THESIS

PROTECTION, FREEDOM AND CHOICE:

A RHETORICAL ANALYSIS OF CURRENT HEALTH CARE REFORM AND ITS RESISTANCE

Submitted by

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WE HEREBY RECOMMEND THAT THE THESIS PREPARED UNDER OUR SUPERVISION BY MARY HELEN KELLY ENTITLED PROTECTION, FREEDOM AND CHOICE: A RHETORICAL ANALYSIS OF CURRENT HEALTH CARE REFORM AND ITS RESISTANCE BE ACCEPTED AS FULFILLING IN PART REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS.

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ABSTRACT OF THESIS

PROTECTION, FREEDOM AND CHOICE:

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The following thesis investigates the most dominant rhetorical strategies used by President Obama in his health care reform proposals, and the resistance which has manifested in their wake by three public non-profit organizations. Due to the complexity and divisiveness of such efforts, this project strives to understand the rhetorical nature of health care reform policy and its resistance by answering the following questions: What kinds of rhetorical strategies are President Obama and these organizations using to establish a position in the current debate surrounding U.S. health care reform and policy? More specifically, how are people within organizations, such as Conservatives for Patients' Rights and Patients United Now, using language to formulate resistance to current health care reform as proposed under the Obama administration in the U.S.? What can be understood by examining the use of these rhetorical strategies through specific theoretical lenses such as affective theories of politics and emotions and cognition and metaphor? Based on my analyses of three speeches and three websites, I conclude that both President Obama and the three public groups are using a rhetoric of crisis to establish and frame their rhetorical positions on health care. Further, I argue that this tool

of crisis works to increasingly destabilize the possibility of a larger public debate or conversation on this issue which impacts the lives of everyone.

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Preface

In the fall of 2008 I enrolled as a first year graduate student in the Rhetoric and Composition Master's program at Colorado State University. Shortly after my arrival, I was informed that my left ankle was in need of surgery as a result of an old soccer injury. As a graduate student at CSU I was required to purchase their health insurance or provide proof of my own comparable insurance plan before I could begin classes. I had purchased their plan for a total cost of approximately $2,000 for one year and began scheduling and attending all the required medical appointments to address the injured ankle. Before long I was required to pay my deductible ($250) for an MRI, and after the surgery was over I quickly learned that I was responsible for 20% of all costs associated with the surgery. In short, on top of the $2,250 I had already paid, I was now responsible for nearly $4,000 in medical bills. I wondered how this equation would have looked without health insurance, or if I was a citizen in a country with a national health insurance program? Admittedly, I had failed to read the fine print embedded within my insurance plan furnished by the university. In addition, I made the mistake of assuming that once I had forked over the money for the premium and my deductible I would be covered.

As a student of rhetoric and writing, with a particular interest in public policy, I began to further question the stability and reliability of the current health care system and its accompanying policies. I, along with the rest of this country, find myself observing the most recent health care reform debate with shock, hope and great interest in both the rhetoric of policy proposals and public response.

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-Mary Kelly

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Introduction: Why Health Care?

"Americans do not think of themselves as callous and cruel, yet, in their readiness to forgo and withhold this most elemental social service, they have been so. This question arises: How did the middle class, its elected representatives, and its doctors accommodate themselves to such neglect?"

David Rothman, "A Century of Failure: Health Care Reform in America"[1]

The topics of health care and health care reform in the United States are both deeply historical and profoundly emotional. Health care reform has often been ranked as a top domestic priority for voters during presidential elections. In 1992, for example, "voters ranked health care as the third most important factor in their presidential choice, behind only the economy and the federal budget deficit" (Kronenfield, 1997, p. 15). Similarly, "Voters ranked health care as the fourth most important issue in deciding their vote for president in 2004" (Blendon et al., 2004). In the most recent presidential election of 2008, Blendon et al. (2008) concluded that the topic of health care had been ranked "as the top domestic issue among voters in Democratic primaries and one of a handful of important domestic issues among voters in Republican primaries" (p. 419). Most commonly, these topics have been ranked as top issues among voters for a variety of reasons including, but not limited to, access to care, cost of care, health insurance, national health care reform, and quality of care. During the last quarter of the twentieth

[1] David Rothman as quoted in Jill Quadagno's book *One Nation, Uninsured: Why the U.S. Has No National Health Insurance* (2005). This particular passage comes from his article "A Century of Failure: Health Care Reform in America" which was published in *The Journal of Health Policy Politics, Policy and Law* (1993).

century, “support for some type of national health insurance” was common, and “support for national health insurance reached a forty-year high of 66 percent in 1992” (Blendon et al. as qtd. in Kronenfield, 1997, p. 15). Importantly, Kronenfield points out that declines in such support would arise if personal sacrifices were implied: “decline in support was particularly strong if people believed that health care reform would limit their own choice of doctors, require rationing, or reduce the current quality of care” (1997, p. 15). Moreover, in a recent study conducted by the Kettering Foundation National Issues Forums in 2008 entitled “Public Thinking about Coping with the Cost of Health Care: How Do We Pay for What We Need?” the authors note that participants generally agreed that the current “health care crisis…involves cost and coverage but not quality, except insofar as people cannot meet the cost and get the coverage” (Doble et al., 2009, p. 1). In other words, for these participants quality of care was not an issue, but access and coverage were top priorities.

According to the U.S. Census Bureau, the number of uninsured in this country reached 46.3 million people at the end of 2008 (“Income, Poverty, Health Insurance,” 2009). For those who did have health insurance, as of 2008, “the average premium for a family plan purchased through an employer was $12,680, nearly the annual earnings of a full-time minimum wage job”, according to a report published by healthreform.gov (“Hidden Costs of Health Care,” 2009). In addition, the cost of a deductible has mirrored rising costs of premiums in that the average deductible for Americans ranged, on average, from a minimum of $3,511 to $5,329 in 2007-2008 for both employer and individual insurance market plans (“Hidden Costs of Health Care,” 2009). How are the costs for health care covered for those without insurance? Quadagno (2005) explains that, “The

expense of their care is borne by taxpayers through various government programs or though cost shifting by physicians and hospitals to privately insured patients" (Quadagno, 2005, p.5). Furthermore, the national gross domestic product (GDP) increasingly accounts for larger and larger percentages of health care costs. In a report issued by the Kaiser Family Foundation in March of 2009, the Centers for Medicare and Medicaid Services (CMS) noted that, "the U.S. is projected to spend over $2.5 trillion on health care in 2009, or $8,160 per U.S. resident. Health spending is projected to account for 17.6% of GDP" ("Trends in Health Care," 2009).

Such a display of numbers could effortlessly occupy an inordinate number of pages for this introduction; however, it is clear at this point that health care is a significant and pressing economic issue for many people in this country for a variety of reasons. Yet, why are there so many who lack access, via a health insurance plan, to health care in this country? And why are "costs associated with health care the principal cause of personal bankruptcy in this country" (NIF, 2009, p. 2)? Quadagno (2005) notes that "nearly half of all individual bankruptcy filings are due to medical bills", according to a report issued by The Institute of Medicine in 2004 (p. 5). While answers to these questions are invariably complex, one avenue of investigation is through an examination of health policy and the debates and conversations leading up to the formation of such policies. Importantly, Kronenfield (1997) urges that:

> …a nation's health policy is part of its general overall social policy and, as a result, health policy formulation is influenced by the variety and array of social and economic factors that impact broader policy development issues in the United States. The nature and history of existing institutions, the general climate of opinion, ritualized methods for dealing with social conflict, and general goals and values of a society all play a role in formulation of such policy. (p.51)

Clearly, then, embarking on an examination or analysis of health policy requires a recognition and consideration for a range of factors associated with the formulation and rationale for different health policies. More specifically, economic and political ideological factors play a significant role in determining the content and shape of a given health policy coupled with the multitude of powerful stakeholders surrounding health care and health policy (Kronenfield, 1997, p. 51).

For decades these issues have entered political and personal arenas, and for decades these issues have been hotly debated with reform effort attempts for national health insurance facing fierce resistance from a variety of stakeholders:

> Current arrangements for financing care have been hammered out through contentious struggles between social reformers, physicians, employers, insurance companies, and trade unions over the proper relationship between government and the private sector. (Quadagno, 2006, p.6)

Moreover, there exists a significant difference in ideologies regarding health care as a right or a product for individuals or for all of society. Kronenfield (1997) explains that:

> Two coexistent, but contradictory, traditions in the United States influence views on access to services, especially health care services. One tradition holds that individuals are responsible for their own welfare, including health care. The other tradition contends that communities have a responsibility to provide access to health care for all citizens, with a special concern about those unable to secure access on their own. (p. 13)

Indeed, such issues are incredibly complex, requiring seemingly complex solutions. The current presidential administration under Barack Obama has proposed and pushed Congress for a set of solutions in the name of health care reform, and these

solutions have been met with staunch opposition and resistance from the public, Republican policy makers, and some of his own Democratic Party members. The focus of this thesis, however, is to investigate the specific rhetorical choices public groups have made in response to the health care reform proposals set forth by Congress and Obama's administration, dating back to the 2008 presidential campaign. More specifically, the emphasis of my analysis will center on the following public groups: Conservatives for Patients' Rights (CPR), Patients United Now (PUN), and Patients First (PF) who have formed and established themselves in direct response to recent health care reform proposals. Such groups have formulated rhetorics of resistance and opposition specifically targeting reform that includes any kind of government-run option and/or intervention. This type of resistance is not new and can be traced through the history of health care reform in this country. The first chapter, then, will present an historical overview of U.S. health care reform and policy in an effort to provide a contextualized perspective on these issues. Chapter two is both a review of the most relevant literature, associated with the rhetorical models and theories I utilize in my analysis, and a discussion of project methodology. Chapter three contains summaries and rhetorical analyses of three speeches delivered by Barack Obama between 2007 and 2009. Chapter four provides summaries and rhetorical analyses of three websites and their texts of resistance to health care reform. Lastly, chapter five presents a discussion of findings, limitations and implications for further research.

Chapter One: Care, Reform and Policy: An Historical Perspective

"According to one common argument, the chief impediment to national health insurance has been an antistatist political culture. Because Americans honor private property, hold individual rights sacred, and distrust state authority, reformers have found it difficult to make a convincing case for government financing of health care. Americans' ambivalence toward government and their bias toward private solutions to public problems stands in the way. We can no more trust the state to make decisions about our health care than we can about what make of car to drive, what color shirt to wear, or which brand of dental floss to use, or so the thinking of many goes."

Jill Quadagno: *One Nation, Uninsured* (2005)

For the purposes of this thesis it is appropriate to historically contextualize health care reform and policy with a specific emphasis on reform that focuses on government-run health care. In other words, this chapter is designed not to trace the history of health care in U.S., but rather to specifically highlight the history of health care reform and, when possible, the resistance to such reform. Thus, I am attempting to provide an account of how government-run health care reform, or national health insurance, has been proposed and strongly opposed over the course of the last century, primarily discussing the major examples of such reform and its corresponding defeat.

According to Kronenfield (1997), "Federal involvement in health is a fairly new occurrence in U.S. history. While a few laws and special concerns were passed prior to the twentieth century, the bulk of federal legislation that has health impact has been passed since 1900…" with the majority of it passing in the latter half of the century (p. 67). Attempts to reform health care with government-run health care programs have

occurred at different points in history over approximately the last one hundred years. Resistance to this type of reform from various stakeholders coincides with each such occurrence.

Quadagno (2005) explains that, “From the Progressive Era to the 1960’s, physicians were the most vocal opponents of government-financed health care,” and their primary aim “was to erect a barrier against any third-party payer, especially the government, that might intrude in the sacred doctor-patient relationship” (p. 6). The first known reform effort to create a plan for “compulsory health insurance” was defeated by “state medical societies” in the 1910’s (Quadagno, 2005, p. 7). Physicians primarily organized themselves under the American Medical Association (AMA), particularly for political matters as the AMA had successfully created a “federated structure” which “made it possible for the AMA to be converted from a professional association into a hard-driving political machine at the local, state, and national levels in each skirmish against government-financed care” (Quadagno, 2005, p. 7). In the 1930’s “the AMA waged a ferocious campaign to prevent federal officials from including national health insurance in the Social Security Act of 1935,” and when a similar national health insurance was in motion in the late 1930’s, “the AMA reluctantly endorsed Blue Cross/Blue Shield plans that the hospitals had created themselves as a way to head off a government program” (Quadagno, 2005, p. 7). When Harry Truman took office in 1946 a plan for national health insurance was marked as a top domestic priority of his Fair Deal, and “the *Journal of the American Medical Association* lambasted this threat to liberty: ‘[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'" (Quadagno, 2005, p.7).

Thus, in the first half of the twentieth century, three marked attempts towards health care reform in the name of national health insurance were thwarted by this powerful group of stakeholders who, importantly, were not alone in their resistance. While the AMA was indeed at the forefront of such resistance, they allied quite consistently with "employer groups, insurance companies, and trade unions" through the Progressive Era, as well as "the business community (i.e., U.S. Chamber of Commerce and the National Association of Manufacturers) from the 1940's to the mid 1960's (Quadagno, 2005, p.8). According to Quadagno (2005), trade unions became an ally after Samuel Gompers, the president of the American Federation of Labor (AFL), "denounced compulsory health insurance as 'a menace to the rights, welfare and liberty of American workers'" (p. 8). In addition, physicians also relied on the support of conservative representatives in Congress such as "Ohio senator Robert Taft… and of southern Democrats such as South Carolina senator Strom Thurmond, who feared any program that might give federal officials the right to intervene in local racial practices" (Quadagno, 2005, p.8). Again, such alliances represent the complexity of interests involved and related to health care, and these interests are arguably situated in deeply held ideologies including the questioning of the role of government, free market principles, racism, individual prosperity and responsibility. Indeed, a significant amount of distrust in government appears to be a consistent and strongly held belief running through the history of health care reform in the U.S. In fact, many of the recent public

campaigns of opposition to health care reform rely heavily on this principle of distrust, or antigovernment sentiment, among others.

According to McLaughlin and McLaughlin (2008), "Contending visions of how the health system should operate have dominated U.S. health care policy making at different times. Yet there has not been a dominant viewpoint since the 1960's, and all of the contending approaches remain on the table" (p. 60). The implementation of Medicare and Medicaid in 1965 under President Lyndon Johnson took more than ten years to pass "following a Democratic sweep of the House and Senate and an AFL-CIO campaign that mobilized trade union members and retirees in every key congressional district" (Quadagno, 2005, p.9).[2] Moreover, "The Social Security Amendments of 1965 established the Medicare program," and these "amendments also established a special program of grants to the states for medical assistance to the poor through Title XIX (Medicaid)" (Kronenfield, 1997, p. 88). The passage of these amendments to the Social Security Act of 1935 marks the successful, and albeit long and difficult, passing of health care reform which included government involvement both financially and legislatively. Much of the debate surrounding this particular legislation centered on struggles between private industry and the role of government in providing health care. Key players representing the opposition looked quite similar:

> By the 1960 election, the various factions had coalesced into two camps. In one camp were Republicans, southern Democrats, the AMA, and the Health Insurance Association of America. In the other camp were Kennedy, northern Democrats, the AFL-CIO, and senior citizens. (Quadagno, 2005, p. 62).

[2] American Federation of Labor – Congress of Industrial Organization (AFL-CIO)

The former camp had successfully mustered a campaign against the latter which relied heavily on claims that Medicare represented an attempt to implement a form of socialized medicine. Individual constituents who echoed this concern wrote to Senator Chris Anderson, the leading advocate of Medicare in the Senate at the time, using language such as:

- "I have no doubt that you are most sincere in feeling that Medicare will not lead to socialized medicine, but I still can't help feeling that any insurance that is forced upon me can't help but lead to something else I don't want. What a horrible waste all our wars for Democracy were if we go back to autocratic rule or throw it away on socialism."[3]
- "Just witnessed your appearance on the Today Show and I must say you sounded more like a Socialist than a Democrat."[4]
- "You fail to represent me when you advocate government controls for any health care bill. Let Americans remain free Americans."[5]

Similar language of fear and resistance to government-run care can certainly be found in the nation's most current health care reform debates where paranoia of government and socialism run rampant in the camps of opposition. Paranoia of government intervention in health care is indeed a recurring theme throughout the history of health care reform.

[3] This passage was pulled directly from a letter written by Martha Botts, a constituent writing to Senator Clinton Anderson (D-N.M.) who was the leading supporter of Medicare at the time. Courtesy of Quadagno (2005).

[4] This passage was taken from Ned Flightner, another constituent writing to Anderson. Courtesy of Quadagno (2005).

[5] This passage was taken from Mrs. J.L. Flinchum, another constituent writing to Anderson. Courtesy of Quadagno (2005).

Interestingly, despite what seemed a victory for advocates of Medicare and Medicaid in 1965, Quadagno (2005) argues that:

> The 20-year period between the end of World War II and the enactment of Medicare in 1965 solidified the private health insurance system in several ways…Medicare further reinforced private health insurance by providing coverage for a costly group and removing from political debates over national health insurance a constituency considered worthy and deserving. (p. 76)

Ironically, over the course of several decades of health care reform attempts and debates, health insurance companies began to gain significant momentum in a burgeoning private industry. Throughout the late 1960's and into the 1970's, national health insurance wavered from being a top domestic priority to something that was outright avoided in political arenas. During this time, what's known as "cost containment", according to Quadagno (2005), "took center stage as the main issue on the health care agenda" (p.138). Cost containment was also met with powerful resistance from health care providers, medical lobbyists, business groups, and trade unions (Quadagno, 2005, p.138). Into the latter half of the 1970's and throughout the 1980's, power was increasingly shifting into the hands of insurance companies and corporations who were purchasing and providing their employees with health insurance. Quadagno (2005) explains that, "While corporations were primarily concerned with containing costs, insurers had a vested interest in preventing the federal government from creating competing products and in structuring any new programs in ways that would preserve the private market" (p. 167). Health care was quickly evolving into a market-driven product for consumption that was subject to both inflation and an increasing lack of regulation.

As we moved into the 1990's, the election of President Clinton in 1992 marked another brief era of health care reform attempts to institute national, or universal, health care. Conversely, McLaughlin and McLaughlin explain that:

> Throughout the 1990's, observers argued that the United States should move rapidly in the direction of a less regulated market in health care, as the Reagan Revolution and success in the Cold War led economists and politicians to seek deregulation and consumer sovereignty in all areas. (p. 74)

Despite both familiar and newly emerging competing interests in the realm of health care reform, the Clinton administration sought to forward a plan entitled The Health Security Act that would "guarantee universal coverage and access to quality medical care" (Quadagno, 2005, p. 166). As discussed earlier, health care reform during this time had been ranked as a top priority for voters when considering presidential candidates (Kronenfield, 1997). Thus, the Clinton administration rightly took up what seemed an overwhelmingly important issue. Quadagno (2005) argues that, "Health Security was the most ambitious policy proposal since the New Deal"; however, it appears as though the health insurance industry was prepared in advance for this move:

> The Health Insurance Association of America had begun to gear up even before Clinton took office. Eleven days after Clinton was sworn in, the association hired Bill Gradison (R-Oh.)…as its president and chief lobbyist. A respected and knowledgeable Washington insider, Gradison resigned from Congress immediately to coordinate the opposition campaign… and initiated a $3 million advertising campaign. Rather than reform outright, these ads questioned government involvement in the health care system. The general message was 'You will lose control' and, alternatively, that the private insurance industry could cover everyone" (p. 167).

