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A Comparative Analysis of Healthcare Policy and Rhetoric: The Harris Campaign and Obama Campaign in Perspective.

Dissertation Submitted in Partial Fulfillment of the Requirements for Master's Degree in Literature and Civilization

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Dedication

We are grateful to Allah to complete this research after all the suffering.
I dedicate this dissertation to my family, friends and everyone who supported me.

And, I dedicate this dissertation to my cousin Abir FARAH, who I would not be here today without her support.

And I cannot forget my dear, lovely sister, Wahiba FARAH, who helped me financially.

FARAH Chamesse

I dedicate my work to my family and my best friends. And, I dedicate this dissertation to those who departed this life but remain alive in my heart: my uncle Ahmed and my aunt Soumeia. May God have mercy on their souls and grant them eternal peace.

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Acknowledgments

Firstly, writing a dissertation is not an easy task. And writing this as best friends was a big challenge; however, we managed to complete this achievement with our love and friendship preserved.

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And above all, we thank Allah we thank Allah, the Most Merciful, for granting us the strength, patience, and clarity to complete this dissertation.

Abstract

This dissertation reports an analytical comparative study of healthcare policy and rhetoric in the electoral campaigns of Kamala Harris and Barack Obama. Overall, it seeks to compare the persuasion strategies of Kamala Harris and Barack Obama and to examine the impact of their rhetoric on public perception and support for healthcare reform. In this regard, it attempts to provide insights into how political leadership shapes healthcare discourse in the U.S., influencing both public opinion and voter behaviour. This study responds to the growing academic interest in how political rhetoric influences healthcare narratives, especially in light of major reforms such as the Affordable Care Act and Medicare for All. Via employing a qualitative comparative analysis approach, seven speeches of both candidates were analysed in order to answer the research question regarding the extent of differences between these two agendas. Accordingly, their rhetorical techniques concerning healthcare reforms were examined by Aristotle's rhetorical triangle method. These concluded on the prominent significance of mental reasoning over emotional connection when it comes to gaining presidential support in the United States of America.

Keywords: Comparative Analysis, Healthcare Policy, Rhetoric, United States of America

List of Abbreviations and Acronyms

ACA	Affordable Care Act
ASPE	Office of the Assistant Secretary for Planning and Evaluation
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare & Medicaid Services
DRGs	Diagnostic-Related Groups
FDA	Food and Drug Administration
FPL	Federal Poverty Level
FY	Fiscal Year
GDP	Gross Domestic Product
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
MACPAC	Medicaid and CHIP Payment and Access Commission
MHS	Military Health Service
NABJ	Military Health Service
OOP	Out-of-Pocket (expenses)
QHPs	Affordable Care Act
U.S.	United States
VHA	Veterans Health Administration

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General Introduction

1. Background of the study

This dissertation seeks to compare the persuasive rhetoric used by Kamala Harris and Barack Obama and examine how it influences voter behaviour by analysing the selected campaign speeches on healthcare. The research investigates how their approaches differ in terms of ethos, pathos, and logos. Understanding the rhetorical strategies is important, as healthcare is one of the most impactful areas in public policy. For a long time, the U.S. healthcare system has been a source of great political and public controversy, marked by basic differences on access, cost, and the part government plays. The differing strategies of the Affordable Care Act (ACA) and the suggested Medicare for All system underline this continuous conversation. Although the ACA increased coverage for millions of Americans, it also created notable access and affordability gaps that have sparked fresh demands for more thorough changes (Oberlander, 2016). By government management, Medicare for All suggests a single-payer system, hence removing premiums and providing consistent benefits, as supported by National Nurses United. Although it promises fair, easy treatment, political opposition persists because of worries about government overreach, innovation, and cost. (Blumenthal, Collins, & Fowler, 2020; Oberlander, 2017). Rhetoric plays an important role in this debate, as George Lakoff (2004) underlines how much political conversation depends on metaphors and frames shaping people's views of complicated topics, including healthcare. This study aims to analyse the ACA and Medicare for All policies, their use of rhetoric, and their place within the broader U.S. political and cultural context.

2. Statement of the problem

Healthcare rhetoric has always played a big role in U.S. political campaigns, influencing public opinion and voter behaviour. Although there have been several studies on Barack Obama’s healthcare rhetoric, and some on Kamala Harris’s campaign, there was a lack on

comparing both campaigns. This study aims to compare the rhetorical strategies of Harris and Obama to fill this gap by analysing and contrasting the persuasive techniques each leader used when promoting healthcare policy.

3. Research Question

How does Kamala Harris' healthcare rhetoric in her 2020 campaign compare to Barack Obama's rhetoric in the 2008 and 2012 campaigns in influencing voter behaviour?

4. Aims of the Study

This dissertation seeks to compare the persuasion strategies of Kamala Harris and Barack Obama and to examine the impact of their rhetoric on public perception and support for healthcare reform. In this regard, it attempts to provide insights into how political leadership shapes healthcare discourse in the U.S., influencing both public opinion and voter behaviour. It also aims to demonstrate the significance of a rhetorical approach in fostering support for healthcare reform and to understand how political communication affects public opinion and policy results in the U.S. when these distinctions are recognised. This study demonstrates the significance of a rhetorical approach in fostering support for healthcare reform. It is easier to understand how political communication affects public opinion and policy results in the U.S. when these distinctions are recognised.

5. Significance of the Study

Recognising how political leaders influence public opinion toward reform requires an understanding of the differences between Barack Obama's and Kamala Harris' healthcare policies and rhetoric. First, this comparison sheds light on how rhetorical strategy contributes to the development of support for significant healthcare ideas. Second, it aids in demonstrating how various approaches to policy and leadership affect public opinion. Lastly, the study adds to current discussions around successful communication in US healthcare reform efforts by examining these rhetorical and policy differences.

6. Research Methodology

In order to achieve the study's objectives and effectively answer the research questions, this study employs a comparative qualitative analysis. Chapter One utilizes historical and descriptive methods to gather and synthesize data from books, articles, websites, and previous studies. This provides a thorough understanding of the historical and theoretical context behind U.S. healthcare policy, particularly focusing on the Affordable Care Act (ACA) and Medicare for All. For Chapter Two, the study applies analytical and comparative methods, using Aristotle's rhetorical triangle (ethos, pathos, logos) to compare the rhetorical strategies used by Barack Obama and Kamala Harris in their healthcare speeches. This comparative analysis will allow for an in-depth exploration of how each figure uses language and persuasion to frame healthcare policy and influence public opinion.

7. Structure of the Study

This dissertation is divided into two main chapters. The first chapter is theoretical and provides a comprehensive background on U.S. healthcare policies, focusing on the complexities of the healthcare system and the evolution of policies under President Barack Obama and vice president Kamala Harris. It explores the role of government in healthcare and traces the historical development of healthcare reforms along with its important with a specific focus on the Affordable Care Act (ACA) and Harris's healthcare policy proposals, and it also compares the positions of Obama and Harris on healthcare. The second chapter is practical and is divided into two parts. The first part offers a theoretical overview of Aristotle's rhetorical framework and its application in political communication. The second part conducts a comparative analysis of the rhetorical strategies used by Obama and Harris in their healthcare speeches, examining how their policies and communication approaches influenced public opinion and policy success.

CHAPTER ONE

Kamala Harris and Barack Obama's Healthcare Presidential Campaign Agenda

Chapter One: Kamala Harris and Barack Obama's Healthcare Presidential Campaign Agenda

Introduction

Healthcare policy has long been a focus of contention in American politics which is often shaped by deeply held beliefs, competing values, and differing policy goals. Nowhere is this more evident than in the ongoing debates around healthcare. Unlike most developed countries, the U.S. spends more on healthcare but continues to struggle with unequal access and a complicated mix of public and private systems. These challenges have kept healthcare reform at the center of political conversations, especially during presidential campaigns. This chapter sets the stage for examining how Barack Obama and Kamala Harris approached healthcare as both a policy issue and a political message. It begins with an overview of how the U.S. healthcare system developed, including the laws, programs, and agencies that make it what it is today. It then moves into Obama's Affordable Care Act, followed by Harris's evolving stance from supporting Medicare for All to proposing a more moderate public option.

1.1 The U.S. Healthcare System: An Overview

1.1.1 Definition of the U.S. Healthcare System

Unlike many other developed nations, the United States has a unique healthcare system that is fragmented in its delivery system, a mix of private and public funding, and notable gaps in coverage. The United States has the most expensive healthcare system in the world, costing about 17.8% of GDP, yet it is characterised by worse health outcomes when compared with other developed countries. The United States ranks worst in healthcare quality by a 2024 report by the Commonwealth Fund among ten developed nations, experiencing the highest rate of avoidable deaths and with more people dying younger (Mills, 2024). This paradox of expensive outlays and below-average outcomes reflect systemic limitations within American healthcare, such as fragmented care pathways, administrative waste, and substantial inequality in access across socioeconomic categories of patients. These systemic problems have spurred multiple rounds of reform efforts across American history, including the landmark legislation known as the Affordable Care Act, or "Obamacare".

1.1.2 Historical Origins and Evolution

Given the importance of healthcare in the US, it is helpful to comprehend the history of health insurance, its development, and the several policies and concepts that preceded the current age of individual insurance brought about by the Affordable Care Act (ACA) (healthmarktdev, 2024).

In the 1890s, Washington logging corporations paid doctors to treat their employees. It was the first step toward what would eventually become health insurance. At this juncture in American healthcare history, insurance began to get national attention. President Theodore Roosevelt and his Progressive party supported social insurance in 1912, and the National Convention of Insurance Commissioners presented a model for health insurance regulation that states could adopt. A bill for mandatory health insurance was put forth by the American Association for Labor Legislation in 1915. The first Blue Cross health insurance programs were established in 1929 when Dallas-based Baylor University Hospital partnered with nearby schools to offer medical treatment to instructors for a $6 monthly subscription. The insurance paid for a 21-day hospital stay at $5 per day. The necessity of health insurance came into sharper light during the Great Depression. Henry Kaiser made arrangements with a local hospital for his aqueduct workers to receive care at a set rate.

This developed into the Kaiser Permanente Health Plan, which served as the model for contemporary HMOs and PPOs and eventually evolved into a managed care system. The Department of Health and Human Services was first established in 1939 as the Federal Security Agency, with an emphasis on social insurance, welfare, and health. The Social Security Board suggested incorporating national health insurance into the Social Security program in 1944. "By preventing illness, by assuring access to needed community and personal health services, by promoting medical research, and by protecting our people against the loss caused by sickness, we shall strengthen our national health, our national defense, and our economic productivity. " The National Health Assembly published a report in 1948 that stressed the need for comprehensive

coverage and supported voluntary health insurance. The Federal Security Agency suggested health insurance coverage for Social Security recipients in 1952.

