarity.

Obama does not focus primarily on the emotions themselves as independent experiences and perceptions. He does not analyze them or dwell upon them. Rather, he instrumentalizes them and uses them in the service of advancing his ethos of communitarian solidarity and care and its revision of the American social imaginary.

For some of Ted Kennedy's critics, his brand of liberalism represented an affront to American *liberty*. In their mind, his passion for universal health care was nothing more than a passion for *big government*. But those of us who knew Teddy and worked with him here – people of both parties – know that what drove him was something more. His friend, Orrin Hatch, knows that. They worked together to provide children with health insurance. His friend John McCain knows that. They worked together on a Patient's Bill of Rights. His friend Chuck Grassley knows that. They worked together to provide health care to children with disabilities.⁵⁶³

Obama (via Kennedy) becomes a synecdoche⁵⁶⁴ for the American people, and in so doing Obama invites the American people to join him and become partners in the

⁵⁶³Obama, 381.

⁵⁶⁴Mary E Stuckey, “The Domain of Public Conscience: Woodrow Wilson and the Establishment of a Transcendent Political Order,” *Rhetoric and Public Affairs* 6 (2003.)

reengagement with a more expansive, more just expression of the American dream, one which conservatives can feel comfortable joining without having to compromise their principles and one towards which liberals will naturally gravitate. Kennedy's bipartisan healthcare reform efforts in partnership with McCain and Grassley demonstrate the bipartisanship to which Obama aspires and the value of political moderation and compromise.

By asserting that Kennedy's drive and his drive – by association with Kennedy – is motivated by a civic and ethical vision of concern for the disadvantaged, and is not a project with ulterior motives to expand government and threaten 'liberty,' Obama establishes his own credibility and enhances his appeal. By referring to Kennedy in this way Obama seeks to reframe the debate about healthcare reform, anchoring the communitarian ethos of solidarity in emotional expressions of care and compassion and in personal experience.

On issues like these, Ted Kennedy's passion was born not of some rigid ideology, but of his own experience. It was the *experience* of having two children stricken with cancer. He never forgot the sheer *terror* and *helplessness* that any parent feels when a child is badly sick; and he was able to imagine what it must be like for those without insurance; what it would be like to have to say to a wife or a child or an aging parent – there is something that could make you better, but I just can't afford it.⁵⁶⁵

These are ethical arguments framed in a humanistic way: rather than arguing on the basis of particular moral principles such as a right to healthcare or equal opportunity Obama advances moral arguments for healthcare reform by eliciting emotions of empathy, compassion, and common human understanding of the anguish caused by being powerless to help a family member. The universal human experiences of sickness, vulnerability, and familial love frame Obama's argument for an ethos of solidarity. By stating, "He [Kennedy] was able to imagine what it must be like for those without

⁵⁶⁵Obama, 381.

insurance” Obama creates the link between the pathos of empathy and compassion and an ethos of solidarity and care.

But Obama also uses Kennedy⁵⁶⁶ to enable him to confront ethical issues directly without invoking pathos and without relying exclusively on the empathy/solidarity linkage which is the predominant way in which ethos manifests itself in the speech.

He [Kennedy] repeated the truth that health care is decisive for our future prosperity, but he also reminded me that "it concerns more than material things." "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."⁵⁶⁷

Reflecting the strategy of moral muting, not once in this speech does Obama use the words ‘moral’ or ‘justice’ himself – it is only when quoting Kennedy that he employs such overtly ethical language and, employing a strategy of moralization, makes ethos so explicitly tied to moral principles. Obama builds upon the phrase ‘character of our country,’ situating his call for healthcare reform in an ethos framework that relates communitarian values of solidarity and care to an ennobling emotionally charged and aspirational patriotic vision of the American people and the United States and a historical arc of social progress.

We have explored how Obama uses Kennedy’s individual experience with his sick children to illustrate the importance of healthcare reform. In the following passage, we see Obama do something similar with depictions of fairly typical Americans, rather than a famous politician. Here Obama articulates ethos with pathos employing the

⁵⁶⁶ Kennedy had recently died and was known for his role in championing universal health insurance and expanding health insurance coverage as much as possible to individuals who could not afford it. Given Kennedy’s record in this regard and Kennedy’s passionate commitment to the principle of universality it is logical that Obama chooses to invoke him, despite the fact that to many conservatives his private life and his form of liberalism were anathema.

⁵⁶⁷Obama, 380.

strategy of personalization to generate pathos and illustrate social injustice which Obama argues should not be sustained.

One man from Illinois lost his coverage in the middle of chemotherapy because his insurer found that he hadn't reported gallstones that he didn't even know about. They delayed his treatment, and he died because of it. Another woman from Texas was about to get a double mastectomy when her insurance company cancelled her policy because she forgot to declare a case of acne. By the time she had her insurance reinstated, her breast cancer more than doubled in size. *That is heart-breaking, it is wrong, and no one should be treated that way in the United States of America.*⁵⁶⁸

What is particularly significant about these two narratives is that neither illustrate the difficulty individuals who all-together lack health insurance face, rather, they show the ways in which a lack of government *regulation* of insurers has perpetuated injustice and avoidable sickness for those who have insurance but are underinsured because insurers are allowed to discriminate against them and severely limit their coverage and thus damage their health. This sector of the population can more securely be characterized as middle-class than those Americans who cannot afford any health insurance whatsoever. Consequently, because audiences will implicitly perceive them as falling reasonably into the 'middle-class' category discussed earlier - and given that the middle-class represents a forceful American aspiration for achievement and identification - it is an ideal rhetorical rallying point.

Although Obama makes a clear and decisive moral judgment by characterizing these two individuals' experiences as 'wrong' and employs a strategy of moralization that is impassioned and firm, he does not explicitly state on what ethical basis he has determined so, relying instead on an intuitionist and visceral emotional appeal. In the last sentence one sees a rhetorically tight synthesis of pathos, ethos, and logos through the

⁵⁶⁸ Obama, 374.

use of the affective phrase ‘heartbreaking,’ the moral category ‘wrong’ providing a clear evaluative stance, and the logical conclusion based on normative categorical modality that no one should be treated that way in the United States.

Obama uses pathos to advance his ethos of solidarity by urging Americans to temper their individualism with an appreciation for social obligation, making a communitarian argument for healthcare reform. Discussing Edward Kennedy’s generous character and concern for the uninsured Obama states,

That *large-heartedness* – that concern and regard for the plight of others – is not a partisan feeling. It is *not a Republican or a Democratic feeling*. It, too, is part of the American character. *Our ability to stand in other people's shoes*. A recognition that we are all in this together; that when fortune turns against one of us, others are there to lend a helping hand. A belief that in this country, hard work and *responsibility* should be rewarded by some measure of *security* and *fair play*; and an acknowledgement that *sometimes* government has to step in to help deliver on that promise.⁵⁶⁹

By acknowledging that such ‘large heartedness’ is not a partisan feeling Obama invokes his ethos of conciliation as he highlights the principle at the center of both his ethos and the logos of the healthcare reform: hard work and responsibility should be rewarded with ‘security’ and that the ethical principle of fairness or ‘fair play’ is at stake in his quest for healthcare reform. His careful use of the word ‘sometimes’ to modify the statement ‘government has to step in to help deliver that promise’ illustrates his gentle rebuttal of the most extreme forms of conservative philosophies of limited government with a moderate call for the kind of government intervention preferred by liberalism. Obama argues that by transcending ideological hostility and political paralysis with civility and openness to change inspired by empathy and solidarity Americans can continue an American tradition of social progress and an expanding, more inclusive moral order.

⁵⁶⁹Obama, 381.

This will revitalize and make more inclusive the American social imaginary and enable Americans to meet ‘history’s test’ through unity in pursuit of national fulfilment of a moral and social vision that Obama presents as a prophetic communion.⁵⁷⁰

8.6.3 An Implied Rather than Explicit Ethos

Obama’s speech does not present a formal, explicit overarching moral order that transcends the issue of healthcare and creates a linkage between healthcare reform and other social issues within the purview of government policy. He advances moral principles not by contextualizing them within a larger ethical framework and discourse such as human rights. Rather, he grounds the speech in practical morality, as we have just seen in the discussion of pathos. His speech can, therefore, be characterized as Aristotelian in that it is not based on theoretical rule making and abstract moral principles; rather, it projects itself through reflection on individual examples and on common experiences. He summons principles such as freedom and equality more in emotional appeal for healthcare reform than in reasoned exposition of the values, rights, and ideas that justify government guarantee of universal health insurance and indeed demand it.

The even-handed approach Obama shows in the logos and ethos of the speech to concerns with liberty and equality, justice and personal autonomy resemble those of communitarianism with its focus on balancing potentially competing values, pragmatism, and respect for values rooted in a particular polity and culture. Indeed many of Obama’s arguments reflect communitarian values in their emphasis on social and civic solidarity and respect for the particularities of American culture. Obama, however, makes no claim to be communitarian or to take inspiration from communitarianism. Obama addresses

⁵⁷⁰ Paul Krugman, “When Zombies Win,” *New York Times*, December 19, 2010. Krugman, http://www.nytimes.com/2010/12/20/opinion/20krugman.html?_r=1&ref=opinion

the subjects of equal opportunity and the maximization of human capabilities largely implicitly through his illustration of how lacking health insurance deprives individuals of their health, welfare, and security and constitutes unfair discrimination. The principle of universal health insurance is an expression of concern for equal opportunity – although Obama never explicitly frames it as such. No where, however, does Obama use a language of rights – neither one grounded in American law or in international law. Strategically, this defining aspect of the speech enables Obama to depoliticize the subject of healthcare reform. Thus while Obama addresses the importance of protecting the economically disadvantaged by providing them with a guarantee of health insurance he does not address any moral and legal claims they may have to other government services. In effect he advances their welfare and interest on the lone front of healthcare without addressing the broader structural injustices they suffer and which demand government redress, demonstrating his pragmatism and its willingness to rhetorically exclude the economically disadvantaged from the American social imaginary.

8.7 Conclusion

Responding to a vigorous and largely successful Republican campaign⁵⁷¹ to delegitimize Obama’s healthcare plan and misrepresent it, one of the core goals and rhetorical functions of Obama’s speech is to legitimize⁵⁷² his healthcare plan. He does

⁵⁷¹Robert Pear, “GOP To Fight Health Law with Purse Strings,” *The New York Times*, November 6, 2010. <http://www.nytimes.com/2010/11/07/health/policy/07health.html?ref=ericcantor>
David M. Herzenhorn, “Senate Rejects Repeal of Health Care Law,” *The New York Times*, February 2, 2011, <http://www.nytimes.com/2011/02/03/health/policy/03congress.html?scp=3&sq=healthc%20are%20&st=cse>
Kevin Sack, “Federal Judge Rules that Health Law Violates Constitution,” *The New York Times*, January 31, 2011, <http://www.nytimes.com/2011/02/01/us/01ruling.html?scp=1&sq=judge%20and%20healthcare&st=cse>
⁵⁷²Andrea Deciu Ritivoi, “Talking the Political Talk: Cold War Refugees and Their Political Legitimation through Style in *Rhetoric in Detail*,” edited by Barbara Johnstone and Christopher Eisenhart, 34. For more on rhetorical means of establishing political legitimacy see Jaworski and Galsinski, 2000 who Ritivoi paraphrases.
Jaworski, A., & Galasinski, D, “Vocative address forms and ideological

this by drawing upon a particular ideology of pragmatic liberalism that incorporates elements of conservative ideology and simultaneously emphasizes the importance of social solidarity, approximating the moral philosophy of communitarianism. Obama's speech is in this sense reactive; it seeks to alleviate the concerns of Americans whose fears have been provoked by Republicans that they will lose their healthcare plans, suffer a decline in healthcare provision quality, and will become subject to government intrusions in the quality and quantity of their care.⁵⁷³

By beginning his speech with policy history about healthcare reform and ending it with policy history about Medicare and Social Security – two key social entitlements and guarantors of middle class lifestyle - Obama locates his healthcare reform plan within a dramatic and temporal logoi of national historical development rather than as a singular moment in time and narrow policy goal, applying a rhetorical strategy of historical temporality. History provides a context which allows Obama to envision a

legitimization in political debates.”

⁵⁷³Surveys have consistently shown that most Americans who are in possession of health insurance are reasonably satisfied with it and wary of changes to it – which they envisage as being potentially likely to harm the quality and availability of their coverage rather than to improve it.

J Gabel, H Cohen and S Fink, “Americans’ Views on Healthcare: Foolish Inconsistencies?” *Health Affairs*, 8 (1989). Kaiser Family Foundation Data Note, ‘Americans’ Satisfaction with Insurance Coverage.’ <http://www.kff.org/kaiserpolls/7979.cfm> and <http://content.healthaffairs.org/content/8/1/103.full.pdf>

David Paul Kuhn, “The Healthcare Reform Paradox,” http://www.realclearpolitics.com/articles/2009/08/13/the_health_care_reform_paradox__97866.html

“Americans Like Their Coverage,” <http://www.americanhealthsolution.org/assets/Uploads/Blog/High-Satisfaction-with-Quality-and-Current-Coverage2.pdf>

Maggie Fox, “Opponents of US Healthcare Reform Wield Fear Weapon,” *Reuters*, August 28, 2009. <http://www.reuters.com/article/2009/08/28/idUSN28381539>

Paul Steinhauser, “Poll Indicates Generational Split Over Health Care,” *CNN Politics*, August 05, 2009, http://articles.cnn.com/2009-08-05/politics/health.care.poll_1_health-care-obama-s-plan-national-poll?_s=PM:POLITICS

Surveys show that senior citizens had some of the gravest doubt amongst all US citizens regarding the value of Obama's plan.

Matt Bai, “The New Old Guard” in *New York Times*, August 26, 2009, <http://www.nytimes.com/2009/08/30/magazine/30FOB-wwln-t.html>

better future and a changed social imaginary grounded in progressive patriotism built on a communitarian ethos and moral order of solidarity and care. At the very beginning of the speech Obama states, “We came to build a future”⁵⁷⁴ and at the closing of the speech he closes the circle stating, “We did not come to fear the future. We came here to shape it.”⁵⁷⁵

Obama uses personalized individual narratives to establish his ethos of solidarity grounded upon pathos of compassion that supports universal health insurance and that illustrates the difficulties vulnerable middle class Americans face in accessing reasonably priced and high quality healthcare. Rhetoric of recognition is a central discursive strategy of the speech. It allows Obama to show deference towards and also to appropriate conservative ideas and concerns as well as to establish his credibility as a centrist moderate who wishes to depolarize politics and advance healthcare reforms that respond to the practical challenges Americans face when adequate healthcare is unavailable or too costly. Defensive and anticipatory rhetoric dovetail with rhetoric of recognition. They enable Obama to situate himself as a bipartisan leader who embraces conservative values, respects them, and integrates them into his own healthcare reform plans.

Moralization enables Obama to make strong arguments in favour of the principle of universal health insurance which guarantees equal healthcare opportunity for Americans. Moral muting and implicit language that often accompany it and toned down emotions of indignation enable Obama to communicate conciliation, redefine the boundaries of the social imaginary, and generate support for Obama’s healthcare reforms by challenging conservative critiques of it without undermining the bipartisanship and spirit of moderation and respect Obama wishes to advance. They enable Obama to

⁵⁷⁴ Obama, 373.

⁵⁷⁵ Obama, 382.

portray himself as open and flexible to various ways of implementing universality, including ones that reflect conservative priorities with maximizing individual choice and ensuring strong free markets unfettered by excessive government regulation.

Obama's healthcare reform address chooses a rhetorical approach of accommodation rather than confrontation. As a result, although it potentially maximizes its appeal across a large section of the American electorate, from moderate conservatives - to independents and moderate liberals - it is only able to do so by rhetorically marginalizing the most economically and socially disadvantaged Americans and thus avoiding a direct and potentially morally and ideologically charged debate about the responsibilities of the government to the most economically disadvantaged Americans. Its fixation on the interests and welfare of the 'middle-class' demonstrates the only partially critical rhetorical orientation of the speech which does not challenge the political and social norms that idealize the middle-class at the expense of acknowledging the working class and most economically disadvantaged.