The association had become the most powerful and vocal opponent to national health care, taking the place of the AMA who clearly occupied this role in the first half of

the twentieth century. “Whereas in the 1940’s the AMA had been the most vocal political opponent of the Truman plan, in the 1990’s physicians were nearly invisible in public debates over Health Security” (Quadagno, 2005, p.192). Insurance companies had acquired a significant financial stake in health care reform, and the last thing they wanted was the possibility of government-financed and regulated health care. This would, indeed, financially impact the industry quite severely, so the association continued to mount attacks on the Clintons’ Health Security Act.

In the latter half of 1993, following the initial launching of the $3 million ad campaign, the association proceeded to launch a second, seemingly more aggressive ad campaign. “The ads featured a husband and wife, Harry and Louise, sitting at the kitchen table worrying about how the president’s plan would affect their coverage,” where language such as “The government may force us to pick from a few health plans designed by government bureaucrats’, ‘mandatory’, ‘billion dollar bureaucracy run by tens of thousands of new bureaucrats’, and ‘government monopoly’ were used (Quadagno, 2005, p.190). Further, Quadagno (2005) notes that “Although 52 percent of those who saw the ads felt they were completely untrue or more wrong than right, they helped frame Health Security in a way that shook public confidence” (p. 190). Other camps of opposition were housed in arenas such as the Republican Party, small businesses, and:

> Various industry groups hired nearly 100 law and public relations firms to lobby. The campaign against health care reform was virtually indistinguishable from presidential campaigns on the scale of field organizing, sophistication, and public relations tactics. (Quadagno, 2005, p. 193)

Despite rising public concern over the cost of health care, issues of access, medical underwriting, and significant rates of health insurance inflation, the opposition to health

care reform was both massive and successful. “Overall, the Center for Public Integrity estimated that 650 organizations spent at least $100 million to defeat the Clinton plan” (Quadagno, 2005, p.193).

Clearly, large scale health care reform efforts for government-run health insurance, in the form of universal access, have historically been met with mighty and steadfast opposition. Indeed, all of these campaigns of opposition were successful throughout the years, leading us to the end of the first decade of the twenty-first century without any form of universal or national health care system. Kronenfield (1997) argues that “The United States has always been a country in which incremental, rather than major, reform is the usual approach to changing policy. This is true in many areas, not only health reform” (p. 148). Such incremental and slow change in health care can be seen in the steps taken to pass legislation such as Social Security, Medicare and Medicaid, while major reform efforts to pass universal or national health insurance programs have failed.

Currently, Congress and the presidential administration under Barack Obama, have teamed up to tackle the ever-present health care crisis, as many of his predecessors have attempted in the past. Much of the same rhetoric is being employed by both major sides of this debate, and it seems that history is indeed repeating itself. Despite the increasing sense of crisis, the opposition remains, resting with powerful groups of stakeholders who have both financial and ideological claims at stake. Will health care reform, which guarantees universal coverage, succeed this time around due to overwhelming signs of dysfunction within the current system, or will it meet the same failure and demise similar to the other attempts made throughout history? While the

answers are yet to be revealed, my task in this thesis is to conduct a rhetorical analysis of the most current rhetoric to illuminate and provide further understanding of how public groups are responding to these attempts. Why rhetoric? Why rhetorical analyses? Why public groups and not political parties? A discussion of methodology, including the selecting and analyzing of public groups and primary texts, as well as a review of the most relevant literature surrounding rhetorical analysis and theory, are provided in the following chapter to address these questions.

Chapter Two: Why Rhetoric? Methodology, Rationale, & Literature Review

"Given the centrality of the art of discourse to human, social, and political endeavors, it is not at all surprising that academics, preachers, politicians, entrepreneurs, and an almost incalculable host of others have all attended closely to the problems and possibilities of human communication. This breadth of attention to the power and art of discourse by groups and individuals with fundamentally different purposes and orientations has produced a wide range of approaches to the study of human communication. One of the most powerful of such approaches from antiquity to the present has operated under the rubric of 'rhetoric' or 'rhetorical studies.'"

John L. Lucaites & Celeste M. Condit
Contemporary Rhetorical Theory: A Reader (1999)

As the epigraph above so eloquently explains, the general interest in studying and understanding human language has transcended a variety of political, social and academic boundaries. Rhetorical studies, specifically, has a great deal of rich insight and understanding to offer regarding effective and ineffective communication, particularly surrounding significant and controversial issues as health care reform. This chapter is designed, as suggested by the title, to provide a review of the most current and relevant literature concerning various approaches to health care reform analyses, with a specific emphasis on rhetoric and rhetorical analyses. In addition, this chapter contains a rationale of methods and a descriptive overview of the methodology I have selected and employed for my rhetorical analyses.

Review of Literature

Much of the academic and scholarly work dealing specifically with health care reform approaches this topic from a variety of academic fields such as Economics, Philosophy, Sociology, History, Public Deliberation, and Public Policy to name but a few! In other words, this topic is approached from a multitude of disciplines. In addition, several sources investigate and analyze the failed health care reform efforts of the Clinton administration in the 1990's. My intent for this review, however, is to present a sample of the kinds of texts I have found and utilized with a specific focus on the rhetoric and rhetorical situations of health care reform which include: the role of the public (audience), presidential rhetoric, rhetorics of crisis, the role of the affective in political rhetoric, and the significance of metaphor.

Health Care Reform and the Role of the Public

From the perspective of health care reform and public interaction, Kronenfield (1997) authored a comprehensive book which predominantly investigates the "changing federal role in health care policy in the United States," with a specific focus on "the interaction between the public (as the ultimate decision makers in a democratic form of government) and the health care system" (p. 4-13). She provides an overview of "The changing image of a 'crisis' in health care," the variance in health care models or systems (i.e. regionalized versus dispersed models), health care and technology, and lastly, "public opinion and health care access." Due to the book's publication date, Kronenfield (1997) is focused on examining specific "changes in the Reagan-Bush years and the failed attempt at major health care reform during the first term of the Clinton presidency" (p. 4). This book examines the important relationship between policy makers and the

public surrounding the topic of health care reform, at times investigating the significance of rhetorical choices regarding the presentation of reform proposals and how the public responds to such choices. For example, in reference to the reform efforts undertaken by the Clinton administration in the early 1990s, "strong support for some type of reform in national health care declined if the questions implied that personal sacrifices would be required" (Kronenfield, 1997, p.15). Importantly, this indicates the crucial nature of rhetorical choices a rhetor (i.e., Obama) is faced with making when addressing the public on health care reform.

With a specific emphasis on the variety and power of stakeholders in health care reform, Quadagno (2005) traces the history of health care reform in the U.S., highlighting why the U.S. has not adopted a national health insurance plan: "Across an entire century, each attempt to enact national health insurance has been met with a fierce attack by powerful stakeholders who have mobilized their considerable resources to keep the financing of health care a private affair" (Quadagno, 2005, p. 6). Quadagno's (2005) aim is to review more specifically how different stakeholders have successfully and continually defeated national health insurance, looking at "how physicians and then insurers and employers were able to mobilize powerful allies to defeat national health insurance and institutionalize market-based alternatives" (p.6). Similar to Kronenfield (1997), Quadagno (2005) also devotes a chapter of her book to demonstrate "how a coalition of insurance companies, small businesses, and managed-care firms…launched an attack on President Clinton's plan for universal health care in the 1990s" (p. 16). Thus, the role of the public and the roles of different stakeholders in this debate clearly work to

shape both how the rhetoric of reform proposals is crafted and delivered, and the outcomes of such reform efforts.

McLaughlin and McLaughlin (2008) write with specific emphases on health policy analysis and audience while employing a variety of perspectives "which include economics, political science, management, communications, and public health" (p.xi). The primary focus of their book is "to enable current and future health professionals to understand and then participate in the health policy process" (McLaughlin and McLaughlin, 2008, p. 21). Their book also deals with issues such as the complicated notion of "we" in health care issues by asking the question "who is the 'we' in 'where do we want to be' (McLaughlin and McLaughlin, 2008, p.88)? Indeed, the employment of the word 'we' can be a powerful rhetorical strategy which often works to organize and form communities or collectives who share similar goals and interests. In addition, much like Quadagno (2005), the authors present and analyze the major stakeholders within the larger issue of health care policy formation and debate which includes a case study of the failed reform efforts during the Clinton administration.

Feldstein (1996) also investigates the case of the Clinton health care reform efforts. The primary purpose of his work, however, "is to demonstrate that legislative and regulatory outcomes in healthcare are consistent with the hypothesis that individuals, groups, and legislators act to serve their own particular self-interest…" and the "approach used in this book to explain legislative outcomes - 'Self-Interest Paradigm' – assumes that individuals act according to self-interest, not necessarily in the public interest" (Feldstein, 1996, p. 3). Feldstein (1996) then applies this economic theory to three different types of health care legislation – "Producer Regulation," "Externalities," and

"Redistributive Legislation" (Feldstein, 1996, p. 10-14). This theory of self-interest arguably provides an important catalyst for President Obama, for example, who asserts that our current health care system is driven by self-interest and not by a philosophy of the greater good for the greatest number. Hence, the kind of rhetoric of crisis he employs in speeches (see more on this in Chapter 3) is in part a response to what he sees as a dysfunctional health care system.

Doble et al. (2009) published a report in 2009 that provides a summary of what the National Issues Forums revealed in terms of results regarding public thinking on the issue of health care in 2008. Importantly, this piece provides an explanation, taken from public deliberation forums, of why heath care is such an important issue for Americans, and at the same time, "how conflicted public thinking can be" on this issue (Doble et al., 2009, p. 3). According to the authors, "The outcomes from these forums suggest that participants see few other problems with greater urgency," and the contributions from the participants "illustrated why Americans think so much is wrong with our health-care system…" (Doble et al., 2009, p. 1). While most of the participants agreed that the quality of care in the country was "very good or excellent," they explained that "The country's health-care crisis…involves cost and coverage…" (Doble et al., 2009, p. 1).

Daniels and Sabin (1997) present a thorough and thoughtful analysis of the moral underpinnings structuring health care issues from equal access to questioning the legitimacy of the limits set by insurance companies on care and access to care. This article is a fascinating philosophical look at issues of trust, legitimacy and democratic deliberation in health care. They explain that, "Anyone who worries about the bureaucrat in Washington setting limits on what the doctor can do should be just as concerned about

vesting that authority in private, increasingly for-profit institutions" (Daniels and Sabin, 1997, p. 2). Interestingly, the rhetorics of crisis I have identified in later chapters focus on issues of trust and legitimacy: President Obama attempts to argue that we can no longer trust the current health care system run mostly by private insurance companies, while the three non-profit groups I have selected urge their audience that government cannot be trusted with individual's health care. In other words, the issues raised in this article of trust and legitimacy clearly remain as important philosophical underpinnings shaping the most current health care reform debate.

Public Policy Analysis and Rhetorical Studies

The study of public policy and health care reform has, as has been demonstrated thus far, been approached by many scholars from a variety of disciplines and perspectives. More generally, public policy analysis is a field of study that seems to straddle a multiplicity of academic disciplines and scholarly inquiries, including rhetoric. The field of rhetoric studies and analysis, as so elegantly explained by Lucaties and Condit (1999) on the opening page of this chapter, has been in existence for thousands of years, dating back to Ancient Greece.

Rhetorical analysis has often intersected with public policy analysis as seen in Fischer et al.'s (2007) edited collection of public policy analysis articles. For example, Gottweis (2007) seeks to extend the focus of public policy analysis beyond "rationalistic" and "post-rationalistic" (i.e. positivist and argumentative respectively) approaches to "a number of phenomena that, no doubt, play crucial roles in many policy-making processes: phenomena such as trust, credibility, virtue, emotions, feelings and passions" (p.237). Overall, Gottweis is calling for a return to the "tradition of rhetoric" in policy

analysis. Fischer (2007) explores what is often referred to as the "argumentative turn" in policy analysis which "emerged to deal with epistemological limitations of 'neopositivist' or empiricist policy analysis and the technocratic decision making practices to which it gave rise" (p.223). The author states that policy can be understood as "crafted argument," and his purpose is to "improve policy argumentation by illuminating contentious questions, identifying the strengths and limitations of supporting evidence, and elucidating the political implications of contending positions" (Fischer, 2007, p.235). van Eeten (2007) provides a rationale for using narrative policy analysis followed by definitions of narrative, analysis and policy taken from Roe (1994). He discusses the important role of meta-narrative and concludes his piece with two exemplary case studies of narrative policy analysis. In an attempt to unravel how, generally, public policies are created and revised, van Eeten (2007) uses case studies to demonstrate how the strategy of narrative analysis can reveal and represent different stakeholder positions on a given issue.

Rhetorics of Crisis

There are many different ways one can approach a rhetorical analysis or study of a text, situation, event, etc. Of particular relevance to this thesis are rhetorical analyses of texts, and, more specifically, analyses of (i) crisis rhetoric, (ii) rhetoric and the affective, and (iii) rhetoric and metaphor.

Wooten (1983) provides an analysis of how prominent leaders historically made rhetorical choices, for public address or oration, to emphasize different types of crisis to generally forward their political agendas. He conducts an extensive comparison of the rhetorics of crisis being employed between Cicero's Phillipics and the speeches delivered

by Demosthenes to Philip of Macedon. He explains that through his analysis of these different ancient texts, one of the most central and:

> …striking characteristics of the rhetoric of crisis is the clarity and simplicity with which the orator views the situation that he faces. To him the contest is black and white, the struggle of good against evil; and what is at stake, he argues, is the very existence of the civilization that he is defending. (Wooten, 1983, p. 58)

Further, Wooten (1983) elaborates that while using a rhetoric of crisis, the orator is looking to, "convince the members of his audience that the history of their state has reached a fundamental crisis in which its very existence as they know it and everything that it represents are in danger" (p.58).

Importantly, though, not all analyses of rhetorics of crisis focus primarily on public address rhetoric; other kinds of analyses certainly provide significant insight and contribution into the power of this particular rhetorical strategy at use in different forums. For example, Cook and Cook (1976) document the implementation of a rhetoric of crisis in what they have called a "criminal victimization of the elderly" (p. 632). They set out to compare the rhetoric of crisis they have identified, using four definitions of crisis, and the available data regarding actual rates of victimization. They write that "there is often a rationale for making rhetorical allusions to crisis when seeking support for a particular course of action" (Cook and Cook, 1976, p. 632). The authors then conclude that in the case of a crisis for the elderly, the evidence of actual victimization and the rhetoric of crisis being employed to describe the situation were not compatible. Importantly, this article emphasizes the need and the difficulty in defining crisis and how best to confirm and respond to a crisis on behalf of public policy makers.

Other authors have investigated how a rhetoric of crisis was becoming overwhelmingly popular in higher education during the 1990s. Tight (1994) sets out to "both justify and challenge" the portrayal of a crisis in higher education, "focusing on British and North American literature published since the Second World War" (p.363). This investigation spends little time looking into rhetorical theory, but does attempt to argue that, "while higher education has suffered both internal and external stresses, these are no more than might have been expected in an activity of its scale and complexity during a period of considerable economic, social and technological change" (Tight, 1994, p. 363-364). Indeed, Tight (1994) is focused primarily on how the impression of crisis is being communicated through written texts, and he conducts a brief analysis of how these texts compare to the severity and significance of the actual issues or problems being raised in the texts. Similarly, Scott (1995) conducts an analysis of the rhetoric of crisis being described in higher education by approaching it "as a series of paradoxes that have produced further paradoxes: seemingly contradictory developments have elicited similar responses from apparently opposing sides" (p.294). Writing from the perspectives of history, feminist theory, and gender theory, Scott (1995) concludes that as a result of this rhetoric of crisis in higher education literature, four different paradoxes have emerged. The author then summarizes and analyzes these paradoxes in the context of the rhetoric of crisis in higher education. Such an analysis indicates the multitude of potential understanding available via the identification and investigation of different rhetorics of crisis.

Emotion Studies & Rhetoric

While the scholars I have listed above are not explicitly writing from the perspective of Emotion Studies, it is clear that their various analyses of a rhetoric of crisis in different contexts and settings brushes up against if not ventures into an analysis of the emotions that so often underpin any kind of discourse of crisis. Emotion Studies has become a burgeoning field of study and inquiry within Cultural Studies, History, Communication, and Rhetoric and Composition. Indeed, the language I have chosen to investigate and analyze is a highly emotional language, which requires a particular perspective on emotions and rhetoric. While Emotion Studies has done little in the way of examining the affective in the rhetoric of health care, much can be taken from what scholars have revealed as a result of their inquiries and studies in other areas.

From this field, Ahmed's (2004) work with emotions, affective economies, and public discourse will be of the most use to this thesis. Ahmed (2004) theorizes emotions as that which occurs in the 'sticky' place between objects, and that which defines oneself and differentiates oneself from an 'other.' Thus, according to this view, emotions do not work from an inside/outside, outside/inside model, but rather function in the space between, hence creating the affective. The inside/outside model can be defined here as a model of emotions that is initiated from the inside (i.e. 'I feel sad') and expressed or distributed to the outside (i.e. you tell someone that you feel sad). Conversely, the outside/inside model is initiated from the outside (i.e. 'My boss really made me mad') and is then internalized on the inside (i.e. 'because my boss made me mad, I now feel angry'). More specifically, Ahmed (2004) explains her theory in the following passage:

> In my model of sociality of emotions, I suggest that emotions create the very effect of the surfaces and boundaries that allow us to distinguish an inside and an outside in the first place. So emotions are not simply something 'I' or 'we' have. Rather, it is through emotions, or how we respond to objects and others, that surfaces or boundaries are made: the 'I' and the 'we' are shaped by, and even take the shape of, contact with others. (p. 10)

Emotions, then, work to distinguish self from other. More specifically, emotions reside in affective domains which are 'sticky' places where emotions develop and eventually stick to certain signs or objects through repeated association. In her book Ahmed (2004) argues that, "emotions work to shape the 'surfaces' of individual and collective bodies" (p.1). Discourse, Ahmed's (2004) main focus and site of analysis, can then serve as an example of how the sticky relation between objects works to preserve an affective economy of power. The affective is then largely the outcome of such stickiness in these spaces – at once rendering the perseverance of the hegemonic and normative structures of power.

Specific to my analyses in future chapters are Ahmed's (2004) concepts of fear and anxiety. Ahmed (2004) considers "fear as an 'affective politics', which 'preserves' only through announcing a threat to life itself", and "fear in its very relationship to an object, in the very intensity of its directedness towards that object, is intensified by the loss of its object" (pp.64-65). Anxiety "is then an effect of the impossibility of love; an impossibility that returns in the diminishment of what it is possible to be. The anxiety about the possibility of loss becomes displaced onto objects of fear, which seem to present themselves from the outside as dangers that could be avoided, and as obstacles to the fulfillment of love itself" (Ahmed, 2004, p.67). Chapters three and four of this thesis

will deal more specifically with Ahmed's concepts of fear and anxiety in relation to political rhetoric.

The Power of Metaphor

Lastly, the development of metaphor as a site for rhetorical study is also quite important to this thesis. Most central is the work of Lakoff and Johnson (1980) and Lakoff (2006). In the former, Lakoff and Johnson (1980) provide a thorough and thoughtful explanation and analysis of metaphor based on their discoveries that, "metaphor is pervasive in everyday life, not just in language but in thought and action" (p. 3). According to the authors, the human "conceptual system is largely metaphorical", which suggests that "the way we think, what we experience, and what we do every day is very much a matter of metaphor" (Lakoff and Johnson, 1980, p.3). This book outlines this idea at great lengths through thirty short chapters, each an investigation surrounding metaphor, the use of metaphor, and the larger relationship between language and reality.