In 1956 and 1959, legislation for this project was presented. President Dwight Eisenhower suggested a federal reinsurance fund for private insurance firms in 1954 in an effort to increase access to health coverage. The government implemented a scheme in 1956 that offered health insurance to family members of military personnel. President Johnson approved the legislation that established the Medicare system four years after President Kennedy laid the foundation for elder health insurance in 1961. Medicare benefits were extended to those with end-stage renal illness and disabled persons under 65 in 1972. Several bills to establish nationwide, single-payer insurance schemes were filed in Congress in 1993. These attempts were all unsuccessful. unsuccessful. The Health Insurance Portability and Accountability Act (HIPAA) amended several regulations pertaining to long-term care insurance and provided further protections for individuals with pre-existing diseases in 1996. In 1997, the Balanced Budget Act established Medicare Advantage, a new insurance program, and reduced the rate of increase in Medicare costs. Medicare Part D prescription medication benefits were established by the 2003 passage of the Medicare Prescription Drug, Improvement, and Modernization Act. Vermont's access to health insurance in 2006 served as a model for the Affordable Care Act. The Healthy Americans Act, which would have mandated health insurance for all Americans, was introduced in the Senate in 2007 (healthmarktdev, 2024).

By signing the Affordable Care Act (ACA) in 2010, President Barack Obama altered the course of American healthcare history. The ACA included safeguards for those with pre-existing diseases and allowed children under the age of 25 to be covered by a parent's plan. Uninsured rates in the US have decreased thanks in part to the Affordable Care Act. As of 2021, over 12 million Americans had enrolled in ACA health insurance plans thanks to this significant advancement. Since 2010, Health Market has assisted more than 4 million Americans in locating insurance (healthmarktdev, 2024).

1.1.3 The Importance of Healthcare

Health is one of the most important sociopolitical concerns in the United States, and Americans now rank "healthcare" as the number-one issue in terms of elections. Until now, the United States has provided health services through certain partnerships between the government and the private sector (Zieff et al., 2020).

Under this model, a commercial insurance company could just sell citizens or a business a health insurance policy. Meanwhile, other people could also receive public insurance through Medicaid, Medicare, and Veteran's Affairs, whose revenues are provided by the government (Zieff et al., 2020). Assuming around 90 percent of Americans are insured for their health, health insurance coverage witnessed a sudden increase in the last five years. Health insurance is characterized by good health outcomes, productivity, and greater life expectancy. It makes it easier to take care of health needs. Even with changes, 28 million other individuals remain without any form of insurance, putting their lives and well-being in danger. Having meaningful health care coverage is essential to leading a secure, healthy, and productive life. With almost 20 million new people now covered, the number of people with health insurance has grown dramatically in recent years. The Affordable Care Act (ACA) permitted coverage programs and insurance market reforms that allowed the majority of these people to enroll in coverage provided through the Medicaid program, their employer, or the individual market. Participation in coverage promotion is directly associated with the health and welfare of families and communities. Having access to care through health insurance is shown to improve health outcomes, including people's opinions of their own health and well-being, encourages an efficient use of health care resources, and reduces the financial burden on individuals, families, and communities. The significance of coverage is put into light by recent research comparing changes in states that opted into Medicaid expansion and those that did not (American Hospital Association, n.d.).

Politics and health policy are closely intertwined. Whoever controls the government has the ability to influence policy since it deals with what the government can do to change the quality, delivery, and financing of health care. Therefore, elections always have an impact on how health policy is shaped, who controls the executive branch as president, which party controls the House and Senate and can influence legislation, and which party controls state houses. Although the president still retains considerable administrative control over health policy, health care legislation frequently stalls when political power in Washington is divided. Additionally, federal deadlocks frequently encourage states to take more action. Politics frequently, but not always, revolves around health care issues. Since health care is a personal matter, voters are frequently moved by it. Aside from other financial concerns, voters usually have a high priority for the affordability of health care. In addition, a large number of industrial stakeholders, accounting for 17% of the economy, seek influence through campaign contributions and lobbying. On the other hand, elections rarely depend on specific policy problems (KFF, 2025).

Health care remains a prime political and personal issue in the U.S., with reforms under the ACA having enhanced coverage while still leaving a mass of uninsured. The political realm greatly affects access to care; hence, the public must engage for health policy to move ahead. Several bills to establish nationwide, single-payer insurance schemes were filed in Congress in 1993. These attempts were all unsuccessful. Unsuccessful. The Health Insurance Portability and Accountability Act (HIPAA) amended several regulations pertaining to long-term care insurance and provided further protections for individuals with pre-existing diseases in 1996. In 1997, the Balanced Budget Act established Medicare Advantage, a new insurance program, and reduced the rate of increase in Medicare costs. Medicare Part D prescription medication benefits were established by the 2003 passage of the Medicare Prescription Drug, Improvement, and Modernization Act. Vermont's access to health insurance in 2006 served as a model for the Affordable Care Act. The Healthy Americans Act, which would have mandated health insurance for all Americans, was introduced in the Senate in 2007.

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1.1.4 The Role of Government in Healthcare

The government ensures that healthcare in the United States is high quality, safe, and accessible. This position is driven by market inefficiencies and societal needs for equity and better health outcomes. There are several critical functions the government performs that respond to these challenges, particularly through its major role in financing the complex healthcare networks that characterize the system (Commonwealth Fund, 2020) .

1.1.4.1 Government's Role in Funding Healthcare

The government is a key payer for the provision of healthcare services via programs like Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). These programs together cover tens of millions of Americans. By 2019, about 20% of U.S. citizens depended on Medicaid (for low-income individuals), 14% depended on Medicare (for the elderly), and 1% depended on other forms of public insurance (for example, Veterans Health Administration (VHA) and Military Health Service (MHS) (MACPAC, 2019; ASPE, 2020). Collectively, these programs illustrate the government's essential responsibility to promote access to health coverage for vulnerable populations. Despite these efforts to keep everyone covered, 9% of Americans were left uninsured (U.S. Census Bureau, 2020).

An overview of the financial flow within the U.S. health system also demonstrates the government's central role, serving both as a direct payer and as an indirect supporter. More than

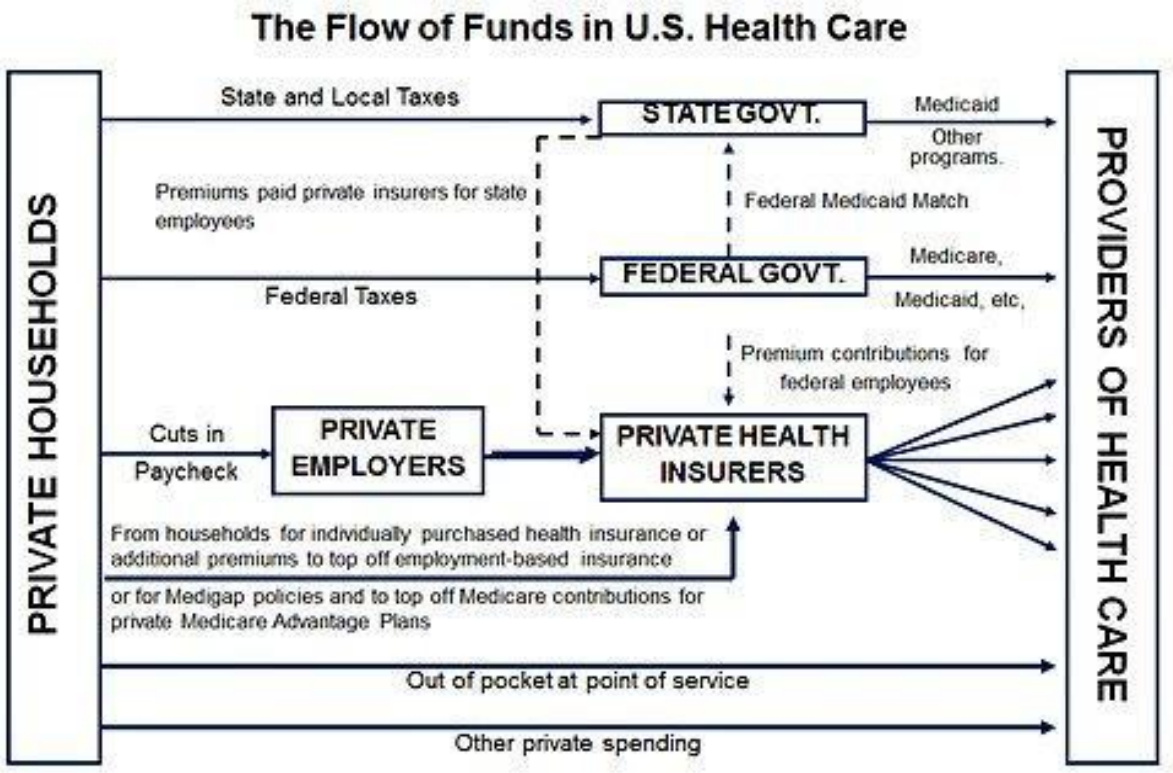
45% of healthcare spending in the United States comes from public funds (CMS, 2019). These funds come from federal taxes, state contributions, and premiums paid by beneficiaries and are allocated to various stakeholders.

Hospitals and other providers are paid directly by public programs like Medicare and Medicaid, payments are made through mechanisms such as Diagnostic-Related Groups (DRGs), which receive fixed payments based on specific medical conditions and sequences of treatment (CMS, n.d.).

Private insurers, on the other hand, are indirectly supported by government subsidies provided under the Affordable Care Act and by directly supporting employer-sponsored insurance plans via tax incentives (KFF, 2024; Tax Policy Center, n.d.).

Figure 1 below provides a visual representation of how funds flow within the U.S. healthcare system.

Figure 1. 1The Flow of Funds in the U.S .Healthcare System)Adapted from The New York Times ,2011 .The Money Flow ***From Households to Health Care Providers).***



1.1.4.2 Government's Role in Regulating Healthcare

Apart from its financing role, the U.S. government performs a foundational regulatory role in ensuring the safety, quality, and equity of the U.S. healthcare system. Federal agencies, including the Food and Drug Administration (the F.D.A.) and the Centers for Disease Control and Prevention (the C.D.C.), play a key role in this (FDA, 2023; CDC, n.d.).

The FDA is responsible for protecting public health by assuring the safety, efficacy, and security of human and veterinary drugs, biological products, and medical devices. It also oversees the safety of the nation's food supply, cosmetics, and products that emit radiation. The FDA regulates these products in a manner that helps promote innovations that lead to more effective, safer, and more affordable medical products (FDA, 2023).

The CDC is responsible for protecting public health and safety by preventing and controlling disease, injury, and disability. It gives advice on infection control and clinical safety in order to help minimize the likelihood of infections in healthcare workers, patients, and visitors. It also serves as a safeguard against the spread of infectious diseases entering and spreading in the

United States, running port health stations and working with partners, including U.S. Customs and Border Protection (CDC, n.d.).