We saw in our analysis of Johnson's speeches how central combating poverty and addressing the needs of the most economically and socially disadvantaged were to both his rhetoric and policies. Obama, in great contrast, is almost rhetorically silent on these issues juxtaposed with Johnson's thundering attacks on the injustices of poverty and the suffering of the impoverished. But, paradoxically, although Obama's *rhetoric* reflects quietism regarding acknowledging deep structural injustices and inequalities in American society and economy the *policy* outcome Obama's healthcare reform advocates does indeed reflect the circumstances and interests of all classes, including those who are economically disadvantaged.

Still, because he does not provide a comprehensive moral philosophy in defense of his healthcare reform and refers to moral principles infrequently, loosely, and tangentially in contrast to Truman and Johnson and reflecting a rhetorical style initiated by Clinton but amplified substantially by Obama, Obama's speech maintains the rhetorical status quo that has emerged since Ronald Reagan's presidency in which public policies are no longer advocated for primarily in relation to their moral content but instead depend largely on pragmatic and technical arguments.⁵⁷⁶ As discussed earlier, this contrasts profoundly with the rhetoric on healthcare reform of Truman and Johnson, which located healthcare within a moral and political philosophy of rights or entitlements and an overarching vision of justice and well being across a range of social domains such as housing and education, and an explicit defense of the primacy of government in guaranteeing that citizen welfare and positive liberty are comprehensively ensured.

Obama does call for a communitarian ethos of solidarity and care with regard to healthcare provision. But while an ethos of solidarity and care may begin with healthcare it certainly cannot and does not end there, although Obama chooses to cap it there for the expedience of maximizing support for his healthcare reforms. He refuses to substantially challenge the conservative philosophy of limited government which still dominates American political culture and continues to play a role in maintaining the marginalization of economically disadvantaged Americans and their increasing invisibility in American public discourse.

⁵⁷⁶ Theodore R. Marmor and Jerry L. Mashaw, "How Do You Say 'Economic Security'" in the *New York Times*, September 23, 2011.
<http://www.nytimes.com/2011/09/24/opinion/how-do-you-say-economic-security.html>

Chapter 9: Conclusion

9.1 How Liberal Arguments for Healthcare Expansion Have Evolved from Truman to Obama & The Patient Protection and Affordable Care Act: Rhetorical and Policy Battles Now and in the Future

There is a massive literature on healthcare reform policy, but there has been very little research about healthcare reform rhetoric that focuses on this topic and examines its evolution in a historical and comparative context. This is true both of scholarly books and articles, all of which focus on policy and politics with only minimal consideration of rhetoric. This thesis seeks to fill this gap in the literature.

How American Presidents talk about healthcare reform provides a commentary on the American moral order and social imaginary as a whole. I have explored the changing American moral order and social imaginary through the lens of Democratic presidential healthcare rhetoric and the way in which it discursively defines the moral order and social imaginary, seeking to expand access to and affordability of healthcare on the basis of diverse principles: ethical, civic, and economic. In so doing it invokes a social imaginary in which US citizens share a common responsibility for each other's welfare, upon which the government acts, and which expands the promise of a right to healthcare, equality of opportunity, and communitarian social solidarity to all citizens irrespective of their economic means and social background. It does this in ongoing contestation to a competing conservative social imaginary which denies the principle that healthcare should be provided to all citizens by the government as a matter of right, equal opportunity, and communitarian obligation and that instead favors treating healthcare as a commodity which should be freely available on the market with minimal government intervention. Whatever distribution results from the market – even if it excludes large numbers of Americans – is considered legitimate.

This conservative social imaginary already existed in Truman's era when its most pronounced advocates were health insurers, medical related businesses, and the American Medical Association – whose activism against Truman's universal health insurance proposals was channelled by Republicans in Congress. But the intensity of the ideology of limited government stemming from Republican politicians became much more fervent during the Reagan era and beyond. Reagan articulated an ideology of limited government increasingly hostile to racial and ethnic minorities and the economically disadvantaged (which often overlapped) that sometimes denigrated and depicted them as not meriting the spending and attention of the government.

We have seen the dramatic change in how liberal American presidents defend the expansion of healthcare in response to the now hegemonic conventional wisdom of Ronald Reagan and the era of 'limited government' conservatism which he ushered, in which government has been and remains vilified as wasteful, ineffective, and a threat to individual liberty. Reagan did not create these ideas, as mentioned. The American social imaginary has long evinced a libertarian streak that looks with ambivalence and even hostility towards government. But Reagan articulated this trend, energized it, defended it, and emboldened it so that it would become prominent and dominant and increasingly strident in its vociferous insistence on tax cuts and cuts in government programming.

A conservative reaction to the manifold social changes in the areas of increasing liberty and equality for women, African-Americans, and other minorities during the 1960s and 1970s to which many Americans responded with ambivalence, fear, and outright hostility also created fertile ground for Reagan's ideology of limited government. It addressed some of these anxieties, especially when it incorporated criticism and denigration of African-American women and the impoverished and used the Cold War to advance traditional forms of patriotism and nationalism, which had weakened since the debacle of the Vietnam War and the massive loss of life it entailed. In short, Reagan

normalized and naturalized one conservative expression of the social imaginary which had previously been present but not necessarily prevalent. These convictions make it exceedingly difficult to protect and promote social and economic rights, maintain equality of opportunity, alleviate poverty, and more specifically in relation to health insurance, universalize it and make it more affordable.

I sought to answer these research questions:

- a. What type of moral order and social imaginary does Truman, Johnson, Clinton, and Obama's rhetoric articulate? What is the role of ethos, pathos and logos in rhetorically constituting this moral order and social imaginary?
- b. How does this rhetoric both challenge conservative ideas and principles and appropriate them? What are the compromises it makes in order to appeal to as broad a segment of American society as possible in advancing the expansion of healthcare and what groups if any are marginalized as a result? How does it depict and address different social and economic classes, particularly the middle class, working class, and most economically disadvantaged?

My original contribution to knowledge is a comparative history and analysis of rhetoric which illustrates how the American social imaginary and its underlying moral order has evolved dramatically from the Truman to the Obama era; from one under Truman and Johnson which embraced social and economic rights and the principle of active government programs to guarantee citizen welfare in a comprehensive way and defend positive liberty to one today which rejects social and economic rights and defends a much smaller role for government in ensuring citizen welfare which emphasizes negative liberty.

Rhetoric about public policy is a conduit by which citizens form an understanding and opinion of public policy. Therefore, analysis of the policy history of healthcare reform needs to take into account how policies were described and rhetorically constructed to the public. Undoubtedly, much presidential rhetoric on healthcare reform and presidential rhetoric generally is filtered and mediated by the media. However, the media's reporting of presidential rhetoric is a separate topic, beyond the scope of this thesis. Nevertheless, it deserves attention and is a rich potential area for further research which can build upon my findings.

Given the depth and breadth of the concept of the social imaginary it is important to emphasize that presidential rhetoric, however important and central to this thesis, is but one manifestation of the social imaginary. Thus, despite this thesis' focus on rhetoric in the four empirical chapters analyzing Truman, Johnson, Clinton, and Obama's presidential addresses on healthcare reform, I took care in Chapters 1 and 2 to address the full range of factors which have impacted healthcare reform in the United States by limiting the potential for expanding and universalizing health insurance. As I have written the thesis there has been a rapid growth in the academic literature examining the history of healthcare reform in the United States and upon which my own research builds. Without this literature I could not meaningfully attempt to make my own distinctive contribution to the interdisciplinary topic of healthcare reform policy, rhetoric, and the changing American moral order and social imaginary.

Let us consider again the main findings of these and other scholars as they seek to understand why the United States lacks universal health insurance and the context in which Presidents Truman, Johnson, Clinton and Obama sought to expand healthcare:

- the lack of legal and civic tradition of social and economic rights in the US and a political culture that emphasizes negative rather than positive liberty
- American cultural scepticism towards government and its intentions
- the widespread belief that healthcare is a commodity rather than a right
- the power of healthcare insurers, doctors, hospital associations, and pharmaceutical companies and their often antagonistic agendas driven by a desire to maximize their profits which can be threatened by healthcare reforms designed to expand healthcare and make it more affordable
- the interest of unions, some of which historically rejected efforts to provide government guaranteed universal health insurance
- the weakness of unions and the labor movement in the United States which often played an important role in Europe in advocating for social and economic rights
- the lack of a tradition of socialism and a strong socialist or social democratic party in the United States
- the structure of US government, with its system of checks and balances, and many opportunities for stalling legislation such as the Senate filibuster
- the fragmented nature of healthcare insurance provision and path dependency which makes it exceedingly difficult to build widespread support for universal health insurance because veterans, the elderly, the extremely impoverished, and the majority of Americans with employer based health insurance already possess their own health insurance and do not necessarily have self – interest in the expansion of health insurance provision.

The thesis illustrates ways in which presidential rhetoric has both reflected and refracted some of these factors, many of which (particularly the lack of a social democratic party and socialist tradition in the US, public scepticism towards government and preference for negative over positive liberty and weak support for social and economic rights, and the widespread belief that healthcare is a commodity rather than a right) inform the social

imaginary and its underlying moral order as to what rights and needs citizens expect government to protect and fulfil. They negatively impact efforts to universalize health insurance in the United States and make it unique amongst wealthy, industrialized nations in its lacking such provision throughout the twentieth century and until the passage of Obama's Patient Protection and Affordable Care Act, finally providing near universal healthcare coverage to American citizens.

9.2 How Contemporary Healthcare Reform Rhetoric Reflects Historical Healthcare Reform Rhetoric

One of the pleasures of writing this thesis and one of its challenges is the fact that though it is rooted in history, healthcare reform is a 'live topic' so to speak, which during the years of my research and writing between 2009 and 2013 was and remains constantly evolving. It is not a settled domain. Continuities are present in, for example, the rhetoric of Republican presidential candidate Mitt Romney, who campaigned vigorously against Obama's healthcare reform and vowed to repeal it if elected and earlier Republican rhetoric.

Romney's now infamous statement casting aspersions on the character of almost half of American citizens echoed the pejorative rhetoric of Ronald Reagan towards many working class and economically disadvantaged Americans that we explored in Chapters 1 and 2. It illustrates these continuities and the way they are felt in the United States today as well as the Republican hostility to social and economic rights and government responsibility to provide for the welfare of US citizens and how these influence their expressions of the social imaginary. As discussed in Chapter 1, conservative attacks on the size of government and the legitimacy of government have far reaching implications. They generate hostility to the principle mechanism society has to address citizen rights

and needs and defend principles of equality of opportunity. The consequences for public policy can be extreme paralysis and/or intractably ponderous and small scale efforts to address large scale social problems which cannot be addressed successfully without sustained government effort and expenditure.

In a private meeting to Republican supporters roughly six weeks before the 2012 presidential election Romney stated,

There are 47% of the people who will vote for the president no matter what. All right, there are 47% who are with him, who are dependent upon government, who believe they are victims, who believe the government has the responsibility to care for them, who believe that they are entitled to healthcare, to food, to housing, to you-name-it... My job is not to worry about those people. I'll never convince them they should take personal responsibility and care for their lives.⁵⁷⁷

Though Democrats and some Republicans challenged this language, Romney and his running mate, Paul Ryan, were quick to assert that while the expression was “inarticulate”⁵⁷⁸ according to Ryan, or “not elegantly stated” according to Romney, it correctly reflected conservative beliefs and their convictions. This discourse and the ideas and values that inform it remains tenacious and while not uncontested, continues to influence much of the American electorate and to limit the scope of public policy.⁵⁷⁹

⁵⁷⁷ Ewen MacAskill, “Mitt Romney Under Fire After Comments Caught on Video,” *Guardian*, September 18, 2012, <http://www.guardian.co.uk/world/2012/sep/18/mitt-romney-secret-video>

⁵⁷⁸ Jim Kuhnhenn and Ken Thomas, “Obama Jabs at Romney Over his 47% Remarks” *Associated Press*, September 19, 2012, <http://www.newstribune.com/news/2012/sep/19/obama-jabs-romney-over-his-47-percent-remarks/>

⁵⁷⁹ At first Romney stuck by his statement, eventually he backed down and offered a retraction, once he recognized the extent of the damage they had caused him, saying that they were “just completely wrong.”

Jim Rutenberg and Ashley Parker, “Romney Says Remarks on Voters Helps Clarify Position,” *New York Times*, September 19, 2012, http://www.nytimes.com/2012/09/19/us/politics/in-leaked-video-romney-says-middle-east-peace-process-likely-to-remain-unsolved-problem.html?pagewanted=all&_r=0

Kasie Hunt, “Mitt Romney: ‘47 Percent Comments Were Just Completely Wrong,’” *Huffington Post*, October 5, 2012, http://www.huffingtonpost.com/2012/10/04/mitt-romney-47-percent_n_1941423.html

We have seen how Harry Truman and Lyndon Baines Johnson defended active government programming to expand healthcare and the realization of social and economic rights generally. We have also seen how Presidents Clinton and Obama advanced healthcare reforms but with great deference to conservative arguments against government and with relatively little overt defense of the principles of equality of opportunity and justice that were so central to Truman and Johnson's rhetoric. Truman and Johnson were unafraid to champion the most economically disadvantaged and vulnerable of American citizens while Clinton and Obama, in contrast, were largely reticent on the matter. In part, this is because the American social imaginary and moral order has changed so drastically, such that what was once conventional wisdom, that government can and should actively enable citizen welfare in a broad range of social domains has now been replaced by an ideology of limited government and low taxes that restrict government efforts to actualize equal opportunity.

Rhetoric creates ethical, affective, cognitive, and perceptual realities and what becomes normalized as conventional wisdom. It both forms a part of the moral order and social imaginary and potentially challenges it. In the cases of Truman and Johnson, they chose to vigorously defend egalitarian principles and governed at a time when these principles (on the basis of class, though certainly not race) were more welcomed than during the Presidencies of Clinton and Obama. But they pushed these boundaries and were unafraid to champion a very explicitly liberal vision of the American moral order and social imaginary. They faced serious obstacles and adversaries in their efforts, and indeed, Truman failed to advance much of his Fair Deal, including his plan for universal health insurance because of intense lobbying against it and other social programs his Fair Deal proposed. Clinton and Obama were certainly constrained by social norms and the dominance of conservative anti-government ideologies in American society, but they chose to respond to these challenges in a particular way, by adopting them and

challenging them only mildly rather than offering a robust liberal alternative, opting for cooperation rather than confrontation and contestation.

As we have seen, Truman and Johnson adopted rhetoric that sought to build upon Franklin Delano Roosevelt's vision of an active government that protects social and economic rights and Truman and Johnson pursued a *proactive* relationship with the American moral order and social imaginary which involved major policy efforts to advance social change on a large scale. The Fair Deal, Great Society, and War on Poverty all respect the concept of social and economic rights and sought to actualize them. Clinton and Obama, in contrast, did not adopt a rhetoric of social and economic rights and did not seek to shift the social imaginary and moral order in a substantial and comprehensive way or embark on major new government programs, which, in turn, will impact the development of the social imaginary. Instead, they favored an incremental *reactive* approach, limited primarily to healthcare reform and not addressing other social needs such as reducing poverty and improving educational opportunity.

Ultimately, as we have just discussed when examining Obama's healthcare reform rhetoric in Chapter 8, Obama was able to defend a moderately liberal healthcare reform program through a rhetoric that shows deference to conservative principles and ideas with regard to *implementation* but not the fundamental principles of health *security, equality of opportunity, and universality*, on which it is uncompromising. But as we have just discussed in Chapter 8, this came at great cost because a prominent feature of this rhetoric is the near effacement of the working class and the economically disadvantaged and a lack of a moral and rhetorical framework for advancing justice and equality of opportunity more broadly, beyond the expansion of healthcare provision. As discussed in the last chapter, in presidential debates Mitt Romney and Barack Obama focused relentlessly and almost exclusively on the 'middle class,' reflecting a shift that began during the Reagan era, was

internalized by Democrats and applied in the rhetoric of Clinton, and emerged in Obama's rhetoric as one of its defining features.

