National Health Care

Framing of the debate on national health insurance in the United States

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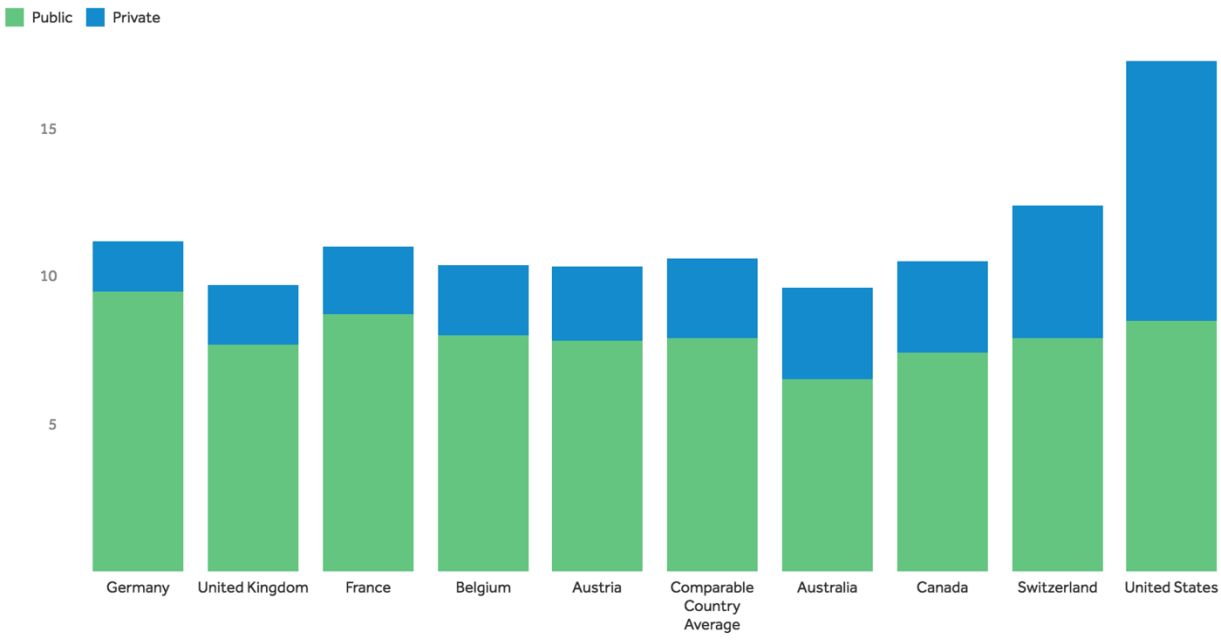
1.0 Introduction

Almost from the beginning of the United States of America, the federal government can be said to have had a role in promoting the health of Americans (Sledge 2017: 15). In the last decades of the 19th century and the first decades of the 20th century, when many European countries started adopting some variety of government run systems of sickness insurance or started subsidizing voluntary insurance, the United States did not institute similar changes (Starr 1982: 237). Today, the U.S. has a much higher overall spending on health care than comparable OECD countries, as evident in Figure 1. And contrary to popular belief, the U.S. spends about 8.5% of its GDP on public funded health, which is essentially equivalent to the average of other comparable OECD countries.

Figure 1: Total health expenditures as percent of GDP by public vs. private spending, 2016 (Sawyer & Cox 2018)



The American health care system is thus much more expensive than other forms of health care systems in comparable countries, where the national government on average is much more involved in funding or running the health care system. Whether the national government should act to ensure access to individual health services, and which form of health care system would provide such access, has been highly contested throughout the 20th century and remain highly contested to this day (Sledge 2017: 3).

In this paper I will first account for the historical background of the debate surrounding universal health care. Secondly, I will develop a set of search terms and a set of keywords in order to isolate newspaper articles on national health care and capture how the debate has changed since 1910. I will go on to show that the debate has always been influenced by arguments about how people deserve national health care, and that these arguments have been met with shifting ideological arguments over time. Thirdly, I will show how the four frames I find interact with public opinion and discuss the limits of my paper while showing a new trend in the debate on national health care and particularly about "Obamacare". Fourthly, I will conclude on my findings.

A final introductory note: When I use the term "health care" I am referring to individual medicine and medical insurance. I do not include "public health" in this category, which I understand as the health of populations and preventive medical care (Sledge 2017: 2). Furthermore, I am specifically interested in the debate about national and government-run, subsidized or funded health care since the absence of government involvement in health care is what separates the U.S. system most from other wealthy, Western countries[1].

[1] See appendix A for figure over percentage of Americans by type of health insurance.