Through these agencies, the government creates and enforces the rules that healthcare providers and related industries must follow to ensure that medical products are safe and effective and that public health measures are in place to prevent and control potential outbreaks of disease (FDA, 2023; CDC, n.d.).

1.2 Obama's Healthcare Policy: The Affordable Care Act (Obamacare)

"The stories of everyday Americans and, more importantly, the courage it took to share those stories is what kept this effort alive and moving forward even when it looked like it was lost. They are why we got this done. They are why I signed this bill into law." Obama, B. (2010, June 22).

Before the Affordable Care Act took effect, health insurance far too frequently caused fear, stress, and anxiety instead of peace of mind. Nearly one in two Americans, or up to 129 million people, may face discrimination due to a pre-existing condition such as diabetes, cancer, heart disease, pregnancy, or even something as ludicrous as acne. To address this issues President Obama made an important change to the American health care system when he signed the Affordable Care Act (ACA) into law on March 23, 2010. Before the ACA, exclusions based on previous conditions and unaffordability resulted high rates of uninsurance. Furthermore, some policyholders had to deal with incredibly high coverage limitations and out-of-pocket (OOP) expenses. While not all of these problems were resolved, the ACA attempted to address them (*United States*, n.d.).

The percentage of people without health insurance has decreased from 16 percent in 2010, the year before the Affordable Care Act became law, to 8.5 percent today. Under federal and state laws, public and commercial insurers determine their own benefit plans and cost-sharing arrangements. The Affordable Care Act. The Patient Protection and Affordable Care Act, or ACA,

became law in 2010, marking the biggest extension of the government's role in funding and regulating healthcare to that point. Components of the law's major coverage expansions, implemented in 2014, included forcing health insurance for the majority of Americans or applying a penalty. Also, allowing young people to stay on their parents' private insurance until they are 26 to enable them to extend their coverage. In addition to expanding the number of people eligible for Medicaid through federal subsidies. Finally, creating exchanges, or markets, for health insurance that provide lower- and middle-income citizens with premium subsidies (*United States*, n.d.). An estimated 20 million people obtained coverage as an outcome of the ACA, which reduced the percentage of persons aged 19 to 64 without insurance from 20% in 2010 to 12% in 2018 (*United States*, n.d.).

1.2.1 Objectives and Key Features

1.2.1.1 Objectives

The Act has several main objectives. In order to get near-universal coverage, the government, people, and businesses must share responsibilities. This is the first and most important goal. Improving the affordability, quality, and equity of health insurance coverage is the second goal. A third goal is to increase the efficiency, quality, and value of healthcare while cutting back on unnecessary expenditure and increasing the system's accountability to a wide range of patients. A fourth goal is to improve access to primary healthcare while implementing longer-term adjustments to primary and preventive care availability. The fifth and last goal is to strategically invest in the health of the general people by increasing clinical preventive care and making community initiatives (Rosenbaum, 2011).

1.2.1.1.1 Health insurance coverage reforms

The Affordable Care Act in the U.S. aims to make health insurance coverage a legal expectation for all citizens and those legally present. It establishes premium and cost-sharing subsidies, new rules for the health insurance industry, and a new market for purchasing health insurance. The act restructures Medicaid to expedite enrollment and provide coverage to all citizens and legal residents with household incomes below 133% of the federal poverty threshold. The act also encourages employers to undertake workplace wellness activities that promote and incentivize actual health outcomes. The act establishes state health insurance exchanges, regulates insurance and group health plan markets, and provides subsidies for coverage (Rosenbaum, 2011).

1.2.1.1.2 Improving health-care quality, efficiency, and accountability

Beyond insurance, the Affordable Care Act starts the process of reorganizing the health care system to accommodate long-term improvements in health care quality, health care practice organization and design, and health information transparency. A multi-payer national quality strategy is also funded by the Act. Its goal is to create multi-payer quality and efficiency metrics that encourage value buying, increased safety, and far more comprehensive health information across public and commercial insurers. Alongside these efforts to improve quality and information, the Act highlights efforts to gather data on health and healthcare disparities so that the country can more accurately assess progress. Additionally, the act creates the Institute for Comparative Clinical Effectiveness Research to support the kind of research necessary to determine the most appropriate and efficient means of providing healthcare for diverse patient populations. Despite spending almost $1 trillion between 2010 and 2019 to make coverage more affordable, the Act more than makes up for these costs by reducing Medicare and Medicaid spending, imposing new taxes on expensive plans, and eliminating tax shelters that are most frequently utilized by wealthy families. Furthermore, the act imposes new conduct and reporting requirements on hospitals as a condition of retaining their federal nonprofit status, which significantly changes the obligations and reporting

rules for nonprofit hospitals. This is especially significant for public health policy and practice (Rosenbaum, 2011).

1.2.1.1.3 Making primary health care more accessible to medically underserved populations

A shortage of primary healthcare providers and increased health risks have resulted in an estimated 60 million people being medically underserved. 36 The act invests in a significant expansion of the National Health Service Corps and community health centers to start to address this shortage more quickly before the health insurance coverage requirements are put into effect. The Act will invest $1.5 billion in the National Health Service Corps and $11 billion in health centers during the fiscal year (FY) 2011–2015 period. It makes it accessible for people with incomes between 139% and 400% of the federal poverty level (FPL) to apply for subsidies to buy qualified health plans (QHPs) in state marketplaces called health insurance exchanges, and it increases access to Medicaid for people with incomes up to 138% of the FPL based only on income. Nearly 50 million Americans, or roughly 19% of the elderly population, lacked health insurance when the law was passed in 2010. Of those uninsured, an estimated 91% had incomes below 400% FPL, making them potentially eligible for ACA benefits. (Rosenbaum, 2011)

1.2.1.2 Key Features

The act protects spouses of people with serious illnesses from poverty and provides new Medicaid options to support community-based care for those in need of long-term care. Additionally, it establishes the Community Living Assistance Services and Support Act, a voluntary long-term care insurance program (Best Insurance, 2024).

1.2.1.2.1 Individual Mandate

One of the main features of the Affordable Care Act was the individual mandate, which aimed to provide health insurance coverage or pay a penalty. The individual mandate seeks to enlarge the number of individuals with insurance so that the risk and cost of healthcare might be

divided more evenly among the population. Although the individual mandate was rescinded by the Tax Cuts and Jobs Act of 2017, its impact on increasing coverage endures to this day (Best Insurance, 2024).

1.2.1.2.2 Health Insurance Marketplaces

The ACT created health insurance marketplaces, also known as exchanges, where individuals and small companies may offer and compare health insurance policies. These marketplaces provide different options, including private plans with subsidies for low-income people and families. A centralized platform is provided by health insurance marketplaces in order to buy health insurance, enhancing competition and openness among insurers (Best Insurance, 2024).

1.2.1.2.3 Premium Tax Credits and Cost-Sharing Reductions

The ACA included cost-sharing reductions and premium tax credits to lower the cost of health insurance for people and families with low and moderate incomes. For qualified individuals and families, premium tax credits help reduce monthly insurance premiums, and for low-income individuals and families, cost-sharing reductions help lower out-of-pocket expenses like deductibles and co-payments (Best Insurance, 2024).

1.2.1.2.4 Medicaid Expansion

Through the expansion of Medicaid, the ACA expanded eligibility to include low-income persons in states opting to expand Medicaid. Prior to the ACA, Medicaid largely covered low-income children, pregnant women, elderly people, and people with disabilities. The Medicaid expansion brought coverage to millions of uninsured individuals with earnings of up to 138 % of the federal poverty level and helped close the coverage gap for low-income individuals in states that participated (Best Insurance, 2024).

1.2.1.2.5 Essential Health Benefits

Preventive care, emergency services, hospitalisations, prescription medications, maternity and newborn care, mental health and substance abuse treatment, and pediatric services are among the essential health benefits that must be covered by health insurance plans offered in the individual and small group markets under the Affordable Care Act. People are guaranteed access to comprehensive coverage that satisfies their healthcare demands thanks to these vital health benefits (Best Insurance, 2024).

1.2.1.2.6 Pre-Existing Condition Protections

Under the Affordable Care Act, insurers cannot reject clients due to existing medical conditions or charge them higher premiums. The provision prohibits health insurance companies from discriminating against applicants with existing medical conditions such as diabetes, asthma, or cancer. The protection for pre-existing medical conditions enables seriously ill individuals to obtain affordable insurance coverage. (Best Insurance, 20)

1.2.2 Implementation and Public Reaction

1.2.2.1 Implementation

The implementation of the Affordable Care Act marks an essential phase of American health reform history by translating legislative ambition into concrete reality. Although the policy promised expanded access, regulatory reform, and improved public health, its real-world rollout faced serious logistical, political, and administrative challenges. This section examines how the ACA was enacted over time, the key measures introduced during each phase, and the mechanisms at the federal and state levels that shaped its effectiveness and reception.

Table 1.1 Aca Evolution Through Time *Adapted from (Rosenbaum, 2011)*

year	Key Provisions and Reforms
2010	-ACA signed on March 23, 2010. - Health insurance comparison platforms (from July 1).

	- Ban on denial of coverage to children under 19 with pre-existing conditions (from Sept 23). - Consumer appeal rights on insurance decisions. - Grants to states for Consumer Assistance Programs (October). - Tax credits for small businesses to provide coverage. - $250 rebate for seniors in the Medicare "donut hole." - $15 billion Prevention and Public Health Fund. - Pre-Existing Condition Insurance Plan (July 1). - Young adults can stay on parents' plan until age 26. - Financial support for early retirees and investment in the primary care workforce (loans/scholarships). - Expanded Medicaid eligibility (retroactive to April 1). - Rural provider payments increased and enhanced community health center funding.
2011	50% discount on brand-name drugs under Medicare Part D. - Medicare & Medicaid Innovation Center launched. - Community Care Transitions Program introduced. - Independent Payment Advisory Board created. - Community First Choice Option for Medicaid home care. - Insurers must spend 80–85% of premiums on care or give rebates. - Reduced overpayments for Medicare Advantage with bonuses for select plans.
2012	The Medicare Hospital Value-Based Purchasing program started (October 1st). - Public reporting on performance measures (October 1st). - Accountable Care Organizations (ACOs) effective (January 1st).