9.3 Ethos/Pathos/Logos in the Presidential Rhetorics

We have explored the rhetorical strategies each president used to advance his healthcare reforms, finding the greatest continuities between Truman and Johnson, and Clinton and Obama, with major differences between each pair: each use moralization but Truman and Johnson do so with far overtly liberal orientations and without self-consciously trying to portray themselves as moderates and advocates of bipartisanship. In the context of moralization communitarian social solidarity is a common component in the rhetoric of each president; it is perhaps the only truly consistent element of ethos that is found in each of their speeches.

Presidents Truman and Johnson applied the rhetorical strategy of linkage in their efforts to generate social solidarity between Americans of different racial, class, and geographic backgrounds. Presidents Clinton and Obama relied on the idealized signifier of the 'middle class' as a transcendent aspiration that unites Americans across social, economic, and racial divisions. Presidents Truman and Johnson used the working class and the poor as focal points for their reform efforts, depicting themselves as their champions. Presidents Clinton and Obama did the opposite, effacing the working class and the poor in a romantic vision of the middle class which as a category deliberately blurs distinctions and the social realities of individuals with vastly different incomes and economic resources.

The rhetorical strategy of historical temporality is a constant in the rhetoric of each of the Presidents, who consciously builds upon predecessors, and particularly on the legacy of Social Security. Truman and Johnson refer to the New Deal, Clinton and

Obama to Medicare. All sought to situate their reforms within the context of a linear expansion of opportunity for American citizens and expanded communitarian social solidarity.

When considering the place of ethos, pathos, and logos in the rhetoric of these presidents we find the greatest commonality on issues of logos which barely change irrespective of changes in the moral order and social imaginary. These include concerns with an individual mandate and the necessity of universal coverage, (with the exception of Johnson because Medicaid and Medicare only cover some, not all Americans) cost control, assurances to insurers, hospitals, and doctors that their profits and freedom will not be curtailed, maximizing the choice of citizens amongst healthcare plans, and slowing the rise in healthcare costs. As we have already discussed, it is in the areas of ethos and pathos that the presidential rhetorics are most clearly divided. Even though all four presidents show some concern with equality of opportunity this is far more pronounced in the rhetorics of Truman and Johnson than those of Clinton and Obama.

9.4 The Value and Significance of this Historical Interdisciplinary Research

In analyzing historically the evolution of American healthcare reform rhetoric my thesis provides a distinctive prism by which to explore and reveal changes in American society and its underlying moral order and social imaginary. Furthermore, by linking the concept of the moral order and social imaginary that Presidents Truman, Johnson, Clinton and Obama *both* constructed and responded to in their efforts to advocate for healthcare reform to larger analyses of how healthcare reform policy has developed in the United States the thesis seeks to offer a new critical perspective on the expansion of healthcare coverage in the United States.

Presidential rhetoric on healthcare reform has significance far beyond the topic of healthcare itself, in that it reflects larger struggles between liberals and conservatives about the legitimate aims of government and its moral and social obligations to citizens. As I argued in Chapter 1, healthcare represents a paramount human need without which life and quality of life cannot be sustained. The lack of universal healthcare for Americans has deprived millions of Americans of health security and caused enormous amounts of suffering to individuals and families alike, reducing life expectancy, life quality, and serving as a major contributor to poverty due to the exorbitant costs of healthcare. For this reason it is a vitally important topic with ramifications for every citizen.

9.5 Methodological and Theoretical Challenges

Presidents give many speeches on public policy issues, and each of the presidents examined spoke about healthcare repeatedly, in diverse settings, to different audiences, and with varying emphases in relation to these factors. Inevitably then, by analyzing only their primary national addresses on healthcare reform made to Congress (with the exception of Johnson) the thesis limits itself to a particular and narrow rhetorical genre. This is both a potential strength and weakness. On the one hand, it provides continuity of analysis in that each president made a similar type of address and it allows for a coherent corpus construction. At the same time, although I take into account other speeches they do not receive the same detailed and focused rhetoric analysis, and consequently the thesis is oriented towards a very particular component of the larger rhetorics on healthcare reform of each of the Presidents.

The concept of the social imaginary, as discussed in Chapter 1, is a very expansive one and there is no agreed upon definition of its exact components and to

what extent each constitute it. Consequently, as I explained in Chapter 1, this thesis relies heavily on the interpretations of its author and the definitions I have set out in creating my conceptual and analytical framework. The idea of the social imaginary and its definition can be contested, as can the ways in which I have analyzed the rhetoric and sought to illustrate how various rhetorical strategies yield a particular moral order and social imaginary. To provide a complementary form of research to the qualitative and interpretive orientation of this thesis other methodologies may be productive in addressing some of these limitations. A researcher using the methodology of content analysis, for example, might have considered a large number of healthcare reform texts and focused on a more schematic analysis of how words and concepts such as ‘middle class,’ ‘liberty,’ and ‘welfare’ are used, when and where, and with what frequency. This could be an area of worthwhile research that would augment my own qualitative research.

Because this thesis is interdisciplinary in nature and incorporates elements of policy analysis, political science, history, and rhetoric analysis it is theoretically and methodologically diverse, and incorporates both the humanities and the social sciences in its intellectual orientation. This diversity may be a strength, but may also frustrate researchers who are firmly rooted in one particular field. It is always a challenge when undertaking interdisciplinary research to successfully integrate different approaches of the disciplines involved, especially when they may lack common definitions of theory and methodology, place different emphasis on these, or even question their relevance.⁵⁸⁰ Qualitative interpretive research of the kind I have undertaken in the four empirical chapters on presidential rhetoric reflects the methodologies of rhetoric analysis in a historical context whereas Chapters 1 and especially 2, with their emphasis on policy

⁵⁸⁰Julie Thompson Kline, *Interdisciplinarity: History, Theory and Practice*, (Detroit: Wayne State University Press, 1990.)

Allen F. Repko et al, *Case Studies in Interdisciplinary Research*, (Thousand Oaks: Sage, 2012.)

Allen F. Repko, *Interdisciplinary Research: Process and Theory*, (Thousand Oaks, Sage, 2012.)

history and the intersection of political rhetoric and policy reflect primarily the fields of history, political science and public policy analysis and provide the necessary context for analyzing the presidential rhetoric.

9.6 Opportunities for Future Research

The years immediately following the implementation of the Affordable Care Act will be particularly worthy of examination and research to consider if and how the law catalyzes a shift in the American moral order and social imaginary. If until now Presidents Clinton and Obama and liberals generally were loathe to offer a vigorous liberal alternative to conservative ideologies of limited government will the passage of this legislation serve as a turning point? Will President Obama shift gears and begin to address the vulnerabilities and injustices faced by economically disadvantaged Americans and working class Americans more explicitly and vigorously? Or has liberalism in America evolved to a place where the incorporation of conservative values of limited government so central to Clinton and Obama's rhetoric and policies will become a defining feature of it for the immediate and short-medium term future and limit its capacity to impact social change and pursue equal opportunity across a variety of social domains beyond healthcare, including education, housing, and reduction of poverty? Will conservatism go through a similar process as liberalism has these past thirty years, appropriating it and adopting a more moderate ideology?, – especially as American demography makes it increasingly difficult for a rigidly conservative Republican party to win presidential elections?⁵⁸¹ These are important questions that need to be asked and the

⁵⁸¹ Ruy Teixeira, *New Progressive America*, March 2009.
http://www.americanprogress.org/issues/2009/03/pdf/progressive_america.pdf
Morley Winograd and Michael D. Hais, *Millennial Momentum: How a New Generation is Remaking America*, (Piscataway: Rutgers University Press, 2011).

coming years will reveal a great deal about the significance of Obama's health care reforms with regard to the American moral order and social imaginary.

As president, until May of 2013 Obama did not refer in his public addresses on healthcare reform to healthcare as a right. Interestingly, however, once the Affordable Care Act was secure after it had been approved by Congress and upheld by the Supreme Court, Obama's rhetoric changed. In May of 2013 Obama referred to healthcare robustly and unapologetically as a right, stating,

The United States of America does not sentence its people to suffering just because they don't make enough to buy insurance on the private market, just because their work doesn't provide health insurance, just because they fall sick or suffer an accident. That could happen to anybody. And regular access to a doctor or medicine or preventive care – that's not some earned privilege; it is a right.⁵⁸²

A little later in the speech he referred to healthcare as a right again, stating, "We're going to keep fighting with everything we've got to secure that right, to make sure that every American gets the care that they need when they need it at a price that they can afford."⁵⁸³ At the recent commemoration of the March on Washington and Martin Luther King Junior's "I Have a Dream" speech, on August 28, 2013, Obama again referred to healthcare as a right commenting on the courage needed to make it a reality, "With that courage we can stand together for the right to health care in the richest nation on Earth for every person."⁵⁸⁴ Such statements are unusual for Obama, and reflect a substantive shift in content and tone of his healthcare reform efforts which merits continued attention to examine if it is part of a pattern or reflects a one-off exception.

Morley Winograd and Michael D. Hais. *Millennial Makeover: MySpace, Youtube, and the Future of American Politics*. (Piscataway: Rutgers University Press, 2009).

⁵⁸²Barack Obama. "Remarks by the President on the Affordable Care Act." May 10, 2013.

<http://www.whitehouse.gov/the-press-office/2013/05/10/remarks-president-affordable-care-act>

⁵⁸³ Ibid.

⁵⁸⁴ "Obama March on Washington Speech Delivered at Lincoln Memorial." *The Huffington Post*, August 28, 2013. http://www.huffingtonpost.com/2013/08/28/obama-march-on-washington-speech-transcript_n_3831576.html

My research questions on how the moral order and social imaginary have changed can be applied fruitfully in a wide range of policy areas that American presidents address rhetorically. Future researchers may wish to comparatively explore presidential rhetoric on education, crime and safety, and poverty reduction policies rather than through the particular prism of healthcare reform. They may find promising insights into the protean nature of the ‘middle class’ in the American social imaginary by examining how class has been constructed and alluded to by US presidents when addressing the aforementioned policy areas. I have not examined how the American public perceived and responded to the presidential rhetoric I have analyzed. Audience analysis – particularly of Obama’s recent rhetoric – could offer rich further avenues for study and complement the research I have undertaken in this thesis.⁵⁸⁵ Sociology and cultural history can offer valuable insights that complement rhetoric analysis and policy history and can also provide a more grassroots perspective on the changing moral order and social imaginary. One of the limitations of the thesis is its focus on presidential rhetoric. How the media, businesses, religious leaders, and government officials and aspiring politicians discuss and conceptualize the American moral order and social imaginary and its relationship to healthcare reform merits research.

9.7 Conclusion

We have seen how the American social imaginary is discursively constituted and how it has changed. Despite the fact that conservative rhetoric about government remains dominant in the United States today, and Obama’s rhetoric affirms this rather than challenges it, and although liberals may have largely lost the discursive struggle over

⁵⁸⁵William G. Howell, Paul E. Peterson, Martin R. West, “The Persuadable Public,” *Education Next* 9 (2009).

healthcare reform, equal opportunity, and the definitions of government responsibility to citizens, they have made substantial progress in the policy struggle.

Ultimately, healthcare reform that respects the liberal principles of universality, affordability, and health security has now been legislated and affirmed by the United States Supreme Court. Even though the law itself reflects many conservative values – particularly with regard to protecting private insurers – for almost one hundred years liberals had failed in the United States to make these principles real. Though Obama chose a discursive and policy pathway of moderation, compromise, and deference to many conservative values, he was able to pass legislation that has long been beyond the grasp of more overtly progressive and uncompromising liberals.

Key questions remain for the healthcare reform policy itself. Although rhetoric about it will continue to be an important area of study, and the policy will continue to be contested at local, state, and national levels important substantive questions remain. Some Republican governors have already indicated antagonism towards the reforms and the desire to frustrate them.⁵⁸⁶ Georgia's state insurance commissioner has stated alongside fellow Republicans he will do "everything in our power to be an obstructionist."⁵⁸⁷ Will ideology yield to pragmatism on the part of Republicans and will they work with the President on efforts to implement the healthcare reform law? Current efforts by members of the House of Representatives to cut off all funding from the

⁵⁸⁶Florida, which has a Republican governor and where the Republicans dominate the legislature has been attempting to stymie the implementation of the Affordable Care Act. According to the New York Times, "the state Department of Health on September 9 [2013] ordered some 60 county health agencies, whose clinics treat large numbers of poor and uninsured people, to bar from their premises counselors or "navigators," seeking to inform people how to enroll in insurance plans and get subsidies under the health reform law." The legislature and governor have also prevented the state insurance commissioner from using his powers to limit health insurance premium levels to ensure fairness and affordability in pricing.

Editorial Board, *The New York Times*, "Blocking Health Care Reform in Florida," September 19, 2013. http://www.nytimes.com/2013/09/20/opinion/blocking-health-care-reform-in-florida.html?_r=0

⁵⁸⁷Michael D. Shear. "Ad Campaigns Compete as Health Law Rollout Looms," *The New York Times*, September 21, 2013.

<http://www.nytimes.com/2013/09/22/us/politics/reignited-battle-over-health-law.html?pagewanted=all>

Affordable Care Act or cut funding to the government and cause a government shutdown if their demands to defund the Affordable Care Act are not met show the current depth of antagonism to the reforms.⁵⁸⁸ What about cost control and for how long are the current reforms economically viable without broader changes in American healthcare? Will the legislation work and will the vast majority of Americans have health insurance within a reasonable timeframe after its full implementation in 2014? A larger question remains to be addressed: How has the social imaginary and moral order changed with the passage of the Affordable Care Act and if the Act is implemented successfully will it continue to push the social imaginary in a more liberal direction?

These are timely and urgent questions and much remains unsettled and unknown at this time in which the United States is on the cusp of implementing near-universal healthcare. But they should not detract from the significance of how far the United States has traveled from the Truman era to the Obama era. Where once tens of millions of Americans went uninsured and underinsured, the United States is now transitioning to a new legal and social reality where the overwhelming majority of Americans who wish to access affordable and accessible healthcare, irrespective of their income and any other factor, can do so. The moral order and social imaginary has shifted, even if only somewhat and not in a clearly measurable way. However tentatively and haltingly, with an uneven pace, unclear direction and great compromise and substantial contradictions, the change is substantive and significant despite these caveats. Exactly how much it has shifted and the qualities of the shift remain to be seen in the years ahead, as well as how they may impact on citizen expectations of government and citizen attitudes towards government responsibility to actualize citizen welfare. Each of these presidents played a role in that lengthy and uneven journey, each articulated it distinctly, and now is the

⁵⁸⁸ Jonathan Weisman. "House Bill Links Health Care Law and Budget Plan," *The New York Times*, September 20, 2013.

moment when the gap between rhetoric and policy – so vast and seemingly impassable for over a century, has finally been crossed.

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<http://bipartisanpolicy.org/library/research/national-survey-registered-voters-regarding-political-polarization>

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Appendix: Presidential Speeches

Harry Truman's Special Message to the Congress Recommending a Comprehensive Health Program

November 19, 1945

To the Congress of the United States:

In my message to the Congress of September 6, 1945, there were enumerated in a proposed Economic Bill of Rights certain rights which ought to be assured to every American citizen.

One of them was: "The right to adequate medical care and the opportunity to achieve and enjoy good health." Another was the "right to adequate protection from the economic fears of . . . sickness"

Millions of our citizens do not now have a full measure of opportunity to achieve and enjoy good health. Millions do not now have protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection.

The people of the United States received a shock when the medical examinations conducted by the Selective Service System revealed the widespread physical and mental incapacity among the young people of our nation. We had had prior warnings from eminent medical authorities and from investigating committees. The statistics of the last war had shown the same condition. But the Selective Service System has brought it forcibly to our attention recently--in terms which all of us can understand.

As of April 1, 1945, nearly 5,000,000 male registrants between the ages of 18 and 37 had been examined and classified as unfit for military service. The number of those rejected for military service was about 30 percent of all those examined. The percentage of rejection was lower in the younger age groups, and higher in the higher age groups, reaching as high as 49 percent for registrants between the ages of 34 and 37. In addition, after actual induction, about a million and a half men had to be discharged from the Army and Navy for physical or mental disability, exclusive of wounds; and an equal number had to be treated in the Armed Forces for diseases or defects which existed before induction.