2.0 Historical Background

Traditionally, medical services in the United States were conducted as fee-for-service. When people couldn't pay for their treatments, they were mainly dependent on charity care (Sledge 2017: 51). At the beginning of the 20th century the US government was highly decentralized and did only rarely engage in direct social welfare regulation (Starr 1982: 240). Southern political representatives often blocked the emergence of more comprehensive social welfare policies in the formative years of social policy because they were concerned with retaining local autonomy and preserving the region's racial caste system (Sledge 2017: 5). At this point in time American workers (compared to European workers) spent a lot of money on insurance for themselves which they purchased through commercial insurance companies (Starr 1982: 242).

The first significant reference to health insurance in U.S. politics came in the 1912 elections from the Progressive Party led by presidential candidate Theodore Roosevelt, who presented compulsory health insurance as a general interest for an enlightened society (Starr 2001: 30-31). After the Progressive Party lost the election, the American Association for Labor Legislation, an academic group of reformers, pushed for compulsory health insurance, and was faced with opposition from both the life insurance industry, business interests, and the ambivalent positions of organized labor, which were divided over whether to pursue health benefits through state action or through collective bargaining (Sledge 2017: 8).

The 1920s saw a steep rise in medical expenses of both physicians' services and hospital care because of improved quality and increasing monopoly power which led to a change in concern among American reformers from the "wage loss of sickness" to "medical expenses" (Starr 1982: 258f). Alongside this change came also a consolidation of professional power. Physicians income

and prestige grew with the successes of medical science, and the American Medical Association (AMA) gained growing influence on public policy (Starr 1982: 260).

The Great Depression in the 1930s meant that fewer and fewer Americans could afford health care (Sledge 2017: 101). The Committee on Cost of Medical Care, a privately funded group, issued a report on a proposed reorganization of medical services where physicians would be connected to hospitals and payments would be financed through voluntary insurance. This report was met with strong opposition from the AMA, who deemed the proposal to be socialist, communist and bordering on revolution (Sledge 2017: 101).

In 1935 the Social Security Act was passed under the presidency of Franklin Roosevelt, who took office in 1932. The framework for the legislation was drafted by the Committee on Economic Security. The Committee deliberately chose to leave out medical insurance from the report to President Roosevelt because it was deemed too politically volatile (Sledge 2017: 97).

During WW2 it became more and more widespread for employers to offer medical insurance as a way of attracting new employees. By the end of the war 32 million Americans had hospital insurance and 4.7 million had insurance for physicians' services (Sledge 2017: 170). In the time after the war a Republican majority in Congress and failure of implementing health insurance bills meant that organized labor turned their attention towards collective bargaining and employer-based health insurance (Sledge 2017: 177). By 1950 76.7 million Americans had hospital insurance and 21.5 million had physicians' services insurance out of a total population of 152 million (Sledge 2017: 177f). By 1960 those numbers had grown to 122.5 million and 83 million respectively out of a total population of 180 million (Sledge 2017: 187)

In 1948-1949 Harry Truman advocated for a prepaid national health insurance program for all U.S. citizens but failed to pass any legislation in part because many Southern Democrats saw

national health insurance as a means of ending segregation for good (Sledge 2017: 179). Around the same time unmet needs of elderly people were debated. They were generally not in the workforce, were almost guaranteed to have significant medical expenses, and were therefore deemed a bad risk not worth insuring for most insurance companies (Sledge 2017: 186).

In 1965 President Johnson signed Medicare and Medicaid into law. This included, among other things, payroll tax-based national hospital insurance and voluntary physicians' insurance for the elderly (Medicare) and to some low-income groups (Medicaid). In 1972 disabled people were included as well (Sledge 2017: 188).

In 1971 President Nixon proposed a comprehensive health insurance plan which would include a public program for everyone not insured through employment and referred to the program as "an idea whose time has come" (Starr 2011: 56). The Watergate scandal did however destroy any hope of passing the bill (ibid.).

In the following decades the costs of hospitals and physicians' services expanded heavily in part because more seniors could access medical services and because service providers at the same time had the freedom to decide what prices they would charge (Sledge 2017: 188). Medicaid also faced criticism because of varying eligibility depending on the state in question which in practice meant that some of the low-income population, which it supposedly targeted, were left without access (Sledge 2017: 188).

When Bill Clinton was elected President in 1993, the issue of health care reform became prominent once again (Starr 2011: 81). Clinton's health care reform plan included health care security cards to every citizen which would entitle them to medical treatment regardless of pre-existing conditions. The plan was met with strong opposition from Republicans and the insurance industry and failed.

In 2010 President Barack Obama signed the Patient Protection and Affordable Care Act (PPACA) which by all accounts is the most significant overhaul of the health care system since Medicare and Medicaid was introduced in 1965 (Holzman 2012). The ACA was a highly profiled healthcare reform bill that sought to reduce the number of uninsured Americans by about 30 million people while also providing already insured individuals with protections (Holzman 2012).