	- Standardized billing and electronic records regulations (October 1st) - Data collection on race, ethnicity, and language for reducing disparities (March). - CLASS long-term care program introduced but later abandoned.
2013	Funding for preventive services in state Medicaid programs (January 1st). - National bundled payment pilot program (January 1st). - Medicaid payments for primary care raised to Medicare levels (January 1st) - Health Insurance Marketplace open enrollment (October 1st)
2014	No denial of coverage or higher premiums based on pre-existing conditions, gender, or health status (January 1st). - Annual limits on coverage eliminated. - Insurance protection for clinical trial participants. - Tax credits for low-/middle-income individuals/families. - More tax credits for small businesses. - Medicaid expansion to under 133% of the poverty level (3 years of full federal funding). - Individual mandate begins (must have insurance or pay a penalty)
2015	Physician payments based on quality, not volume (January 1st) - No enforcement action on stand-alone retiree-only private plans (HHS policy)

1.2.1.3 Public Reaction

As shown in table 1, it illustrates the changing public opinion on the Affordable Care Act (ACA), also known as Obamacare, from 2010 to 2019, based on research published in *Health Affairs* and conducted by the Kaiser Family Foundation. (Inserro, 2020)

In April 2010, 46% of respondents had a good impression of the legislation, while 40% had a negative opinion. In 2013, public sentiment declined due to technical issues with the HealthCare.gov website. Between October 2013 and October 2016, the average positive opinion was 39.3%, and the unfavorable opinion was 45.4%. Since November 2016, 49.4% of the population has had a favorable opinion of the law, while 41.6% have had a negative opinion. In November 2019, 52% of respondents had a positive opinion, compared to 41% who had a negative opinion (Inserro, 2020) .

Chart 2 illustrates how perceptions of the law's personal impact changed: Between 2016 and 2019, the share of people who felt that the ACA helped them rose from 18% to 23%. The share who felt it harmed them dropped from 29% to 23%. From June 2016 to September 2019, those who said the law benefited their family increased by 5 percentage points, while those who said it harmed them dropped by 6 points (Inserro, 2020) .

Finally, the 3rd chart represents the partisan gap in ACA favorability: In 2010, there was a 55.7 %-point gap. In 2013, the gap dropped to 48.9 points. In the last year, the gap increased to 64.1 points. (Inserro, 2020)

This indicates increasing favorability among Democrats, while Republicans' views remained largely unchanged.

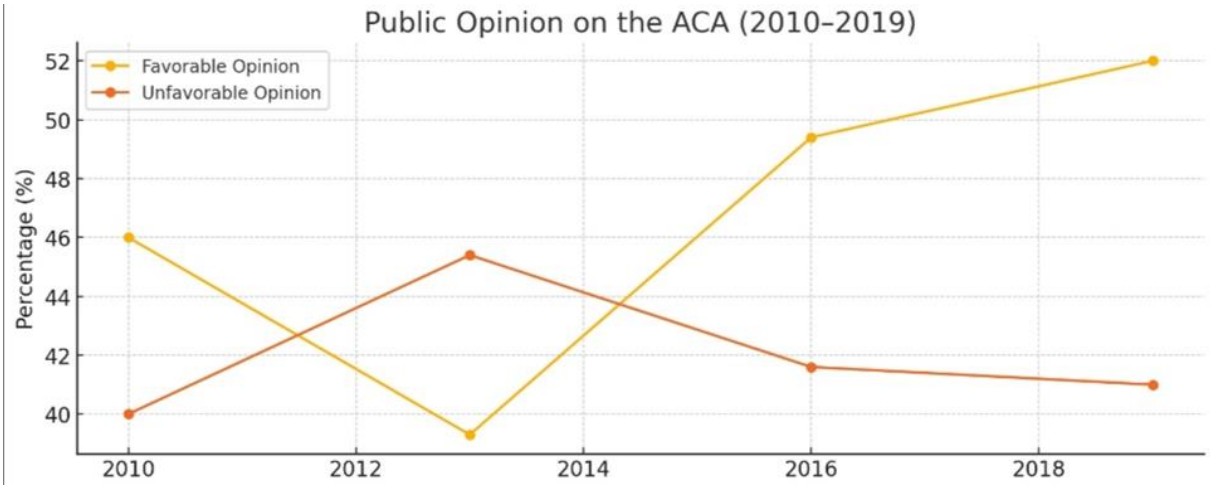


Figure 1. 2Public Opinion on the ***ACA (2010-2019)***

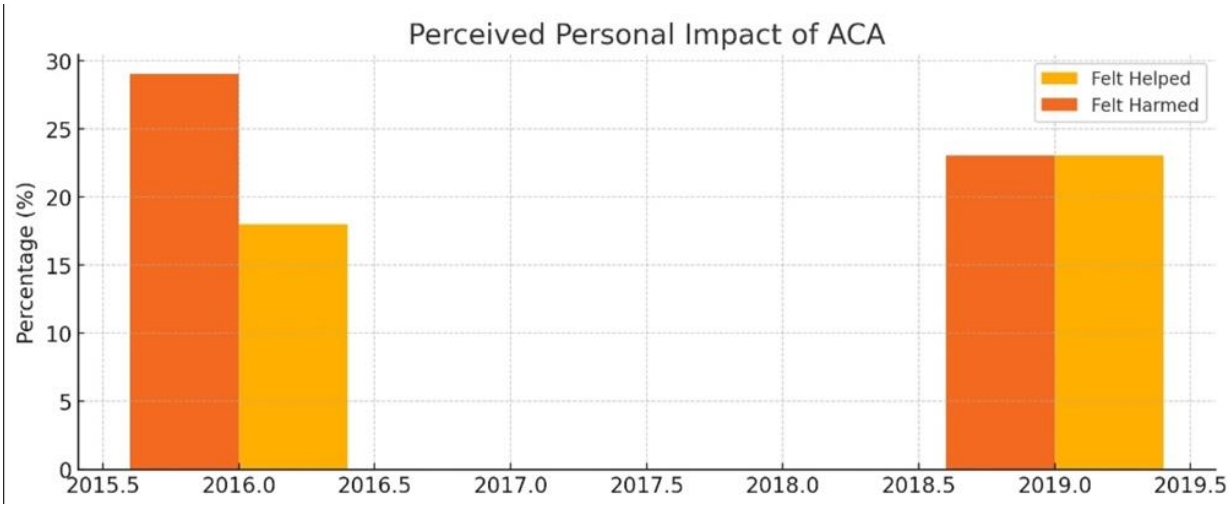


Figure 1. 3Perceived Personal Impact of ACA

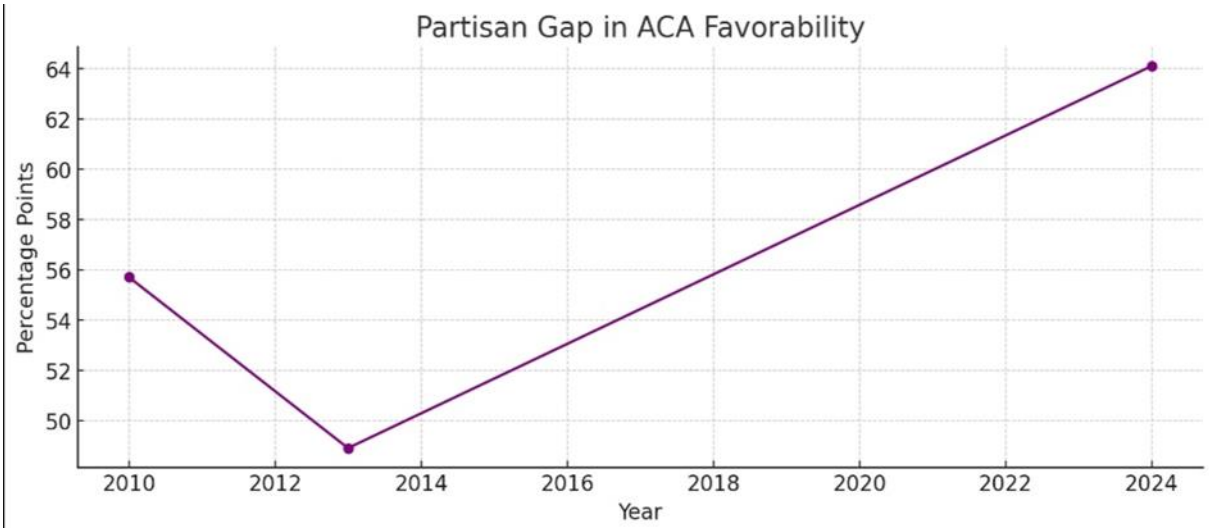


Figure 1. 4Partisan Gap in ACA Favorability

1.2.2 Challenges and Criticism of Obamacare

Through major obstacles making their way across the program's life span and all through its implementation period, an array of critiques from lawmakers, stakeholders, and the public arise. Some of these major obstacles faced during its rollout and immediately thereafter are to be talked about here. The period of instant debate has also begun, whereby economic impacts continue to come under scrutiny as some states stay unsupportive of the law on ideological

grounds. The opposition from within political circles posed, on one hand, great difficulties to the implementation of the ACA; on the other hand, other difficulties arising within the peculiar system of state-level governance have further challenged this implementation.

1.2.2.1 Challenges

The Affordable Care Act is a federal law; however, its implementation varies from state to state. While some states choose to expand, others have declined, establishing a disparity for access. It is still politically divisive, and many lawmakers resist its implementation, arguing that the federal government should not be meddling in health coverage. Some states, like Missouri, even go as far as completely banning local officials from assisting with any rollout. Overhauling the healthcare industry is complex enough, and these variations from state to state add on another level of difficulty. A big challenge is the establishment of the online exchanges wherein consumers can offer insurance, with different states ranging in cooperation levels.

One of the healthcare analysts' big frustrations is the refusal of many states to expand Medicaid, even though the federal government will cover the initial costs. As economist Christine Eibner warns, this could leave millions of low-income people 'completely left in the dust.' The economics also come into play, with some lawmakers being fearful that when the federal subsidy for Medicaid drops from 100% to 90%, their states won't be able to stand the costs. Additionally, many people still do not understand the law itself or what it entails for their benefit. Further, there is uncertainty about the new plans' premiums since costs will vary according to the state, town, and age group. Analysts raise concerns about a doctor shortage because of an influx of insured patients seeking care.

The Obama administration wants the first year to enroll 7 million people, yet if small numbers are accepted or if there is a major disaster, that will trigger a political response that will check future improvements to the law. Starting on October 1st, the exchanges became available, but officials warn that a simple error may be expected that would further burden (Rice et al., 2014).

1.2.2.2 Criticism

In spite of its intentions to make healthcare more accessible and affordable, the Affordable Care Act (ACA) has been under considerable criticism for its efficacy and economic effect. One of the substantial issues is the rise in spending on healthcare for numerous Americans. As per 2017 research in Pain Physician, though the ACA might have lessened a few costs, huge groups of people witnessed higher premiums, deductibles, and out-of-pocket expenses. For example, out-of-pocket maximums increased significantly from 2014 to 2017, and premiums for employees increased by 20% from 2011 to 2016, in front of inflation and wage increases. (Pain Physician, 2017).