Among the young women who applied for admission to the Women's Army Corps there was similar disability. Over one-third of those examined were rejected for physical or mental reasons.

These men and women who were rejected for military service are not necessarily incapable of civilian work. It is plain, however, that they have illnesses and defects that handicap them, reduce their working capacity, or shorten their lives.

It is not so important to search the past in order to fix the blame for these conditions. It is more important to resolve now that no American child shall come to adult life with diseases or defects which can be prevented or corrected at an early age.

Medicine has made great strides in this generation--especially during the last four years. We owe much to the skill and devotion of the medical profession. In spite of great scientific progress, however, each year we lose many more persons from preventable and premature deaths than we lost in battle or from war injuries during the entire war.

We are proud of past reductions in our death rates. But these reductions have come principally from public health and other community services. We have been less effective in making available to all of our people the benefits of medical progress in the care and treatment of individuals.

In the past, the benefits of modern medical science have not been enjoyed by our citizens with any degree of equality. Nor are they today. Nor will they be in the future--unless government is bold enough to do something about it.

People with low or moderate incomes do not get the same medical attention as those with high incomes. The poor have more sickness, but they get less medical care. People who live in rural areas do not get the same amount or quality of medical attention as those who live in our cities.

Our new Economic Bill of Rights should mean health security for all, regardless of residence, station, or race--everywhere in the United States.

We should resolve now that the health of this Nation is a national concern; that financial barriers in the way of attaining health shall be removed; that the health of all its citizens deserves the help of all the Nation.

There are five basic problems which we must attack vigorously if we would reach the health objectives of our Economic Bill of Rights.

The first has to do with the number and distribution of doctors and hospitals. One of the most important requirements for adequate health service is professional personnel--doctors, dentists, public health and hospital administrators, nurses and other experts.

The United States has been fortunate with respect to physicians. In proportion to population it has more than any large country in the world, and they are well trained for their calling. It is not enough, however, that we have them in sufficient numbers. They should be located where their services are needed. In this respect we are not so fortunate.

The distribution of physicians in the United States has been grossly uneven and unsatisfactory. Some communities have had enough or even too many; others have had too few. Year by year the number in our rural areas has been diminishing. Indeed, in 1940, there were 31 counties in the United States, each with more than a thousand inhabitants, in which there was not a single practicing physician. The situation with respect to dentists was even worse.

One important reason for this disparity is that in some communities there are no adequate facilities for the practice of medicine. Another reason--closely allied with the first--is that the earning capacity of the people in some communities makes it difficult if not impossible for doctors who practice there to make a living.

The demobilization of 60,000 doctors, and of the tens of thousands of other professional personnel in the Armed Forces is now proceeding on a large scale. Unfortunately, unless we act rapidly, we may expect to see them concentrate in the places with greater financial resources and avoid other places, making the inequalities even greater than before the war.

Demobilized doctors cannot be assigned. They must be attracted. In order to be attracted, they must be able to see ahead of them professional opportunities and economic assurances.

Inequalities in the distribution of medical personnel are matched by inequalities in hospitals and other health facilities. Moreover, there are just too few hospitals, clinics and health centers to take proper care of the people of the United States.

About 1,200 counties, 40 percent of the total in the country, with some 15,000,000 people, have either no local hospital, or none that meets even the minimum standards of national professional associations.

The deficiencies are especially severe in rural and semirural areas and in those cities where changes in population have placed great strains on community facilities.

I want to emphasize, however, that the basic problem in this field cannot be solved merely by building facilities. They have to be staffed; and the communities have to be able to pay for the services. Otherwise the new facilities will be little used.

2. The second basic problem is the need for development of public health services and maternal and child care. The Congress can be justifiably proud of its share in making recent accomplishments possible. Public health and maternal and child health programs already have made important contributions to national health. But large needs remain. Great areas of our country are still without these services. This is especially true among our rural areas; but it is true also in far too many urban communities.

Although local public health departments are now maintained by some 18,000 counties and other local units, many of these have only skeleton organizations, and approximately 40,000,000 citizens of the United States still live in communities lacking full-time local public health service. At the recent rate of progress in developing such service, it would take more than a hundred years to cover the whole Nation.

If we agree that the national health must be improved, our cities, towns and farming communities must be made healthful places in which to live through provision of safe water systems, sewage disposal plants and sanitary facilities. Our streams and rivers must be safeguarded against pollution. In addition to building a sanitary environment for ourselves and for our children, we must provide those services which prevent disease and promote health.

Services for expectant mothers and for infants, care of crippled or otherwise physically handicapped children and inoculation for the prevention of communicable diseases are accepted public health functions. So too are many kinds of personal services such as the diagnosis and treatment of widespread infections like tuberculosis and venereal disease. A large part of the population today lacks many or all of these services.

Our success in the traditional public health sphere is made plain by the conquest over many communicable diseases. Typhoid fever, smallpox, and diphtheria--diseases for which there are effective controls--have become comparatively rare. We must make the same gains in reducing our maternal and infant mortality, in controlling tuberculosis, venereal disease, malaria, and other major threats to life and health. We are only beginning to realize our potentialities in achieving physical well-being for all our people.

3. The third basic problem concerns medical research and professional education.

We have long recognized that we cannot be content with what is already known about health or disease. We must learn and understand more about health and how to prevent and cure disease.

Research--well directed and continuously supported--can do much to develop ways to reduce those diseases of body and mind which now cause most sickness, disability, and premature death--diseases of the heart, kidneys and arteries, rheumatism, cancer, diseases of childbirth, infancy and childhood, respiratory diseases and tuberculosis. And research can do much toward teaching us how to keep well and how to prolong healthy human life.

Cancer is among the leading causes of death. It is responsible for over 160,000 recorded deaths a year, and should receive special attention. Though we already have the National Cancer Institute of the Public Health Service, we need still more coordinated research on the cause, prevention and cure of this disease. We need more financial support for research and to establish special clinics and hospitals for diagnosis and treatment of the disease especially in its early stages. We need to train more physicians for the highly specialized services so essential for effective control of cancer.

There is also special need for research on mental diseases and abnormalities. We have done pitifully little about mental illnesses. Accurate statistics are lacking, but there is no doubt that there are at least two million persons in the United States who are mentally ill, and that as many as ten million will probably need hospitalization for mental illness for some period in the course of their lifetime. A great many of these persons would be helped by proper care. Mental cases occupy more than one-half of the hospital beds, at a cost of about 500 million dollars per year--practically all of it coming out of taxpayers' money. Each year there are 125,000 new mental cases admitted to institutions. We need more mental-disease hospitals, more out-patient clinics. We need more services for early diagnosis, and especially we need much more research to learn how to prevent mental breakdown. Also, we must have many more trained and qualified doctors in this field.

It is clear that we have not done enough in peace-time for medical research and education in view of our enormous resources and our national interest in health progress. The money invested in research pays enormous dividends. If any one doubts this, let him think of penicillin, plasma, DDT powder, and new rehabilitation techniques.

4. The fourth problem has to do with the high cost of individual medical care. The principal reason why people do not receive the care they need is that they cannot afford to pay for it on an individual basis at the time they need it. This is true not only for needy persons. It is also true for a large proportion of normally self-supporting persons.

In the aggregate, all health services--from public health agencies, physicians, hospitals,

dentists, nurses and laboratories--absorb only about 4 percent of the national income. We can afford to spend more for health.

But four percent is only an average. It is cold comfort in individual cases. Individual families pay their individual costs, and not average costs. They may be hit by sickness that calls for many times the average cost--in extreme cases for more than their annual income. When this happens they may come face to face with economic disaster. Many families, fearful of expense, delay calling the doctor long beyond the time when medical care would do the most good.

For some persons with very low income or no income at all we now use taxpayers' money in the form of free services, free clinics, and public hospitals. Tax-supported, free medical care for needy persons, however, is insufficient in most of our cities and in nearly all of our rural areas. This deficiency cannot be met by private charity or the kindness of individual physicians.

Each of us knows doctors who work through endless days and nights, never expecting to be paid for their services because many of their patients are unable to pay. Often the physician spends not only his time and effort, but even part of the fees he has collected from patients able to pay, in order to buy medical supplies for those who cannot afford them. I am sure that there are thousands of such physicians throughout our country. They cannot, and should not, be expected to carry so heavy a load.

5. The fifth problem has to do with loss of earnings when sickness strikes. Sickness not only brings doctor bills; it also cuts off income.

On an average day, there are about 7 million persons so disabled by sickness or injury that they cannot go about their usual tasks. Of these, about 3 1/4 millions are persons who, if they were not disabled, would be working or seeking employment. More than one-half of these disabled workers have already been disabled for six months; many of them will continue to be disabled for years, and some for the remainder of their lives.

Every year, four or five hundred million working days are lost from productive employment because of illness and accident among those working or looking for work--about forty times the number of days lost because of strikes on the average during the ten years before the war. About nine-tenths of this enormous loss is due to illness and accident that is not directly connected with employment, and is therefore not covered by workmen's compensation laws.

These then are the five important problems which must be solved, if we hope to attain our objective of adequate medical care, good health, and protection from the economic fears of sickness and disability.

To meet these problems, I recommend that the Congress adopt a comprehensive and modern health program for the Nation, consisting of five major parts--each of which contributes to all the others.

FIRST: CONSTRUCTION OF HOSPITALS AND RELATED FACILITIES

The Federal Government should provide financial and other assistance for the construction of needed hospitals, health centers and other medical, health, and

rehabilitation facilities. With the help of Federal funds, it should be possible to meet deficiencies in hospital and health facilities so that modern services--for both prevention and cure--can be accessible to all the people. Federal financial aid should be available not only to build new facilities where needed, but also to enlarge or modernize those we now have.

In carrying out this program, there should be a clear division of responsibilities between the States and the Federal Government. The States, localities and the Federal Government should share in the financial responsibilities. The Federal Government should not construct or operate these hospitals. It should, however, lay down minimum national standards for construction and operation, and should make sure that Federal funds are allocated to those areas and projects where Federal aid is needed most. In approving state plans and individual projects, and in fixing the national standards, the Federal agency should have the help of a strictly advisory body that includes both public and professional members.

Adequate emphasis should be given to facilities that are particularly useful for prevention of diseases--mental as well as physical--and to the coordination of various kinds of facilities. It should be possible to go a long way toward knitting together facilities for prevention with facilities for cure, the large hospitals of medical centers with the smaller institutions of surrounding areas, the facilities for the civilian population with the facilities for veterans.

The general policy of Federal-State partnership which has done so much to provide the magnificent highways of the United States can be adapted to the construction of hospitals in the communities which need them.

SECOND: EXPANSION OF PUBLIC HEALTH, MATERNAL AND CHILD HEALTH SERVICES

Our programs for public health and related services should be enlarged and strengthened. The present Federal-State cooperative health programs deal with general public health work, tuberculosis and venereal disease control, maternal and child health services, and services for crippled children.

These programs were especially developed in the ten years before the war, and have been extended in some areas during the war. They have already made important contributions to national health, but they have not yet reached a large proportion of our rural areas, and, in many cities, they are only partially developed.

No area in the Nation should continue to be without the services of a full-time health officer and other essential personnel. No area should be without essential public health services or sanitation facilities. No area should be without community health services such as maternal and child health care.

Hospitals, clinics and health centers must be built to meet the needs of the total population, and must make adequate provision for the safe birth of every baby, and for the health protection of infants and children.

Present laws relating to general public health, and to maternal and child health, have built

a solid foundation of Federal cooperation with the States in administering community health services. The emergency maternity and infant care program for the wives and infants of servicemen--a great wartime service authorized by the Congress--has materially increased the experience of every State health agency, and has provided much-needed care. So too have other wartime programs such as venereal disease control, industrial hygiene, malaria control, tuberculosis control and other services offered in war essential communities.

The Federal Government should cooperate by more generous grants to the States than are provided under present laws for public health services and for maternal and child health care. The program should continue to be partly financed by the States themselves, and should be administered by the States. Federal grants should be in proportion to State and local expenditures, and should also vary in accordance with the financial ability of the respective States.

The health of American children, like their education, should be recognized as a definite public responsibility.

In the conquest of many diseases prevention is even more important than cure. A well-rounded national health program should, therefore, include systematic and wide-spread health and physical education and examinations, beginning with the youngest children and extending into community organizations. Medical and dental examinations of school children are now inadequate. A preventive health program, to be successful, must discover defects as early as possible. We should, therefore, see to it that our health programs are pushed most vigorously with the youngest section of the population.

Of course, Federal aid for community health services--for general public health and for mothers and children--should complement and not duplicate prepaid medical services for individuals, proposed by the fourth recommendation of this message.

THIRD; MEDICAL EDUCATION AND RESEARCH

The Federal Government should undertake a broad program to strengthen professional education in medical and related fields, and to encourage and support medical research.

Professional education should be strengthened where necessary through Federal grants-in-aid to public and to non-profit private institutions. Medical research, also, should be encouraged and supported in the Federal agencies and by grants-in-aid to public and non-profit private agencies.

In my message to the Congress of September 6, 1945, I made various recommendations for a general Federal research program. Medical research--dealing with the broad fields of physical and mental illnesses--should be made effective in part through that general program and in part through specific provisions within the scope of a national health program.

Federal aid to promote and support research in medicine, public health and allied fields is an essential part of a general research program to be administered by a central Federal research agency. Federal aid for medical research and education is also an essential part of any national health program, if it is to meet its responsibilities for high grade medical services and for continuing progress. Coordination of the two programs is obviously

necessary to assure efficient use of Federal funds. Legislation covering medical research in a national health program should provide for such coordination.

FOURTH: PREPAYMENT OF MEDICAL COSTS

Everyone should have ready access to all necessary medical, hospital and related services.

I recommend solving the basic problem by distributing the costs through expansion of our existing compulsory social insurance system. This is not socialized medicine.

Everyone who carries fire insurance knows how the law of averages is made to work so as to spread the risk, and to benefit the insured who actually suffers the loss. If instead of the costs of sickness being paid only by those who get sick, all the people--sick and well--were required to pay premiums into an insurance fund, the pool of funds thus created would enable all who do fall sick to be adequately served without overburdening anyone. That is the principle upon which all forms of insurance are based.

During the past fifteen years, hospital insurance plans have taught many Americans this magic of averages. Voluntary health insurance plans have been expanding during recent years; but their rate of growth does not justify the belief that they will meet more than a fraction of our people's needs. Only about 3% or 4% of our population now have insurance providing comprehensive medical care.

A system of required prepayment would not only spread the costs of medical care, it would also prevent much serious disease. Since medical bills would be paid by the insurance fund, doctors would more often be consulted when the first signs of disease occur instead of when the disease has become serious. Modern hospital, specialist and laboratory services, as needed, would also become available to all, and would improve the quality and adequacy of care. Prepayment of medical care would go a long way toward furnishing insurance against disease itself, as well as against medical bills.

Such a system of prepayment should cover medical, hospital, nursing and laboratory services. It should also cover dental care--as fully and for as many of the population as the available professional personnel and the financial resources of the system permit.

The ability of our people to pay for adequate medical care will be increased if, while they are well, they pay regularly into a common health fund, instead of paying sporadically and unevenly when they are sick. This health fund should be built up nationally, in order to establish the broadest and most stable basis for spreading the costs of illness, and to assure adequate financial support for doctors and hospitals everywhere. If we were to rely on state-by-state action only, many years would elapse before we had any general coverage. Meanwhile health service would continue to be grossly uneven, and disease would continue to cross state boundary lines.

Medical services are personal. Therefore the nation-wide system must be highly decentralized in administration. The local administrative unit must be the keystone of the system so as to provide for local services and adaptation to local needs and conditions. Locally as well as nationally, policy and administration should be guided by advisory committees in which the public and the medical professions are represented.

Subject to national standards, methods and rates of paying doctors and hospitals should

be adjusted locally. All such rates for doctors should be adequate, and should be appropriately adjusted upward for those who are qualified specialists.

People should remain free to choose their own physicians and hospitals. The removal of financial barriers between patient and doctor would enlarge the present freedom of choice. The legal requirement on the population to contribute involves no compulsion over the doctor's freedom to decide what services his patient needs. People will remain free to obtain and pay for medical service outside of the health insurance system if they desire, even though they are members of the system; just as they are free to send their children to private instead of to public schools, although they must pay taxes for public schools.