Lakoff's (2006) more recent work focuses more specifically on the metaphor of freedom and how it is used in political contexts in the United States. He argues that there are two very distinct and albeit divisive ideas of freedom, "arising from two very different moral and political worldviews dividing the country" (p. 3). These two definitions of freedom are "progressive" and "conservative" according to Lakoff (2006) and they primarily function on the basis of what he has titled "the nation-as-family metaphor." Lakoff (2006) also uses the idea of mental frames which are "mental structures of limited scope, with a systematic internal organization" to establish his position on metaphor and, more specifically, the metaphor of freedom (p. 10). More

specific explanation and application of Lakoff's (2006) work with metaphor, freedom and political language can be found in chapter four of this thesis.

In sum, a multitude of theoretical perspectives and texts are informing this thesis - from public policy analysis, rhetorics of crisis and emotion studies to cognitive linguistic concepts of metaphor. Indeed, recognition of the multiplicity of approaches and perspectives on the topic of health care reform is necessary for an informed rhetorical analysis.

Methodology & Rationale

The purpose of this thesis is to investigate and analyze the rhetoric being used by both President Obama and three public, non-profit groups who have formed directly in response to the current administration's health care reform proposals. The following section will provide an explanation of how and why I selected presidential speeches, as well as an explanation of how and why I chose the websites created by these three groups.

The Speeches

I have selected three speeches delivered by President Barack Obama from 2007 to 2009. The speeches I have chosen to analyze are in transcript form as the focus of my analysis for the speeches is indeed textual and rhetorical; hence I have elected to exclude analyzing any visual or audio components of the speeches. The rhetorical situation for each speech is very different. As a result, I selected the speeches based on criteria which included three different speeches given at different times to different audiences for the purposes of understanding how the rhetoric may have changed over time when delivered

in varying contexts to different audiences. For example, the first speech I selected from 2007 was delivered during Mr. Obama's time campaigning for the democratic candidacy, and the last speech was given nine months into his first year as president, during which he was already facing increasing resistance to his reform proposals. Thus, it is important to include more than one speech from the archives of dozens of President Obama's speeches on health care reform to fully understand what type of reform he has been proposing over the last three years, and how these policies being proposed have changed.

The first speech I have selected was given by Senator Barack Obama January 25, 2007 at a Families USA Conference in Washington, D.C. during his democratic presidential campaign. According to their website, Families USA:

> …is a national nonprofit, non-partisan organization dedicated to the achievement of high-quality, affordable health care for all Americans. Working at the national, state, and community levels, we have earned a national reputation as an effective voice for health care consumers for 25 years (Families USA, 2010).

The conference this organization held in 2007 entitled "Health Action 2007" was designed as a platform to forward health care reform. The second speech was delivered on June 15, 2009 to the American Medical Association (AMA) in Chicago, IL. According to Pear (2009), "The A.M.A., with about 250,000 members, is America's largest physician organization" which is "committed to the goal of affordable health insurance for all" (p. 1). Leading up to this speech in June of 2009, according to Pear (2009), the AMA had already established a clear position on reform in the name of any kind of government run program (i.e. universal health care/insurance):

> The A.M.A. does not believe that creating a public health insurance option for non-disabled individuals under age 65 is the best way to expand health insurance coverage and lower costs. The introduction of a new public plan threatens to

> restrict patient choice by driving out private insurers, which currently provide coverage for nearly 70 percent of Americans. (AMA as qtd. in Pear 2009, p.1).

The third and last speech I have selected was delivered to Congress on September 2, 2009. This speech garnered a lot of publicity and media coverage following an outburst from a Republican representative from South Carolina: "When Obama touched on the issue of health care coverage for illegal immigrants, the president's speech was interrupted by Rep. Joe Wilson, R-South Carolina, who shouted 'you lie'" (Hornick et. al, 2009, p.1). Moreover, the large majority of Republicans in Congress had already taken a clear position on health care reform prior to this speech: "Republicans are unanimous in opposing a public option, calling it an unfair competitor that would drive private insurers from the market and lead to a government takeover of health insurance" (Hornick et. al 2009, p.1). Please note that full transcripts of each speech can be located in the Appendices.

What can be understood from political and presidential rhetoric more specifically? In other words, why is it important to examine and analyze this type of rhetoric? Rhetoric and rhetorical studies are valuable tools and avenues which we can utilize to further our understanding of how language does its work; how language is both shaped by and shapes our realities. Zarefsky (2004) provides an important rationale for studying rhetoric, and, more specifically, presidential rhetoric, which I have borrowed and fully endorse to explain why I have chosen presidential speeches regarding health care reform as opposed to other political, private and/or public explanations of the topic. He explains that, "Rhetoric is not only an alleged cause of shifts in audience attitudes. It is also a reflection of a president's values and world view. And it is also a work of practical art,

often richly layered and multivocal, that calls for interpretation" (Zarefsky, 2004, pp. 609-10).

Importantly, using rhetorical analysis as a tool can expand and deepen our understanding of human communication which provides a unique and valuable perspective on the power of communication and the potential for failure and success of public policy implementation:

> The field of rhetorical studies, by and large, makes different ontological assumptions and relies on a more complex view of the rhetorical transaction. It emphasizes contingency and choice rather than predictability and control. According to this view, the rhetor (speaker or writer) makes choices, with an audience in mind, about the best way to achieve his or her goals in the context of a specific situation. Those choices – about such matters as argument selection, framing, phrasing, evidence, organization, and style, as well as about staging, choreography, and other aspects of the presidential performance – are embodied in the text that the rhetor composes and the context in which it is delivered. An audience, also influenced by context, perceives this text, interprets it, participates thereby in determining what it means, and is affected by it. (Zarefsky, 2004, p. 609)

Therefore, we must not underestimate the importance of the rhetorical situation and the power of presidential rhetoric, particularly in conjunction with public policy proposals and how they are received by the public.

The Websites

In conjunction with the three speeches I have selected by President Obama, I have also selected three non-profit groups or organizations that developed directly in response to these current health care reform proposals. These groups have formulated very specific resistance to any kind of government-run program or initiative. As suggested by the title of the thesis, a large part of the focus here is to investigate how public groups are using a rhetoric of resistance. So, I was faced with the task of selecting such groups. As a result, I

have developed a list of questions I used to establish criteria describing how I chose the following groups: Conservatives for Patients Rights (CPR), Patients United Now (PUN), and Patients First (PF).

- Who are the frontrunners or most prominent opponents of resistance to health care reform?
  - ✔ Identify the most prominent groups (i.e., public protests, well funded, identified in news media stories, etc.).
- How long have these groups been in opposition to health care?
  - ✔ Identify the groups who have developed in direct response to the current proposals for health care reform in an effort to establish immediacy and relevancy to such proposals.
- Due to time constraints, how can I best study the language and positions of these groups?
  - ✔ Choose groups who have publicly accessible websites for analysis as I do not have the time and resources to conduct interviews and/or distribute surveys, etc.

Each of the three groups, or their sponsors, has been cited in news media articles, and, it follows, that each is a prominent force in the opposition to government run health care reform. The three groups all have stable and sizable sources of funding, and they have all created publicly accessible websites which contain a great deal of information regarding their goals, mission statements, and more general political positions in their fight against government run health care. In addition to the above listed criteria, I also selected these websites according to the following:

- Each group is attempting to create a strong sense of ethos or credibility on their websites with different informational sections entitled “The Facts” for example, or a section entitled “The Plans” which allows users to compare different plans that have been created and/or proposed.

- Each group centers their resistance on opposing any kind of government run program or initiative. Moreover, each group consistently portrays the government as a non-human entity which is working against the freedom of the individual.
- Lastly, each group is also utilizing the rhetorical tool or strategy of crisis to frame their positions on health care reform. Importantly, the crisis is the impending invasion of the government into the lives of individual patients.

Further, and albeit more generally, these websites contain a wealth of information and text and therefore function as rich sites of rhetorical analysis for this thesis.

Importantly, the three groups I have selected identify themselves as conservatives, politically, and Sherman (2009) explains that more and more conservative groups are using the internet to expand and mobilize different constituencies. "That's a shift…from recent years of GOP strategy, where the shaping of the party's message had been largely top-down, with message coming from party leaders. Now, the message is bubbling up more from groups of online activists" (Sherman, 2009, p.1). Looking specifically at Americans for Prosperity, the sponsor of Patients First, Sherman (2009) explains that the group is "looking to recoup the party's [GOP's] clout", and is "borrowing a page from liberal Democrats by beefing up Internet efforts to energize grass roots" (p.1). Indeed, the three websites I have selected for analysis contain a great deal of information on the issue of health care reform. That is, these groups are clearly utilizing the internet to mobilize action and continue forming constituencies to oppose any kind of government run health care program. In sum, these groups are well organized, powerful, and have had some success in mobilizing against any kind of government-run program or initiative.

First, however, the upcoming chapter will examine and analyze the three of President Obama's health care reform speeches, while further discussion and analysis of these three groups and their websites will occur in chapter four.

Chapter Three: Presidential Proposals for Health Care Reform

An Analysis of the Public Address Rhetoric Delivered by President Barack Obama from 2007 to 2009

"Let me therefore advance a claim about what presidential rhetoric does: It defines political reality. The key assumption I make is that characterizations of social reality are not 'given'; they are chosen from among multiple possibilities and hence always could have been otherwise. Whatever characterization prevails will depend on choices made by political actors. People participate actively in shaping and giving meaning to their environment, and they do so primarily by means of naming situations within it. Naming a situation provides the basis for understanding it and determining the appropriate response. Because of his prominent political position and his access to the means of communication, the president, by defining a situation, might be able to shape the context in which events or proposals are viewed by the public."

David Zarefsky,

"Presidential Rhetoric and the Power of Definition" (2004)

"If everyone is in charge, then no one is in charge. Health policy is a problematic issue throughout the world, but it is particularly challenging in the United States, where there is no consensus about which government agency or social institution, if any, has the legitimate role of developing or implementing national health policy."

McLaughlin & McLaughlin,

Health Policy Analysis: An Interdisciplinary Approach (2008)

Barack Obama is currently the 44th President of the United States, and during his time campaigning for the Democratic Party nomination and for President, health care reform in the name of universal health coverage was a key issue of his political platform.

Following his election, this key issue has remained an important part of his presidency, as he has named health care reform a top domestic priority for his administration. The aim of this chapter is to closely examine and analyze his proposals for reform using rhetorical theory and criticism.

First, considering the significance of a rhetorical situation is crucial in establishing an understanding of rhetorical analysis. More generally, a rhetorical situation presents an expected opportunity or space for rhetorical discourse, according to Bitzer (1968), and "a particular discourse comes into existence because of some specific condition or situation which invites utterance" (p. 217-219). Further, Bitzer (1968) defines a rhetorical situation as "a natural context of persons, events, objects, relations, and an exigence which strongly invites utterance; this invited utterance participates naturally in the situation, is in many instances necessary to the completion of situational activity, and by means of its participation with situation obtains its meaning and its rhetorical character" (p. 219).

In conjunction with the importance of the rhetorical situation is a discussion of audience. In his book on rhetoric and argumentation entitled *The Realm of Rhetoric*, Perelman (1982) explains that when a philosopher (speaker or orator) delivers a speech he or she is faced with a more difficult situation than a "specialist who addresses a learned society and the priest who preaches in his church" because the philosopher's "discourse is addressed to everyone, to a universal audience composed of those who are disposed to hear him and are capable of following his argumentation" (Perelman, 1982, p.17). Therefore, according to Perelman, when the philosopher is addressing this type of

audience, “he searches for facts, truths, and universal values that, even if all the members of the universal audience do not explicitly adhere to them…are nevertheless supposed to compel the assent of every sufficiently enlightened being” (Perelman, 1982, p.17). Moreover, the philosopher will most likely employ “appeals to common sense or common opinion, to intuition or to self-evidence, presuming that each member of the universal audience is part of the community to which he alludes, sharing the same intuitions and self-evident truths” (Perelman, 1982, p.17). Conversely, a specific audience, as defined by Perelman, comprises a specialized audience such as a group of experts “in physics, history, or law for example,” of which each corresponding discipline “possesses a group of theses and methods which every specialist is supposed to acknowledge and which is rarely called into question” (Perelman, 1982, p. 16).

Keeping in mind the work of Bitzer (1968) and Perelman (1982), the following chapter consists of a rhetorical analysis of three selected speeches given by President Barack Obama from 2007 to 2009. More specifically, the purpose of this chapter is to summarize and then analyze what rhetorical choices President Obama is making in his proposals for health care reform.

Speech One: Pre-Presidential Proposals

The first transcript is from a speech President Obama delivered at a Families USA Conference in Washington, D.C. on January 25, 2007, while he was in the running as a candidate for the 2008 Democratic ticket (full transcripts of all three speeches can be located in the Appendices). This particular speech, as are the rest, is devoted entirely to

the subject of health care reform. First, a summary of each speech will be provided, followed by an analysis.

The beginning of the speech calls for universal health care by the end of the new president's term in 2012: "I am absolutely determined that, by the end of the first term of the next president, we should have universal health care in this country. There's no reason why we can't accomplish that" (Obama, 2007). Obama continues that while universal health care reform has historically been resisted and denied for nearly a century, America cannot risk engaging in "another disappointing charade in 2008 and 2009 and 2010. It's not only tiresome, it's wrong" (Obama, 2007). A further delay, he says, would be a profound and dire economic mistake, because "In recent years, what's caught the attention of those who haven't always been in favor of reform is the realization that this crisis isn't just morally offensive, it's economically untenable" (Obama, 2007).

Obama then briefly mentions how the camps of opposition have historically used fear tactics to defeat health care reform in the name of universal coverage, and then moves into a brief re-cap of the striking numbers surrounding the current health care crisis (i.e., number of uninsured, rising health insurance premium costs, etc.). He returns to what he calls the "skeptics" of health reform to conclude his speech: "But the skeptics tell us that reform is too costly, too risky, too impossible for America to achieve. The skeptics must be living somewhere else…because when you see what the health care crisis is doing to our families, to our economy, to our country, you realize that what is too costly is caution" (Obama, 2007). In sum, Obama is interested in mobilization through a call to action in the name of national health care reform that would provide coverage to everyone. This call to action is most clearly justified or warranted based on the claim that

the current health care system is a system in crisis – a national crisis from every perspective: economically, politically, socially, morally, etc.

Speech Two: Presidential Address to the American Medical Association

The second transcript is from a speech delivered to the American Medical Association (AMA) in Chicago, IL on June 15, 2009, approximately six months following Obama's presidential inauguration (full speech can be located in Appendix B). The president begins by prefacing his speech with a note on the economic recession that he and his administration have faced and continue to face since the day his presidency commenced. This preface provides a segue into the central topic of his speech: health care reform. From the start he is making a case for reform that will be essential to recovery from such a dire economic recession of the last several years. "Make no mistake: The cost of our health care is a threat to our economy. It's an escalating burden on our families and businesses. It's a ticking time bomb for the federal budget. And it is unsustainable for the United States of America" (Obama-AMA, 2009).[6] Following this statement he provides a string of stories which exemplify the portrait of crisis he has just painted for his audience. He tells the story of an individual patient, of a doctor, of a small business and even a story of a large corporation. Action towards health care reform he then says is a necessity (Obama-AMA, 2009). He explains that if there is failure to act upon our current health care system the crisis will only expand and worsen from skyrocketing costs to lower standards of living (Obama-AMA, 2009). "So to say it as

[6] To avoid confusion between the two speeches delivered in 2009, I have named the first 2009 speech 'Obama-AMA 2009' and the second 2009 speech 'Obama-Congress 2009.'

plainly as I can, health care is the single most important thing we can do for America's long-term fiscal health. That is a fact. That's a fact" (Obama-AMA, 2009).

The next section of his speech is primarily a summary and response of opposition to reform which ends with the following statement: "And despite this long history of failure, I'm standing here because I think we're in a different time" (Obama-AMA, 2009). This statement is followed by numerous examples of why he believes the time is different for health care reform and why this country must unify and act in the name of reform. He also explains his vision for health care reform and what he and the different branches of government were proposing in their various versions of health care reform. For example, he insists that despite reform efforts, patients will be able to retain their doctors and their health insurance plans if they are satisfied with them. Obama then proceeds to spend a significant amount of time outlining the steps to what he has called "structural reform" efforts, which include items such as preventive medicine to lower the rising costs of care, subsidizing medical education programs, investing in medical research and the widespread dissemination of the most up-to-date medical and scientific information (Obama-AMA, 2009).

The speech then transitions into a discussion of national identity and reform in the name of economic incentive and re-shaping this identity:

> We are not a nation that accepts nearly 46 million uninsured men, women and children. We are not a nation that lets hardworking families go without coverage, or turns its back on those in need. We're a nation that cares for its citizens. We look out for one another. That's what makes us the United States of America. We need to get this done. (Obama-AMA, 2009)

He then describes what he sees as the necessary steps to accomplishing health care reform regarding controlling and cutting costs. "What I am trying to do – and what a public option will help do – is put affordable health care within reach for millions of Americans" (Obama-AMA, 2009). The issue of health care is, Obama explains, personal for him as he proceeds to share a story about his mother. He begins to wrap up his speech with a brief discussion of how Medicare will be impacted by reform efforts, including specific changes to the financial structure of the Medicare system. Finally, he concludes his speech with a note on acting for reform for future generations and a restoration of the medical profession's identity.

This speech was indeed lengthy and captured many pieces of the health care reform puzzle: costs, the current crisis, morals, ethics, national and professional identities, to name a few. While this speech bears some resemblance to the first speech discussed above, it is quite different primarily due to the change in context (i.e., he is already president now trying to pass reform) and a change in audience. Thus, the rhetorical situation is quite different regarding audience, context and exigence; yet, the structure of the speech and the employment of a rhetoric of crisis remain consistent.

Speech Three: A Rationale To Congress

The third and final transcript I have selected is from the speech President Obama delivered to Congress on September 9, 2009 (full speech can be located in Appendix C). Indeed, the general outline of this speech closely resembles the speech Obama delivered to the AMA just three months before (speech two). Again, he prefaces this speech with a note on the slow recovery from the "worst economic crisis since the Great Depression" to lead into his discussion of reforming health care as an essential part of this recovery

(Obama-Congress, 2009). He provides stories of ordinary citizens who are struggling financially due to their battles with paying for health care and explains that similar struggles to stay afloat financially or losing one's health insurance coverage "can happen to anyone" (Obama-Congress, 2009). "We are the only advanced democracy on Earth – the only wealthy nation – that allows such hardships for millions of its people" (Obama-Congress, 2009). He continues to explain that health care is also a significant financial problem impacting everyone in the country: "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" (Obama-Congress, 2009).

Obama then provides an outline of what his plan for reform will accomplish while insisting that it must be a collective reform effort; everyone must be involved in these changes. He addresses the arguments that have formulated in response to his proposals and claims that, "My guiding principle is, and always has been, that consumers do better when there is choice and competition" (Obama-Congress, 2009). Similarly, he emphasizes this idea of choice and his promise that government will not be involved in relegating care to individual consumers: "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" (Obama-Congress, 2009). From here, Obama provides an explanation of how his plans for reform will be funded and paid for over a ten-year period.

As the speech concludes, Obama again addresses elements of national identity and character and he ends his speech with a call to action: “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” (Obama-Congress 2009).