3.0 Data Collection

Previous literature on the topic of national health insurance has looked quantitatively at selected periods of time and particular health care programs or qualitatively at the history of national health care in the U.S (Sei-Hill et al. 2015; Starr 1982; Starr 2011). In this study, I will examine the framing of the debate during a period of over a hundred years (1910-2016) by looking at articles from the national newspaper the New York Times (NYT) and analyze the frames from a psychological perspective by looking at how the different frames have evoked different considerations and focused on different aspects of national health insurance. By analyzing NYT stories quantitatively, I find a similar shift in negative framing of the issue, around 1965 when Medicare and Medicare were introduced, as that proposed by Prof. Paul Starr. I also find that one positive frame has been dominant throughout the whole period of time despite the continuous failures of different presidents to institute national health care reforms. I explain my coding procedure below.

3.1 New York Times Stories on National Health Insurance

To identify all stories on the topic of health insurance from 1910-2010 in the NYT I identified common terms used to refer to this debate such as “health insurance,” “health care,” “health coverage,” “health benefits,” “sickness insurance,” and “medical insurance.” I used these to create

my initial string of search terms. I developed these terms from reading extensively about the historical debates on health insurance. I became aware that the terms for describing health insurance had changed significantly over time. Therefore, I developed a more nuanced set of terms to target the whole time period of 1910 to 2016. I then searched the online version of the NYT through ProQuest using these search terms. I limited my search to abstracts in order to only find articles that focused primarily on national health insurance. From here I started going through the articles that came up, sorted by time, while trying to find common themes for "false hits". I excluded stories that did not focus on health care by adding restrictions to my search such as other countries than the U.S. and articles about books on the subject. Arriving at my current search terms took around 80 different searches and refinements based on a trial-and-error method. I tested the validity of the current string of search terms by reading through 10 randomly selected articles from all decades and found that approximately 86 percent (95 out of 110) of the stories were indeed about national health insurance in the U.S. It is however impossible to know how many stories I have missed with this string of search terms. But even if I have missed a certain percentage of all stories, the trends over time will not be affected unless the proportion of missed stories varies across time, which I have no reason to expect. Table 1 shows my string of search terms.

Table 1: Search Terms Used to Identify National Health Insurance-Related Stories[2]

Time period	Search Terms
1910-2016	(((ab("health insurance" OR "medical insurance" OR "sickness insurance" OR "health coverage" OR "health care coverage" OR "health care" OR "health benefits" OR "medical care" OR medicare OR medicaid OR ppaca OR "affordable care act" OR obamacare) NOT (vacation OR animal OR school OR sport OR book OR London OR England OR China OR Sweden OR Denmark OR Britain OR "United Nations" OR "league of nations" OR France OR "city health plan" OR "mental health insurance" OR "disability insurance" OR "steel" OR "health insurance plan of Greater New York" OR "health insurance plan of New York" OR utica OR "psychiatric insurance" OR advertisement OR ads OR advertising OR cooking OR food OR Tokyo OR Belgium OR Canada OR trial OR "health care center" OR knicks OR "local-care plan" OR "truck drivers" OR contamination OR "hospital project" OR automakers OR hunterdon OR Bronx OR chess OR "panther leader" OR trading OR Philadelphia OR "auto workers" OR "hospital union plans" OR "living wills")) AND rtype.exact("Editorial_article" OR "Editorial Article" OR "Article")) AND (national OR nation OR federal OR government OR president OR congress OR senate OR House OR "U.S." OR "United States" OR "American people" OR medicare OR medicaid OR "Affordable Care Act" OR Obamacare OR ppaca)) AND pd(19100101-20161231)

[2] Throughout my trial and error searches I found many false hits in the form of articles focused on different kinds of health insurance that were not national, such as city-, state-, group-, and union health insurance. Therefore, I added an extra "AND" requirement in the form of terms such as "national", "government", "president" or "congress" so as to specify my search results to articles focused solely on national health insurance.

Figure 2: Attention to National Health Insurance in the New York Times (1910-2016)