Likewise physicians should remain free to accept or reject patients. They must be allowed to decide for themselves whether they wish to participate in the health insurance system full time, part time, or not at all. A physician may have some patients who are in the system and some who are not. Physicians must be permitted to be represented through organizations of their own choosing, and to decide whether to carry on in individual practice or to join with other doctors in group practice in hospitals or in clinics.

Our voluntary hospitals and our city, county and state general hospitals, in the same way, must be free to participate in the system to whatever extent they wish. In any case they must continue to retain their administrative independence.

Voluntary organizations which provide health services that meet reasonable standards of quality should be entitled to furnish services under the insurance system and to be reimbursed for them. Voluntary cooperative organizations concerned with paying doctors, hospitals or others for health services, but not providing services directly, should be entitled to participate if they can contribute to the efficiency and economy of the system.

None of this is really new. The American people are the most insurance-minded people in the world. They will not be frightened off from health insurance because some people have misnamed it "socialized medicine".

I repeat--what I am recommending is not socialized medicine.

Socialized medicine means that all doctors work as employees of government. The American people want no such system. No such system is here proposed.

Under the plan I suggest, our people would continue to get medical and hospital services just as they do now--on the basis of their own voluntary decisions and choices. Our doctors and hospitals would continue to deal with disease with the same professional freedom as now. There would, however, be this all-important difference: whether or not patients get the services they need would not depend on how much they can afford to pay at the time.

I am in favor of the broadest possible coverage for this insurance system. I believe that all persons who work for a living and their dependents should be covered under such an insurance plan. This would include wage and salary earners, those in business for themselves, professional persons, farmers, agricultural labor, domestic employees, government employees and employees of non-profit institutions and their families.

In addition, needy persons and other groups should be covered through appropriate premiums paid for them by public agencies. Increased Federal funds should also be made available by the Congress under the public assistance programs to reimburse the States for part of such premiums, as well as for direct expenditures made by the States in paying for medical services provided by doctors, hospitals and other agencies to needy persons.

Premiums for present social insurance benefits are calculated on the first \$3,000 of earnings in a year. It might be well to have all such premiums, including those for health, calculated on a somewhat higher amount such as \$3,600.

A broad program of prepayment for medical care would need total amounts approximately equal to 4% of such earnings. The people of the United States have been spending, on the average, nearly this percentage of their incomes for sickness care. How much of the total fund should come from the insurance premiums and how much from general revenues is a matter for the Congress to decide.

The plan which I have suggested would be sufficient to pay most doctors more than the best they have received in peacetime years. The payments of the doctors' bills would be guaranteed, and the doctors would be spared the annoyance and uncertainty of collecting fees from individual patients. The same assurance would apply to hospitals, dentists and nurses for the services they render.

Federal aid in the construction of hospitals will be futile unless there is current purchasing power so that people can use these hospitals. Doctors cannot be drawn to sections which need them without some assurance that they can make a living. Only a nation-wide spreading of sickness costs can supply such sections with sure and sufficient purchasing power to maintain enough physicians and hospitals.

We are a rich nation and can afford many things. But ill-health which can be prevented or cured is one thing we cannot afford.

FIFTH: PROTECTION AGAINST LOSS OF WAGES FROM SICKNESS AND DISABILITY

What I have discussed heretofore has been a program for improving and spreading the health services and facilities of the Nation, and providing an efficient and less burdensome system of paying for them.

But no matter what we do, sickness will of course come to many. Sickness brings with it loss of wages.

Therefore, as a fifth element of a comprehensive health program, the workers of the Nation and their families should be protected against loss of earnings because of illness. A comprehensive health program must include the payment of benefits to replace at least part of the earnings that are lost during the period of sickness and long-term disability. This protection can be readily and conveniently provided through expansion of our present social insurance system, with appropriate adjustment of premiums.

Insurance against loss of wages from sickness and disability deals with cash benefits, rather than with services. It has to be coordinated with the other cash benefits under

existing social insurance systems. Such coordination should be effected when other social security measures are reexamined. I shall bring this subject again to the attention of the Congress in a separate message on social security.

I strongly urge that the Congress give careful consideration to this program of health legislation now.

Many millions of our veterans, accustomed in the armed forces to the best of medical and hospital care, will no longer be eligible for such care as a matter of right except for their service-connected disabilities. They deserve continued adequate and comprehensive health service. And their dependents deserve it too.

By preventing illness, by assuring access to needed community and personal health services, by promoting medical research, and by protecting our people against the loss caused by sickness, we shall strengthen our national health, our national defense, and our economic productivity. We shall increase the professional and economic opportunities of our physicians, dentists and nurses. We shall increase the effectiveness of our hospitals and public health agencies. We shall bring new security to our people.

We need to do this especially at this time because of the return to civilian life of many doctors, dentists and nurses, particularly young men and women.

Appreciation of modern achievements in medicine and public health has created widespread demand that they be fully applied and universally available. By meeting that demand we shall strengthen the Nation to meet future economic and social problems; and we shall make a most important contribution toward freedom from want in our land.
HARRY S. TRUMAN

Available at:

<http://www.trumanlibrary.org/publicpapers/index.php?pid=483&st=&st1=>

**President Lyndon B. Johnson's
Remarks With President Truman at the Signing in
Independence of the Medicare Bill**

July 30, 1965

PRESIDENT TRUMAN. Thank you very much. I am glad you like the President. I like him too. He is one of the finest men I ever ran across.

Mr. President, Mrs. Johnson, distinguished guests:

You have done me a great honor in coming here today, and you have made me a very, very happy man.

This is an important hour for the Nation, for those of our citizens who have completed their tour of duty and have moved to the sidelines. These are the days that we are trying to celebrate for them. These people are our proudest responsibility and they are entitled, among other benefits, to the best medical protection available.

Not one of these, our citizens, should ever be abandoned to the indignity of charity. Charity is indignity when you have to have it. But we don't want these people to have anything to do with charity and we don't want them to have any idea of hopeless despair.

Mr. President, I am glad to have lived this long and to witness today the signing of the Medicare bill which puts this Nation right where it needs to be, to be right. Your inspired leadership and a responsive forward-looking Congress have made it historically possible for this day to come about.

Thank all of you most highly for coming here. It is an honor I haven't had for, well, quite awhile, I'll say that to you, but here it is:

Ladies and gentlemen, the President of the United States.

THE PRESIDENT. *President and Mrs. Truman, Secretary Celebrezze, Senator Mansfield, Senator Symington, Senator Long, Governor Hearnes, Senator Anderson and Congressman King of the Anderson-King team, Congressman Mills and Senator Long of the Mills-Long team, our beloved Vice President who worked in the vineyard many years to see this day come to pass, and all of my dear friends in the Congress--both Democrats and Republicans:*

The people of the United States love and voted for Harry Truman, not because he gave them hell--but because he gave them hope.

I believe today that all America shares my joy that he is present now when the hope that he offered becomes a reality for millions of our fellow citizens.

I am so proud that this has come to pass in the Johnson administration. But it was really Harry Truman of Missouri who planted the seeds of compassion and duty which have today flowered into care for the sick, and serenity for the fearful.

Many men can make many proposals. Many men can draft many laws. But few have the piercing and humane eye which can see beyond the words to the people that they touch. Few can see past the speeches and the political battles to the doctor over there that is tending the infirm, and to the hospital that is receiving those in anguish, or feel in their heart painful wrath at the injustice which denies the miracle of healing to the old and to the poor. And fewer still have the courage to stake reputation, and position, and the effort of a lifetime upon such a cause when there are so few that share it.

But it is just such men who illuminate the life and the history of a nation. And so, President Harry Truman, it is in tribute not to you, but to the America that you represent, that we have come here to pay our love and our respects to you today. For a country can be known by the quality of the men it honors. By praising you, and by carrying forward your dreams, we really reaffirm the greatness of America.

It was a generation ago that Harry Truman said, and I quote him: "Millions of our citizens do not now have a full measure of opportunity to achieve and to enjoy good health. Millions do not now have protection or security against the economic effects of sickness. And the time has now arrived for action to help them attain that opportunity and to help them get that protection."

Well, today, Mr. President, and my fellow Americans, we are taking such action--20 years later. And we are doing that under the great leadership of men like John McCormack, our Speaker; Carl Albert, our majority leader; our very able and beloved majority leader of the Senate, Mike Mansfield; and distinguished Members of the Ways and Means and Finance Committees of the House and Senate--of both parties, Democratic and Republican.

Because the need for this action is plain; and it is so clear indeed that we marvel not simply at the passage of this bill, but what we marvel at is that it took so many years to pass it. And I am so glad that Aime Forand is here to see it finally passed and signed--one of the first authors.

There are more than 18 million Americans over the age of 65. Most of them have low incomes. Most of them are threatened by illness and medical expenses that they cannot afford.

And through this new law, Mr. President, every citizen will be able, in his productive years when he is earning, to insure himself against the ravages of illness in his old age.

This insurance will help pay for care in hospitals, in skilled nursing homes, or in the home. And under a separate plan it will help meet the fees of the doctors.

Now here is how the plan will affect you.

During your working years, the people of America--you--will contribute through the social security program a small amount each payday for hospital insurance protection. For example, the average worker in 1966 will contribute about \$1.50 per month. The employer will contribute a similar amount. And this will provide the funds to pay up to 90 days of hospital care for each illness, plus diagnostic care, and up to 100 home health visits after you are 65. And beginning in 1967, you will also be covered for up to 100 days of care in a skilled nursing home after a period of hospital care.

And under a separate plan, when you are 65--that the Congress originated itself, in its own good judgment--you may be covered for medical and surgical fees whether you are in or out of the hospital. You will pay \$3 per month after you are 65 and your Government will contribute an equal amount.

The benefits under the law are as varied and broad as the marvelous modern medicine itself. If it has a few defects--such as the method of payment of certain specialists--then I am confident those can be quickly remedied and I hope they will be.

No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents, and to their uncles, and their aunts.

And no longer will this Nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive country.

And this bill, Mr. President, is even broader than that. It will increase social security benefits for all of our older Americans. It will improve a wide range of health and medical services for Americans of all ages.

In 1935 when the man that both of us loved so much, Franklin Delano Roosevelt, signed the Social Security Act, he said it was, and I quote him, "a cornerstone in a structure which is being built but it is by no means complete."

Well, perhaps no single act in the entire administration of the beloved Franklin D. Roosevelt really did more to win him the illustrious place in history that he has as did the laying of that cornerstone. And I am so happy that his oldest son Jimmy could be here to share with us the joy that is ours today. And those who share this day will also be remembered for making the most important addition to that structure, and you are making it in this bill, the most important addition that has been made in three decades.

History shapes men, but it is a necessary faith of leadership that men can help shape history. There are many who led us to this historic day. Not out of courtesy or deference, but from the gratitude and remembrance which is our country's debt, if I may be pardoned for taking a moment, I want to call a part of the honor roll: it is the able leadership in both Houses of the Congress.

Congressman Celler, Chairman of the Judiciary Committee, introduced the hospital insurance in 1952. Aime Forand from Rhode Island, then Congressman, introduced it in the House. Senator Clinton Anderson from New Mexico fought for Medicare through the years in the Senate. Congressman Cecil King of California carried on the battle in the House. The legislative genius of the Chairman of the Ways and Means Committee, Congressman Wilbur Mills, and the effective and able work of Senator Russell Long, together transformed this desire into victory.

And those devoted public servants, former Secretary, Senator Ribicoff; present Secretary, Tony Celebrezze; Under Secretary Wilbur Cohen; the Democratic whip of the House, Hale Boggs on the Ways and Means Committee; and really the White House's best

legislator, Larry O'Brien, gave not just endless days and months and, yes, years of patience--but they gave their hearts--to passing this bill.

Let us also remember those who sadly cannot share this time for triumph. For it is their triumph too. It is the victory of great Members of Congress that are not with us, like John Dingell, Sr., and Robert Wagner, late a Member of the Senate, and James Murray of Montana.

And there is also John Fitzgerald Kennedy, who fought in the Senate and took his case to the people, and never yielded in pursuit, but was not spared to see the final concourse of the forces that he had helped to loose.

But it all started really with the man from Independence. And so, as it is fitting that we should, we have come back here to his home to complete what he began.

President Harry Truman, as any President must, made many decisions of great moment; although he always made them frankly and with a courage and a clarity that few men have ever shared. The immense and the intricate questions of freedom and survival were caught up many times in the web of Harry Truman's judgment. And this is in the tradition of leadership.

But there is another tradition that we share today. It calls upon us never to be indifferent toward despair. It commands us never to turn away from helplessness. It directs us never to ignore or to spurn those who suffer untended in a land that is bursting with abundance.

I said to Senator Smathers, the whip of the Democrats in the Senate, who worked with us in the Finance Committee on this legislation--I said, the highest traditions of the medical profession are really directed to the ends that we are trying to serve. And it was only yesterday, at the request of some of my friends, I met with the leaders of the American Medical Association to seek their assistance in advancing the cause of one of the greatest professions of all--the medical profession--in helping us to maintain and to improve the health of all Americans.

And this is not just our tradition--or the tradition of the Democratic Party--or even the tradition of the Nation. It is as old as the day it was first commanded: "Thou shalt open thine hand wide unto thy brother, to thy poor, to thy needy, in thy land."

And just think, Mr. President, because of this document--and the long years of struggle which so many have put into creating it--in this town, and a thousand other towns like it, there are men and women in pain who will now find ease. There are those, alone in suffering who will now hear the sound of some approaching footsteps coming to help. There are those fearing the terrible darkness of despairing poverty--despite their long years of labor and expectation--who will now look up to see the light of hope and realization.

There just can be no satisfaction, nor any act of leadership, that gives greater satisfaction than this.

And perhaps you alone, President Truman, perhaps you alone can fully know just how grateful I am for this day.

NOTE: The President spoke at 2:55 p.m. in the auditorium of the Harry S. Truman Library in Independence, Mo. In his opening words he referred to former President and Mrs. Harry S. Truman, Secretary of Health, Education, and Welfare Anthony J. Celebrezze, Senator Mike Mansfield of Montana, majority leader of the Senate, Senator Stuart Symington and Senator Edward V. Long of Missouri, Governor Warren E. Hearnes of Missouri, Senator Clinton P. Anderson of New Mexico, Representative Cecil R. King of California, Representative Wilbur D. Mills of Arkansas, Senator Russell B. Long of Louisiana, and Vice President Hubert H. Humphrey.

During his remarks the President referred to, among others, Representative John W. McCormack of Massachusetts, Speaker of the House of Representatives, Representative Carl Albert of Oklahoma, majority leader of the House of Representatives, Aime Forand, Representative from Rhode Island 1937-1939 and 1941-1961, Representative Emanuel Celler of New York, Senator Abraham Ribicoff of (Pg. 815) Connecticut, former Secretary of Health, Education, and Welfare, Under Secretary of Health, Education, and Welfare Wilbur J. Cohen, Representative Hale Boggs of Louisiana, Lawrence F. O'Brien, Special Assistant to the president, John D. Dingell, Representative from Michigan 1933-1955, Robert F. Wagner, Senator from New York 1927-1949, James E. Murray; Senator from Montana 1934-1961, and Senator George A. Smathers of Florida.

As enacted, the Medicare bill (H.R. 6675) is Public Law 89-97 (79 Stat. 286).

Available at:

<http://www.lbjlib.utexas.edu/johnson/archives.hom/speeches.hom/650730.asp>

President Clinton's Address on Health Care Reform

September 22, 1993

Mr. Speaker, Mr. President, Members of Congress, distinguished guests, my fellow Americans, before I begin my words tonight I would like to ask that we all bow in a moment of silent prayer for the memory of those who were killed and those who have been injured in the tragic train accident in Alabama today. Amen.

My fellow Americans, tonight we come together to write a new chapter in the American story. Our forebears enshrined the American dream: life, liberty, the pursuit of happiness. Every generation of Americans has worked to strengthen that legacy, to make our country a place of freedom and opportunity, a place where people who work hard can rise to their full potential, a place where their children can have a better future.