Further criticism is leveled at the affordability and sustainability of the ACA marketplaces. A study published in JAMA in 2016 highlights that though more Americans were insured, it has yet to be demonstrated that the quality of care is enhanced and that the insurance exchanges have struggled with affordability and stability. The majority of new enrollees are on Medicaid and not the exchanges, and the exchanges are struggling with insurer losses and requested government bailouts. Moreover, consolidation of the markets by both hospitals and insurance companies has reduced competition that may undermine cost control efforts. (JAMA, 2016).

Moreover, the House Education and Workforce Committee issued a report in 2022 that outlined dozens of failures of the ACA, such as increased reliance on federal government programs and improper Medicaid sign-ups costing billions in improper payments. It also argues that employer-sponsored plans remain the best value for taxpayers compared to those government-run plans under the ACA. Critics also contend that the mandates and spending of the ACA have raised the price of healthcare and pushed Americans into higher-deductible policies with narrower networks. (House Education and Workforce Committee, 2022). while the ACA expanded coverage, these academic criticisms indicate ongoing issues with rising costs, market volatility, and doubts about the law's long-term sustainability and impact on healthcare quality.

1.3 Harris' Healthcare Policy Proposals.

1.3.1 Medicare for All vs. Public Option

Medicare is a government health insurance program mainly for people 65 and older and some younger people with chronic conditions. supplemented with private insurance for extra coverage. If the Medicare for All Act is enacted, the U.S. would switch to a single-payer healthcare system, where the federal government provides health insurance to everyone in the U.S. It would include coverage for all medical care and would remove fees, co-payment, and deductible. Private insurers could only sell insurance for non-essential medical care. However, it requires greater taxes and may lead to longer wait times as demand increases for such an accessible system. Plus, some people like private insurance, and eliminating it would curtail flexibility and choice. On the other hand, The Public Option is a government-funded healthcare plan that presents itself as a replacement for private insurance. Unlike Medicare for All, it is not required; individuals can select between public and private plans. Much work and debate still require consideration of how this program might be funded, whether through taxes, our paychecks, or by individuals as they apply. Similar to Medicare for All, its goal is to provide affordable healthcare, but unlike Sanders's plan, it would work in conjunction with private insurance, allowing the option of keeping their current coverage. In short, Medicare for All would make government-sponsored health care universal and abolish private insurance, while the Public Option introduces a government option but provides space for private insurance. Both systems emphasize affordable, accessible healthcare, yet they diverge in structure, funding, and effect on private insurance. (Nall, 2024)

1.3.2 Political Shifts and Challenges

Harris first supported the Medicare for All plan by Bernie Sanders during her 2020 presidential campaign. It was designed to replace private insurance with a single-payer system. She criticized the profit-driven nature of private insurance and the barriers it created for citizens,

emphasizing that healthcare should be a right rather than a privilege. "We need to have Medicare for all," then Sen. Kamala Harris said. "The idea is everyone gets access to medical care." "We have to appreciate and understand that access to health care should not be thought of to be a privilege," Harris said, then added, "it should be understood to be a right." However, she later modified her position to include a role for private insurers under strict regulations, similar to Medicare Advantage, and proposed a 10-year transition period. Harris made an important shift in her own position on Medicare for All in response to pressure and criticism from labor leaders urging her to retain employer-sponsored benefits for healthcare. She eventually withdrew her support for the original full Medicare for All proposal in favor of aligning with President Biden's efforts to strengthen the Affordable Care Act (ACA).

While Vice President Harris championed incremental advances, such as increasing benefits under the Medicare program and reducing the cost of prescription drugs, instead of a full-blown single-payer system, her modified version of Medicare for All was not a standalone public option but incorporated some of its features, including a public option, as it allowed private insurers to sell Medicare-structured plans under strict regulatory oversight. Her shift made her face some challenges that were further exacerbated by the media, which cast doubt on her seriousness regarding health care reform and framed her policy shift as indecisiveness within the familiar narrative of political flip-flopping. That picture was part of a broader story about her political vacillations, which caused the public to lose faith in her policy program. The implementation of comprehensive healthcare reform was ultimately hampered by strong opposition from both industry representatives and political rivals. (Collins, 2024; Krieg & Luhby, 2024)

1.3.3 Harris' Position on Healthcare Compared to Obama

About healthcare, Kamala Harris' position has changed significantly, striking a balance between practical measures and progressive principles. She initially supported Bernie Sanders's "Medicare for All" bill, which would have replaced private insurance with a single-payer system,

even more extreme than Barack Obama's Affordable Care Act (ACA), " More than 30 million people have health insurance coverage because of the Affordable Care Act, they called it Obamacare also, 30 million people. More people today are covered through the Affordable Care Act than ever before, and President Joe Biden and I, are purposely and intentionally building on its success to further bring down healthcare costs" Harris said. (PBS NewsHour, 2021). The ACA expanded coverage by expanding Medicaid and the private insurance marketplaces, all while still maintaining a mostly private insurance-based system. Harris's initial support for Medicare for All would have barred private insurance altogether, though she later settled for regulated private plans. As vice president, Harris has continued the incremental approach initiated by President Biden, which includes direct benefits granted under the Affordable Care Act (ACA) through caps on the cost of insulin, expansion of Medicaid postpartum coverage, and a challenge to allow price negotiations for prescribed medicines provided under Medicare. This indicates both awareness of the need to make access wider and an intention to pursue that through the system we have by expanding upon the achievements of the ACA, as Obama did in his push to expand access without tearing down the existing system. (Health Care That Works for Americans, n.d.; Kekatos, 2024)

Conclusion

Since Chapter One has traced the evolution of the U.S. healthcare system and its attendant structural complexities and pricing disparities, it has established that government has the central role of appointing and legislating on care. Even though it has been the costliest healthcare system in the world, it continues to offer uneven outcomes because of lack of coordination, fragmentation, and inequities. The chapter discussed major historical developments leading awry into the ACA, whose enactment situates Barack Obama's healthcare reform as one among a chain of failed attempts at systemic change. The ACA was a watershed change in federal involvement, which now extended coverage on a broad scale and contained protections of vital importance, though it had its own set of problems and controversies. The chapter further discussed Kamala Harris's healthcare platform with focus on her initial support for Medicare for All and later shift toward a

softened public option. Her policy trajectory reflects wider conflicts within the Democratic Party between incrementalism and structural change. Her proposals reinforce the ACA while signaling movement toward a more just and workable healthcare system, even if limited on account of the political environment.

Ultimately, the comparison between Obama's and Harris's visions of healthcare highlights not only the diverging strategies for reform but also the gradual transformations of healthcare into a crucial issue in American political discourse. This would lead us on to the next chapter, examining how both figures rhetorically cast healthcare as a moral, political, and economic necessity.

CHAPTER TWO

Rhetorical and Discourse Analysis of Obama and Harris

Chapter Two: The Obama and Harris Healthcare Policies

1 Introduction

Scholars have long been drawn to the analysis of political speeches, particularly those addressing strategies of persuasion used by politicians. While extensive work exists on Barack Obama's rhetoric, particularly regarding the Affordable Care Act (ACA), little exploration of Kamala Harris's healthcare rhetoric has occurred, thus leaving open questions regarding how hers differs or resembles the strategy employed by him. On these premises, an empirical study is conducted in the current chapter through examining the ways each of them employed persuasive language in their diverse healthcare proposals, particularly the ACA and Medicare for All. Using Aristotle's framework of ethos, pathos and logos, it investigates how their distinct rhetorical methods shape public perception and debate around healthcare reform in the United States.

1.2 Methodology and Methods

This study used a qualitative, comparative rhetorical analysis to assess Barack Obama and Kamala Harris' healthcare policy rhetoric. The qualitative method was particularly suited for the objectives of this study because it allowed for an interpretive, in-depth examination of political rhetorical techniques of persuasion, a methodology better suited to rhetorical and discourse analysis than to numerical or statistical analysis. It is not just what is said, but how it is said, and why it affects people. The data set included seven main sources: four from Kamala Harris and three from Barack Obama. Kamala Harris's materials included the Maternal Health Day of Action Speech (December 7, 2021), the Affordable Care Act Speech (August 10, 2024), the "Our America" Campaign Launch Speech (January 28, 2019), and the Medicare for All Policy Proposal (published on Medium). Barack Obama's selected speeches were the Address to Congress on Health Care Reform (September 9, 2009), the Speech on Health Care Reform (March 15, 2010), and the Remarks on the Affordable Care Act (October 20, 2016).

All texts were obtained from official sources, including government websites and publicly available transcript databases like Rev.com and Medium.com. To ensure accuracy and

authenticity, each transcript was cross-checked against any audio or video recordings. The collection process included obtaining complete transcripts of each speech and policy document. These items were chosen because they are thematically relevant to healthcare reform and were written by either Obama or Harris during or in connection with their electoral campaigns. Audio recordings were also examined to determine vocal tone, emphasis, and delivery style. The texts were not edited, abridged, or reformatted; rather, they were evaluated in their entirety to preserve rhetorical context. During the initial readings, notes were taken by hand, with keywords and persuasive methods highlighted for subsequent research.

The analysis followed Aristotle's rhetorical appeals, ethos (credibility), pathos (emotion), and logos (logic), to evaluate persuasive strategies. Each speech and document were closely read to identify statements that built personal or political credibility (ethos), emotional appeals directed at the audience (pathos), and logical arguments, data usage, and policy reasoning (logos). In addition, the tone of each speech was assessed by listening to the delivery. Elements such as pitch, tempo, and vocal modulation were used to infer the speaker's intended emotional register (e.g., urgency, compassion, assertiveness). While repeated words and phrases were noted (e.g., "access," "care," "justice"), no formal frequency analysis was performed. Comparative interpretations were drawn by contrasting Harris's and Obama's use of rhetorical techniques, their framing of healthcare issues, and the emotional and logical dimensions of their appeals. The emphasis remained on thematic depth and narrative structure rather than quantifiable data.