The Rhetoric of Crisis: An Analysis

The following section is devoted to closely and critically examining the three speeches summarized above through a lens of a rhetoric of crisis. More specifically, the aim of my analysis is to illustrate that President Obama employs a rhetoric of crisis as a tool to forward health care reform throughout the three speeches I have selected. The rhetoric of crisis that President Obama is using in his public addresses is utilized through a variety of methods. That is, the portrait of a crisis is painted at various moments throughout his speeches in multiple ways which I identify below:

1. The Crisis in Numbers:

The inclusion of numbers in the discussion of the health care crisis is a staple of each speech that I have selected. President Obama explains that as a result of the failings of our current health care system, a great deal of statistical data indicates a state of crisis in sheer numbers. The numbers he discusses in his speeches are usually big, overwhelming numbers such as the number of uninsured, how much of our Gross Domestic Product (GDP) we spend on health care per person in this country, the rising costs of health

insurance plans and the resulting bankruptcies, as well as the bills that taxpayers foot when the uninsured seek medical care:

- "…46 million Americans have no health care at all" (Obama, 2007).
- "Family premiums are up by nearly 87% over the last five years, growing five times faster than workers' wages. Deductibles are up 50%. Co-payments for care and prescriptions are through the roof. Nearly 11 million Americans who are already insured spent more than a quarter of their salary on health care last year. And over half of all family bankruptcies today are caused by medical bills" (Obama, 2007).
- "Today, we are spending over $2 trillion a year on health care – almost 50 percent more per person than the next most costly nation (Obama-AMA, 2009).
- "Each time an uninsured American steps foot into an emergency room with no way to reimburse the hospital for care, the cost is handed over to every American family as a bill of about $1,000 that's reflected in higher taxes, higher premiums, and higher health care costs" (Obama-AMA, 2009).
- "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 insurance premiums have gone up three times faster than wages" (Obama-Congress, 2009).

Interestingly, this picture of crisis in numbers is also described as one that could become increasingly more devastating if, according to Obama, health care reform is not enacted:

- "If we fail to act, premiums will climb higher, benefits will erode further, the rolls of the uninsured will swell to include millions more Americans...If we fail to act, one out of every five dollars we earn will be spent on health care within a decade. And in 30 years, it will be about one out of every three – a trend that will mean lost jobs, lower take-home pay, shuttered businesses, and a lower standard of living for all Americans" (Obama-AMA, 2009).

- "And remember, failing to reform our health care system in a way that genuinely reduces cost growth will cost us trillions of dollars more in lost economic growth and lower wages" (Obama-AMA, 2009).

Indeed, these statements indicate an escalating sense of crisis due to their positioning as forecasted numbers which arguably create a more devastating picture of a crisis than the numbers Obama uses to describe our current health care crisis. In other words, these predictions of a worsening crisis engage a deepening sense of fear, anxiety and urgency: If you think it is bad now, just imagine what it would like if we did not do anything to change our current health care system… Thus, Obama uses numbers to successfully create and sustain a state of crisis in health care as they provide a tangible set of outcomes this crisis has produced. Yalch and Elmore-Yalch (1984) explain that, "Quantification is thought to provide integrity to a communication because of the credibility associated with numbers" (1984, p. 523). That is, numbers have the potential to carry weight and can help to promote advocacy, reform and persuasion in the midst of a crisis; the numbers therefore can enhance and bolster the rhetoric of crisis that is clearly being used in these three speeches.

2. Economics and Ethics

The state of crisis in health care is also framed, at various points throughout Obama's speeches, as an overarching economic problem that impacts everyone from individual patients, families, doctors, small businesses, and large corporations to the burgeoning national deficit. Thus, the statements identified in this category all discuss, albeit more

generally, without specific numbers, how the economics of our current health care system are wrong for everyone in this country.

- "Make no mistake: The cost of our health care is a threat to our economy. It's an escalating burden on our families and businesses. It's a ticking time bomb for the federal budget. And it is unsustainable for the United States of America" (Obama-AMA, 2009).
- "Put simply, our health care problem is our deficit problem. Nothing else even comes close" (Obama-Congress, 2009).
- "And as we seek to contain the cost of health care, we also have to ensure that every American can get coverage they can afford. We must do so in part because it's in all of our economic interests." (Obama-AMA, 2009).
- "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 meeting, in emails, and in letters" (Obama-Congress, 2009).

This approach then involves everyone, like it or not. For example, even if you are someone who is satisfied with our current health care system, Obama's strategy here is to make this crisis engage your interests and hopefully move you to act as he frames the health care crisis as an all encompassing economics issue that negatively impacts everyone and every part of our economy. Moreover, the crisis is being framed as an urgent issue that affects everyone in this country, whether you are insured or uninsured, whether you work for or own a small business or a corporation, etc. In addition, Obama is using a similar structure as that found in the discussion of the crisis in numbers: He sets

the stage for crisis by explaining everything that is going wrong with our current health care system, and then furthers his message of crisis by explaining what will happen to us as a nation if we do not act on this crisis (i.e., "If we fail to act…" etc.). Thus, this rhetoric of crisis is not aimed at only a specific audience but also a universal audience (Perelman, 1982).

3. It Can Happen To Anyone, Any Day.…:

An important and seemingly related rhetorical choice that Obama makes in the 2009 speeches to the AMA and Congress is the presentation of the crisis hitting individuals and families at any time. This choice is a clear attempt to make the crisis appear as though it is looming and ready to strike someone's life at any point, which in turn warrants the claim that action must be taken to reform the current health care system – a system in crisis according to Obama. The following statements describe the consequences of the current system, with the follow up conclusion that as a result of these figures, this kind of tragedy could happen to anyone, any day.

- "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." (Obama-Congress, 2009)
- "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" (Obama-Congress, 2009).

Again, even if you are insured and you are seemingly content with your plan, insurance companies could drop you from their list at a moment's notice; this could happen to anyone, and, as Obama states in the second point, it happens every day. The combined framing of numbers and the preceding highly emotional statement that you could lose your coverage because it can happen to anyone, elicits an incredibly strong sense of crisis and impending chaos.

4. Our National Character – The Crisis of American Identity:

A common thread throughout all of the speeches is an emphasis on the American character and identity in the context of our current health care system/crisis, and what reform would mean for our national identity and character. More specifically, Obama urges his audience to think about implications of our national identity and character as it relates to the clear crisis he has worked to present during earlier parts of his speeches. That is, he frames the crisis through the abovementioned themes: numbers, broad economics, it can happen to anyone, any day, and then discusses what these themes mean for our sense of national identity and character. Furthermore, he adds a brief discussion of what this crisis, if left unattended, will represent for future generations of Americans, again, adding a sense of fear and guilt to this crisis if we fail to reform our current health care system.

- "We are the only advanced democracy on Earth – the only wealthy nation – that allows such hardships for millions of its people" (Obama-Congress, 2009).
- "But alongside these economic arguments, there's another, more powerful one. And it is simply this: We are not a nation that accepts nearly 46 million uninsured

men, women and children. We are not a nation that lets hardworking families go without coverage, or turns its back on those in need. We're a nation that cares for its citizens. We look out for one another. That's what makes us the United States of America. We need to get this done" (Obama-AMA, 2009).

- "…I'm here today because I don't want our children and their children to still be speaking of a crisis in American medicine 50 years from now. I don't want them to still be suffering from spiraling costs that we did not stem, or sicknesses that we did not cure. I don't want them to be burdened with massive deficits we did not curb or a worsening economy that we did not rebuild" (Obama-AMA, 2009).

Interestingly, Obama juxtaposes what he believes this crisis means for our national identity in the first quote with the kind of identity he believes we should strive for. In other words, he is making it very clear that we are currently the only nation who permits the continuation and expansion of a broken health care system. At the same time he is also trying to make it clear that this is not the kind of identity or character that America should have, implying that we are not that heartless and cruel even though the quantification of our system seems to indicate this. Further, he similarly uses the tactic of discussing the future and future generations to enhance the state of crisis in American identity and character through the solicitation of many strong emotions (fear, guilt, anxiety, etc.). In other words, he is clearly attempting to set up the national identity and character as on the verge of crisis, for if we fail to act as a nation, our identity will become one of selfishness and lack of foresight for the children and grandchildren of the future.

In sum, the four themes I have identified here strongly indicate that President Obama is deliberately using a rhetoric of crisis to frame and forward his message of

health care reform. Indeed, these themes are not mutually exclusive; however, each theme does contain a unique and consistent position within the rhetoric of crisis of the current health care system. The picture of crisis is painted at every level in these three speeches from the individual patient to large corporations and even to the impending dilemma of the nation's character and identity. The focus of reform is financial, moral, and ethical. In other words, regardless of who you are or what your position may be on this topic, Obama is attempting to argue that it will impact your life in some way, shape, or form; if not your life, the lives of future generations. Thus, I argue that one of Obama's primary rhetorical tools for communication and argument is that of crisis which is exemplified in the preceding quotes I have selected.

Crisis and the Affective Politics of Fear and Anxiety

Having established the overwhelming sense of crisis in Obama's speeches, I will now turn to a more critical analysis of the president's health care reform rhetoric. More specifically, the focus of this section will largely draw from emotion or affective studies, a relatively recent and burgeoning field emerging out of cultural and gender studies. I will argue here that through the creation of a crisis in Mr. Obama's health care reform rhetoric, there is a subsequent creation of a highly emotional and affective political rhetoric of fear and anxiety. Importantly, however, this crisis both came into being as a result of an already existing structure of an affective politics of fear and anxiety, and resulted in, as I will argue in Chapter Four, a more heightened state of political fear and anxiety which public organizations have used to respond to Mr. Obama's proposals. In her book *The Cultural Politics of Emotion,* Ahmed (2004) importantly notes that:

…narratives of crisis are used within politics to justify a 'return' to values and traditions that are perceived to be under threat. However, it is not simply that these crises exist, and that fears and anxieties come into being as a necessary effect of that existence. Rather, it is the very production of the crisis that is crucial. To declare a crisis is not 'to make something out of nothing': such declarations often work with real events, facts or figures. (Ahmed, 2004, pp. 76-77)

Using and expanding upon this definition, as well as those offered in chapter 2 of Ahmed, the following analysis will be categorized according to two prominent themes I have identified from the speeches.

1. *Fear, The Future, and The Loss of Life*

Ahmed explains that, "Fear involves an *anticipation* of hurt or injury. Fear projects us from the present into a future…So the object that we fear is not simply before us, or in front of us, but impresses upon us in the present, an anticipated pain in the future" (Ahmed, 2004, p.65). Obama makes it clear in his speeches that if we fail to act as a nation upon this crisis, we can expect a variety of losses in the future:

- "If we fail to act, premiums will climb higher, benefits will erode further, the rolls of the uninsured will swell to include millions more Americans...If we fail to act, one out of every five dollars we earn will be spent on health care within a decade. And in 30 years, it will be about one out of every three – a trend that will mean lost jobs, lower take-home pay, shuttered businesses, and a lower standard of living for all Americans" (Obama-AMA, 2009).
- "And remember, failing to reform our health care system in a way that genuinely reduces cost growth will cost us trillions of dollars more in lost economic growth and lower wages" (Obama-AMA, 2009).
- "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" (Obama-Congress, 2009).

Such losses can be understood as the impending loss of life. For example, all of the stated potential economic or financial losses are important due to our nation's economic system of capitalism. Money is what allows for our survival, and, as mentioned in the first quote above, it can also provide for a particular standard or quality of life. Therefore, if we fail to act upon the health care crisis we can expect great losses (jobs, quality of life, etc.) which subtly imply the possibility of the loss of life itself. "…the possibility of the loss of the object makes what is fearsome all the more fearsome" (Ahmed, 2004, p.65). Similarly, it can be argued that our financial security and stability are currently under threat and will remain under threat in the future. "Through designating something as already under threat in the present that very thing becomes installed as that which we must fight for in the future, a fight which is retrospectively understood to be a matter of life and death" (Ahmed, 2004, p.77). Moreover, fear is working as an affective political tool, which, according to Ahmed's reading of Machiavelli, is most often quite successful: "Fear is understood as a safer instrument of power than love given its link to punishment" (Ahmed, 2004, p.71). Indeed, Obama is asserting that inaction will result in the losses discussed above, and these losses can be translated into widespread punishment for the preservation of the status quo in health care.

In addition, the notion that this crisis could strike at any moment, upon anyone's life intensifies this fear and perhaps justifies a course of action to protect individuals from the possible "passing by" or encounter with this object of crisis:

- “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.” (Obama-Congress, 2009)
- “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” (Obama-Congress, 2009).

Again, the notion of loss is emphasized in these two passages; the loss of health insurance coverage, specifically, that individuals across the nation experience on a daily basis highlights an important stakeholder in the health care debate who, according to Obama, threatens this loss of coverage: insurance companies. Ahmed (2004) explains that rather than fear being conceived of as only “a symptom of transformation, or as a technology of governance,” fear also “involves the intensification of ‘threats’, which works to create a distinction between those who are ‘under threat’ and those who threaten. Fear is an effect of this process, rather than its origin” (p. 72). Thus, the fear employed by Obama can be seen as a rhetorical move to distinguish between those who are under threat – individual consumers of health insurance plans – and those who threaten – the insurance companies who have the power to drop their customers. Further, “Through the generation of ‘the threat’, fear works to align bodies with and against others” (Ahmed, 2004, p.72).

2. Anxiety, National Identity and the Impossibility to Love

Much of the language used by Obama positions the national character and identity of the United States as a key principle in health care reform. He calls the national character and identity into question by inadvertently asking questions such as: What does the current health care system (i.e., the status quo) mean for our national character? If we fail to act upon health care reform, what does that say about the kind of people we are in terms of how we treat each other and care for one another? The following quote clearly exemplifies this sentiment:

- "We are the only advanced democracy on Earth – the only wealthy nation – that allows such hardships for millions of its people" (Obama-Congress, 2009).

Importantly, the word 'allows' emphasizes a sense of shame and anxiety insofar as the collective 'we' is one that can be identified as a group of people which allows for the suffering of others. Again, Ahmed reminds us that, "anxiety is then an effect of the impossibility of love" (Ahmed, 2004, p.67). Anxiety emerges as a result of the impossibility to love those that do not have health insurance, implying that our national identity is wrapped up in our impossibility to love one another. More specifically, this impossiblity of love is manifested in our inability, as a nation, to reform the current health care system into a new system that would theoretically create more equitable access to care. Thus, the emergence of anxiety becomes a result of Obama's consistent use of a rhetoric of crisis to persuade his audience to enact reform.

On the other hand, Obama also makes very strong claims about the kind of character and identity he thinks America already possesses or should possess. Reform,

according to Obama, aligns more correctly with this kind of character he believes America prides itself on:

- "That large-heartedness – that concern and regard for the plight of others – is not a partisan feeling. It is not a Republican or Democrat 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" (Obama-Congress, 2009).
- "But alongside these economic arguments, there's another, more powerful one. And it is simply this: We are not a nation that accepts nearly 46 million uninsured men, women and children. We are not a nation that lets hardworking families go without coverage, or turns its back on those in need. We're a nation that cares for its citizens. We look out for one another. That's what makes us the United States of America. We need to get this done" (Obama-AMA, 2009).

The latter two passages communicate a different message about national identity and character; there is a greater sense of urgency regarding the need to preserve the aforementioned values and ideals of American identity. However, within this sense of urgency exists an underlying affective position of anxiety regarding the loss of such values and ideals which is henceforth a clear rhetorical move to justify action for health care reform as such action signifies an attempt to preserve these values and ideals. Ahmed asserts that, "The definition of values that will allow America to prevail in the face of terror – values that have been named as freedom, love, and compassion – involves

the defence of particular institutional and social forms against the danger posed by others" (Ahmed, 2004, p.78). In addition, and albeit more broadly throughout Obama's speeches, there exists a sense of impending degeneration of values, morals, and ideals in the wake of inaction for reform. Thus, "the emphasis on values, truths and norms that will allow survival *slides easily into the defence of particular social forms or institutions*" (Ahmed, 2004, p. 78). Interestingly, the preservation of such social forms or institutions is the preservation of the role of government in relationship to health care access and coverage:

- "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 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" (Obama-Congress, 2009).

This essential something is unclear; however, and what is important about this last passage is the Obama's rhetorical move towards the preservation of government in making decisions regarding the welfare of all its citizens. And if we cannot accomplish this, then an 'essential' part of our collective or national identity will be at once in danger

and already transformed. Such a rhetorical move, as indicated by the application of Ahmed's framework, is laden with the affective politics of fear and anxiety.

The next chapter investigates how the rhetorical strategies employed by Obama, as described throughout this chapter, are responded to by a handful of public organizations who staunchly oppose Obama's health care reform proposals.

Chapter Four: Public Responses to Health Care Reform in 2009

"Our determination to pursue truth by setting up a fight between two sides leads us to believe that every issue has two sides – no more, no less: If both sides are given a forum to confront each other, all the relevant information will emerge, and the best case will be made for each side. But opposition does not lead to truth when an issue is not composed of two opposing sides but is a crystal of many sides. Often the truth is in the complex middle, not the oversimplified extremes."

Deborah Tannen, *The Argument Culture (1998)*

"It is no accident that in political rhetoric, freedom and fear are increasingly opposed: the new freedom is posited as the freedom from fear, and as the freedom to move. But which bodies are granted such freedom to move? And which bodies become read as the origin of fear and as threatening 'our' freedom?"

Sara Ahmed

The Cultural Politics of Emotion (2004)

As stated earlier in the introduction, health care reform in the name of universal coverage or national health insurance, run by the federal government, has repeatedly met staunch and indeed fierce opposition from a variety of stakeholders over the course of the last century. As President Obama and his administration continue to work on passing a version of health care reform, the resistance to this reform has been quick to establish and gain momentum following their proposals. While the sites of this resistance are many (Republicans, insurance companies, physicians, etc.) and take on an array of different

platforms with varying agendas, the focus of this thesis is to investigate the rhetorical positions of public groups and/or organizations who have established themselves in direct response to the current administration's proposals for health reform. More specifically, the focus will be on three organizations that I have identified via internet searches that are particularly active in their pursuit to oppose any kind of government run health care reform. It is worth noting that these groups do support specific types of reform efforts; however, they all vehemently oppose any type of reform plan that includes the government (this will be covered more explicitly in the overviews of each organization in this chapter).

As discussed in chapter two, I have selected the websites created by these groups as the primary texts of investigation and analysis. The aim of this chapter is to conduct a rhetorical analysis of the language used by these three groups in an effort to provide a more nuanced and analytical perspective of the rhetoric of resistance to health care reform. By conducting an analysis of these websites I intend to provide specific (rhetorical) lenses with which to read and understand the language of resistance to this highly charged issue. I will provide a brief overview of each group and their website which will be followed by a section of rhetorical analysis of all three groups.

Group 1: Conservatives for Patients' Rights www.cprights.org

Conservatives for Patients' Rights (CPR) was formed in March of 2009 by multi-millionaire businessman Rick Scott. According to a March 2009 article in *The*

Washington Post, Scott quickly emerged as a leader of opposition to the Obama administration's reform efforts:

> Scott, a multimillionaire investor and controversial former hospital chief executive, has become an unlikely and prominent leader of the opposition to health-care reform plans that Congress is expected to take up later this year. While disorganized Republicans and major health-care companies wait for President Obama and Democratic leaders to reveal the details of their plan before criticizing it, Scott is using $5 million of his own money and up to $15 million more from supporters to try to build resistance to any government-run program. (Eggen, 2009).