From the settling of the frontier to the landing on the Moon, ours has been a continuous story of challenges defined, obstacles overcome, new horizons secured. That is what makes America what it is and Americans what we are. Now we are in a time of profound change and opportunity. The end of the cold war, the information age, the global economy have brought us both opportunity and hope and strife and uncertainty. Our purpose in this dynamic age must be to make change our friend and not our enemy.

To achieve that goal, we must face all our challenges with confidence, with faith, and with discipline, whether we're reducing the deficit, creating tomorrow's jobs and training our people to fill them, converting from a high-tech defense to a high-tech domestic economy, expanding trade, reinventing Government, making our streets safer, or rewarding work over idleness. All these challenges require us to change.

If Americans are to have the courage to change in a difficult time, we must first be secure in our most basic needs. Tonight I want to talk to you about the most critical thing we can do to build that security. This health care system of ours is badly broken, and it is time to fix it. Despite the dedication of literally millions of talented health care professionals, our health care is too uncertain and too expensive, too bureaucratic and too wasteful. It has too much fraud and too much greed.

At long last, after decades of false starts, we must make this our most urgent priority, giving every American health security, health care that can never be taken away, health care that is always there. That is what we must do tonight.

On this journey, as on all others of true consequence, there will be rough spots in the road and honest disagreements about how we should proceed. After all, this is a complicated issue. But every successful journey is guided by fixed stars. And if we can agree on some basic values and principles, we will reach this destination, and we will reach it together.

So tonight I want to talk to you about the principles that I believe must embody our efforts to reform America's health care system: security, simplicity, savings, choice, quality, and responsibility.

When I launched our Nation on this journey to reform the health care system I knew we

needed a talented navigator, someone with a rigorous mind, a steady compass, a caring heart. Luckily for me and for our Nation, I didn't have to look very far.

Over the last 8 months, Hillary and those working with her have talked to literally thousands of Americans to understand the strengths and the frailties of this system of ours. They met with over 1,100 health care organizations. They talked with doctors and nurses, pharmacists and drug company representatives, hospital administrators, insurance company executives, and small and large businesses. They spoke with self-employed people. They talked with people who had insurance and people who didn't. They talked with union members and older Americans and advocates for our children. The First Lady also consulted, as all of you know, extensively with governmental leaders in both parties in the States of our Nation and especially here on Capitol Hill. Hillary and the task force received and read over 700,000 letters from ordinary citizens. What they wrote and the bravery with which they told their stories is really what calls us all here tonight.

Every one of us knows someone who's worked hard and played by the rules and still been hurt by this system that just doesn't work for too many people. But I'd like to tell you about just one. Kerry Kennedy owns a small furniture store that employs seven people in Titusville, Florida. Like most small business owners, he's poured his heart and soul, his sweat and blood into that business for years. But over the last several years, again like most small business owners, he's seen his health care premiums skyrocket, even in years when no claims were made. And last year, he painfully discovered he could no longer afford to provide coverage for all his workers because his insurance company told him that two of his workers had become high risks because of their advanced age. The problem was that those two people were his mother and father, the people who founded the business and still work in the store.

This story speaks for millions of others. And from them we have learned a powerful truth. We have to preserve and strengthen what is right with the health care system, but we have got to fix what is wrong with it.

Now, we all know what's right. We're blessed with the best health care professionals on Earth, the finest health care institutions, the best medical research, the most sophisticated technology. My mother is a nurse. I grew up around hospitals. Doctors and nurses were the first professional people I ever knew or learned to look up to. They are what is right with this health care system. But we also know that we can no longer afford to continue to ignore what is wrong.

Millions of Americans are just a pink slip away from losing their health insurance and one serious illness away from losing all their savings. Millions more are locked into the jobs they have now just because they or someone in their family has once been sick and they have what is called the preexisting condition. And on any given day, over 37 million Americans, most of them working people and their little children, have no health insurance at all.

And in spite of all this, our medical bills are growing at over twice the rate of inflation, and the United States spends over a third more of its income on health care than any other nation on Earth. And the gap is growing, causing many of our companies in global competition severe disadvantage. There is no excuse for this kind of system. We know other people have done better. We know people in our own country are doing better. We have no excuse. My fellow Americans, we must fix this system, and it has to begin with

congressional action.

I believe as strongly as I can say that we can reform the costliest and most wasteful system on the face of the Earth without enacting new broad-based taxes. I believe it because of the conversations I have had with thousands of health care professionals around the country, with people who are outside this city but are inside experts on the way this system works and wastes money.

The proposal that I describe tonight borrows many of the principles and ideas that have been embraced in plans introduced by both Republicans and Democrats in this Congress. For the first time in this century, leaders of both political parties have joined together around the principle of providing universal, comprehensive health care. It is a magic moment, and we must seize it.

I want to say to all of you I have been deeply moved by the spirit of this debate, by the openness of all people to new ideas and argument and information. The American people would be proud to know that earlier this week when a health care university was held for Members of Congress just to try to give everybody the same amount of information, over 320 Republicans and Democrats signed up and showed up for 2 days just to learn the basic facts of the complicated problem before us.

Both sides are willing to say, "We have listened to the people. We know the cost of going forward with this system is far greater than the cost of change." Both sides, I think, understand the literal ethical imperative of doing something about the system we have now. Rising above these difficulties and our past differences to solve this problem will go a long way toward defining who we are and who we intend to be as a people in this difficult and challenging era. I believe we all understand that. And so tonight, let me ask all of you, every Member of the House, every Member of the Senate, each Republican and each Democrat, let us keep this spirit and let us keep this commitment until this job is done. We owe it to the American people. [Applause]

Thank you. Thank you very much.

Now, if I might, I would like to review the six principles I mentioned earlier and describe how we think we can best fulfill those principles.

First and most important, security. This principle speaks to the human misery, to the costs, to the anxiety we hear about every day, all of us, when people talk about their problems with the present system. Security means that those who do not now have health care coverage will have it, and for those who have it, it will never be taken away. We must achieve that security as soon as possible.

Under our plan, every American would receive a health care security card that will guarantee a comprehensive package of benefits over the course of an entire lifetime, roughly comparable to the benefit package offered by most Fortune 500 companies. This health care security card will offer this package of benefits in a way that can never be taken away. So let us agree on this: Whatever else we disagree on, before this Congress finishes its work next year, you will pass and I will sign legislation to guarantee this security to every citizen of this country.

With this card, if you lose your job or you switch jobs, you're covered. If you leave your

job to start a small business, you're covered. If you're an early retiree, you're covered. If someone in your family has unfortunately had an illness that qualifies as a preexisting condition, you're still covered. If you get sick or a member of your family gets sick, even if it's a life-threatening illness, you're covered. And if an insurance company tries to drop you for any reason, you will still be covered, because that will be illegal. This card will give comprehensive coverage. It will cover people for hospital care, doctor visits, emergency and lab services, diagnostic services like Pap smears and mammograms and cholesterol tests, substance abuse, and mental health treatment.

And equally important, for both health care and economic reasons, this program for the first time would provide a broad range of preventive services including regular checkups and well baby visits. Now, it's just common sense. We know, any family doctor will tell you, that people will stay healthier and long-term costs of the health system will be lower if we have comprehensive preventive services. You know how all of our mothers told us that an ounce of prevention was worth a pound of cure? Our mothers were right. And it's a lesson, like so many lessons from our mothers, that we have waited too long to live by. It is time to start doing it.

Health care security must also apply to older Americans. This is something I imagine all of us in this room feel very deeply about. The first thing I want to say about that is that we must maintain the Medicare program. It works to provide that kind of security. But this time and for the first time, I believe Medicare should provide coverage for the cost of prescription drugs.

Yes, it will cost some more in the beginning. But again, any physician who deals with the elderly will tell you that there are thousands of elderly people in every State who are not poor enough to be on Medicaid but just above that line and on Medicare, who desperately need medicine, who make decisions every week between medicine and food. Any doctor who deals with the elderly will tell you that there are many elderly people who don't get medicine, who get sicker and sicker and eventually go to the doctor and wind up spending more money and draining more money from the health care system than they would if they had regular treatment in the way that only adequate medicine can provide.

I also believe that over time, we should phase in long-term care for the disabled and the elderly on a comprehensive basis. As we proceed with this health care reform, we cannot forget that the most rapidly growing percentage of Americans are those over 80. We cannot break faith with them. We have to do better by them.

The second principle is simplicity. Our health care system must be simpler for the patients and simpler for those who actually deliver health care: our doctors, our nurses, our other medical professionals. Today we have more than 1,500 insurers, with hundreds and hundreds of different forms. No other nation has a system like this. These forms are time consuming for health care providers. They're expensive for health care consumers. They're exasperating for anyone who's ever tried to sit down around a table and wade through them and figure them out.

The medical care industry is literally drowning in paperwork. In recent years, the number of administrators in our hospitals has grown by 4 times the rate that the number of doctors has grown. A hospital ought to be a house of healing, not a monument to paperwork and bureaucracy.

Just a few days ago, the Vice President and I had the honor of visiting the Children's Hospital here in Washington where they do wonderful, often miraculous things for very sick children. A nurse named Debbie Freiberg told us that she was in the cancer and bone marrow unit. The other day a little boy asked her just to stay at his side during his chemotherapy. And she had to walk away from that child because she had been instructed to go to yet another class to learn how to fill out another form for something that didn't have a lick to do with the health care of the children she was helping. That is wrong, and we can stop it, and we ought to do it.

We met a very compelling doctor named Lillian Beard, a pediatrician, who said that she didn't get into her profession to spend hours and hours—some doctors up to 25 hours a week—just filling out forms. She told us she became a doctor to keep children well and to help save those who got sick. We can relieve people like her of this burden. We learned, the Vice President and I did, that in the Washington Children's Hospital alone, the administrators told us they spend \$2 million a year in one hospital filling out forms that have nothing whatever to do with keeping up with the treatment of the patients.

And the doctors there applauded when I was told and I related to them that they spend so much time filling out paperwork, that if they only had to fill out those paperwork requirements necessary to monitor the health of the children, each doctor on that one hospital staff, 200 of them, could see another 500 children a year. That is 10,000 children a year. I think we can save money in this system if we simplify it. And we can make the doctors and the nurses and the people that are giving their lives to help us all be healthier a whole lot happier, too, on their jobs.

Under our proposal there would be one standard insurance form, not hundreds of them. We will simplify also—and we must—the Government's rules and regulations, because they are a big part of this problem. This is one of those cases where the physician should heal thyself. We have to reinvent the way we relate to the health care system, along with reinventing Government. A doctor should not have to check with a bureaucrat in an office thousands of miles away before ordering a simple blood test. That's not right, and we can change it. And doctors, nurses, and consumers shouldn't have to worry about the fine print. If we have this one simple form, there won't be any fine print. People will know what it means.

The third principle is savings. Reform must produce savings in this health care system. It has to. We're spending over 14 percent of our income on health care. Canada's at 10. Nobody else is over 9. We're competing with all these people for the future. And the other major countries, they cover everybody, and they cover them with services as generous as the best company policies here in this country.

Rampant medical inflation is eating away at our wages, our savings, our investment capital, our ability to create new jobs in the private sector, and this public Treasury. You know the budget we just adopted had steep cuts in defense, a 5-year freeze on the discretionary spending, so critical to reeducating America and investing in jobs and helping us to convert from a defense to a domestic economy. But we passed a budget which has Medicaid increases of between 16 and 11 percent a year over the next 5 years and Medicare increases of between 11 and 9 percent in an environment where we assume inflation will be at 4 percent or less. We cannot continue to do this. Our competitiveness, our whole economy, the integrity of the way the Government works, and ultimately, our

living standards depend upon our ability to achieve savings without harming the quality of health care.

Unless we do this, our workers will lose \$655 in income each year by the end of the decade. Small businesses will continue to face skyrocketing premiums. And a full third of small businesses now covering their employees say they will be forced to drop their insurance. Large corporations will bear bigger disadvantages in global competition. And health care costs devour more and more and more of our budget. Pretty soon all of you or the people who succeed you will be showing up here and writing out checks for health care and interest on the debt and worrying about whether we've got enough defense, and that will be it, unless we have the courage to achieve the savings that are plainly there before us. Every State and local government will continue to cut back on everything from education to law enforcement to pay more and more for the same health care.

These rising costs are a special nightmare for our small businesses, the engine of our entrepreneurship and our job creation in America today. Health care premiums for small businesses are 35 percent higher than those of large corporations today. And they will keep rising at double-digit rates unless we act.

So how will we achieve these savings? Rather than looking at price control or looking away as the price spiral continues, rather than using the heavy hand of Government to try to control what's happening or continuing to ignore what's happening, we believe there is a third way to achieve these savings. First, to give groups of consumers and small businesses the same market bargaining power that large corporations and large groups of public employees now have, we want to let market forces enable plans to compete. We want to force these plans to compete on the basis of price and quality, not simply to allow them to continue making money by turning people away who are sick or old or performing mountains of unnecessary procedures. But we also believe we should back this system up with limits on how much plans can raise their premiums year-in and year-out, forcing people, again, to continue to pay more for the same health care, without regard to inflation or the rising population needs.

We want to create what has been missing in this system for too long and what every successful nation who has dealt with this problem has already had to do: to have a combination of private market forces and a sound public policy that will support that competition, but limit the rate at which prices can exceed the rate of inflation and population growth, if the competition doesn't work, especially in the early going.

The second thing I want to say is that unless everybody is covered—and this is a very important thing—unless everybody is covered, we will never be able to fully put the brakes on health care inflation. Why is that? Because when people don't have any health insurance, they still get health care, but they get it when it's too late, when it's too expensive, often from the most expensive place of all, the emergency room. Usually by the time they show up, their illnesses are more severe, and their mortality rates are much higher in our hospitals than those who have insurance. So they cost us more. And what else happens? Since they get the care but they don't pay, who does pay? All the rest of us. We pay in higher hospital bills and higher insurance premiums. This cost shifting is a major problem.

The third thing we can do to save money is simply by simplifying the system, what we've already discussed. Freeing the health care providers from these costly and unnecessary

paperwork and administrative decisions will save tens of billions of dollars. We spend twice as much as any other major country does on paperwork. We spend at least a dime on the dollar more than any other major country. That is a stunning statistic. It is something that every Republican and every Democrat ought to be able to say, we agree that we're going to squeeze this out.

We cannot tolerate this. This has nothing to do with keeping people well or helping them when they're sick. We should invest the money in something else.

We also have to crack down on fraud and abuse in the system. That drains billions of dollars a year. It is a very large figure, according to every health care expert I've ever spoken with. So I believe we can achieve large savings.

And that large savings can be used to cover the unemployed, uninsured and will be used for people who realize those savings in the private sector to increase their ability to invest and grow, to hire new workers or to give their workers pay raises, many of them for the first time in years.

Now, nobody has to take my word for this. You can ask Dr. Koop. He's up here with us tonight, and I thank him for being here. Since he left his distinguished tenure as our Surgeon General, he has spent an enormous amount of time studying our health care system, how it operates, what's right and wrong with it. He says we could spend \$200 billion every year, more than 20 percent of the total budget, without sacrificing the high quality of American medicine.

Ask the public employees in California, who've held their own premiums down by adopting the same strategy that I want every American to be able to adopt, bargaining within the limits of a strict budget. Ask Xerox, which saved an estimated \$1,000 per worker on their health insurance premium. Ask the staff of the Mayo Clinic, who we all agree provides some of the finest health care in the world. They are holding their cost increases to less than half the national average. Ask the people of Hawaii, the only State that covers virtually all of their citizens and has still been able to keep costs below the national average.

People may disagree over the best way to fix this system. We may all disagree about how quickly we can do the thing that we have to do. But we cannot disagree that we can find tens of billions of dollars in savings in what is clearly the most costly and the most bureaucratic system in the entire world. And we have to do something about that, and we have to do it now.

The fourth principle is choice. Americans believe they ought to be able to choose their own health care plan and keep their own doctors. And I think all of us agree. Under any plan we pass, they ought to have that right. But today, under our broken health care system, in spite of the rhetoric of choice, the fact is that that power is slipping away for more and more Americans.