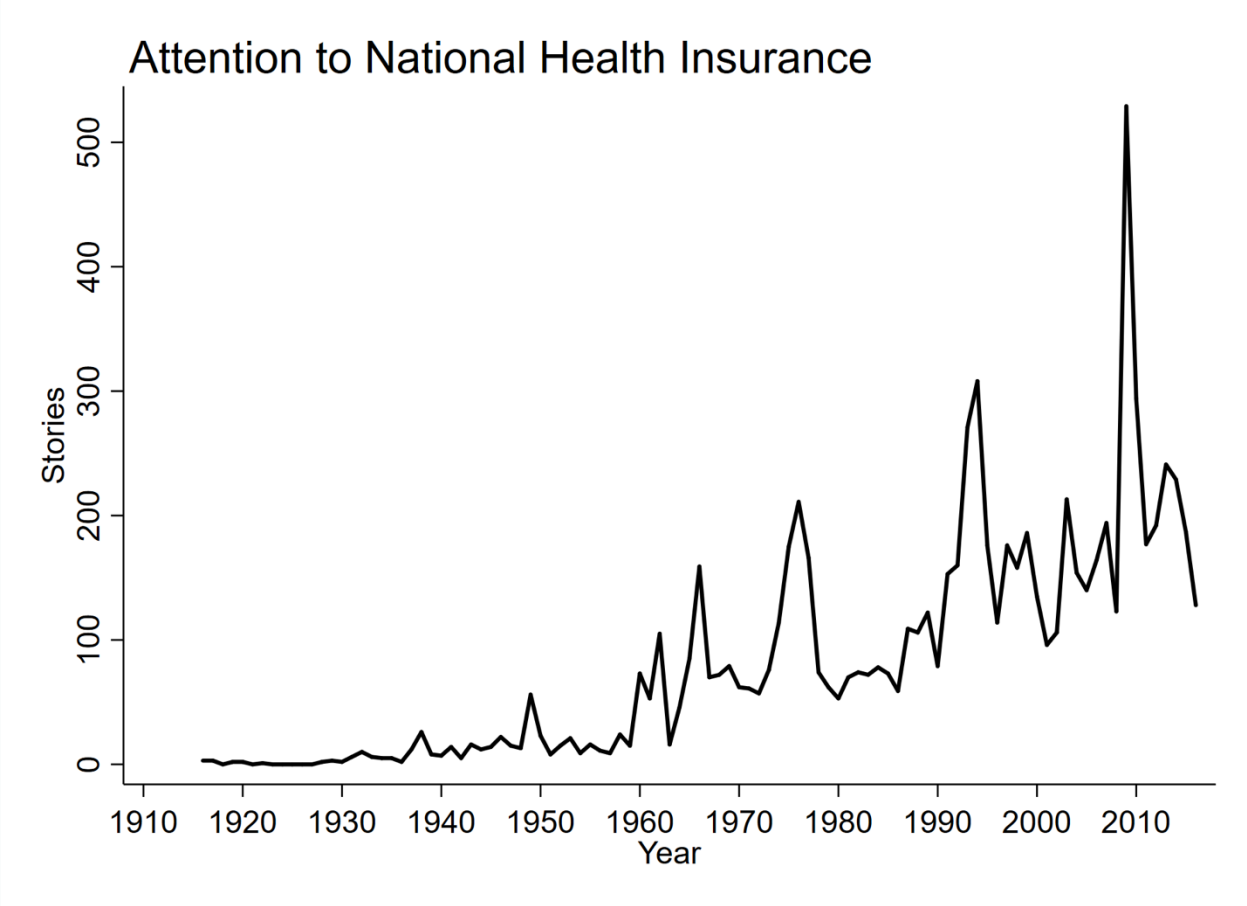
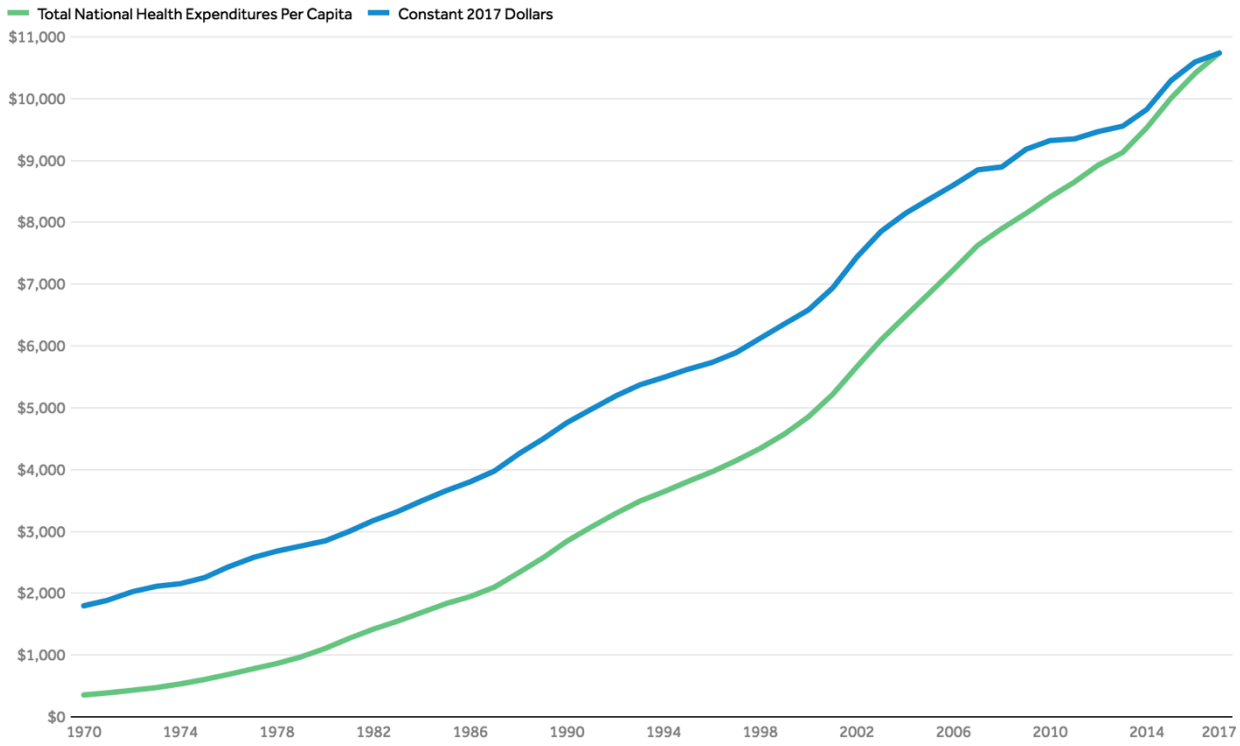