The CPR website contains two different PDF documents describing who Rick Scott is, his accomplishments, and his philosophies on health care and the role of government in its distribution and control. "The son of a truck driver and JC Penney clerk, Scott has spent his career working to provide innovative, affordable, high quality health care services by emphasizing a patient-centric approach to cost and care" ("Richard L. Scott," 2009). Conversely, Maggie Mahar, author of *Money-Driven Medicine: The Real Reason Health Care Costs So Much* (2006), explains that:

> In July of 1997, the FBI swooped down on HCA hospitals in five states. Within weeks, three executives were indicted on charges of Medicare fraud, and the board had ousted Scott. The investigation revealed that the hospital chain had been bilking Medicare while simultaneously handing over kickbacks and perks to physicians who steered patients to its hospitals. One can only wonder how many of those patients really needed to be hospitalized—and how many were harmed. The company did not fight the charges. In 2000, HCA (which by then had expunged "Columbia" from its name) pleaded guilty to no fewer than 14 felonies. Over the next two years, it would pay a total of $1.7 billion in criminal and civil fines. [7]

The CPR website does not include any of this information pertaining to Scott and his track record as CEO of Columbia/HCA in the 1980's and 90's.

[7] This particular quoted passage is from Mahar's blog: www.healthbeatblog.org

CPR has posted the following passage which resembles a mission statement or more general description of the group and its aims:

> Conservatives for Patients' Rights is a non-profit organization dedicated to educating and informing the public about the principles of patients' rights and, in doing so, advancing the debate over health care reform. Those principles include choice, competition, accountability and responsibility. We believe the path to effective health care reform must be based on the doctor-patient relationship and not from a top-down, big government perspective. Anything that interferes with an individual's freedom to consult their doctor of choice to make health care decisions defeats the purpose of meaningful health care reform. (CPR, 2009).

The website is organized according to the following major sections:

1. *Home*: This page contains hyperlinks to the rest of the website's sections and includes the following description of the group's position on health care and health care reform: "Any serious discussion of health care reform that does not include choice, competition, accountability and responsibility — the four 'pillars' of patients' rights — will result in our government truly becoming a 'nanny-state,' making decisions based on what is best for society and government rather than individuals deciding what is best for each of us." The home page also has two different YouTube videos which are entitled "Congress Needs to 'Learn Their Lesson'" and "Listen to the Voices of Government-Run HealthCare."
2. *The Plans:* In this section, CPR "takes a look at plans that have been discussed, written about or offered up as legislation." Each plan can be accessed as a PDF file, and the group has designed this section so that you can also compare two to four different plans.
3. *International:* Located in this section is a description of health care systems in eleven different countries around the world – mostly countries in Europe. In

addition this section contains dozens of news articles published in countries such as the UK, Canada, Sweden and others. The majority of the articles discuss the shortcomings or negative impacts of government run health care.

4. *Videos:* Here one can view a variety of YouTube videos (approximately 50 total) which range in content from CPR created ads to clips from different political representatives speaking out against government run health care to television appearances made by Rick Scott.
5. *The Daily Dose:* This section contains a variety of news articles written by the 'CPR staff', and you can also sign up to receive the group's daily articles. The website does not provide any description or information on who the 'CPR staff' is.
6. *Resources:* This section is divided into three categories: 'White Papers', 'Handouts', and 'Information from Other Organizations.'
7. *Action Center:* In this last section users have the following options to take action: 'Sign a Petition Against Government Run Health Care', 'Contact Congress', 'Write a Letter to the Editor', 'Host a Video Screening', and 'Attend a Town Hall Meeting.'

Group 2: Patients United Now www.patientsunitednow.com

Patients United Now (PUN) is an organization that developed in response to proposed health care reform efforts under the guise of the Americans for Prosperity Foundation (AFPF) in 2009. AFPF made this statement following the establishment of PUN:

> Americans for Prosperity Foundation has launched a new effort to educate citizens about the threat of government controlled health care. Learn all you can, become part of our team and spread the word. Help us stop government controlled health care. By joining Patients United Now, you can add your voice against a Washington takeover of your family's health care, and support real health care choices for every American. (AFPF, 2010)

AFPF is a non-profit organization that is affiliated with but separate from Americans for Prosperity (AFP) which is a national organization with numerous state chatpers. AFPF offers the following mission statement on its website:

> Americans for Prosperity (AFP) Foundation is committed to educating citizens about economic policy and a return of the federal government to its Constitutional limits. AFP Foundation's educational programs and analyses help policymakers, the media and individual citizens understand why policies that promote the American enterprise system are the best method to ensuring prosperity for all Americans. To that end, AFP Foundation supports:
>
> - Cutting taxes and government spending in order to halt the encroachment of government in the economic lives of citizens by fighting proposed tax increases and pointing out evidence of waste, fraud, and abuse.
> - Tax and Expenditure Limitations to promote fiscal responsibility.
> - Removing unnecessary barriers to entrepreneurship and opportunity by sparking citizen involvement in the regulatory process early on in order to reduce red tape.
> - Restoring fairness to our judicial system. (AFPF, 2010)

PUN is a group that, much like CPR (group 1), is primarily interested in opposing any kind of government run health care reform efforts, which can be verified in the language they utilize to describe their own position on the topic:

> We are Americans just like you. We believe patients and doctors should make health care choices, not Washington bureaucrats. We know America needs *real* health care reform focused on delivering affordable, quality choices to *all* Americans. And we know that a government takeover of our health care will *hurt* American patients by delaying – and denying – critical treatments. (PUN, 2009)

Their website is organized according to the following major sections:

1. *Home:* This page contains links to several YouTube videos ranging in content from advertisements created by PUN to titles such as “The Public Plan Deception.” In addition, there are articles posted here from a variety of named and some unnamed authors and sources discussing the topic of health care reform. There is a small recurring screen with different images of people asking different questions that all begin with the phrase “If Washington takes over health care…. Will we have access to the newest cancer treatments? Could I lose my private insurance? Could my care be denied because of my age or because I am too sick? Would it solve a health care crisis? Will my privacy be respected?” The home page also contains hyperlinks to the rest of the website’s sections.
2. *About:* This brief section describes the group’s position on health care and what they are attempting to achieve in terms of reform including contact information. They also list what they call their ‘guiding principles’ which are:

> Nothing is more personal or more important than the health of our families.
> Our health is too important to gamble on a system designed and run by bureaucrats in Washington, D.C. As an American, you deserve the right to make *all* your own health care choices – and those choices should *never* be limited by government bureaucrats.
> - **YOU** should have the right to choose the doctor that is best for you.
> - **YOU** should have the right to choose who can see and keep your personal health information.
> - **YOU** should have the right to choose what care is needed and best for your family.
> - **YOU** should **NOT** be forced into a “one-size–fits-all” government-controlled health insurance system.
>
> If you agree, join *Patients United Now* – and let’s support *real* health care reform.”

3. *Facts:* On this page the group has compiled what they are calling five ‘real facts’ about health care reform: “1. Washington May be Close to Taking Over Your Health Care; 2. Medicare-for-All is Bad News; 3. The ‘Public Option’ is a Step

Toward Total Government Control; 4. Your Medical Privacy is in Jeopardy; 5. The Impact of Government Health Care Mandates."

4. *Questions:* In this section the group has put together a list of questions and answers about health care reform.
5. *Great Information:* This is a big section that has links to numerous pages. It is organized according to the following categories: "Front Page, Government Mandates, Health Care Delayed and Denied, News and Updates, and General." The author of many of these posts in this section and for many of the larger website's posts is 'tdoheny.' Users can contact this person via email; however, there is no information on the website identifying who this person is.
6. *Your Stories:* This is also a fairly large section that has links to numerous pages, including links to stories sent in by members. It is organized according to the following categories: "Benefits of Patient Choice, Foreign Health Care Systems, and Government Health Care in America."
7. *What You Can Do:* The group has provided a list of ten items that users can do to take action and join their cause. "Join the majority, learn all you can, become part of our team---spread the word. Help us stop government controlled health care. If you get busy, **TRUTH CAN GO VIRAL**."
8. *Events:* This page contains information on past and upcoming events sponsored by PUN.
9. *Videos:* This section contains a variety of YouTube videos. Examples of titles include: "How Obama Will Ruin Health Care, Government Health Care Plan Not Necessary, and The End of Patients Rights."

10. *Contribute:* Here users can make a financial contribution to PUN:

    By investing in **Patients United Now**, you can help educate more Americans about the risk of a Washington takeover of our health care. A government takeover will hurt Americans by eliminating our choices, lowering the quality of care and delaying – or even denying – critical treatments. Americans need real health care reform – with more access to more doctors and more treatments, and less interference from Washington politicians and special interests like the insurance companies.Your investment today can help bring affordable, quality health care choices to all Americans. (PUN, 2010)

11. *Share Your Story:* In this last section, users can send in a personal story about "how making your own choices in health care has benefitted you and your family." They also are looking for stories about "how new treatments and inventions have benefitted you, how getting to choose between doctors has been the answer, how much privacy means to you, or your concerns about what a government plan could mean."

Group 3: Patients First www.joinpatientsfirst.com

Patients First (PF) was launched in 2009 as a health care project of Americans for Prosperity (AFP) which is affiliated yet considered a separate entity from AFPF (the sponsor for PUN). AFP was founded in 2003 and is considered a non-profit organization with state chapters across the nation and a total of 700,000 members. In short, their mission is as follows, according to their website: "AFP is an organization of grassroots leaders who engage citizens in the name of limited government and free markets on the local, state and federal levels." In an August 2009 article *The Wall Street Journal* explained that:

> The group was formed in the split of conservative Citizens for a Sound Economy, with one faction establishing FreedomWorks, led by former House Speaker Dick Armey, and the other, Americans for Prosperity. Both are driving the opposition to the proposed health-care overhaul. Some of the group's funding comes from David H. Koch, co-owner of oil-and-gas company Koch Industries Inc., whose net worth is estimated at around $20 billion. Americans for Prosperity said it received $14.5 million in contributions in 2008. (Sherman, 2009)

PF's primary area of resistance to health care reform is, as seen with the first two groups, located within the notion of government involvement and control of health care. The group consistently uses the phrase "Hands off My Health Care!" throughout their website which is also the name of their petition to Congress. At the top of each page on their website this same message is visible: "Join the over 281,973 Americans who have already signed the petition!" The focus of their efforts is to expand the group's size by encouraging users to sign their petition entitled "Hands Off My Health Care!" Right below this exclamation it says: "More than 280,000 people have signed the petition against a Washington takeover of our health care. Sign-up today and send Congress a clear message: Hands off my health care!"

The website is organized according to the following sections:

1. *Home:* This is a large section which contains nearly 30 pages of stories and posts. Examples of story titles are "Government Takeover Still Alive, Obamacare Rejected in Most Liberal State in Nation, and Obama Hasn't Learned Any Lessons." Note: there are no authors or names attached to these stories/posts.
2. *About Us*: This section provides a brief description of the group, its aims and its sponsor – AFP. "Patients First is a project focused on real health care reform —

reform that puts patients first. We are concerned about the impact more government control will have on your health care. We believe Americans want and need more health insurance options – not just a costly, government-defined plan paid for by American taxpayers. Decisions about health insurance and health care belong to individuals and families, not Washington bureaucrats and politicians."

3. *The Facts:* This section is given the full title of "The Facts: Government Health Care Drives Up Costs & Limits Innovation." The question "Why is a Washington Takeover of Health Care Wrong for America?" is presented followed by a long list of bulleted answers according to different sub-headings.
4. *Videos:* Several YouTube videos are posted here ranging in content from PF's own health care ads to a short film entitled "Survivor" which recounts a story of a Canadian patient speaking out against government run health care.

5. *Sign Petition:* Lobbyists, unions, and politicians in Washington are trying to seize control of our health care. Patients like us have been left out. We can't sit by and let this happen, or else we lose:

    - Our choice of doctors
    - All control of our health insurance options
    - Timely access to quality health care
    - Money by paying for a government takeover.

6. *Action Center:* This section provides different ways for users to take action.

    "We proved in August that we, normal taxpaying Americans, can have a positive impact on this debate. If enough of us tell our members of Congress we oppose government-run health care, we can stop this legislation. We have significantly slowed it, and we now need to stop it."

7. *Contribute:* Here users can make a financial contribution to PF.

8. *En Español:* This section provides a translation of the entire website in Spanish.

Sites of Resistance: A Rhetorical Analysis of Public Opposition to Reform

As shown in the summaries of each group discussed above, the dominant focal point of opposition to health care reform is the involvement of the government, specifically 'Washington bureaucrats' as much of the language from the different websites indicates, in health care access, distribution and regulation. Indeed, some of the groups I have selected support health care reform in ways that make care more affordable and accessible to everyone, while others even offer their continued support of government run programs such as Medicare and Medicaid. What seems consistent across the three groups, however, is a shared perspective that government is inherently bad, fearsome, and at times malicious if and when they are given the opportunity to 'interfere' with the functions of America's health care system. Further, each group posits that the government is attempting to fully take over health care which, according to these groups, will directly interfere with the rights of the patient in a variety of ways. As a result, this focal point of government in health care reform will in turn be a general focal point of this chapter's analysis, as well as more general themes including individualism, patient rights, choice, freedom, and protection. In addition, the following analysis will sustain a more specific theoretical focus on rhetorical strategies of crisis, Ahmed's (2004) "affective economies of fear", and George Lakoff's (2006) development of metaphor in the context of the word freedom and American politics and identity. But first, a quick note on audience and the important role of audience in rhetorical discourse.

Rhetoric & Audience: A Point of Departure

The concept of audience has been widely theorized and discussed at length in a variety of academic fields including, but not limited to, Composition Studies, Communication Studies, and Rhetoric. For example, Ede and Lunsford (1984) explain that "because of the complex reality to which the term audience refers and because of its fluid, shifting role in the composing process, any discussion of audience which isolates it from the rest of the rhetorical situation or which radically overemphasizes or underemphasizes its function in relation to other rhetorical constraints is likely to oversimplify" (p. 92). It is indeed a very important and at times difficult concept to flesh out. Lucaites et. al (1999) summarize this when they explain that,

> Rhetorical discourse is *addressed* to particular audiences. To speak rhetorically is neither to articulate abstract truths in a universal void nor to practice a purely aestheticized self-expression through language. To address an audience is rather to create a message that accounts for the character of a specific group of people who are imagined as the receivers of that message. To unravel what it means to address an audience, however, is a more difficult task than it might at first seem. (p. 327)

Importantly, this passage speaks directly to the crucial role of audience and the character of a particular audience that is being imagined or invoked in the language employed in the websites I have identified. That is, the specific emphasis on a particular perspective or ideology of the role of government in health care is supported by this important concept of audience as discussed above. There is very little explanation as to why government is bad; it becomes an assumed perspective that is shared among the group and its wider online audience. Phrases such as "Decisions about health insurance and health care belong to individuals and families, not Washington bureaucrats and politicians" function as *true* and not worthy of any further explanation of what exactly it would mean or what

it might look like if Washington bureaucrats and politicians make decisions about health care matters (PF, 2009).

Thus, the character of this audience is imagined as one that could be defined as fearful and condemning of government more generally, an audience which has a shared set of assumptions about the role of government in the control and regulation of health care more specifically. Again, Ede and Lunsford (1984) provide a useful explanation of this crucial relationship between writer, text, and audience: "…writers conjure their vision – a vision which they hope readers will actively come to share as they read the text – by using all the resources of language available to them to establish a broad, and ideally coherent, range of cues for the reader" (p. 90). Clearly, such cues are represented in particular word choices as identified above, and these cues seem to both address and invoke a character or role which an audience may then come to occupy. This is particularly important for the following analysis as the specifics of the audiences being addressed are indeed speculative, and "Put simply, the rhetorical study of the audience is much more than a matter of public opinion polling. It entails examining the complex of relationships between speakers, texts, and the society as a whole" (Lucaties et. al., 1999, p. 328).

A Rhetoric of Crisis (Again), In a Different Context (However)

A great deal of my analysis in chapter three focused on President Obama's use of a rhetoric of crisis throughout the three speeches I selected. I will argue that this same rhetorical strategy is also being used by the three groups who are in opposition to any kind of government run health care. This rhetorical tool of crisis is identifiable in

numerous phrases and passages in the three groups' websites which I have summarized above. Clearly, there are significant differences in the rhetorical situation these groups find themselves in comparison to President Obama. That is, the former is addressing a specific audience with distinct purposes in mind while the latter, despite what seem to be very specific audiences for each speech, is addressing a much larger, universal audience accompanied by its own distinct purposes. In other words, the groups who have formed the websites are in essence looking to expand their numbers and are speaking to an audience that either shares a common set of assumptions regarding health care and the role of government. Conversely, while Obama is speaking to specific audiences in each of his speeches, all of his speeches can be publicly accessed, and, as a result, he is attempting to persuade a much larger, national audience. In addition, for Obama the root of the crisis is, what he considers, a broken health care system, while the three groups under analysis (CPR, PUN, and PF) define the root of the crisis as being the threat of government and the possibility of government involvement in health care regulation, distribution, and control.

Therefore, the aim of this analysis is to highlight a rhetoric of crisis at work in the following public responses to health care reform proposals. Moreover, the integration of Ahmed's (2004) theoretical work on pain, anxiety, and "affective economies of fear" will be woven into this analysis as much of the examination of crisis intersects with Ahmed's concepts regarding the role of the affective in politics and, more specifically, political rhetoric. In addition, Lakoff's (2006) work with metaphor, the idea of freedom, and political rhetoric will also be woven into the following analysis in an effort to provide an important theoretical angle on the relationship between language and cognition.

The Looming Threat of Government, and the Loss of the Individual

According to the overviews of each website provided at the beginning of this chapter, it has been clearly established that the role of government in health care poses a serious threat to the three groups I have selected to analyze. In many cases this threat is juxtaposed with the potential loss of the individual patient's ability to make their own choices and to maintain their rights as a patient. Quite boldly, CPR presents this idea in the following passage, clearly indicating a sense of incompatibility between government and individual in making choices regarding health care:

> Any serious discussion of health care reform that does not include choice, competition, accountability and responsibility — the four "pillars" of patients' rights — will result in our government truly becoming a "nanny-state," making decisions based on what is best for society and government rather than individuals deciding what is best for each of us. (CPR, 2009).

This is a very clear representation of the government as posing a serious threat and, subsequently, a potential crisis to and for individual patients. In other words, the individual is facing a serious crisis of losing their freedom and rights (i.e., to make their own choices) if any kind of government run health care initiative is passed. The government then becomes the central or primary object to be feared. Ahmed (2004) explains that "It is not fear that begins in a body and then restricts the mobility of that body…the response of fear is itself dependent on particular narratives of what and how is fearsome that are already in place" (p. 69). The idea that the government is threatening and therefore would be feared is clearly already in place – stemming from a broader ideological position on government and the role of government in the life of the individual that is shared amongst this particular group of people who identify as conservatives.

Lakoff (2006) argues that the ideological differences between liberals and conservatives stems from what he has called "the nation-as-family metaphor." According to this metaphor, "the strict father model is that basis of radically conservative politics and the nurturant parent model informs progressive politics" (Lakoff, 2006, p. 66). More specifically, Lakoff argues that conservatives indeed share a perspective on government as something that interferes with their definition of freedom as a result of the strict father model. He lists some of the underlying tenets of conservative political ideology as situated within the strict father model:

- It's individual initiative that has made this country great.
- The unfettered free market is the engine of American prosperity. It is natural and moral.
- Everyone can pull themselves up by their bootstraps. Responsibility is individual responsibility.
- The government just gets in the way; it is inefficient, bureaucratic, and wasteful. It's your money; you can spend it better than the government can. (Lakoff 2006, p.102).

Moreover, the freedom and rights of the individual are clearly at stake as indicated by CPR's description of the government presenting the possibility of a forthcoming 'takeover'. Importantly, Lakoff (2006) argues that freedom for conservatives can be defined as "the freedom to become disciplined, freedom from government interference, and the freedom to enter the free market and become prosperous" (p. 102). And it is not just a freedom from government interference that is crucial to the conservative perspective of freedom, but that because government "imposes regulations and taxes…in whose courts lawsuits take place" it is then "interfering with freedom" (Lakoff, 2006, p. 106). In other words, through a reading of CPR's website via Lakoff's framework,

freedom and government certainly cannot co-exist. Hence, the impending crisis becomes more certain as a result of this reading.