Of course, it is usually the employer, not the employee, who makes the initial choice of what health care plan the employee will be in. And if your employer offers only one plan, as nearly three-quarters of small or medium-sized firms do today, you're stuck with that plan and the doctors that it covers.

I propose to give every American a choice among high quality plans. You can stay with your current doctor, join a network of doctors and hospitals, or join a health maintenance organization. If you don't like your plan, every year you'll have a chance to choose a new one. The choice will be left to the American citizen, the worker, not the boss and certainly not some Government bureaucrat.

We also believe that doctors should have a choice as to what plans they practice in. Otherwise, citizens may have their own choices limited. We want to end the discrimination that is now growing against doctors and to permit them to practice in several different plans. Choice is important for doctors, and it is absolutely critical for our consumers. We've got to have it in whatever plan we pass.

The fifth principle is quality. If we reformed everything else in health care but failed to preserve and enhance the high quality of our medical care, we will have taken a step backward, not forward. Quality is something that we simply can't leave to chance. When you board an airplane, you feel better knowing that the plane had to meet standards designed to protect your safety. And we can't ask any less of our health care system.

Our proposal will create report cards on health plans, so that consumers can choose the highest quality health care providers and reward them with their business. At the same time, our plan will track quality indicators, so that doctors can make better and smarter choices of the kind of care they provide. We have evidence that more efficient delivery of health care doesn't decrease quality. In fact, it may enhance it.

Let me just give you one example of one commonly performed procedure, the coronary bypass operation. Pennsylvania discovered that patients who were charged \$21,000 for this surgery received as good or better care as patients who were charged \$84,000 for the same procedure in the same State. High prices simply don't always equal good quality. Our plan will guarantee that high quality information is available in even the most remote areas of this country so that we can have high quality service, linking rural doctors, for example, with hospitals with high-tech urban medical centers. And our plan will ensure the quality of continuing progress on a whole range of issues by speeding research on effective prevention and treatment measures for cancer, for AIDS, for Alzheimer's, for heart disease, and for other chronic diseases. We have to safeguard the finest medical research establishment in the entire world. And we will do that with this plan. Indeed, we will even make it better.

The sixth and final principle is responsibility. We need to restore a sense that we're all in this together and that we all have a responsibility to be a part of the solution. Responsibility has to start with those who profit from the current system. Responsibility means insurance companies should no longer be allowed to cast people aside when they get sick. It should apply to laboratories that submit fraudulent bills, to lawyers who abuse malpractice claims, to doctors who order unnecessary procedures. It means drug companies should no longer charge 3 times more per prescription drugs, made in America here in the United States, than they charge for the same drugs overseas.

In short, responsibility should apply to anybody who abuses this system and drives up the cost for honest, hard-working citizens and undermines confidence in the honest, gifted health care providers we have. Responsibility also means changing some behaviors in this country that drive up our costs like crazy. And without change in them we'll never have the system we ought to have, we will never.

Let me just mention a few and start with the most important: The outrageous costs of violence in this country stem in large measure from the fact that this is the only country in the world where teenagers can walk the streets at random with semiautomatic weapons and be better armed than the police.

But let's not kid ourselves; it's not that simple. We also have higher rates of AIDS, of smoking and excessive drinking, of teen pregnancy, of low birth weight babies. And we have the third worst immunization rate of any nation in the Western Hemisphere. We have to change our ways if we ever really want to be healthy as a people and have an affordable health care system. And no one can deny that.

But let me say this—and I hope every American will listen, because this is not an easy thing to hear—responsibility in our health care system isn't just about them. It's about you. It's about me. It's about each of us. Too many of us have not taken responsibility for our own health care and for our own relations to the health care system. Many of us who have had fully paid health care plans have used the system whether we needed it or not without thinking what the costs were. Many people who use this system don't pay a penny for their care even though they can afford to. I think those who don't have any health insurance should be responsible for paying a portion of their new coverage. There can't be any something for nothing, and we have to demonstrate that to people. This is not a free system. Even small contributions, as small as the \$10 copayment when you visit a doctor, illustrates that this is something of value. There is a cost to it. It is not free.

And I want to tell you that I believe that all of us should have insurance. Why should the rest of us pick up the tab when a guy who doesn't think he needs insurance or says he can't afford it gets in an accident, winds up in an emergency room, gets good care, and everybody else pays? Why should the small business people who are struggling to keep afloat and take care of their employees have to pay to maintain this wonderful health care infrastructure for those who refuse to do anything? If we're going to produce a better health care system for every one of us, every one of us is going to have to do our part. There cannot be any such thing as a free ride. We have to pay for it. We have to pay for it.

Tonight I want to say plainly how I think we should do that. Most of the money will come, under my way of thinking, as it does today, from premiums paid by employers and individuals. That's the way it happens today. But under this health care security plan, every employer and every individual will be asked to contribute something to health care.

This concept was first conveyed to the Congress about 20 years ago by President Nixon. And today, a lot of people agree with the concept of shared responsibility between employers and employees and that the best thing to do is to ask every employer and every employee to share that. The Chamber of Commerce has said that, and they're not in the business of hurting small business. The American Medical Association has said that.

Some call it an employer mandate, but I think it's the fairest way to achieve responsibility in the health care system. And it's the easiest for ordinary Americans to understand because it builds on what we already have and what already works for so many Americans. It is the reform that is not only easiest to understand but easiest to implement in a way that is fair to small business, because we can give a discount to help

struggling small businesses meet the cost of covering their employees. We should require the least bureaucracy or disruption and create the cooperation we need to make the system cost conscious, even as we expand coverage. And we should do it in a way that does not cripple small businesses and low-wage workers.

Every employer should provide coverage, just as three-quarters do now. Those that pay are picking up the tab for those who don't today. I don't think that's right. To finance the rest of reform, we can achieve new savings, as I have outlined, in both the Federal Government and the private sector through better decision making and increased competition. And we will impose new taxes on tobacco. I don't think that should be the only source of revenues. I believe we should also ask for a modest contribution from big employers who opt out of the system to make up for what those who are in the system pay for medical research, for health education centers, for all the subsidies to small business, for all the things that everyone else is contributing to. But between those two things, we believe we can pay for this package of benefits and universal coverage and a subsidy program that will help small business.

These sources can cover the cost of the proposal that I have described tonight. We subjected the numbers in our proposal to the scrutiny of not only all the major agencies in Government—I know a lot of people don't trust them, but it would be interesting for the American people to know that this was the first time that the financial experts on health care in all of the different Government agencies have ever been required to sit in the room together and agree on numbers. It had never happened before. But obviously, that's not enough. So then we gave these numbers to actuaries from major accounting firms and major Fortune 500 companies who have no stake in this other than to see that our efforts succeed. So I believe our numbers are good and achievable.

Now, what does this mean to an individual American citizen? Some will be asked to pay more. If you're an employer and you aren't insuring your workers at all, you'll have to pay more. But if you're a small business with fewer than 50 employees, you'll get a subsidy. If you're a firm that provides only very limited coverage, you may have to pay more. But some firms will pay the same or less for more coverage.

If you're a young, single person in your twenties and you're already insured, your rates may go up somewhat because you're going to go into a big pool with middle-aged people and older people, and we want to enable people to keep their insurance even when someone in their family gets sick. But I think that's fair because when the young get older they will benefit from it, first, and secondly, even those who pay a little more today will benefit 4, 5, 6, 7 years from now by our bringing health care costs closer to inflation.

Over the long run, we can all win. But some will have to pay more in the short run. Nevertheless, the vast majority of the Americans watching this tonight will pay the same or less for health care coverage that will be the same or better than the coverage they have tonight. That is the central reality.

If you currently get your health insurance through your job, under our plan you still will. And for the first time, everybody will get to choose from among at least three plans to belong to. If you're a small business owner who wants to provide health insurance to your family and your employees, but you can't afford it because the system is stacked against you, this plan will give you a discount that will finally make insurance affordable. If you're already providing insurance, your rates may well drop because we'll help you as

a small business person join thousands of others to get the same benefits big corporations get at the same price they get those benefits. If you're self-employed, you'll pay less, and you will get to deduct from your taxes 100 percent of your health care premiums. If you're a large employer, your health care costs won't go up as fast, so that you will have more money to put into higher wages and new jobs and to put into the work of being competitive in this tough global economy.

Now, these, my fellow Americans, are the principles on which I think we should base our efforts: security, simplicity, savings, choice, quality, and responsibility. These are the guiding stars that we should follow on our journey toward health care reform.

Over the coming months, you'll be bombarded with information from all kinds of sources. There will be some who will stoutly disagree with what I have proposed and with all other plans in the Congress, for that matter. And some of the arguments will be genuinely sincere and enlightening. Others may simply be scare tactics by those who are motivated by the self-interest they have in the waste the system now generates, because that waste is providing jobs, incomes, and money for some people. I ask you only to think of this when you hear all of these arguments: Ask yourself whether the cost of staying on this same course isn't greater than the cost of change. And ask yourself, when you hear the arguments, whether the arguments are in your interest or someone else's. This is something we have got to try to do together.

I want also to say to the Representatives in Congress, you have a special duty to look beyond these arguments. I ask you instead to look into the eyes of the sick child who needs care, to think of the face of the woman who's been told not only that her condition is malignant but not covered by her insurance, to look at the bottom lines of the businesses driven to bankruptcy by health care costs, to look at the "for sale" signs in front of the homes of families who have lost everything because of their health care costs.

I ask you to remember the kind of people I met over the last year and a half: the elderly couple in New Hampshire that broke down and cried because of their shame at having an empty refrigerator to pay for their drugs; a woman who lost a \$50,000 job that she used to support her six children because her youngest child was so ill that she couldn't keep health insurance, and the only way to get care for the child was to get public assistance; a young couple that had a sick child and could only get insurance from one of the parents' employers that was a nonprofit corporation with 20 employees, and so they had to face the question of whether to let this poor person with a sick child go or raise the premiums of every employee in the firm by \$200; and on and on and on.

I know we have differences of opinion, but we are here tonight in a spirit that is animated by the problems of those people and by the sheer knowledge that if we can look into our heart, we will not be able to say that the greatest nation in the history of the world is powerless to confront this crisis.

Our history and our heritage tell us that we can meet this challenge. Everything about America's past tells us we will do it. So I say to you, let us write that new chapter in the American story. Let us guarantee every American comprehensive health benefits that can never be taken away.

You know, in spite of all the work we've done together and all the progress we've made,

there's still a lot of people who say it would be an outright miracle if we passed health care reform. But my fellow Americans, in a time of change you have to have miracles. And miracles do happen. I mean, just a few days ago we saw a simple handshake shatter decades of deadlock in the Middle East. We've seen the walls crumble in Berlin and South Africa. We see the ongoing brave struggle of the people of Russia to seize freedom and democracy.

And now it is our turn to strike a blow for freedom in this country, the freedom of Americans to live without fear that their own Nation's health care system won't be there for them when they need it. It's hard to believe that there was once a time in this century when that kind of fear gripped old age, when retirement was nearly synonymous with poverty and older Americans died in the street. That's unthinkable today, because over a half a century ago Americans had the courage to change, to create a Social Security System that ensures that no Americans will be forgotten in their later years.

Forty years from now, our grandchildren will also find it unthinkable that there was a time in this country when hardworking families lost their homes, their savings, their businesses, lost everything simply because their children got sick or because they had to change jobs. Our grandchildren will find such things unthinkable tomorrow if we have the courage to change today.

This is our chance. This is our journey. And when our work is done, we will know that we have answered the call of history and met the challenge of our time.

Thank you very much, and God bless America.

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September 10, 2009

Barack Obama's Health Care Speech to Congress

Madame Speaker, Vice President Biden, Members of Congress, and the American people:

When I spoke here last winter, this nation was facing the worst economic crisis since the Great Depression. We were losing an average of 700,000 jobs per month. Credit was frozen. And our financial system was on the verge of collapse.

As any American who is still looking for work or a way to pay their bills will tell you, we are by no means out of the woods. A full and vibrant recovery is many months away. And I will not let up until those Americans who seek jobs can find them; until those businesses that seek capital and credit can thrive; until all responsible homeowners can stay in their homes. That is our ultimate goal. But thanks to the bold and decisive action we have taken since January, I can stand here with confidence and say that we have pulled this economy back from the brink.

I want to thank the members of this body for your efforts and your support in these last several months, and especially those who have taken the difficult votes that have put us on a path to recovery. I also want to thank the American people for their patience and resolve during this trying time for our nation.

But we did not come here just to clean up crises. We came to build a future. So tonight, I return to speak to all of you about an issue that is central to that future – and that is the issue of health care.

I am not the first President to take up this cause, but I am determined to be the last. It has now been nearly a century since Theodore Roosevelt first called for health care reform. And ever since, nearly every President and Congress, whether Democrat or Republican, has attempted to meet this challenge in some way. A bill for comprehensive health reform was first introduced by John Dingell Sr. in 1943. Sixty-five years later, his son continues to introduce that same bill at the beginning of each session.

Our collective failure to meet this challenge – year after year, decade after decade – has led us to a breaking point. Everyone understands the extraordinary hardships that are placed on the uninsured, who live every day just one accident or illness away from bankruptcy. These are not primarily people on welfare. These are middle-class Americans. Some can't get insurance on the job. Others are self-employed, and can't afford it, since buying insurance on your own costs you three times as much as the coverage you get from your employer. Many other Americans who are willing and able to pay are still denied insurance due to previous illnesses or conditions that insurance companies decide are too risky or expensive to cover.

We are the only advanced democracy on Earth – the only wealthy nation – that allows such hardships for millions of its people. There are now more than thirty million American citizens who cannot get coverage. In just a two year period, one in every three Americans goes without health care coverage at some point. And every day, 14,000 Americans lose their coverage. In other words, it can happen to anyone.

But the problem that plagues the health care system is not just a problem of the uninsured. Those who do have insurance have never had less security and stability than they do today. More and more Americans worry that if you move, lose your job, or change your job, you'll lose your health insurance too. More and more Americans pay their premiums, only to discover that their insurance company has dropped their coverage when they get sick, or won't pay the full cost of care. It happens every day.

One man from Illinois lost his coverage in the middle of chemotherapy because his insurer found that he hadn't reported gallstones that he didn't even know about. They delayed his treatment, and he died because of it. Another woman from Texas was about to get a double mastectomy when her insurance company canceled her policy because she forgot to declare a case of acne. By the time she had her insurance reinstated, her breast cancer more than doubled in size. That is heart-breaking, it is wrong, and no one should be treated that way in the United States of America.

Then there's the problem of rising costs. We spend one-and-a-half times more per person on health care than any other country, but we aren't any healthier for it. This is one of the reasons that insurance premiums have gone up three times faster than wages. It's why so many employers – especially small businesses – are forcing their employees to pay more for insurance, or are dropping their coverage entirely. It's why so many aspiring entrepreneurs cannot afford to open a business in the first place, and why American businesses that compete internationally – like our automakers – are at a huge disadvantage. And it's why those of us with health insurance are also paying a hidden and growing tax for those without it – about \$1000 per year that pays for somebody else's emergency room and charitable care.

Finally, our health care system is placing an unsustainable burden on taxpayers. When health care costs grow at the rate they have, it puts greater pressure on programs like Medicare and Medicaid. If we do nothing to slow these skyrocketing costs, we will eventually be spending more on Medicare and Medicaid than every other government program combined. Put simply, our health care problem is our deficit problem. Nothing else even comes close.

These are the facts. Nobody disputes them. We know we must reform this system. The question is how.

There are those on the left who believe that the only way to fix the system is through a single-payer system like Canada's, where we would severely restrict the private insurance market and have the government provide coverage for everyone. On the right, there are those who argue that we should end the employer-based system and leave individuals to buy health insurance on their own.

I have to say that there are arguments to be made for both approaches. But either one would represent a radical shift that would disrupt the health care most people currently have. 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 past several months.

During that time, we have seen Washington at its best and its worst.

We have seen many in this chamber work tirelessly for the better part of this year to offer thoughtful ideas about how to achieve reform. Of the five committees asked to develop bills, four have completed their work, and the Senate Finance Committee announced today that it will move forward next week. That has never happened before. Our overall efforts have been supported by an unprecedented coalition of doctors and nurses; hospitals, seniors' groups and even drug companies – many of whom opposed reform in the past. And there is agreement in this chamber on about eighty percent of what needs to be done, putting us closer to the goal of reform than we have ever been.