1.2.1 Methods

This study applies Aristotle's rhetorical triangle, ethos, pathos, and logos, as its core analytical framework, as previously outlined in the methodology section. This framework was selected because it provides a systematic way to examine how politicians build credibility, appeal to emotions, and use logical arguments to persuade voters. Aristotle defines rhetoric as an art, a technique, for determining how to persuade in any particular instance, whether in ceremonial,

legal, or political contexts. He further explains that there are three core methods of persuading someone: ethos, pathos, and logos; the moral, emotional, and logical arguments that collectively serve as the basis of rhetorical theory. (Rhetoric I.2, 1356a2-18). The following table summarizes the three modes of persuasion and their rhetorical functions in the context of political speech:

Table 2. 1Rhetorical Features in Obama's and Harris's Healthcare Speeches

Mode	**Definition**	**Key features**	**Ethical dimension**	**Political Examples**
Ethos	The moral character and credibility perceived of the speaker.	Use of language, tone, and behavior to present trustworthiness, competence, and moral uprightness.	Must be authentic and grounded in genuine integrity, not merely reputation; ethical when honestly established.	Politicians emphasizing experience, moral values, and concern for public welfare to build legitimacy.
Pathos	Appeal to the audience's emotions (pride, fear, hope, compassion) to influence judgment.	Evocative language, repetition, imagery, storytelling, references to shared identity or national events.	Valid when used with moral intent to motivate ethically; unethical if manipulative or fear-mongering.	Highlighting national tragedies or victories to evoke unity, urgency, or hope.
Logos	Logical appeal using well-structured arguments, evidence, and causal reasoning	Presentation of data, statistics, concrete examples, policy plans, and legal reasoning.	Must be based on sound logic and truthful evidence; misleading or fallacious arguments are unethical.	Citing health or economic statistics, structured policy proposals, or cause-effect analyses in political discourse

1.3 Obama's Rhetoric on Healthcare Analysis

Table 2.***2 Obama's Rhetoric on Healthcare Analysis***

Speech	**Mode**	**Extract**	**Analysis and Meaning**
Address to Congress on Health Care	Ethos	"I am not the first president to take up this cause, but I am	links his leadership to a historical legacy, aligning his crusade with Theodore Roosevelt and demonstrating a moral commitment. He

Reform (Sep 9, 2009)		determined to be the last."	frames the ACA as a historic and final push for justice.
		" I want to thank the members of this body for your efforts… and particularly those who have taken the tough votes…"	Obama is highlighted as a leader who values bipartisan cooperation and legislative bravery. He shows appreciation and positions himself as inclusive and respectful to others.
	Pathos	"We are the only advanced democracy on Earth... that allows such hardships for millions of its people."	Obama emphasizes the shared responsibility and national character of America, urging Americans to view reform as a moral imperative, not just a policy question. Urges Americans to consider reform as a matter of national decency and identity.
		"Now is the season for action. Now is when we must bring the best ideas of both parties together."	An urgent tone backed by repetition encourages unity and immediate response. He calls the nation to collective moral and political responsibility.
	Logos	"There are now more than thirty million American citizens who cannot get coverage."	Uses real data to highlight the extent of the problem. He Establishes a quantitative basis for action and uses logical argument that delay harms thousands.
		" Every day, 14,000 Americans lose their coverage."	
Health Care Reform (Mar 15, 2010)	Ethos	"This proposal is paid for. It's not my numbers; that's what the nonpartisan Congressional Budget Office finds."	Obama uses fiscal responsibility as a persuasive argument, citing the nonpartisan Congressional Budget Office to demonstrate its impartiality. He reinforces his image as a fact-driven, trustworthy leader.
		" This is the kind of woman we need to be helping."	Refers to Natoma's personal story to link policy with real-life results and show his concern for ordinary Americans. He Enhances moral credibility and builds emotional trust with the audience.
	Pathos	"What's at stake in this debate... is our ability to solve any problem."	Moves beyond health care to portray the debate as a test of national will and capacity. He inspires a sense of unity and responsibility in addressing broader democratic challenges.
		"We need courage."	A brief but powerful emotional appeal, calling for bravery in a moment of political risk. He

			encourages Americans to be brave and do the right thing.
	Logos	"Bring down our deficit by up to a trillion dollars over the next two decades."	The empirical rationale effectively counters emotionally driven criticisms by demonstrating that proposed reforms are not only morally necessary but also economically viable. Positions reform as fiscally responsible and forward-looking.
Remarks on the Affordable Care Act (Oct 20, 2016)	Ethos	"Instead of repealing the law, I think the next President and the next Congress should take what we've learned… "	Obama presents himself as a rational, experienced leader who believes in evolving policy based on experience. Reinforces credibility by portraying reform as a continuous, data-informed process.
	Pathos	"20 million people out there will testify. "	He highlights the real, human impact of the ACA, appealing to shared experiences. He evokes empathy and gives voice to those positively affected.
	Logos	"No major social innovation in America has ever worked perfectly at the start."	He uses historical comparison to defend the ACA's flaw. He Suggests that reforms, like Social Security or Medicare, naturally evolve. He shows the lack of credible alternatives from opponents. He represents ACA as the only viable option in the debate.
		"They criticize, but they don't have a plan."	

1.2.1 Media and Public Responses to Harris' Rhetoric

The argument concerning health care reform in the United States has persistently evoked high passion and deep controversy. In 2009, President Obama delivered a historic address championing the correction of the health care system in the country. He called for changes to increase the affordability, availability, and general quality of health care for everyone. The address not only sparked policy debates but also elicited emotional reactions from lawmakers, experts, and the public. The criticism provided in this paper analyzes the speech's rhetorical strategies employed by Obama in that speech and the wide variety of reactions it evoked, demonstrating the complex and personalized nature of the health care issue.

Families throughout America are depending on Congress to make changes to our dysfunctional healthcare system this year. Furthermore, there is no denying the urgency of their

reform. Patients, healthcare professionals, and caregivers alike agree that the current state of affairs is untenable and unsustainable. You and millions of individuals across the country are among the thousands of National Partnership supporters who have spoken out because they understand that we need serious reform to make high-quality, affordable care a reality (Velazquez, 2024).

In order to ensure that everyone, regardless of age, gender, or pre-existing conditions, can rely on their health care benefits when they need them most, the President called for urgently needed reforms to the insurance market. In order to finally provide complete, coordinated, and high-quality healthcare, he also realized that our current system needed to be changed from a pay-for-volume to a pay-for-value model. In order to finally have stability and security about their own and their loved ones' health, the public is looking on Congress to adopt a health insurance reform plan this year (Velazquez, 2024).

Now is the time to answer the President's call by putting politics aside and working toward a goal we all share, healthy futures for America's families. We are also closer than ever to reform that lowers costs, guarantees coverage, and gives all Americans more choice, despite a vocal minority that is determined to play politics with health care. These what Debra L. Ness wrote in Blog site (Velazquez, 2024). Brendan Nyhan examines on his blog whether Obama's 2009 major health care address changed public perceptions. He concluded that there was a small bounce in support for health care reform after the speech, but part of the effect dissipated. Meanwhile, estimated opposition to reform, which dipped in the wake of the speech, quickly rebounded toward previous levels and is now greater than it was before the speech (Marx, 2009).

Given that presidential speeches rarely have a significant impact on people's perceptions of a topic, this is not surprising. Although some of the reporting and commentary at the time did recognize the limitations of public appeals, Nyhan's statement that "there's a misperception among journalists that the president can easily move public opinion" is a bit overbroad. Nevertheless, it serves as a helpful counterpoint to the widespread tendency to treat political theater as significant news events (Marx, 2009).

Some of the nation's top health care policy experts were asked to react by the ABC News Medical Unit after President Obama's speech on health care reform. Many of them gave their opinions in response, and although over half of them agreed with the speech's principles, many others had at least some doubts (ABC News, 2009).

"No one could hear President Obama's speech and fail to be convinced by the urgency of action on health reform," said Karen Davis, president of the Commonwealth Fund and a nationally recognized economist with a distinguished career in public policy and research. "He painted the need for reform in both human and economic terms…and made it clear that failure is not an option.". Dr. Henry Black, a clinical professor of internal medicine at New York University, commented that he was "particularly pleased that some sort of public option was included." Black said he was "very impressed with the tone, firmness, and especially the way he systematically dealt with all the accusations that have been leveled at him and the need for reform.". "He portrayed himself as a centrist who differs from those on the left and right.... His position on the public plan sowed the seeds of compromise. He explained the position for it but clearly indicated that he will compromise," Robert Field, a professor of health management and policy at Drexel University in Philadelphia, said of Obama, who "added his passion to balance the passion on the other side." Timothy Jost, a law professor at Washington & Lee University, remarked, "I thought it was a great speech... all in all, a wonderful performance." (ABC News, 2009).

Although the majority expressed positive opinions, some harsh criticism was also expressed. The worldwide health education nonprofit Project Hope's Gail Wilensky, a senior fellow, stated Obama's speech was "moving and emotional at the end but... would have been more powerful if there had been more of that and less of some of the earlier discussion.". Wilensky also discussed her views on the cost of health care. "I strongly support the need to slow spending on Medicare as well as the rest of health care spending but doing it by reforming the delivery system will take time and be uncertain in its path," she stated. "The sure way to get money out of Medicare

is by whacking prices, and this doesn't go after inefficiency and reimbursement." (ABC News, 2009).

President Obama's 2009 healthcare speech was a powerful moment in the decades-long battle for reform, generating enthusiasm and skepticism both. While others praised his summons to comprehensive and inclusive change, some questioned the feasibility and effectiveness of his recommendations. The opposed public and expert reaction underscore the challenge of coming to agreement on something so intimate and political. Ultimately, the speech demonstrated the virtue of good communication, policy compromise, and relentless effort to initiate meaningful health care reform.

1.3 Harris' Rhetoric on Healthcare Analysis

Table 2.3 Harris' Rhetoric on Healthcare Analysis

Speech	**Mode**	**Extract**	**Analysis and Meaning**
Our America Campaign Launch (2019)	Ethos	"I am so proud to be a daughter of Oakland." "Donald, my father, is from Jamaica. Shyamala, my mother, is from India."	shares her background and family history in her campaign launch speech, demonstrating her identity as a proud daughter of Oakland. This private disclosure highlights her understanding of the American immigrant experience and her humanity, presenting her as an embodiment of the American Dream and a political leader.
		"My whole life, I've only had one client: the people."	Here, Harris prioritises the public service, which contributes to strengthening her reputation as a public leader.
	Pathos	"As children growing up here in the East Bay, we were raised by a community with a deep belief in the promise of our country"	Harris uses personal and shared memories, highlighting community support during her childhood, emphasising solidarity, caring, empathy, and connection in difficult times.
		"During the healthcare fight, I saw parents and children with grave illnesses walk the halls"	By talking about others' suffering and mentioning real faces, Harris makes the audience also feel it for themselves.
	Logos	"$20 billion for CA homeowners"	Using Data and statistics makes Harris' logical arguments stronger. Also highlighting the gender and racial pay gaps, which supports her demands for equality.
		"Women are paid 80 cents on the dollar. Black women, 63 cents. Latinas, 53 cents."	
Maternal Health Day of Action (2021)	Ethos	"When I was Attorney General of California, I established the Bureau of Children's Justice to prioritise the needs of our children and their parents and to mitigate against adverse childhood experiences."	She emphasizes maternal health as part of her long career, mentioning her achievements to show her deep care for the people.
		"As a United States senator, I crafted one of the first bills in the history of the United States Senate to target racial disparities in maternal mortality and to take on the challenge of dealing with	The specificity of "one of the first bills" highlights her leading work in a field that legislators frequently ignore, presenting her as both a proactive change agent and a person with empathy. Harris uses her past

		implicit bias in our healthcare delivery system."	actions to win audience trust, showing her commitment to morals and equality.
	Pathos	"Women in our nation are dying, before, during, and after childbirth, and women in our nation are dying at a higher rate than any other developed nation in our world."	The repetition of " women in our nation are dying" and discussing death and childbirth in the same context, along with racial disparities, evokes an immersive emotional response. Starting with "when we know" and closing with "we should do something about that," the structure of this phrase forms a rhythmic ethical imperative. It is about developing ethical urgency, not only raising awareness,
	Logos	"When we know that, today, Black women are three times as likely to die from pregnancy-related complications, we should do something about that."	
		"One estimate suggests that the direct and indirect cost of poor maternal healthcare could total more than $30 billion in a single year"	Concrete solutions like birthing-friendly hospitals, extended Medicaid coverage, and a $30B cost estimate provide logical rationale.
		"Our law will require state Medicaid and CHIP programs to provide a full year of coverage after a woman has given birth."	Harris demonstrates that she is putting into action actual changes designed to produce tangible results rather than just advocating for vague improvements
Affordable Care Act Speech (2021)	Ethos	"President Joe Biden and I are purposely and intentionally building on its success to further bring down healthcare costs."	Harris aligns herself with the leadership of Biden's administration, to express control and credibility.