Figure 2 shows the number of stories according to the search over time. The peaks in attention seem, quite intuitively, to be correlated with the different health care reform proposals that U.S. presidents have put forward throughout the time period like Truman's from 1949-1950, Johnson's Medicare and Medicaid in 1965, Nixon's in 1971-1974, Clinton's in 1993 and Obama from 2008-2010. There has been a substantial increase in attention to the issue of national health insurance over time from just a few stories a year from 1915-1940s up to around 60 articles a year in 1949-50, all the way up to more than 500 stories in 2010. As seen in figure 3, the overall increase in health care costs from 1970 onwards coincide with the rising national health expenditures per capita.

Figure 3: Total national health expenditures, US $ per capita, 1970-2017 (Sawyer & Cox 2018)



Having identified the total number of articles for any given year throughout the whole time period, I now turn to the identification and analysis of frames in the debate about national health insurance.

3.2 Four Frames

After having read through some 100 articles in the New York Times and a handful of historical books on the topic, I identified four distinct frames. The frames encompass a significant amount of diversity but have one distinct theme to them that leads to very different ways of considering the topic. I have split the frames up into negative and positive frames.

<u>Negative frames</u>

"Un-American": This frame focuses on how the idea of universal or comprehensive government-run health care stems from foreign influence from the authoritarian Germany (up until the end of WW2), the communist Soviet Union (during the Cold War) and socialist Europe (ongoing) and how the idea therefore should be seen as an encroachment of American Life (Starr 1992: 13). The frame is akin to a form of American exceptionalism, where the unique American highly privatized health care system is deemed to be in accordance with the unique character of the United States as a whole.

"Free Market": This frame reflects a libertarian understanding that the health insurance market will regulate itself in accordance with economic principles if left alone, and how any government intrusion will undermine competition and decrease the quality of health care insurance.

"Professional autonomy": This frame focuses on how the government should not interfere in the medical profession or in the relation between doctor and patient and on how interference and regulations might lessen the otherwise high quality of American medicine (Sledge 2017: 55; Starr 1982: 271).

Positive frame

"Moral compassion": Focusing on how poverty caused by sickness can happen to anyone and how many deserving citizens are without health insurance. The frame emphasizes the economic ruin for individuals and families as a result of unexpected and expensive medical bills and how the government ought to protect its citizens (Sledge 2017: 46 & 113).

By reading through dozens of articles and background literature on the topic I identified language and words that usually accompanied the different frames. Through a trial and error approach, similar to the one I used for national health care stories in general, I developed a string of search terms for each of the four frames, which are shown in Table 2[3].

Table 2: Identifying Six Frames of Health Insurance

Frames	Search Terms
Moral compassion	"shared responsibility" OR "human right" OR "right to treatment" OR ("protection" NOT "protected through voluntary" OR "voluntary sickness insurance protection" OR "consumer protection") OR suffer OR suffering OR "well-being" OR moral OR ("security" NOT "social security" OR "security administrator") OR deserve OR dignity OR "gaps in coverage"
Un-American	"socialized medicine" OR communism OR socialism OR German OR nationalization OR statism OR totalitarian OR "state medicine" OR paternalism OR europeanization OR "american way" OR "british-style" OR "un-American
Professional autonomy	Invasion OR "state interference" OR "physician-patient relationship" OR "political control" OR "manipulation" OR "patient and his doctor"