The most tangible explanation of what this crisis will look like is stated as the government "truly becoming a 'nanny-state.'" This is a powerful metaphor that provides an important launching pad for this notion of crisis as being equated with an authority (a nanny in this case) taking full control of your health care. Lakoff (2006) explains that "much of everyday thought is metaphorical….and metaphorical thought is normal and used constantly, and we act on these metaphors. In a phrase like 'tax relief,' for example, taxation is seen as an affliction to be eliminated. Moral and political reasoning are highly metaphorical, but we are usually unaware of the metaphors we think with and live by" (p.13, 28). Dealing more specifically with the idea of freedom, and the metaphor of a "nanny-state" Lakoff (2006) further explains that "Freedom is a marvel of metaphorical thought. The idea of freedom is felt viscerally, in our bodies, because it is fundamentally understood in terms of our bodily experiences…It is tied, fundamentally via metaphor, to our ability to move and to interference with moving" (p. 29-31). Thus, the metaphor of the government becoming a true "nanny-state" involves interference with an individual's ability to move (or make choices) within the health care system. This metaphor works to secure the idea that if any kind of government run health care is initiated, we will move from an adult system of access ripe with choice to a system of being restricted both physically and intellectually. "The language expressing the metaphorical ideas jumps out at you when you think of the opposite of freedom: 'in chains,' 'imprisoned,' 'enslaved,' 'trapped,' 'held back,'… We all had the experience as children of wanting to do

something and being held down or held back, so that we were not free to do what we wanted" (Lakoff 2006, p. 29).

If we then return to the idea of freedom and metaphor, Lakoff (2006) reminds us that "metaphorical thought links abstract ideas to visceral, bodily experiences", and "Freedom requires access – to a location, to an object, or to space to perform an action" (p. 28-30). So, the freedom to *move* with choice to access health care is perceived as under threat due to government interference. Again, individual freedom and government are pinned as opposites which cannot form a working relationship; the government is posited as an object that will take away, seize control of, and hurt individuals and their families. The government poses as an object that restricts movement and access to a location, object or space to perform an action. "[Freedom] is tied, fundamentally via metaphor, to our ability to move and to interference with moving…It is the embodiment of freedom via metaphor that makes it such an important and emotionally powerful concept" (Lakoff 2006, p. 31).

So, the answer or solution CPR provides to the users of its website, to avoid returning to a government as nanny system, is to take action by signing a petition which is given the name "Say No to Government-Run Health Care – Join thousands of others in standing up against a government takeover of health care in America." For CPR, the individual holds the most important and powerful role in a narrative that portrays the government as an entity that wants to essentially kill the conservative idea of the individual by controlling its every move regarding health care. Crisis, for this group then, is presented in the form of certain threat or annihilation of the individual. The individual is subsumed by the government's ideas of what is best for everyone and thus makes

choices regarding health according to this principle of the greatest good for the greatest number.

Similarly, PUN and PF are self-described anti-government health care reform groups. PUN specifically uses language such as “threat of government controlled health care”, and “We believe patients and doctors should make health care choices, not Washington bureaucrats. And we know that a government takeover of our health care will *hurt* American patients by delaying – and denying – critical treatments.” PF explains that “Lobbyists, unions, and politicians in Washington are trying to seize control of our health care. Patients like us have been left out. We can’t sit by and let this happen, or else we lose: Our choice of doctors, all control of our health insurance options, timely access to quality health care, money by paying for a government takeover.” Again, the word ‘threat’ is purposefully used to communicate a sense of impending loss of individual control of one’s life, of an impending crisis which involves the loss of an individual’s ability to make health care choices, and ‘hurt’ to individual patients through denial or delaying of access to health care.

The rhetorical strategy of associating the government with threat is important and powerful because, “the language of fear involves the intensification of ‘threats’, which works to create a distinction between those who are ‘under threat’ and those who threaten. Fear is an effect of this process, rather than its origin” (Ahmed 2004, p. 72). I argue that this intensification of threat is possible through repetition of the word ‘threat’ (the more general idea of the government as a symbol of threat is used repeatedly throughout the different websites in both language and short videos) and the repeated

presentation of a successfully growing collective force which is fighting against this threat. Importantly, Ahmed (2004) explains that "Through the generation of 'the threat', fear works to align bodies with and against others" (p. 72). By using language such as "Government bureaucrats already run some of the nation's banks, insurance and car companies, but do you trust Washington – with your life?" and video titles such as "End of Patients Rights", "Government-Run Health Care: Longer Waits, Higher Costs", "The Public Plan Deception", and "Harry's Chamber and the Bill of Secrets", these groups are making a clear case that government is posing as a threat to individual patients.

Therefore, government becomes the source of fear causing the mobilization of the bodies who belong to and organize these groups against the bodies of the government. In addition, the repeated naming and association of government as fearsome and threatening also works to enhance and reinforce a state of crisis. Moreover, Lakoff (2006) explains that, "the point of repetition is to change not just people's minds but also their very brains" (p. 10). With specific reference to the repeated use of the word freedom, Lakoff argues that:

> …the word 'freedom', if repeatedly associated with radical conservative themes [i.e., the freedom of the individual as being under threat by the government], may be learned not with its traditional progressive meaning, but with a radical conservative meaning. (10) (parenthetical example added).

Thus, the frameworks of Lakoff (2006) and Ahmed (2004) provide a lens with which to view the association of threat and government in the context of health care reform. More specifically, these frameworks illuminate the underlying ideological positions that are informing the rhetorical resistance of these three groups, as well as the power and significance of metaphor and emotion.

Indeed this narrative of crisis is similar to that employed by CPR, as discussed above, and what PUN adds that is new to this crisis is the variable of individuals being physically hurt in the future. This goes beyond the concept of a "nanny-state" taking control of the individual's life related to health care and into the concept of physical pain or 'hurt' being inflicted upon the individual on behalf of the government. Thus, the government is beginning to take on the role of a nanny that will stand in the way of health care decisions such that the individual will not be allowed access to the treatments or care they need, and thus will be 'hurt.' So, the element of anticipating future pain enters the picture. Ahmed (2004) theorizes the function of pain in politics and explains that while "Pain has often been described as a private, even lonely experience... the pain of others is continually evoked in public discourse, as that which demands a collective as well as individual response" (p.20).

Identifying the government as the source of control, takeover, and hurt works to strengthen the mobilization of a collective to directly fight this source as the fear of pain is invoked and anticipated. "Through designating something as already under threat in the present that very thing becomes installed as that which we must fight for in the future, a fight which is retrospectively understood to be a matter of life and death…to announce a crisis is to produce the moral and political justification for maintaining 'what is' in the name of future survival" (Ahmed, 2004, p. 77). Thus, the freedom of the individual to make choices as a free, autonomous being becomes under threat, and the collective must work to stave off this threat and the anticipated pain for future survival.

In order to communicate this message of mobilization and action PUN solicits its users with the following message: "We invite <u>YOU</u> to Join Us! *Learn* all you can, *Help*

us get the word out, and *Protect* those you love from some bad ideas. Together We can Make a Difference (emphases in original)." Similarly, PF's petition which users can sign to take action reads as follows:

> I urge you to oppose any legislation that imposes greater government control over my health care that would mean fewer choices for me and my family and even deny treatments to those in need. Congress must not let government get between my family and my doctor. Please protect patient freedom and expand our health care options with real reforms – focused on patients, not on politics. (PF, 2010)

The most important and powerful word in these calls to action, relative to the context of the analysis thus far, is the word 'protection' or 'protect.' Now that the government has been established as threat, albeit wrapped up in a larger context of crisis, individuals must mobilize to *protect* themselves and their loved ones from "bad ideas" and, well, from the government getting "between my family and my doctor." Politicians then are rendered as objects that will disrupt the connection between family and doctor. "What is important, then, is that the narratives that seek to preserve the present, through working on anxieties of death as the necessary consequence of the demise of the traditional forms, also seek to locate that anxiety in some bodies, which then take on fetish qualities as objects of fear" (Ahmed, 2004, p.79). Indeed, the bodies of the politicians or 'Washington bureaucrats' (the seemingly favored label throughout the websites) become an object or sign of fear that successfully circulates in a larger affective economy of fear, and "The present hence becomes preserved by defending the community against the imagined others [i.e. Washington bureaucrats] …" (Ahmed 2004, p.79 parenthetical example added).

An affective economy operates as a hybrid model of psychoanalysis Marxist economic theories: "…emotions work as a form of capital: affect does not reside

postively in the sign or commodity, but is produced as an effect of its circulation" (Ahmed, 2004, p.45). So, the affective is not functioning in terms of the government as the object of fear, but the government becomes a sign or object that is circulated successfully in an affective economy of fear. "Affect does not reside in an object or sign, but is an effect of the circulation between objects and signs. Signs increase in affective value as an effect of the movement between signs: the more signs circulate, the more affective they become" (Ahmed, 2004, p. 45). The more the sign or object of the government circulates within this affective economy of fear and crisis, the more value it accumulates amongst its followers. In addition, this particular affective economy is strengthened with the repeated naming (or circulation) of the government as threatening and fearsome, which works to add or increase its value.

In an effort to understand how these groups are using rhetoric to formulate resistance to health care reform in the name of government-run initiatives I have utilized frameworks of cognition and metaphor, affective (fear and anxiety) domains of politics and rhetoric. As a result, there now exists a more nuanced and analytical perspective on why and how these groups are so resistant to any health care equation that involves the hand of the government, in addition to understanding how they garner support and collective action in their opposition. The next and last chapter will briefly place the rhetoric of President Obama and these three groups together in an effort to understand how this particular part of the larger conversation on health care reform is functioning.

Chapter Five: Conclusion

Where do we go from Here?

"The United States, though a modern, noncolonial society, has its own fears of loss of control- to foreign threats, but also to a national government many Americans have come to mistrust. Rumors operate in this context as well, though we'll see that that contemporary media often serve a rumorlike role as well. The result is recognizable historically – one of several episodes of a society open to periodic deep fears – but surprising in terms of the American self-image of modern rationality and emotional cool."

Peter Sterns
American Fear: The Causes and Consequences of High Anxiety (2006)

In closing I would like to spend some time exploring how these two different groups, President Obama and the three groups, are positioning themselves in the larger conversation on health care reform. At this point in time, primarily based on the rhetorics I have emphasized, these two groups are arguably not engaged in a productive conversation with one another; they have both arrived at a divide or large canyon, looking across at one another, yet often turning around and preaching to their own choirs, as it were. However, I would like to suggest that while this certainly may be true at times, there are in fact different kinds of persuasion at work despite this apparent divide and lack of deliberation.

Ultimately, as Lakoff (2006) and others including Kronenfield (1997), Feldstein (1996), and Quadagno (2005) suggest, this lack of deliberation or dialogue stems from very different ideas of things like freedom, the individual, the role of government, and patients' rights. Or, as Tannen (1999) suggests, we live in an "argument culture" in which we find ourselves in a "pervasive warlike atmosphere that makes us approach public dialogue, and just about anything we need to accomplish, as if it were a fight…The argument culture urges us to approach the world – and the people in it – in an adversarial frame of mind" (p. 3). In other words, the kind of public communications or rhetorics which we have adopted as a culture inevitably set us up for the type of failed communication efforts I have observed in the present work. Thus, I would first like to address these failed efforts contextualized in the rhetorics of crisis I have identified, and then I would like to briefly discuss how and where I see persuasion and possible communication between these different groups at work.

An Ever Growing Divide

From a rhetorical perspective, the three speeches I selected given by President Obama can be defined by their distinct audiences, purposes and contexts. When these speeches are put in conversation with the language from the three different websites it can certainly appear as though the speeches and the websites are discussing and responding to a different topic altogether. However, when comparing the rhetorical positions of the groups, who all of course formed and established themselves directly in response to health care reform proposals put forth by Mr. Obama and his administration, to the speeches I selected, it is clear that both groups are discussing the same topic (health care reform) with very different ideologies, value systems and worldviews. At times,

though, such different ideologies, values and worldviews can work to distort and even misinform as seen in the websites I selected for analysis.

For example, in his speech to the AMA in 2009, Obama explains that his reform plans will ensure that if individuals are satisfied with their current health insurance plan, "you'll be able to keep your health care plan, period", and further, "If you like your doctor, you will be able to keep your doctor" (Speech-AMA 2009). Obama goes on to say, in the same speech, that "identifying what works is not about dictating what kind of care should be provided. It's about providing patients and doctors with the information they need to make the best medical decisions" (Speech-AMA 2009). Now, keeping these two quoted passages in mind let's look at the following passages from the different websites I selected for analysis:

- "We believe the path to effective health care reform must be based on the patient-doctor relationship and not from a top-down, big government perspective. Anything that interferes with an individual's freedom to consult their doctor of choice to make health care decisions defeats the purpose of meaningful health care reform" (CPR 2009).
- "Washington politicians will use everything in their bag of tricks to ram government-run health care through Congress. If successful, you will lose your choice of doctors and insurance plans, pay much higher taxes and have to navigate added layers of bureaucracy between you and your health care provider" (PF 2010).
- "We know America needs *real* health care reform focused on delivering affordable, quality choices to *all* Americans. And we know that a government takeover of our health care will *hurt* American patients by delaying – and denying – critical treatments" (PUN 2010).

Comparing these passages reveals a very clear and large divide between these groups and President Obama. In his speech to the AMA, Obama clearly states that an individual patient's choice of doctor and health insurance plan would not be taken away in the reform he and his administration are looking to pass. Yet, the three quotes I pulled from the three different websites make a point to emphasize that reform equals government run health care which then equals a loss of choice and access.

Indeed, it is disheartening and discouraging to make this kind of comparison between these two very different ideological and rhetorical positions. More specifically, I have argued in both chapters three and four that Obama and the three groups utilize a rhetoric of crisis to frame their positions on health care reform. So, what does this mean for our country if such a great divide exists and different parties are using the same rhetorical and very emotional tool of crisis?

New models of communication are needed to foster more productive and effective discussion or conversation on issues that impact everyone so significantly. This is not to say that emotions must be intentionally avoided or treated as obstacles towards making progress, or that from time to time a crisis is indeed in existence and must be addressed. It is to say that our communication as a nation is in need of a re-conceptualization in order to more effectively ensure that people are listening to and understanding one another to address, to the best of our abilities, the needs, thoughts and contributions of a variety of individuals, and groups. The growing field of Public Deliberation, for example, offers new models of public communication forums which can provide spaces for

individuals representing a variety of stakeholders and interests to participate in a discussion of important issues, particularly those that influence public policy.

Following Aristotle, we must work to use rhetoric not to create divides but as "an ability, in each case, to see the available means of persuasion" (Aristotle as qtd. in Kennedy 2007, p. 40). For truth and reality are so very idiosyncratic and contingent and it seems, therefore, that we must work to develop such an ability as Aristotle so suggests to understand how others may view the available means of persuasion regarding a highly important and emotional topic.

Persuasion Somewhere

While this ever growing divide is apparent, it is also important to recognize that elements of persuasion are certainly at work in a variety of ways. In Obama's speech to the AMA, for example, he is attempting to persuade an audience of individuals who belong to an organization which has a long history of consistently and regularly opposing government run health care initiatives. Currently, the AMA has taken quite a different position on health care reform, stating that "We became doctors to help people. Now we're also helping by working to change the system, so people can lead healthier, more fulfilling lives" (AMA 2010). This is not to say that AMA supports a fully government run health care system, but they are interested in working to ensure that everyone has health insurance coverage, according to their "Vision for Health System Reform" (AMA 2010). Meanwhile, Congress, who Obama addressed in the third speech I selected, is still in a stalemate and little progress has been made in passing a health care reform bill. It is difficult to tell whether or not any kind of reform will be passed in the near future.

Theoretically, in a democracy politicians are elected by voters and are meant to

reflect the concerns, interests, and needs of their respective constituents. Given the current stalemate in Congress regarding health care reform, the case could indeed be made that some Congressional representatives have effectively listened to their constituents and reflected their positions on reform. That is, some of these constituents are clearly those who have organized the groups and websites I selected for analysis. Patients First, for example, indicate this on their website quite clearly: "We proved in August that we, normal taxpaying Americans, can have a positive impact on this debate. If enough of us tell our members of Congress we oppose government-run health care, we can stop this legislation. We have significantly slowed it, and we now need to stop it" (PF 2009). Thus, while there seems to be little persuasion occurring between President Obama and these groups, it is clear that persuasion is certainly at work in a variety of other contexts.

Limitations

This thesis is not intended to identify a solution or set of solutions to health care reform, nor is it interested in taking sides in this highly polarized debate. It is simply examining and analyzing the rhetoric being used which may offer insight into how Americans can create a more useful dialogue surrounding this topic. Therefore, I recognize that my thesis contains limitations specifically related to my methodology and analyses. First, the methodology I have used is limited in that I have only selected three speeches by one individual and only three groups and their websites. In addition, by only selecting three speeches delivered by President Obama I have not represented a comprehensive picture of the full variety of proposals being put forth by different governmental branches including the House and the Senate who have drafted their own

versions of a health care reform bill, for example. By only selecting three speeches I have excluded dozens of other speeches Obama has given specifically on health care reform over the last three years. In other words, I am presenting a small snapshot of the current proposals which limits the analysis and the subsequent argument. Secondly, I have only selected three public groups or organizations to represent what I am calling the public resistance to health care reform. By doing so, I am clearly limited to particular rhetoric, and very specific authored language on websites without any kind of personal interviews or surveys to expand my understanding of these groups. Lastly, by choosing a handful of theoretical frameworks with which to interpret and analyze the different rhetorics, I have excluded a multitude of other rhetorical analysis avenues.

As a result, there exist many possibilities for further research and investigation. There remains much to be studied and researched in the topic of health care reform rhetoric in an effort to more fully understand and achieve effective and productive communication. As demonstrated by the current thesis, I believe that the analysis of rhetoric can yield a great deal of valuable and fruitful information regarding how we use and respond to the language of the important and highly charged topic of health care reform**.**

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Appendix A

Delivered by Senator Barack Obama of Illinois, a candidate for the 2008 Democratic nomination for the presidency.

THE TIME HAS COME FOR UNIVERSAL HEALTH CARE
Thursday, January 25, 2007
Families USA Conference, Washington, DC

Thank you Ron Pollack and thank you Families USA for inviting me to speak here this morning.

On this January morning of two thousand and seven, more than sixty years after President Truman first issued the call for national health insurance, we find ourselves in the midst of an historic moment on health care.

From Maine to California, from business to labor, from Democrats to Republicans, the emergence of new and bold proposals from across the spectrum has effectively ended the debate over whether or not we should have universal health care in this country.
Plans that tinker and halfway measures now belong to yesterday. The President's latest proposal he announced this week has some elements that are interesting, but it basically does little to bring down cost or guarantee coverage.

There will be many others offered in the coming campaign, and I am working with experts to develop my own plan as we speak, but let's make one thing clear right here, right now:

Universal Health Care within Six Years

In the 2008 presidential campaign and Congressional campaigns all across the country, affordable, universal health care for every single American must not be a question of whether. It must be a question of how.

We have the ideas. We have the resources. Now we have to find the will to pass a plan by the end of the next president's first term.

Let me repeat that: I am absolutely determined that, by the end of the first term of the next president, we should have universal health care in this country. There's no reason why we can't accomplish that I know there's a cynicism out there about whether this can happen, and there's reason for it. Every four years, health care plans are offered up in campaigns with great fanfare and promise.