In addition, Harris's tone was mostly empathetic, showing care. She shows that she experiences the same suffering as the rest of the Americans, emphasizing moral clarity and the importance of equity, claiming that this is just not right. Harris's tone was full of hope, making her

supporters see her as the ultimate savior. After sensing a danger that she is losing this, her tone shifts to a harsher, criticizing tone for her opponent, Trump, which shows her defensiveness. For the stylistic tools, Harris used imagery to evoke emotionally charged scenes, such as the hospital scene. Through moral assertion, she shows that what she believes in is ethically correct. When she says healthcare is a right, not a privilege, she is saying this is a core value and a moral truth that everyone should agree on. Harris also used direct address to build a connection with the audience and make them feel personally involved, like when she said, "We are all in this", "you shouldn't have the right to fight to get care". Through her careful use of ethos, pathos, and logos, along with her special tone and use of stylistic tools, Kamala Harris tries to persuade the people and by connecting her experience, emotions, and facts, she creates a powerful call to action that is hard to ignore.

1.3.1 Media and Public Responses to Harris' Rhetoric

Kamala Harris' healthcare rhetoric has received mixed reactions in the media, with both positive and negative framings depending on the outlet's focus and audience. While mainstream media often focused on her policy shifts and inconsistencies, Black media platforms highlighted her identity, values, and cultural representation.

1.3.1.1 Negative Framing in Mainstream Media

Some mainstream media sources introduced Harris's plan for Medicare for All as being unclear or inconsistent. For example, ***The New York Times*** said that Harris's hesitation on private insurance generated "confusion" among voters and made it harder for her to earn trust (Astor, 2019). ***Vox*** also claimed that Harris' healthcare message gave the impression that she was "trying to please everybody," hence calling into question her actual stance (Scott, 2019). Her rhetorical strategy in such speeches had been described as one of strategic ambiguity, especially as she moved from advocating for full Medicare for All to a public-option hybrid program. Mainstream opinion pieces also questioned whether Harris's healthcare rhetoric was genuine. ***Politico*** noted

that her campaign struggled to maintain a “clear and consistent message” on healthcare (Caputo, 2019). These media portrayals tended to focus more on political strategy than moral intent, framing Harris as a candidate adjusting her speech to suit polling rather than convictions.

1.3.1.2 Positive Framing in Black Media

Although certain media sources framed Harris unfavorably, others presented her in a more positive light, offering a more balanced view. ***The Black*** media presented rhetorics of Harris in a more sympathetic and affirming manner, particularly regarding identity and community association. In an open letter published by ***Essence*** magazine, Harris stated, “I was raised by a mother who taught me to never be silent in the face of injustice” (Harris, 2020). Her personal stories helped in building a connection between the people and her policy initiatives, including healthcare, based on their values and background. An ***Essence*** article titled "Kamala Harris' Rise and Black Voters' Power Shift," portrayed Harris as not just a candidate but also as a symbol of advancement. This demonstrates her efforts to address community-specific health issues, such as Black maternal mortality and healthcare access, claiming that her campaign was defined by "the intersections of race, gender, and healthcare justice." (Essence Staff, 2024).

In like manner, in a National Association of Black Journalists (NABJ) event on ***PBS NewsHour***, Harris spoke racially to health disparities directly, declaring, "Black women are three times more likely to die from pregnancy-related causes. This is a crisis" (PBS NewsHour, 2020). Her statements were framed as honest, urgent, and justice-seeking. In addition, ***The Atlantic*** noted her use of Black media as a strategic but respectful gesture. The publication in ***Essence***, the article noted, enabled Harris to gain the confidence of Black women and present her healthcare ideas to a community that values cultural identity and stories of community (The Atlantic, 2019). The media’s reaction to Harris’s healthcare rhetoric depends heavily on the platform. While mainstream media often criticized her for shifting positions and lacking clarity, Black media tended to focus on her personal connection, moral framing, and representation of marginalized

voices. This contrast shows how political rhetoric is not just judged by content, but also by audience, context, and platform

People on social media especially on X went crazy over how Kamal changed her plan and how illogical some of her plans were. Concerning the 10-year phase-in, a lot of people were very skeptical of it. They contended that if the changeover took so long, Republicans may sabotage or overturn the plan before it could be properly implemented. Some said it was more of a stalling strategy than a sincere attempt to provide universal healthcare, such as "10 years? Have you met the Republicans? They'll have shredded it by the time it attempts to get halfway." And someone else said "10 year transition period? Just long enough to give lip service for two terms and not actually do anything." Also, some complained that Harris's plan would continue to support private insurance companies, instead of eliminating them as she promised in her Medicare for All proposals. Critics accused her of protecting the interests of for-profit insurers and undermining the spirit of true single-payer healthcare, like "Your plan is for taxpayers to fully subsidize multi-billion-dollar private health insurance companies, forever?".

She also was criticized in a number of tweets of appropriating the "Medicare for All" slogan without fulfilling its promises. The label "Medicare for All" alone, according to users, did not equate to the more comprehensive plans put forth by Bernie Sanders or Pramila Jayapal, like "Calling it Medicare For All doesn’t make it so, Kamala. Not only do we vote, turns out we can read too.". Economists who claimed that a longer transition would make universal healthcare more challenging, costly, and ultimately weaker were mentioned by some users. There were concerns that Harris's proposal would weaken the case for an effective, all-encompassing system, such as "Economists have concluded a longer transition would be more difficult, more expensive, and lead to a weaker UHC." There was widespread sarcasm and downright mistrust. Harris' promises were contrasted by some to other unfulfilled political claims, like "If you like your

doctor, you can keep them." Others merely rejected her strategy as being ineffective or dishonest, such as "I don't trust you and your plan is useless."

The public reaction on Twitter to Kamala Harris's healthcare plan was almost all negative, full of disappointment and criticism. Their concerns were focused on the long transition period, the idea that her proposal catered to private insurers, and the belief that her plan did not live up to the promise of true Medicare for All. Many users expressed a clear preference for more progressive alternatives and doubted Harris's commitment to comprehensive healthcare reform.

1.4 Results

The analysis revealed some similarities and significant differences in how Barack Obama and Kamala Harris communicate their healthcare policies. These differences appear in the tone of their speeches, the persuasive strategies they use, and how they connect with their audiences. The findings are summarized in the table below.

Table 2.4 Rhetorical Strategies and Appeals in the Healthcare Discourse of Barack Obama and Kamala Harris

Aspects	Barack Obama	Kamala Harris
Ethos	Builds credibility through presidential authority, bipartisan experiences, and historical references.	Establishes ethos through her vice-presidential role, alignment with Biden, empathy, and connection to communities.
Pathos	Appeals to national unity and responsibility using personal stories and American identity.	Focuses on present-day suffering, pandemic experiences, and emotional urgency.
Logos	Uses economic reasoning, statistics, and references to nonpartisan sources.	Emphasizes real results, avoid abstract economic discussion.
Stylistic Devices	Uses repetition, metaphors, humor, and contrast to support unity and hope.	Uses strong imagery, ethical language, and inclusive language to emphasize justice.
Tone and Audience	Serious but hopeful, targets a centrist audience and encourages bipartisanship.	Urgent and morally intense, appeals to a progressive audience and highlights systematic injustice.

The analysis shows that Obama's rhetoric is characterised by historicising, bipartisan appeal, and economic reasoning, while Harris's approach emphasises urgency, moral framing, and direct appeals to justice and empathy. Both leaders adapt their rhetorical strategies to their political roles and target audiences, but their methods and emphases differ substantially across ethos, pathos, and logos.

1.5 Discussion

Obama establishes his ethos by invoking his position in history and his bipartisan stance, casting himself as a statesman who is beyond political rift. He alludes to his involvement in crisis management "we have pulled this economy back from the brink" and aligns himself with earlier presidential initiatives "I am not the first president to take up this cause". His insistence on legislative courage and bipartisan cooperation on both sides "ideas Republicans should like reaffirms his reputation as a pragmatic and reliable leader. While Harris grounds her authority in her current administrative role and policy alignment with President Biden, she emphasizes reflective governance "purposely and intentionally building on the ACA's success" and involves healthcare providers and community health centers. Her ethos is drawn from empathy-based values "dignity and respect" and not from prior precedent.

Obama appeals to moral imperatives by using personal narratives, such as stories of individuals dying due to denial of insurance coverage "a man who lost his coverage in the middle of chemotherapy". The personal anecdotes link health reform to collective responsibility and national identity. Obama's tone vacillates between restrained calm and aspirational hope, appealing to the conscience of his audience. But Harris concentrates on relatable, present situations, e.g., a parent who is reluctant to go into an ER because of the expense. She connects policy to shared suffering, especially pandemic suffering, and uses moral framing "just not right" to try to provoke outrage. Her emotional appeals emphasize empathy and justice more than historical comparisons.

Obama frames healthcare reform as economically responsible, tying it to budget accountability. "Our healthcare problem is our deficit problem." He employs statistics (e.g., gaps in coverage) and refers to nonpartisan authorities like the Congressional Budget Office. His appeals are to systemic consequences rather than personal outcomes. Unlike Harris, who emphasizes measurable policy outcomes, citing the ACA's success in insuring "30 million Americans." Her causality argument links policy change to tangible advancements in access and equity. She avoids abstract economic claims in favor of direct impact on vulnerable populations.