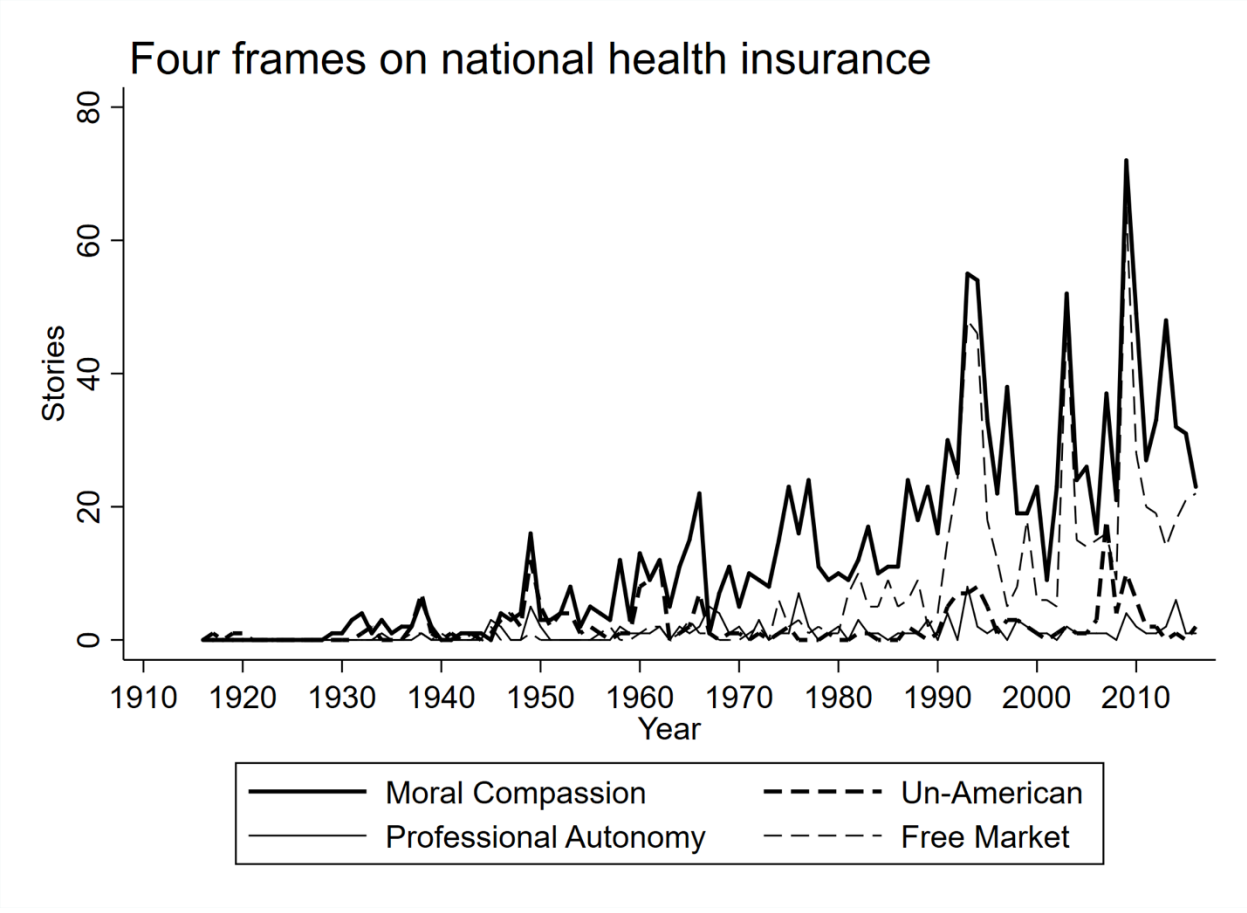
[3] To check for accuracy, I read 20 randomly selected *New York Times* articles for each frame from the period 1910-1990. Out of the 80 articles, 71, or 88.75%, were positive hits. I revised my frames from 1990-2016 extensively through trial-and-error, but because of time constraints I did not have time to do a proper test of validity. I have no reason to suspect that the validity should have decreased significantly, but I still have to account for this in my analysis and conclusions based on the data.

	OR "patient and doctor" OR "doctor and patient" OR "red tape" OR "regimentation" OR "relationship between doctor and patient" OR "medical integrity" OR "doctors as slaves"
Free market	"Free market" OR "government takeover" OR "federal bureaucracy" OR "self-regulate" OR competition OR "free economy" OR "free enterprise" OR "free economic system" OR "market based"

4.0 Analysis and discussion of findings

Figure 4 shows the trends for the *New York Times* in how many times each frame occurred over time.