I'm sure that this campaign season will be no exception. People evaluate them for a day, and then they move on to find out who made the latest blooper or gaffe on the campaign trail. And by the time a president is sworn in, the interest groups and the partisans have torn down whatever ideas have been offered... and we're back to business as usual. But once those campaigns end, the plans collapse under the weight of Washington politics, leaving the rest of America to struggle with skyrocketing costs.

For too long, this debate has been stunted by what I call the smallness of our politics - the idea that there isn't much we can agree on or do about the major challenges facing our country.

And when some try to propose something bold, the interests groups and the partisans treat it like a sporting event, with each side keeping score of who's up and who's down, using fear and divisiveness and other cheap tricks to win their argument, even if we lose our solution in the process.

No More Health Care Charades in 2008

Well we can't afford another disappointing charade in 2008 and 2009 and 2010. It's not only tiresome, it's wrong.

Wrong when businesses have to layoff one employee because they can't afford the health care of another.

Wrong when a parent cannot take a sick child to the doctor because they cannot afford the bill that comes with it.

Wrong when 46 million Americans have no health care at all. In a country that spends more on health care than any other nation on Earth, it's just wrong.
And we can do something about it.

Morally Offensive, Economically Untenable

In recent years, what's caught the attention of those who haven't always been in favor of reform is the realization that this crisis isn't just morally offensive, it's economically untenable.

For years, the can't-do crowd has scared the American people into believing that universal health care would mean socialized medicine, burdensome taxes, rationing - that we should just stay out of the way, let the market do what it will, and tinker at the margins.

You know the statistics. Family premiums are up by nearly 87% over the last five years, growing five times faster than workers' wages. Deductibles are up 50%. Co-payments for care and prescriptions are through the roof.

Nearly 11 million Americans who are already insured spent more than a quarter of their salary on health care last year. And over half of all family bankruptcies today are caused by medical bills.

But they say it's too costly to act.

Almost half of all small businesses no longer offer health care to their workers, and so many others have responded to rising costs by laying off workers or shutting their doors for good. Some of the biggest corporations in America, giants of industry like GM and Ford, are watching foreign competitors based in countries with universal health care run circles around them, with a GM car containing twice as much health care cost as a Japanese car.

But they say it's too risky to act.

They tell us it's too expensive to cover the uninsured, but they don't mention that every time an American without health insurance walks into an emergency room, we pay even more. Our family's premiums are $922 higher because of the cost of care for the uninsured.

We pay $15 billion more in taxes because of the cost of care for the uninsured. And it's trapped us in a vicious cycle. As the uninsured cause premiums to rise, more employers drop coverage. As more employers drop coverage, more people become uninsured, and premiums rise even further.

But the skeptics tell us that reform is too costly, too risky, too impossible for America to achieve. The skeptics must be living somewhere else... because when you see what the health care crisis is doing to our families, to our economy, to our country, you realize that what is too costly is caution.

It's inaction that's too risky. Doing nothing is what's impossible when it comes to health care in America.
It's time to act.

U.S. Already Spends $2.2 Trillion Annually on Health Care

This isn't a problem of money, this is a problem of will. A failure of leadership. We already spend $2.2 trillion a year on health care in this country. My colleague, Senator Ron Wyden, who's recently developed an interesting new health care plan of his own, tells it this way:

"For the money Americans spent on health care last year, we could have hired a group of skilled physicians, paid each one of them $200,000 to care for just seven families, and guaranteed every single American quality, affordable health care.

So where's all that money going? We know that a quarter of it - one out of every four health care dollars - is spent on non-medical costs; mostly bills and paperwork. And we also know that this is completely unnecessary. Almost every other industry in the world has saved billions on these administrative costs by doing it all online. Every transaction you make at a bank now costs them less than a penny. Even at the Veterans Administration, where it used to cost nine dollars to pull up your medical record, new technology means you can call up the same record on the internet for next to nothing.

But because we haven't updated technology in the rest of the health care industry, a single transaction still costs up to twenty-five dollars - not one dime of which goes toward improving the quality of our health care."

Simply Inexcusable

This is simply inexcusable.

And if we brought our entire health care system online into the 21st century, something everyone from Ted Kennedy to Newt Gingrich believes we should do, we'd already be saving over $600 million a year on health care costs that we could apply to providing coverage for more peoople.

It's not a problem of lack of ideas. It's a problem of political will. The federal government should be leading the way here. If you do business with the federal employee health benefits program, you should move to an electronic claims system.

If you are a provider who works with Medicare, you should have to report your patient's health outcomes, so that we can figure out, on a national level, how to improve health care quality.

These are all things experts tell us must be done but aren't being done. And the federal government should lead.

Record-Breaking Profits in the Health Care Industry

Another, more controversial area we need to look at is how much of our health care spending is going toward the record-breaking profits earned by the drug and health care industry.

It's perfectly understandable for a corporation to try and make a profit, but when those profits are soaring higher and higher each year while millions lose their coverage and premiums skyrocket, we have a responsibility to ask why.

At a time when businesses are facing increased competition and workers rarely stay with one company throughout their lives, we also have to ask if the employer-based system of health care itself is still the best for providing insurance to all Americans.

We have to ask what we can do to provide more Americans with preventative care, which would mean fewer doctor's visits and less cost down the road.

We should make sure that every single child who's eligible is signed up for the children's health insurance program, and the federal government should make sure that our states have the money to make that happen.

And we have to start looking at some of the interesting ideas on comprehensive reform that are coming out of states like Maine, Illinois, California, Massachusetts, to see what we can replicate on a national scale and what will move us toward that goal of universal coverage for all.

But regardless of what combination of policies and proposals get us to this goal, we must reach it. We must act. And we must act boldly. As one health care advocate recently said, "The most expensive course is to do nothing." But it wasn't a liberal Democrat or union leader who said this.

It was the president of the very health industry association that funded the "Harry and Louise" ads designed to kill the Clinton health care plan in the early nineties.

America Can No Longer Afford Inaction

The debate in this country over health care has shifted.

The support for comprehensive reform that organizations like Families USA have worked so hard to build is now widespread, and the diverse group of business and health industry interests that are part of your Health Care Coverage Coalition is a testament to that success.

And so Washington no longer has an excuse for caution. Leaders no longer have a reason to be timid. And America can no longer afford inaction. That's not who we are - and that's not the story of our nation's improbable progress.

Harry Truman, First President for Universal Health Coverage

Half a century ago, America found itself in the midst of another health care crisis. For millions of elderly Americans, the single greatest cause of poverty and hardship was the crippling cost of health care and the lack of affordable insurance. Two out of every three elderly Americans had annual incomes of less than $1,000, and only one in eight had health insurance.

As health care and hospital costs continued to rise, more and more private insurers simply refused to insure our elderly, believing they were too great of a risk to care for.

The resistance to action was fierce. Proponents of health care reform were opposed by well-financed, well-connected interest groups who spared no expense in telling the American people that these efforts were "dangerous" and "un-American," "revolutionary" and even "deadly."

And yet the reformers marched on. They testified before Congress and they took their case to the country and they introduced dozens of different proposals but always, always they stood firm on their goal to provide health care for every American senior. And finally, after years of advocacy and negotiation and plenty of setbacks, President Lyndon Johnson signed the Medicare bill into law on July 30th of 1965.

The signing ceremony was held in Missouri, in a town called Independence, with the first man who was bold enough to issue the call for universal health care - President Harry Truman.

And as he stood with Truman by his side and signed what would become the most successful government program in history - a program that had seemed impossible for so long - President Johnson looked out at the crowd and said, *"History shapes men, but it is a necessary faith of leadership that men can help shape history."*

Time to Push Health Care Boundaries Again

Never forget that we have it within our power to shape history in this country. It is not in our character to sit idly by as victims of fate or circumstance, for we are a people of action and innovation, forever pushing the boundaries of what's possible.

Now is the time to push those boundaries once more.

We have come so far in the debate on health care in this country, but now we must finally answer the call first issued by Truman, advanced by Johnson, and fought for by so many leaders and Americans throughout the last century.

The time has come for universal health care in America. And I look forward to working with all of you in the coming months to meet that challenge.

I am absolutely confident that we are going to get there, not just because of the leadership in Washington, not just because of the leadership in the state capitals, but because of the leadership of all of you. Thank you.

Appendix B

June 15, 2009

Text: Obama's AMA Speech On Health Care (CBS)

Transcript Of President Obama's Remarks On Health Care To The American Medical Association

PRESIDENT OBAMA: Thank you so much. Good to see you. (Applause.) Thank you so much. Please, everybody be seated. Thank you very much. You're very kind. (Applause.)

Let me begin by thanking Nancy for the wonderful introduction. I want to thank Dr. Joseph Heyman, the chair of the Board of Trustees, as well as Dr. Jeremy Lazarus, speaker of House of Delegates. Thanks to all of you for bringing me home, even if it's just for a day. (Applause.)

From the moment I took office as President, the central challenge we've confronted as a nation has been the need to lift ourselves out of the worst recession since World War II. In recent months, we've taken a series of extraordinary steps, not just to repair the immediate damage to our economy, but to build a new foundation for lasting and sustained growth. We're here to create new jobs, to unfreeze our credit markets. We're stemming the loss of homes and the decline of home values.

All this is important. But even as we've made progress, we know that the road to prosperity remains long and it remains difficult. And we also know that one essential step on our journey is to control the spiraling cost of health care in America. And in order to do that, we're going to need the help of the AMA. (Applause.)

Today, we are spending over $2 trillion a year on health care -- almost 50 percent more per person than the next most costly nation. And yet, as I think many of you are aware, for all of this spending, more of our citizens are uninsured, the quality of our care is often lower, and we aren't any healthier. In fact, citizens in some countries that spend substantially less than we do are actually living longer than we do.

Make no mistake: The cost of our health care is a threat to our economy. It's an escalating burden on our families and businesses. It's a ticking time bomb for the federal budget. And it is unsustainable for the United States of America.

It's unsustainable for Americans like Laura Klitzka, a young mother that I met in

Wisconsin just last week, who's learned that the breast cancer she thought she'd beaten had spread to her bones, but who's now being forced to spend time worrying about how to cover the $50,000 in medical debts she's already accumulated, worried about future debts that she's going to accumulate, when all she wants to do is spend time with her two children and focus on getting well. These are not the worries that a woman like Laura should have to face in a nation as wealthy as ours. (Applause.)

Stories like Laura's are being told by women and men all across this country -- by families who've seen out-of-pocket costs soar, and premiums double over the last decade at a rate three times faster than wages. This is forcing Americans of all ages to go without the checkups or the prescriptions they need -- that you know they need. It's creating a situation where a single illness can wipe out a lifetime of savings.

Our costly health care system is unsustainable for doctors like Michael Kahn in New Hampshire, who, as he puts it, spends 20 percent of each day supervising a staff explaining insurance problems to patients, completing authorization forms, writing appeal letters -- a routine that he calls disruptive and distracting, giving him less time to do what he became a doctor to do and actually care for his patients. (Applause.)

Small business owners like Chris and Becky Link in Nashville are also struggling. They've always wanted to do right by the workers at their family-run marketing firm, but they've recently had to do the unthinkable and lay off a number of employees -- layoffs that could have been deferred, they say, if health care costs weren't so high. Across the country, over one-third of small businesses have reduced benefits in recent years and one-third have dropped their workers' coverage altogether since the early '90s.

Our largest companies are suffering, as well. A big part of what led General Motors and Chrysler into trouble in recent decades were the huge costs they racked up providing health care for their workers -- costs that made them less profitable and less competitive with automakers around the world. If we do not fix our health care system, America may go the way of GM -- paying more, getting less, and going broke.

When it comes to the cost of our health care, then, the status quo is unsustainable. (Applause.) So reform is not a luxury; it is a necessity. When I hear people say, well, why are you taking this on right now, you've got all these other problems, I keep on reminding people I'd love to be able to defer these issues, but we can't. I know there's been much discussion about what reform would cost, and rightly so. This is a test of whether we -- Democrats and Republicans alike -- are serious about holding the line on new spending and restoring fiscal discipline.

But let there be no doubt -- the cost of inaction is greater. If we fail to act -- (applause) -- if we fail to act -- and you know this because you see it in your own individual practices -- if we fail to act, premiums will climb higher, benefits will erode further, the rolls of the uninsured will swell to include millions more Americans -- all of which will affect your practice.

If we fail to act, one out of every five dollars we earn will be spent on health care within a decade. And in 30 years, it will be about one out of every three -- a trend that will mean lost jobs, lower take-home pay, shuttered businesses, and a lower standard of living for all Americans.

And if we fail to act, federal spending on Medicaid and Medicare will grow over the coming decades by an amount almost equal to the amount our government currently spends on our nation's defense. It will, in fact, eventually grow larger than what our government spends on anything else today. It's a scenario that will swamp our federal and state budgets, and impose a vicious choice of either unprecedented tax hikes, or overwhelming deficits, or drastic cuts in our federal and state budgets.

So to say it as plainly as I can, health care is the single most important thing we can do for America's long-term fiscal health. That is a fact. That's a fact. (Applause.)

It's a fact, and the truth is most people know that it's a fact. And yet, as clear as it is that our system badly needs reform, reform is not inevitable. There's a sense out there among some, and perhaps some members who are gathered here today of the AMA, that as bad as our current system may be -- and it's pretty bad -- the devil we know is better than the devil we don't. There's a fear of change -- a worry that we may lose what works about our health care system while trying to fix what doesn't.

I'm here to tell you I understand that fear. And I understand the cynicism. They're scars left over from past efforts at reform. After all, Presidents have called for health care reform for nearly a century. Teddy Roosevelt called for it. Harry Truman called for it. Richard Nixon called for it. Jimmy Carter called for it. Bill Clinton called for it. But while significant individual reforms have been made -- such as Medicare, Medicaid, and the Children's Health Insurance Program -- efforts at comprehensive reform that covers everyone and brings down costs have largely failed.

Part of the reason is because the different groups involved -- doctors, insurance companies, businesses, workers, and others -- simply couldn't agree on the need for reform or what shape it would take. And if we're honest, another part of the reason has been the fierce opposition fueled by some interest groups and lobbyists -- opposition that has used fear tactics to paint any effort to achieve reform as an attempt to, yes, socialize medicine.

And despite this long history of failure, I'm standing here because I think we're in a different time. One sign that things are different is that just this past week, the Senate passed a bill that will protect children from the dangers of smoking, a reform the AMA has long championed -- (applause) -- this organization long championed; it went nowhere when it was proposed a decade ago -- I'm going to sign this into law. (Applause.)

Now, what makes this moment different is that this time -- for the first time -- key stakeholders are aligning not against, but in favor of reform. They're coming out -- they're coming together out of a recognition that while reform will take everyone in our health

care community to do their part -- everybody is going to have to pitch in -- ultimately, everybody will benefit.

And I want to commend the AMA, in particular, for offering to do your part to curb costs and achieve reform. Just a week ago, you joined together with hospitals, labor unions, insurers, medical device manufacturers and drug companies to do something that would have been unthinkable just a few years ago -- you promised to work together to cut national health care spending by $2 trillion over the next decade, relative to what it would have otherwise been. And that will bring down costs; that will bring down premiums. That's exactly the kind of cooperation we need, and we appreciate that very much. Thank you. (Applause.)

Now, the question is how do we finish the job? How do we permanently bring down costs and make quality, affordable health care available to every single American? That's what I've come to talk about today. We know the moment is right for health care reform. We know this is a historic opportunity we've never seen before and may not see again. But we also know that there are those who will try and scuttle this opportunity no matter what -- who will use the same scare tactics and fear-mongering that's worked in the past; who will give warnings about socialized medicine and government takeovers, long lines and rationed care, decisions made by bureaucrats and not doctors. We have heard this all before. And because these fear tactics have worked, things have kept getting worse.

So let me begin by saying this to you and to the American people: I know that there are millions of Americans who are content with their health care coverage -- they like their plan and, most importantly, they value their relationship with their doctor. They trust you. And that means that no matter how we reform health care, we will keep this promise to the American people: If you like your doctor, you will be able to keep your doctor, period. (Applause.) If you like your health care plan, you'll be able to keep your health care plan, period. (Applause.) No one will take it away, no matter what. My view is that health care reform should be guided by a simple principle: Fix what's broken and build on what works. And that's what we intend to do.

If we do that, we can build a health care system that allows you to be physicians instead of administrators and accountants; a system that gives Americans -- (applause) -- a system that gives Americans the best care at the lowest cost; a system that eases up the pressure on businesses and unleashes the promise of our economy, creating hundreds of thousands of jobs, making take-home wages thousands of dollars higher, and growing our economy by tens of billions of dollars more every year. That's how we'll stop spending tax dollars to prop up an unsustainable system, and start investing those dollars in innovations and advances that will make our health care system and our economy stronger.

That's what we can do with this opportunity. And that's what we must do with this moment.

Now, the good news is that in some instances, there's already widespread agreement on

the steps necessary to make our health care system work better.

First, we need to upgrade our medical records by switching from a paper to an electronic system of record keeping. And we've already begun to do this with an investment we made as part of our Recovery Act.

It simply doesn't make sense that patients in the 21st century are still filling out forms with pens on papers that have to be stored away somewhere. As Newt Gingrich has rightly pointed out -- and I don't quote Newt Gingrich that often -- (laughter) -- we do a better job tracking a FedEx package in this country than we do tracking patients' health records. (Applause.)

You shouldn't have to tell every new doctor you see about your medical history or what prescriptions you're taking. You shouldn't have to repeat costly tests. All that information should be stored securely in a private medical record so that your information can be tracked from one doctor to another -- even if you change jobs, even if you move, even if you have to see a number of different specialists. That's just common sense. (Applause.)

And that will not only mean less paper-pushing and lower administrative costs, saving taxpayers billions of dollars; it will also mean all of you physicians will have an easier time doing your jobs. It will tell you, the doctors, what drugs a patient is taking so you can avoid prescribing a medication that could cause a harmful interaction. It will prevent the wrong dosages from going to a patient. It will reduce medical errors, it's estimated, that lead to 100,000 lives lost unnecessarily in our hospitals every year.

So there shouldn't be an argument there. And we want to make sure that we're helping providers computerize so that we can get this system up and running.

The second step that we can all agree on is to invest more in preventive care so we can avoid illness and disease in the first place. (Applause.) That starts with each of us taking more responsibility for our health and for the health of our children. (Applause.) It means quitting smoking. It means going in for that mammogram or colon cancer screening. It means going for a run or hitting the gym, and raising our children to step away from the video games and spend more time playing outside. (Applause.)

It also means cutting down on all the junk food that's fueling an epidemic of obesity -- (applause) -- which puts far too many Americans, young and old, at greater risk of costly, chronic conditions. That's a lesson Michelle and I have tried to instill in our daughters. As some of you know, we started a White House vegetable garden. I say "we" generously, because Michelle has done most of the work. (Laughter.) That's a lesson that we should work with local school districts to incorporate into their school lunch programs.

Building a health care system that promotes prevention rather than just managing diseases will require all of us to do our parts. It will take doctors telling us what risk factors we should avoid and what preventive measures we should pursue. It will take employers following the example of places like Safeway that is rewarding workers for

taking better care of their health while reducing health care costs in the process.

If you're one of three-quarters of Safeway workers enrolled in their "Healthy Measures" program, you can get screened for problems like high cholesterol or high blood pressure. And if you score well, you can pay lower premiums; you get more money in your paycheck. It's a program that has helped Safeway cut health care spending by 13 percent, and workers save over 20 percent on their premiums. (Applause.) And we're open to doing more to help employers adopt and expand programs like this one.