Both Barack Obama and Kamala Harris use sets of stylistic devices in their healthcare rhetoric that suit their respective political stances and situations. Obama uses repetition marked by phrases like "Now is the season for action" habitually in order to establish a rhythmic pace and underscore major premises, and his contrast, as when he opposes the "higher plane" of rhetoric and partisanship gridlock, reaffirms his call for unity. Metaphors, such as the explanation of increasing healthcare costs as a "breaking point," build a sense of urgency, and instances of humor have the impact of making the message more accessible and engaging to a broad audience. Harris, on the other hand, depends on strong imagery, creating gut-wrenching scenes such as packed hospital parking lots to gain sympathy. Her ethical declarations defining healthcare as "a right, not a privilege." combined with her use of inclusive language such as "we are all in this together," assists in setting up her thesis as a collective moral obligation.

They also differ in rhetorical strategies of tone and audience targeting. Obama's tone is serious, hopeful, and reconciliatory, most likely to attract centrist voters and encourage bipartisan collaboration. Obama frames healthcare reform as an economic imperative instead of an ideological issue, which reflects his presidential role during the signing of the ACA into law. Harris, by contrast, has a tone of passionate intensity, urgency, and moral concern, most likely to strongly resonate with progressive voters. Her oratory concentrates on systemic injustice and positions healthcare as a moral imperative, resonating with contemporary discussions regarding

Medicare for All. The most glaring differences in their rhetoric, Obama's historicizing vs. Harris's urgency, bipartisan appeal vs. progressive appeal, and economic vs. moral reasoning represent not just their various styles but also the evolving political contexts they are working in. They are shaped by their roles as president and vice president and by the passage of time itself in the unfolding of the healthcare debate. Both leaders can mobilize support, but they do so through methods peculiarly appropriate to different audiences and circumstances in the course of American political history.

Barack Obama's rhetorical strategies were responsible for the Affordable Care Act (ACA) passing successfully because he focused on moral appeal, economic rationale, and bipartisanship. Repeatedly, Obama positioned health care reform not as a political struggle but rather as a national imperative grounded in moral value and fiscal prudence. He anchored his arguments in support of bipartisan entitlement programs like Social Security and Medicare and pointed to the fact that the ACA would reduce the deficit by 1 trillion dollars. Obama's choice to leverage an economic argument appealed to moderate legislators and those concerned with fiscal responsibility in a committee where it mattered. Obama's speech to Congress in 2009 amplified his rhetorical position when he called on them to collaborate and repudiated obstructionism in Washington.

Personal stories appealed emotionally and served as a useful addition to his arguments; for example, individuals were described as being unable to get life-saving treatment or who saw their insurance coverage dropped because of a minor complication, and evidence of systematic failure highlighted the basics of health care as an American right. After overcoming challenges of early communication issues, Obama established a clear and openly transparent communication approach, assuring Americans that the ACA would protect their current plans, give them access, and build a model to lower costs. One of the major rhetorical shifts in his 2013 embrace of "Obamacare" was the commitment to health care reform and differentiated him from Republican

opposition Obama framed healthcare reform in terms of macroeconomic health, saying that runaway costs were a threat to businesses and the national deficit as much as people's health, which gave comfort to skeptics of reform and created a broader coalition. His rhetorical maneuver was not only a guarantee to pass the ACA, but it also framed his presidency and insured millions of people for health while allowing him to position himself as a pragmatic but transformative president.

Kamala Harris's pronouncements against healthcare reform and against Medicare for All changed too many times and disappointed too many voters, losing her credibility and stopping any chances of political viability. Kamala Harris was an early co-sponsor of Medicare for All as introduced by Bernie Sanders in 2017 and made an announcement that healthcare is a human right, which put her with the progressive side of the Democratic Party. By 2019, she had changed her position to a more moderate proposal with a longer, 10-year transition plan to maintain access to private insurers via a Medicare Advantage-style plan after addressing labor union concerns of losing benefits through negotiated health care. This radically altered position was viewed as a deal, and opposition from Sanders and other Medicare for All proponents was embodied in their concerns over realizing corporate interests as diluted compromises to their serious efforts to reform healthcare. Consequently,

Harris's communication messages made matters worse; she maintained she was preserving private insurance plans, while her proposal's heavy federal regulation would effectively tear out private providers from the conversation. It was not clear to voters and served to perpetuate more confusion. Mighty media authorities, including The Washington Post, publicly highlighted her "shifting positions" and concurrent lack of clarity on health care policy, ultimately alienating both moderate Democrats and progressives. Her inconsistent embrace of health care reform became a political liability as political opponents such as Donald Trump publicly painted her as a "radical

liberal flip-flopper" and, through over-reliance on political aides to help clarify her positions, reinforced ventures of inauthenticity.

While the economists quickly expressed policy concerns about her proposal for failing to impose appropriate cost containment and imposing bureaucratic inefficiencies, which they contended would lead to higher costs without providing a better quality or degree of care, the rhetorical and policy missteps signaled larger ideological divides within the Democratic Party and hampered her capacity to build a solid coalition. Barnett's proposal raised doubts amongst some economists and ultimately not only snagged Harris's efforts to articulate a cohesive message about affordable health care but also errors of language that did not unite the Democratic Party behind a common agenda. Unlike Obama's appeal as a unifier and pragmatist, Harris's approach to straddle and accommodate ideologies ultimately failed and became a key factor in the ending of her 2020 presidential campaign.

Conclusion

As a summary, this is the comparative chapter of our research, attempting to compare Barack Obama's and Kamala Harris' healthcare rhetoric through the lens of Aristotle's rhetorical theory. This chapter started with the discussion of methodological approach and the presentation of ethos, pathos, and logos as the main instruments of rhetorical analysis. Then, we highlighted Obama's healthcare speeches, focusing on his deployment of character, emotion, and logic to persuade. Similarly, we analysed Kamala Harris's healthcare rhetoric during her different campaign events and proposals, focusing specifically on her thematic focus on justice, equity, and moral appeal. The chapter finished by contrasting the two leaders' rhetorical approaches and media and public responses to their message, whereby the common and distinctive elements shaping their influence on healthcare policy and public opinion were clarified.

General Conclusion

The present study aims to compare and contrast the healthcare rhetoric of Barack Obama and Kamala Harris via reviewing and analysing the existing literature associated with the issue in hand. For that reason, this study firstly introduces Obama's rhetorical style, then Harris's one, focusing on their use of persuasive strategies, political themes, emotional tone, and finally their influence on public opinion. Then, the focus is shifted to the common and distinctive features in both leaders' healthcare discourse. That is to say, the study attempts to explain the role of language in shaping healthcare messaging in both campaigns.

This study started by describing Barack Obama's healthcare rhetoric through elaborating sub-related issues such as his campaign themes, persuasive tools, tone of delivery, and his approach to public health framing. Similarly, the current study represented Kamala Harris's healthcare discourse, concentrating on certain points such as her political positioning, emotional appeals, focus on equity, and finally her rhetorical style during the 2020 campaign. The study ended up with identifying the common and distinctive elements between both politicians'

strategies in healthcare communication. In this part, the hypotheses were proved valid through data description and analysis.

The study attempted to test the validity of one main research hypothesis: that Barack Obama's and Kamala Harris's healthcare rhetoric would differ in style and thematic focus, reflecting their distinct political identities and campaign contexts. The findings confirmed this hypothesis, showing that Obama's rhetoric emphasized unity, hope, and incremental reform, while Harris's rhetoric focused more directly on equity, justice, and systemic change. These differences illustrate how political language evolves to address changing voter expectations and policy debates.

This study contributed to the field of political communication by providing a comparative analysis of two significant figures in American healthcare politics. By showing how rhetoric is shaped to meet changing social and political demands, it offers insights for campaign strategists, communicators, and scholars interested in the power of language to shape policy debates and voter attitudes.

This study is limited in several aspects. First, time constraints affected negatively the organization of this research work. Additionally, the shortage of detailed studies comparing both figures' healthcare rhetoric added complexity to the research. Also, rhetorical analysis of political discourse required deeper knowledge of public opinion data, which was not fully available during this research. Finally, the use of Aristotle's rhetorical triangle, while effective, also limited the scope by excluding other discourse analysis frameworks that might offer different insights. Yet, the researcher tried to approach the subject with care and a strong understanding of political messaging.

The study suggests further research addressing the theme of rhetoric analysis and political discourse to cover the current study gaps. To be more precise, comparing Kamala Harris' rhetoric and Barack Obama's rhetoric from different angels not just healthcare and through different lenses and analytical methods.

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Appendices

Affordable Care Act Speech (Aug 10, 2024)

https://www.rev.com/transcripts/kamala-harris-affordable-care-act-healthcare-speech-transcript-august-10**Maternal Health Day of Action Speech (Dec 7, 2021)**

https://www.rev.com/transcripts/kamala-harris-maternal-health-day-of-action-speech-transcript**"Our America" Campaign Launch Speech (Jan 28, 2019)**

https://kamalaharris.medium.com/our-america-4642b443d529**Speech on Health Care Reform (Mar 15, 2010)**

https://millercenter.org/the-presidency/presidential-speeches/march-15-2010-speech-health-care-reform**Address to Congress on Health Care Reform (Sep 9, 2009)**

https://abcnews.go.com/Politics/HealthCare/transcript-president-obama-address-joint-congress-health-care/story?id=8527252

الملخص العربي

تُقدم هذه الأطروحة دراسة تحليلية نوعية مقارنة لسياسة الرعاية الصحية وخطابها في الحملات الانتخابية لكل من كامالا هاريس وباراك أوباما. وتهدف الدراسة، بشكل عام، إلى مقارنة استراتيجيات الإقناع لكل من كامالا هاريس وباراك أوباما، ودراسة تأثير خطابهما على الرأي العام ودعم إصلاح الرعاية الصحية. وفي هذا الصدد، تسعى الدراسة إلى تقديم رؤى ثاقبة حول كيفية تشكيل القيادة السياسية لخطاب الرعاية الصحية في الولايات المتحدة، وتأثيرها على كل من الرأي العام وسلوك الناخبين. وتستجيب هذه الدراسة للاهتمام الأكاديمي المتزايد حول كيفية تأثير الخطاب السياسي على سرديات الرعاية الصحية، لا سيما في ضوء الإصلاحات الرئيسية مثل قانون الرعاية الصحية الميسرة والرعاية الطبية للجميع. ومن خلال استخدام نهج التحليل المقارن النوعي، تم تحليل سبعة خطابات لكلا المرشحين للإجابة على سؤال البحث المتعلق بمدى الاختلافات بين هاتين الأجندتين. وبناءً على ذلك، تمت دراسة أساليبهما البلاغية المتعلقة بإصلاحات الرعاية الصحية من خلال نظرية المثلث البلاغي لأرسطو. وقد توصلت هذه الدراسات إلى أن التفكير المنطقي له أهمية أكبر من الإرتباط العاطفي في كسب الدعم للرئاسة في الولايات المتحدة الأمريكية.