Figure 4: Four frames on national health insurance (1910-2016)



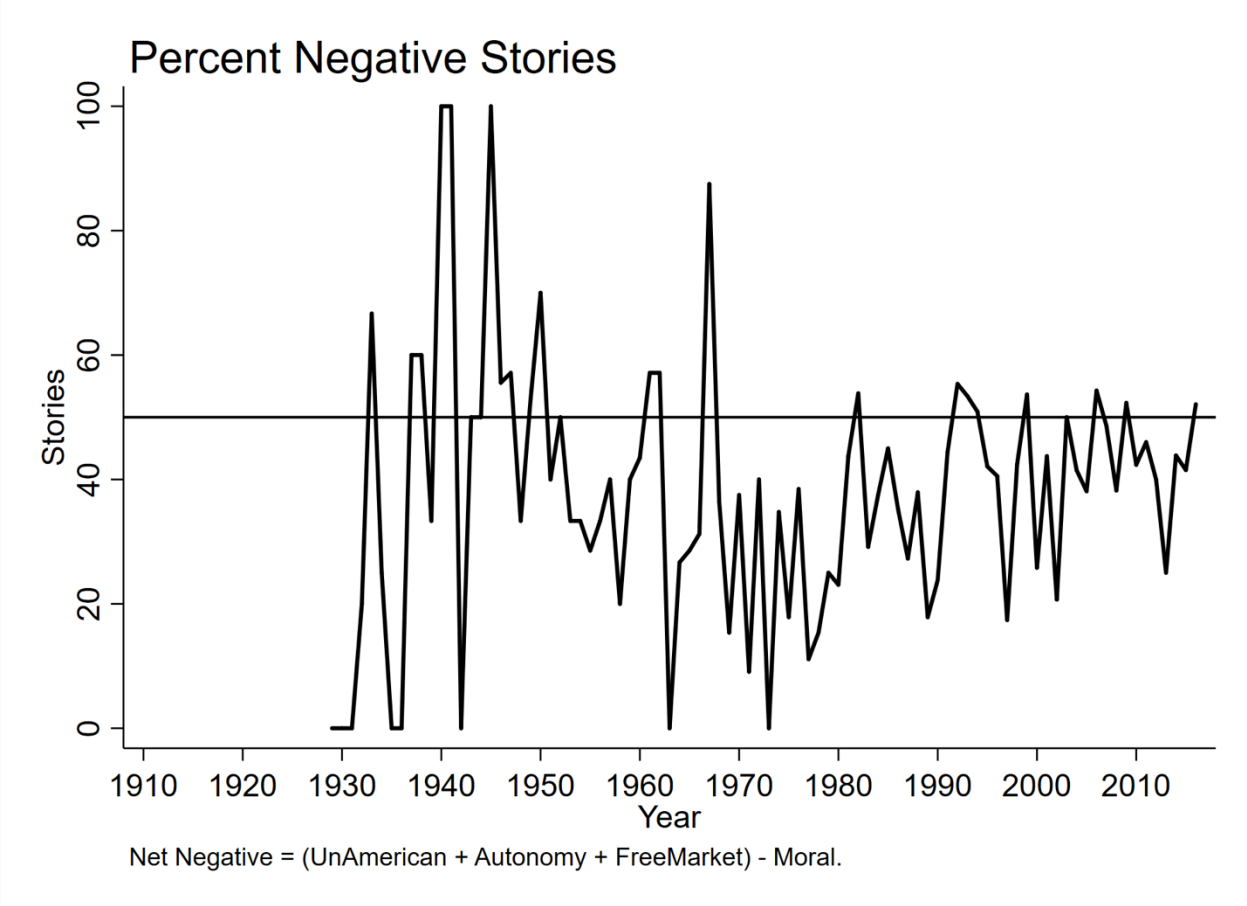
From the data in Figure 4 it is evident that the "Moral compassion" frame has been the single most used frame out of the four over the years and was by far the dominating frame after the introduction of Medicare and Medicaid in 1965 up until Clintons health care reform proposal in 1993. Before and after this period the issue seems highly contested by the negative frames "Un-American" and "Free Market" respectively. Before 1965 the "Un-American" frame was nearly on par with "Moral compassion", and from 1993 and onwards the same can be said about the "Free Market" frame. While "Professional autonomy" does have a few stories to its name, especially before 1965, it seems to be not nearly as widespread as the other three.

As Starr has claimed, I also find that the ideologically based debate around national health insurance from the first part of the 20th century did not die out with the introduction of Medicare and Medicaid, but rather that it changed its main focus from socialism to how much Americans should rely on the government for carrying out health care (Starr 2011: 52). While the "Un-American" frame, which focuses on "state- and socialized medicine" and the connection to authoritarianism and communism, was the main frame used to oppose the idea of government involvement before Medicare and Medicaid, the most used negative frame throughout the last 50 years has been the "Free market" frame, which relies on the idea of superiority of the free market rather than contempt for socialism.

4.1 Framing, public opinion and legislation

I will now look at the framing of national health insurance and how it might relate to public opinion and legislation.

Figure 5: Percentage of negatively framed stories (1910-2016)



As evident in Figure 5, which shows the percentage of negatively framed stories throughout the whole period, the number of negatively framed stories have been mostly lower than the number of positively framed stories since the introduction of Medicare and Medicaid in 1965. But despite the higher number of positively framed stories, it was not until the Affordable Care Act in 2010 that the U.S. had a major reform of its health care system. This, I will argue, can partly be explained by the relationship between the frames and public opinion on national health insurance because

the relationship suggests that the negative frames might be more impactful than the positive frame because of better conditions[4].