Our federal government also has to step up its efforts to advance the cause of healthy living. Five of the costliest illnesses and conditions -- cancer, cardiovascular disease, diabetes, lung disease, and strokes -- can be prevented. And yet only a fraction of every health care dollar goes to prevention or public health. And that's starting to change with an investment we're making in prevention and wellness programs that can help us avoid disease that harm our health and the health of our economy.

But as important as they are, investments in electronic records and preventive care, all the things that I've just mentioned, they're just preliminary steps. They will only make a dent in the epidemic of rising costs in this country.

Despite what some have suggested, the reason we have these spiraling costs is not simply because we've got an aging population; demographics do account for part of rising costs because older, sicker societies pay more on health care than younger, healthier ones, and there's nothing intrinsically wrong in us taking better care of ourselves. But what accounts for the bulk of our costs is the nature of our health care delivery system itself -- a system where we spend vast amounts of money on things that aren't necessarily making our people any healthier; a system that automatically equates more expensive care with better care.

Now, a recent article in the New Yorker, for example, showed how McAllen, Texas, is spending twice as much as El Paso County -- twice as much -- not because people in McAllen, Texas, are sicker than they are in El Paso; not because they're getting better care or getting better outcomes. It's simply because they're using more treatments -- treatments that, in some cases, they don't really need; treatments that, in some cases, can actually do people harm by raising the risk of infection or medical error.

And the problem is this pattern is repeating itself across America. One Dartmouth study shows that you're less likely -- you're no less likely to die from a heart attack and other ailments in a higher-spending area than in a lower-spending one.

There are two main reasons for this. The first is a system of incentives where the more tests and services are provided, the more money we pay. And a lot of people in this room know what I'm talking about. It's a model that rewards the quantity of care rather than the quality of care; that pushes you, the doctor, to see more and more patients even if you can't spend much time with each, and gives you every incentive to order that extra MRI or EKG, even if it's not necessary. It's a model that has taken the pursuit of medicine from

a profession -- a calling -- to a business.

That's not why you became doctors. That's not why you put in all those hours in the Anatomy Suite or the O.R. That's not what brings you back to a patient's bedside to check in, or makes you call a loved one of a patient to say it will be fine. You didn't enter this profession to be bean-counters and paper-pushers. You entered this profession to be healers. (Applause.) And that's what our health care system should let you be. That's what this health care system should let you be. (Applause.)

Now, that starts with reforming the way we compensate our providers -- doctors and hospitals. We need to bundle payments so you aren't paid for every single treatment you offer a patient with a chronic condition like diabetes, but instead paid well for how you treat the overall disease. We need to create incentives for physicians to team up, because we know that when that happens, it results in a healthier patient. We need to give doctors bonuses for good health outcomes, so we're not promoting just more treatment, but better care.

And we need to rethink the cost of a medical education, and do more to reward medical students who choose a career as a primary care physician -- (applause) -- who choose to work in underserved areas instead of the more lucrative paths. (Applause.) That's why we're making a substantial investment in the National Health Service Corps that will make medical training more affordable for primary care doctors and nurse practitioners so they aren't drowning in debt when they enter the workforce. (Applause.) Somebody back there is drowning in debt. (Laughter.)

The second structural reform we need to make is to improve the quality of medical information making its way to doctors and patients. We have the best medical schools, the most sophisticated labs, the most advanced training of any nation on the globe. Yet we're not doing a very good job harnessing our collective knowledge and experience on behalf of better medicine.

Less than 1 percent of our health care spending goes to examining what treatments are most effective -- less than 1 percent. And even when that information finds its way into journals, it can take up to 17 years to find its way to an exam room or operating table. As a result, too many doctors and patients are making decisions without the benefit of the latest research.

A recent study, for example, found that only half of all cardiac guidelines are based on scientific evidence -- half. That means doctors may be doing a bypass operation when placing a stent is equally effective; or placing a stent when adjusting a patient's drug and medical management is equally effective -- all of which drives up costs without improving a patient's health.

So one thing we need to do is to figure out what works, and encourage rapid implementation of what works into your practices. That's why we're making a major investment in research to identify the best treatments for a variety of ailments and

conditions. (Applause.)

Now, let me be clear -- I just want to clear something up here -- identifying what works is not about dictating what kind of care should be provided. (Applause.) It's about providing patients and doctors with the information they need to make the best medical decisions. See, I have the assumption that if you have good information about what makes your patients well, that's what you're going to do. (Applause.) I have confidence in that. We're not going to need to force you to do it. We just need to make sure you've got the best information available.

Still, even when we do know what works, we are often not making the most of it. And that's why we need to build on the examples of outstanding medicine at places like the Cincinnati Children's Hospital, where the quality of care for cystic fibrosis patients shot up after the hospital began incorporating suggestions from parents. And places like Tallahassee Memorial Health Care, where deaths were dramatically reduced with rapid response teams that monitored patients' conditions, and "multidisciplinary rounds" with everyone from physicians to pharmacists. And places like Geisinger Health System in rural Pennsylvania, and Intermountain Health in Salt Lake City, where high-quality care is being provided at a cost well below the national average. These are all islands of excellence that we need to make the standard in our health care system.

So replicating best practices, incentivizing excellence, closing cost disparities -- any legislation sent to my desk that does not these -- does not achieve these goals in my mind does not earn the title of reform.

But my signature on a bill is not enough. I need your help, doctors, because to most Americans you are the health care system. The fact is Americans -- and I include myself and Michelle and our kids in this -- we just do what you tell us to do. (Laughter.) That's what we do. We listen to you, we trust you. And that's why I will listen to you and work with you to pursue reform that works for you. (Applause.)

Together, if we take all these steps, I am convinced we can bring spending down, bring quality up; we can save hundreds of billions of dollars on health care costs while making our health care system work better for patients and doctors alike. And when we align the interests of patients and doctors, then we're going to be in a good place.

Now, I recognize that it will be hard to make some of these changes if doctors feel like they're constantly looking over their shoulders for fear of lawsuits. I recognize that. (Applause.) Don't get too excited yet. Now, I understand some doctors may feel the need to order more tests and treatments to avoid being legally vulnerable. That's a real issue. (Applause.) Now, just hold on to your horses here, guys. (Laughter.) I want to be honest with you. I'm not advocating caps on malpractice awards -- (boos from some in audience) -- (laughter) -- which I personally believe can be unfair to people who've been wrongfully harmed.

But I do think we need to explore a range of ideas about how to put patient safety first;

how to let doctors focus on practicing medicine; how to encourage broader use of evidence-based guidelines. I want to work with the AMA so we can scale back the excessive defensive medicine that reinforces our current system, and shift to a system where we are providing better care, simply -- rather than simply more treatment.

So this is going to be a priority for me. And I know, based on your responses, it's a priority for you. (Laughter.) And I look forward to working with you. And it's going to be difficult. But all this stuff is going to be difficult. All of it's going to be important.

Now, I know this has been a long speech, but we got more to do. (Laughter.) The changes that I have already spoken about, all that is going to need to go hand-in-hand with other reforms. Because our health care system is so complex and medicine is always evolving, we need a way to continually evaluate how we can eliminate waste, reduce costs, and improve quality.

That's why I'm open to expanding the role of a commission created by a Republican Congress called the Medicare Payment Advisory Commission, which happens to include a number of physicians on the commission. In recent years, this commission proposed roughly $200 billion in savings that never made it into law. These recommendations have now been incorporated into our broader reform agenda, but we need to fast-track their proposals, the commission's proposals, in the future so that we don't miss another opportunity to save billions of dollars, as we gain more information about what works and what doesn't work in our health care system.

And as we seek to contain the cost of health care, we also have to ensure that every American can get coverage they can afford. (Applause.) We must do so in part because it's in all of our economic interests. Each time an uninsured American steps foot into an emergency room with no way to reimburse the hospital for care, the cost is handed over to every American family as a bill of about $1,000 that's reflected in higher taxes, higher premiums, and higher health care costs. It's a hidden tax, a hidden bill that will be cut as we insure all Americans. And as we insure every young and healthy American, it will spread out risk for insurance companies, further reducing costs for everyone.

But alongside these economic arguments, there's another, more powerful one. And it is simply this: We are not a nation that accepts nearly 46 million uninsured men, women and children. (Applause.) We are not a nation that lets hardworking families go without coverage, or turns its back on those in need. We're a nation that cares for its citizens. We look out for one another. That's what makes us the United States of America. We need to get this done. (Applause.)

So we need to do a few things to provide affordable health insurance to every single American. The first thing we need to do is to protect what's working in our health care system. So just in case you didn't catch it the first time, let me repeat: If you like your health care system and your doctor, the only thing reform will mean to you is your health care will cost less. If anyone says otherwise, they are either trying to mislead you or don't have their facts straight.

Now, if you don't like your health care coverage or you don't have any insurance at all, you'll have a chance, under what we've proposed, to take part in what we're calling a Health Insurance Exchange. This exchange will allow you to one-stop shop for a health care plan, compare benefits and prices, and choose a plan that's best for you and your family -- the same way, by the way, that federal employees can do, from a postal worker to a member of Congress. (Applause.) You will have your choice of a number of plans that offer a few different packages, but every plan would offer an affordable, basic package.

Again, this is for people who aren't happy with their current plan. If you like what you're getting, keep it. Nobody is forcing you to shift. But if you're not, this gives you some new options. And I believe one of these options needs to be a public option that will give people a broader range of choices -- (applause) -- and inject competition into the health care market so that force -- so that we can force waste out of the system and keep the insurance companies honest. (Applause.)

Now, I know that there's some concern about a public option. Even within this organization there's healthy debate about it. In particular, I understand that you're concerned that today's Medicare rates, which many of you already feel are too low, will be applied broadly in a way that means our cost savings are coming off your backs.

And these are legitimate concerns, but they're ones, I believe, that can be overcome. As I stated earlier, the reforms we propose to reimbursement are to reward best practices, focus on patient care, not on the current piecework reimbursements. What we seek is more stability and a health care system that's on a sounder financial footing.

And the fact is these reforms need to take place regardless of whether there's a public option or not. With reform, we will ensure that you are being reimbursed in a thoughtful way that's tied to patient outcomes, instead of relying on yearly negotiations about the Sustainable Growth Rate formula that's based on politics and the immediate state of the federal budget in any given year. (Applause.)

And I just want to point out the alternative to such reform is a world where health care costs grow at an unsustainable rate. And if you don't think that's going to threaten your reimbursements and the stability of our health care system, you haven't been paying attention.

So the public option is not your enemy; it is your friend, I believe.

Let me also say that -- let me also address a illegitimate concern that's being put forward by those who are claiming that a public option is somehow a Trojan horse for a single-payer system. I'll be honest; there are countries where a single-payer system works pretty well. But I believe -- and I've taken some flak from members of my own party for this belief -- that it's important for our reform efforts to build on our traditions here in the United States. So when you hear the naysayers claim that I'm trying to bring about

government-run health care, know this: They're not telling the truth. (Applause.)

What I am trying to do -- and what a public option will help do -- is put affordable health care within reach for millions of Americans. And to help ensure that everyone can afford the cost of a health care option in our exchange, we need to provide assistance to families who need it. That way, there will be no reason at all for anyone to remain uninsured. (Applause.)

Indeed, it's because I'm confident in our ability to give people the ability to get insurance at an affordable rate that I'm open to a system where every American bears responsibility for owning health insurance -- (applause) -- so long as we provide a hardship waiver for those who still can't afford it as we move towards this system.

The same is true for employers. While I believe every business has a responsibility to provide health insurance for its workers, small businesses that can't afford it should receive an exemption. And small business workers and their families will be able to seek coverage in the exchange if their employer is not able to provide it.

Now, here's some good news. Insurance companies have expressed support for the idea of covering the uninsured and they certainly are in favor of a mandate. I welcome their willingness to engage constructively in the reform debate. I'm glad they're at the table. But what I refuse to do is simply create a system where insurance companies suddenly have a whole bunch of more customers on Uncle Sam's dime, but still fail to meet their responsibilities. We're not going to do that. (Applause.)

Let me give you an example of what I'm talking about. We need to end the practice of denying coverage on the basis of preexisting conditions. (Applause.) The days of cherry-picking who to cover and who to deny, those days are over. (Applause.) I know you see it in your practices, and how incredibly painful and frustrating it is -- you want to give somebody care and you find out that the insurance companies are wiggling out of paying.

This is personal for me also. I've told this story before. I'll never forget watching my own mother, as she fought cancer in her final days, spending time worrying about whether her insurer would claim her illness was a preexisting condition so it could get out of providing coverage. Changing the current approach to preexisting conditions is the least we can do -- for my mother and for every other mother, father, son, and daughter, who has suffered under this practice, who've been paying premiums and don't get care. We need to put health care within the reach for millions of Americans. (Applause.)

Now, even if we accept all of the economic and moral reasons for providing affordable coverage to all Americans, there is no denying that expanding coverage will come at a cost, at least in the short run. But it is a cost that will not -- I repeat -- will not add to our deficits. I've set down a rule for my staff, for my team -- and I've said this to Congress -- health care reform must be, and will be, deficit-neutral in the next decade.

Now, there are already voices saying the numbers don't add up. They're wrong. Here's

why. Making health care affordable for all Americans will cost somewhere on the order of $1 trillion over the next 10 years. That's real money, even in Washington. (Laughter.) But remember, that's less than we are projected to have spent on the war in Iraq. And also remember, failing to reform our health care system in a way that genuinely reduces cost growth will cost us trillions of dollars more in lost economic growth and lower wages.

That said, let me explain how we will cover the price tag. First, as part of the budget that was passed a few months ago, we put aside $635 billion over 10 years in what we're calling a Health Reserve Fund. Over half of that amount -- more than $300 billion -- will come from raising revenue by doing things like modestly limiting the tax deductions the wealthiest Americans can take to the same level that it was at the end of the Reagan years -- same level that it was under Ronald Reagan. Some are concerned that this will dramatically reduce charitable giving, for example, but statistics show that's not true. And the best thing for our charities is the stronger economy that we will build with health care reform.

But we can't just raise revenues. We're also going to have to make spending cuts, in part by examining inefficiencies in our current Medicare program. There are going to be robust debates about where these cuts should be made, and I welcome that debate. But here's where I think these cuts should be made.

First, we should end overpayments to Medicare Advantage. (Applause.) Today, we're paying Medicare Advantage plans much more than we pay for traditional Medicare services. Now, this is a good deal for insurance companies. It's a subsidy to insurance companies. It's not a good deal for you. It's not a good deal for the American people. And by the way, it doesn't follow free market principles, for those who are always talking about free market principles. That's why we need to introduce competitive bidding into the Medicare Advantage program, a program under which private insurance companies are offering Medicare coverage. That alone will save $177 billion over the next decade, just that one step. (Applause.)

Second, we need to use Medicare reimbursements to reduce preventable hospital readmissions. Right now, almost 20 percent of Medicare patients discharged from hospitals are readmitted within a month, often because they're not getting the comprehensive care that they need. This puts people at risk; it drives up cost. By changing how Medicare reimburses hospitals, we can discourage them from acting in a way that boosts profits but drives up costs for everyone else. That will save us $25 billion over the next decade.

Third, we need to introduce generic biologic drugs into the marketplace. (Applause.) These are drugs used to treat illnesses like anemia. But right now, there is no pathway at the FDA for approving generic versions of these drugs. Creating such a pathway will save us billions of dollars. We can save another roughly $30 billion by getting a better deal for our poorer seniors while asking our well-off seniors to pay a little more for their drugs.

So that's the bulk of what's in the Health Reserve Fund. I've also proposed saving another $313 billion in Medicare and Medicaid spending in several other ways. One way is by adjusting Medicare payments to reflect new advances and productivity gains in our economy. Right now, Medicare payments are rising each year by more than they should. These adjustments will create incentives for providers to deliver care more efficiently, and save us roughly $109 billion in the process.

Another way we can achieve savings is by reducing payments to hospitals for treating uninsured people. I know hospitals rely on these payments now, legitimately, because of the large number of uninsured patients that they treat. But if we put in a system where people have coverage and the number of uninsured people goes down with our reforms, the amount we pay hospitals to treat uninsured people should go down, as well. Reducing these payments gradually, as more and more people have coverage, will save us over $106 billion. And we'll make sure the difference goes to the hospitals that need it most.

We can also save about $75 billion through more efficient purchasing of prescription drugs. And we can save about $1 billion more by rooting out waste, abuse, fraud throughout our health care system so that no one is charging more for a service than it's worth or charging a dime for a service that they don't provide.

Let me be clear: I'm committed to making these cuts in a way that protects our senior citizens. In fact, these proposals will actually extend the life of the Medicare Trust Fund by seven years, and reduce premiums for Medicare beneficiaries by roughly $43 billion over the next 10 years. And I'm working with AARP to uphold that commitment.

Now, for those of you who took out your pencil and paper -- (laughter) -- altogether, these savings mean that we've put about $950 billion on the table -- and that doesn't count some of the long-term savings that we think will come about from reform -- from medical IT, for example, or increased investment in prevention. So that stuff in congressional jargon is not scorable; the Congressional Budget Office won't count that as savings, so we're setting that aside. We think that's going to come, but even separate and far from that, we've put $950 billion on the table, taking us almost all the way to covering the full cost of health care reform.

In the weeks and months ahead, I look forward to working with Congress to make up the difference so that health care reform is fully paid for -- in a real, accountable way. And let me add that this does not count longer-term savings. I just want to repeat that. By insisting that the reforms that we're introducing are deficit-neutral over the next decade, and by making the reforms that will help slow the growth rate of health care costs over the coming decades -- bending the curve -- we can look forward to faster economic growth, higher living standards, and falling, instead of rising, budget deficits.

Now, let me just wrap up by saying this. I know people are cynical whether we can do this or not. I know there will be disagreements about how to proceed in the days ahead. There's probably healthy debate within the AMA. That's good. I also know this: We can't let this moment pass us by.

You know, the other day, a friend of mine, Congressman Earl Blumenauer, handed me a magazine with a special issue titled, "The Crisis in American Medicine." One article notes "soaring charges." Another warns about the "volume of utilization of services." Another asks if we can find a "better way than fee-for-service for paying for medical care." It speaks to many of the challenges we face today. The thing is, this special issue was published by Harper's Magazine in October of 1960 -- (laughter) -- before I was born. (Laughter.)

Members of the American Medical Association, and my fellow Americans, I'm here today because I don't want our children and their children to still be speaking of a crisis in American medicine 50 years from now. I don't want them to still be suffering from spiraling costs that we did not stem, or sicknesses that we did not cure. I don't want them to be burdened with massive deficits we did not curb or a worsening economy that we did not rebuild.

I want them to benefit from a health care system that works for all of us; where families can open a doctor's bill without dreading what's inside; where parents are talking to their kids and getting them to get regular checkups, and testing themselves for preventable ailments; where parents are feeding their kids healthier food and kids are exercising more; where patients are spending more time with their doctors, and doctors can pull up on a computer all the medical information and latest research they'll ever want to know to meet patients' needs; where orthopedists and nephrologists and oncologists are all working together to treat a single human being; where what's best about America's health care system has become the hallmark of America's health care system.

That's the health care system we can build. That's the future I'm convinced is within our reach. And if we're willing to come together and bring about that future, then we will not only make Americans healthier, we will not only unleash America's economic potential, but we will reaffirm the ideals that led you into this noble profession and we'll build a health care system that lets all Americans heal.

Thank you very much, AMA. Appreciate it, thank you. (Applause.)

Appendix C

The New York Times

September 10, 2009

Obama's Health Care Speech to Congress

Following is the prepared text of President Obama's speech to Congress on the need to overhaul health care in the United States, as released by the White House.

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 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.