But what we have also seen in these last months is the same partisan spectacle that only hardens the disdain many Americans have toward their own government. Instead of honest debate, we have seen scare tactics. Some have dug into unyielding ideological camps that offer no hope of compromise. Too many have used this as an opportunity to score short-term political points, even if it robs the country of our opportunity to solve a long-term challenge. And out of this blizzard of charges and counter-charges, confusion has reigned.

Well the time for bickering is over. The time for games has passed. Now is the season for action. Now is when we must bring the best ideas of both parties together, and show the American people that we can still do what we were sent here to do. Now is the time to deliver on health care.

The plan I'm announcing tonight would meet three basic goals:

It will provide more security and stability to those who have health insurance. It will provide insurance to those who don't. And it will slow the growth of health care costs for our families, our businesses, and our government. It's a plan that asks everyone to take responsibility for meeting this challenge – not just government and insurance companies, but employers and individuals. And it's a plan that incorporates ideas from Senators and Congressmen; from Democrats and Republicans – and yes, from some of my opponents in both the primary and general election.

Here are the details that every American needs to know about this plan:

First, if you are among the hundreds of millions of Americans who already have health insurance through your job, Medicare, Medicaid, or the VA, nothing in this plan will require you or your employer to change the coverage or the doctor you have. Let me repeat this: nothing in our plan requires you to change what you have.

What this plan will do is to 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 pre-existing 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 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 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.

That's what Americans who have health insurance can expect from this plan – more security and stability.

Now, if you're one of the tens of millions of Americans who don't currently have health insurance, the second part of this plan will finally offer you quality, affordable choices. If you lose your job or change your job, you will be able to get coverage. If you strike out on your own and start a small business, you will be able to get coverage. We will do this by creating a new insurance exchange – a marketplace where individuals and small businesses will be able to shop for health insurance at competitive prices. Insurance companies will have an incentive to participate in this exchange because it lets them compete for millions of new customers. As one big group, these customers will have greater leverage to bargain with the insurance companies for better prices and quality coverage. This is how large companies and government employees get affordable insurance. It's how everyone in this Congress gets affordable insurance. And it's time to give every American the same opportunity that we've given ourselves.

For those individuals and small businesses who still cannot afford the lower-priced insurance available in the exchange, we will provide tax credits, the size of which will be based on your need. And all insurance companies that want access to this new marketplace will have to abide by the consumer protections I already mentioned. This exchange will take effect in four years, which will give us time to do it right. In the meantime, for those Americans who can't get insurance today because they have pre-existing medical conditions, we will immediately offer low-cost coverage that will protect you against financial ruin if you become seriously ill. This was a good idea when Senator John McCain proposed it in the campaign, it's a good idea now, and we should embrace it.

Now, even if we provide these affordable options, there may be those – particularly the young and healthy – who still want to take the risk and go without coverage. There may still be companies that refuse to do right by their workers. The problem is, such irresponsible behavior costs all the rest of us money. If there are affordable options and people still don't sign up for health insurance, it means we pay for those people's expensive emergency room visits. If some businesses don't provide workers health care, it forces the rest of us to pick up the tab when their workers get sick, and gives those businesses an unfair advantage over their competitors. And unless everybody does their part, many of the insurance reforms we seek – especially requiring insurance companies to cover pre-existing conditions – just can't be achieved.

That's why under my plan, individuals will be required to carry basic health insurance – just as most states require you to carry auto insurance. Likewise, businesses will be required to either offer their workers health care, or chip in to help cover the cost of their workers. There will be a hardship waiver for those individuals who still cannot afford coverage, and 95% of all small businesses, because of their size and narrow profit margin, would be exempt from these requirements. But we cannot have large businesses and individuals who can afford coverage game the system by avoiding responsibility to themselves or their employees. Improving our health care system only works if everybody does their part.

While there remain some significant details to be ironed out, I believe a broad consensus exists for the aspects of the plan I just outlined: consumer protections for those with insurance, an exchange that allows individuals and small businesses to purchase

affordable coverage, and a requirement that people who can afford insurance get insurance.

And I have no doubt that these reforms would greatly benefit Americans from all walks of life, as well as the economy as a whole. Still, given all the misinformation that's been spread over the past few months, I realize that many Americans have grown nervous about reform. So tonight I'd like to address some of the key controversies that are still out there.

Some of people's concerns have grown out of bogus claims spread by those whose only agenda is to kill reform at any cost. The best example is the claim, made not just by radio and cable talk show hosts, but prominent politicians, that we plan to set up panels of bureaucrats with the power to kill off senior citizens. Such a charge would be laughable if it weren't so cynical and irresponsible. It is a lie, plain and simple.

There are also those who claim that our reform effort will insure illegal immigrants. This, too, is false – the reforms I'm proposing would not apply to those who are here illegally. And one more misunderstanding I want to clear up – under our plan, no federal dollars will be used to fund abortions, and federal conscience laws will remain in place.

My health care proposal has also been attacked by some who oppose reform as a "government takeover" of the entire health care system. As proof, critics point to a provision in our plan that allows the uninsured and small businesses to choose a publicly-sponsored insurance option, administered by the government just like Medicaid or Medicare.

So let me set the record straight. My guiding principle is, and always has been, that consumers do better when there is choice and competition. Unfortunately, in 34 states, 75% of the insurance market is controlled by five or fewer companies. In Alabama, almost 90% is controlled by just one company. Without competition, the price of insurance goes up and the quality goes down. And it makes it easier for insurance companies to treat their customers badly – by cherry-picking the healthiest individuals and trying to drop the sickest; by overcharging small businesses who have no leverage; and by jacking up rates.

Insurance executives don't do this because they are bad people. They do it because it's profitable. As one former insurance executive testified before Congress, insurance companies are not only encouraged to find reasons to drop the seriously ill; they are rewarded for it. All of this is in service of meeting what this former executive called "Wall Street's relentless profit expectations."

Now, 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. The insurance reforms that I've already mentioned would do just that. But an additional step we can take to keep insurance companies honest is by making a not-for-profit public option available in the insurance exchange. Let me be clear – it would only be an option for those who don't have insurance. No one would be forced to choose it, and it would not impact those of you who already have insurance. In fact, based on Congressional Budget Office estimates, we believe that less than 5% of Americans would sign up.

Despite all this, the insurance companies and their allies don't like this idea. They argue that these private companies can't fairly compete with the government. And they'd be right if taxpayers were subsidizing this public insurance option. But they won't be. I have insisted that like any private insurance company, the public insurance option would have to be self-sufficient and rely on the premiums it collects. But by avoiding some of the overhead that gets eaten up at private companies by profits, excessive administrative costs and executive salaries, it could provide a good deal for consumers. It would also keep pressure on private insurers to keep their policies affordable and treat their customers better, the same way public colleges and universities provide additional choice and competition to students without in any way inhibiting a vibrant system of private colleges and universities.

It's worth noting that a strong majority of Americans still favor a public insurance option of the sort I've proposed tonight. But its impact shouldn't be exaggerated – by the left, the right, or the media. It is only one part of my plan, and should not be used as a handy excuse for the usual Washington ideological battles. To my progressive friends, I would remind you that for decades, the driving idea behind reform has been to end insurance company abuses and make coverage affordable for those without it. The public option is only a means to that end – and we should remain open to other ideas that accomplish our ultimate goal. And to my Republican friends, I say that rather than making wild claims about a government takeover of health care, we should work together to address any legitimate concerns you may have.

For example, some have suggested that the public option go into effect only in those markets where insurance companies are not providing affordable policies. Others propose a co-op or another non-profit entity to administer the plan. These are all constructive ideas worth exploring. But I will not back down on the basic principle that 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.

Finally, let me discuss an issue that is a great concern to me, to members of this chamber, and to the public – and that is how we pay for this plan.

Here's what you need to know. First, I will not sign a plan that adds one dime to our deficits – either now or in the future. Period. And to prove that I'm serious, there will be a provision in this plan that requires us to come forward with more spending cuts if the savings we promised don't materialize. Part of the reason I faced a trillion dollar deficit when I walked in the door of the White House is because too many initiatives over the last decade were not paid for – from the Iraq War to tax breaks for the wealthy. I will not make that same mistake with health care.

Second, we've estimated that most of this plan can be paid for by finding savings within the existing health care system – a system that is currently full of waste and abuse. Right now, too much of the hard-earned savings and tax dollars we spend on health care doesn't make us healthier. That's not my judgment – it's the judgment of medical professionals across this country. And this is also true when it comes to Medicare and Medicaid.

In fact, I want to speak directly to America's seniors for a moment, because Medicare is another issue that's been subjected to demagoguery and distortion during the course of this debate.

More than four decades ago, this nation stood up for the principle that after a lifetime of hard work, our seniors should not be left to struggle with a pile of medical bills in their later years. That is how Medicare was born. And it remains a sacred trust that must be passed down from one generation to the next. That is why not a dollar of the Medicare trust fund will be used to pay for this plan.

The only thing this plan would eliminate is the hundreds of billions of dollars in waste and fraud, as well as unwarranted subsidies in Medicare that go to insurance companies – subsidies that do everything to pad their profits and nothing to improve your care. And we will also create an independent commission of doctors and medical experts charged with identifying more waste in the years ahead.

These steps will ensure that you – America's seniors – get the benefits you've been promised. They will ensure that Medicare is there for future generations. And we can use some of the savings to fill the gap in coverage that forces too many seniors to pay thousands of dollars a year out of their own pocket for prescription drugs. That's what this plan will do for you. So don't pay attention to those scary stories about how your benefits will be cut – especially since some of the same folks who are spreading these tall tales have fought against Medicare in the past, and just this year supported a budget that would have essentially turned Medicare into a privatized voucher program. That will never happen on my watch. I will protect Medicare.

Now, because Medicare is such a big part of the health care system, making the program more efficient can help usher in changes in the way we deliver health care that can reduce costs for everybody. We have long known that some places, like the Intermountain Healthcare in Utah or the Geisinger Health System in rural Pennsylvania, offer high-quality care at costs below average. The commission can help encourage the adoption of these common-sense best practices by doctors and medical professionals throughout the system – everything from reducing hospital infection rates to encouraging better coordination between teams of doctors.

Reducing the waste and inefficiency in Medicare and Medicaid will pay for most of this plan. Much of the rest would be paid for with revenues from the very same drug and insurance companies that stand to benefit from tens of millions of new customers. This reform will charge insurance companies a fee for their most expensive policies, which will encourage them to provide greater value for the money – an idea which has the support of Democratic and Republican experts. And according to these same experts, this modest change could help hold down the cost of health care for all of us in the long-run.

Finally, many in this chamber – particularly on the Republican side of the aisle – have long insisted that reforming our medical malpractice laws can help bring down the cost of health care. I don't believe malpractice reform is a silver bullet, but I have talked to enough doctors to know that defensive medicine may be contributing to unnecessary costs. So I am proposing that we move forward on a range of ideas about how to put patient safety first and let doctors focus on practicing medicine. I know that the Bush Administration considered authorizing demonstration projects in individual states to test

these issues. It's a good idea, and I am directing my Secretary of Health and Human Services to move forward on this initiative today.

Add it all up, and the plan I'm proposing will cost around \$900 billion over ten years – less than we have spent on the Iraq and Afghanistan wars, and less than the tax cuts for the wealthiest few Americans that Congress passed at the beginning of the previous administration. Most of these costs will be paid for with money already being spent – but spent badly – in the existing health care system. The plan will not add to our deficit. The middle-class will realize greater security, not higher taxes. And if we are able to slow the growth of health care costs by just one-tenth of one percent each year, it will actually reduce the deficit by \$4 trillion over the long term.

This is the plan I'm proposing. It's a plan that incorporates ideas from many of the people in this room tonight – Democrats and Republicans. And I will continue to seek common ground in the weeks ahead. If you come to me with a serious set of proposals, I will be there to listen. My door is always open.

But know this: I will not waste time with those who have made the calculation that it's better politics to kill this plan than improve it. I will not stand by while the special interests use the same old tactics to keep things exactly the way they are. If you misrepresent what's in the plan, we will call you out. And I will not accept the status quo as a solution. Not this time. Not now.

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 most. And more will die as a result. We know these things to be true.

That is why we cannot fail. Because there are too many Americans counting on us to succeed – the ones who suffer silently, and the ones who shared their stories with us at town hall meetings, in emails, and in letters.

I received one of those letters a few days ago. It was from our beloved friend and colleague, Ted Kennedy. He had written it back in May, shortly after he was told that his illness was terminal. He asked that it be delivered upon his death.

In it, he spoke about what a happy time his last months were, thanks to the love and support of family and friends, his wife, Vicki, and his children, who are here tonight. And he expressed confidence that this would be the year that health care reform – "that great unfinished business of our society," he called it – would finally pass. He repeated the truth that health care is decisive for our future prosperity, but he also reminded me that "it concerns more than material things." "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."

I've thought about that phrase quite a bit in recent days – the character of our country. One of the unique and wonderful things about America has always been our self-reliance, our rugged individualism, our fierce defense of freedom and our healthy skepticism of government. And figuring out the appropriate size and role of government has always been a source of rigorous and sometimes angry debate.

For some of Ted Kennedy's critics, his brand of liberalism represented an affront to American liberty. In their mind, his passion for universal health care was nothing more than a passion for big government.

But those of us who knew Teddy and worked with him here – people of both parties – know that what drove him was something more. His friend, Orrin Hatch, knows that. They worked together to provide children with health insurance. His friend John McCain knows that. They worked together on a Patient's Bill of Rights. His friend Chuck Grassley knows that. They worked together to provide health care to children with disabilities.

On issues like these, Ted Kennedy's passion was born not of some rigid ideology, but of his own experience. It was the experience of having two children stricken with cancer. He never forgot the sheer terror and helplessness that any parent feels when a child is badly sick; and he was able to imagine what it must be like for those without insurance; what it would be like to have to say to a wife or a child or an aging parent – there is something that could make you better, but I just can't afford it.

That large-heartedness – that concern and regard for the plight of others – is not a partisan feeling. It is not a Republican or a Democratic feeling. It, too, is part of the American character. Our ability to stand in other people's shoes. A recognition that we are all in this together; that when fortune turns against one of us, others are there to lend a helping hand. A belief that in this country, hard work and responsibility should be rewarded by some measure of security and fair play; and an acknowledgement that sometimes government has to step in to help deliver on that promise.

This has always been the history of our progress. In 1933, when over half of our seniors could not support themselves and millions had seen their savings wiped away, there were those who argued that Social Security would lead to socialism. But the men and women of Congress stood fast, and we are all the better for it. In 1965, when some argued that Medicare represented a government takeover of health care, members of Congress, Democrats and Republicans, did not back down. They joined together so that all of us could enter our golden years with some basic peace of mind.

You see, our predecessors understood that government could not, and should not, solve every problem. They understood that there are instances when the gains in security from government action are not worth the added constraints on our freedom. But they also understood that the danger of too much government is matched by the perils of too little; that without the leavening hand of wise policy, markets can crash, monopolies can stifle competition, and the vulnerable can be exploited. And they knew that when any government measure, no matter how carefully crafted or beneficial, is subject to scorn; when any efforts to help people in need are attacked as un-American; when facts and reason are thrown overboard and only timidity passes for wisdom, and we can no longer even engage in a civil conversation with each other over the things that truly matter – that at that point we don't merely lose our capacity to solve big challenges. We lose something essential about ourselves.

What was true then remains true today. I understand how difficult this health care debate has been. I know that many in this country are deeply skeptical that government is looking out for them. I understand that the politically safe move would be to kick the can

further down the road – to defer reform one more year, or one more election, or one more term.

But that's not what the moment calls for. That's not what we came here to do. We did not come to fear the future. We came here to shape it. I still believe we can act even when it's hard. I still believe we can replace acrimony with civility, and gridlock with progress. I still believe we can do great things, and that here and now we will meet history's test.

Because that is who we are. That is our calling. That is our character. Thank you, God Bless You, and may God Bless the United States of America.

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