A majority of Americans have quite consistently reported substantial dissatisfaction with the American health care system and with the private health insurance industry in general from 1950-2000 (Blendon & Benson 2001: 43). A majority of Americans have also indicated support for a national health system financed through taxes and higher national health spending in general (ibid.). This shows that the trend in Figure 5, where positively framed stories have mostly outnumbered the negative ones since 1965, is reflected in public opinion. However, the same surveys from 1950-2000 also show that most Americans have generally been satisfied with their medical arrangements at the time of questioning (Blendon & Benson 2001: 43). This is significant because the negative frames "Un-American" and "Professional autonomy" stresses the value and high quality of the current private health care system. The two frames positions citizens in the domain of gains where they stand to potentially lose something valuable to them if a new health care plan were to be adopted. In this scenario risk-aversion is likely to arise which will make people overvalue the status quo relative to the uncertain alternatives and thus decrease support for any specific health care reform (Starr 1982: 257; Quattrone & Tversky 1998). Whether these two frames had an impact on public opinion is plausibly but not necessarily the case. Nevertheless, the satisfaction people have felt with the erstwhile health care system have created very good

[4] I will point to simultaneity and potential interconnection between frames and views in public opinion without commenting on the causality of any relationship between the two, since I do not have any evidential support for such a claim.

conditions for the two frames to make these kinds of considerations more salient and thus more impactful.

The surveys also show that a majority of Americans have not trusted the government to do what is right throughout the whole period from 1950-2000 (Blendon & Benson 2001: 43). This distrust of government is reflected in the two frames "Un-American" and "Free market" where any form of governmental involvement is portrayed as an intrusion on either Americans' freedom to choose or the markets self-regulating mechanisms. This distrust in government involvement have created optimal conditions for these frames to evoke a feeling of anger at the government, who are portrayed as the villain that is trying to steal something from you (individuals' freedom to choose) or from society (the free market). This anger will in turn increase a feeling of individual control over the situation and motivate opposition to organize in the face of a specific health care reform (Lerner & Keltner 2001). The distrust of government thus sets the perfect conditions for advocates against national health care who want to motivate opposition by making people angry.

Furthermore, the surveys found that a majority of Americans have not seen health care as a top priority for government action in most of the time period from 1950-2000 and that most Americans do not favor a single-payer (government) type of national health care (Blendon & Benson 2001: 43). So even though the "Moral compassion" frame was the most used in the same period, it did not succeed in creating sufficient urgency, emotional connection, or other motivating factors for the issue to be perceived as really important to the American people. And it did not succeed in framing health care as a human right that every citizen deserves so as to justify a single-payer system. In fact, even framing the poor people as deserving has been a struggle. The frame tries to shift focus to the deservingness of the recipients of national health insurance by increasing attention to the moral responsibility people have to protect other people in need (see Jensen &

Petersen 2017 for a discussion on the 'deservingness heuristic'). However, it was not until the recipient group was framed as, and constituted of, 'the elderly' and 'the poor' by Medicare and Medicaid that the first national health care legislation was passed. At the time the elderly were, and still is to this day, perceived as a recipient group that had earned their right to health care, and the poor were a recipient group that was perceived to have been neglected and therefore deserved charity (Rose & Baumgartner 2008: 31). Since then, poor people have been increasingly framed as lazy and individually responsible for their problems and therefore undeserving of welfare (Rose & Baumgartner 2008: 43). This effects of this reframing is reflected in how Medicaid has been more politically insecure and more vulnerable to cutbacks than Medicare has because of the difference in perception of deservingness of poor and elderly (Starr 2011: 47). Thus, in the case of a single-payer health care system, it is clear how a recipient group consisting of every American rather than just 'the elderly' or 'the poor' have struggled to become considered as a deserving group.

4.2 A frame in disguise: Obamacare and implicit racial associations

As a way to show the limits of my paper while also showing a recent development in the debate on national health care, I will now look into the nickname "Obamacare", which is a nickname that opposition to the Affordable Care Act (ACA) of 2010 used to refer to the health care bill.

Studies have shown that support for the ACA was more divided by racial attitudes than by nonracial attitudes (Banks 2014: 106). In his study, Antoine Banks showed that there was an 80-percentage point shift in predicted probability of opposing health care reform between whites who were low and whites who were high in symbolic racism, even after controlling for variables such as party, ideology and socioeconomics (Banks 2014: 115). This is puzzling, seeing as the beneficiaries of the health care bill include every American citizen rather than just African

Americans and because I did not find any frames that made use of overt racial references. I will argue that the following factors can explain this relation between racial attitudes and opinions on the ACA.

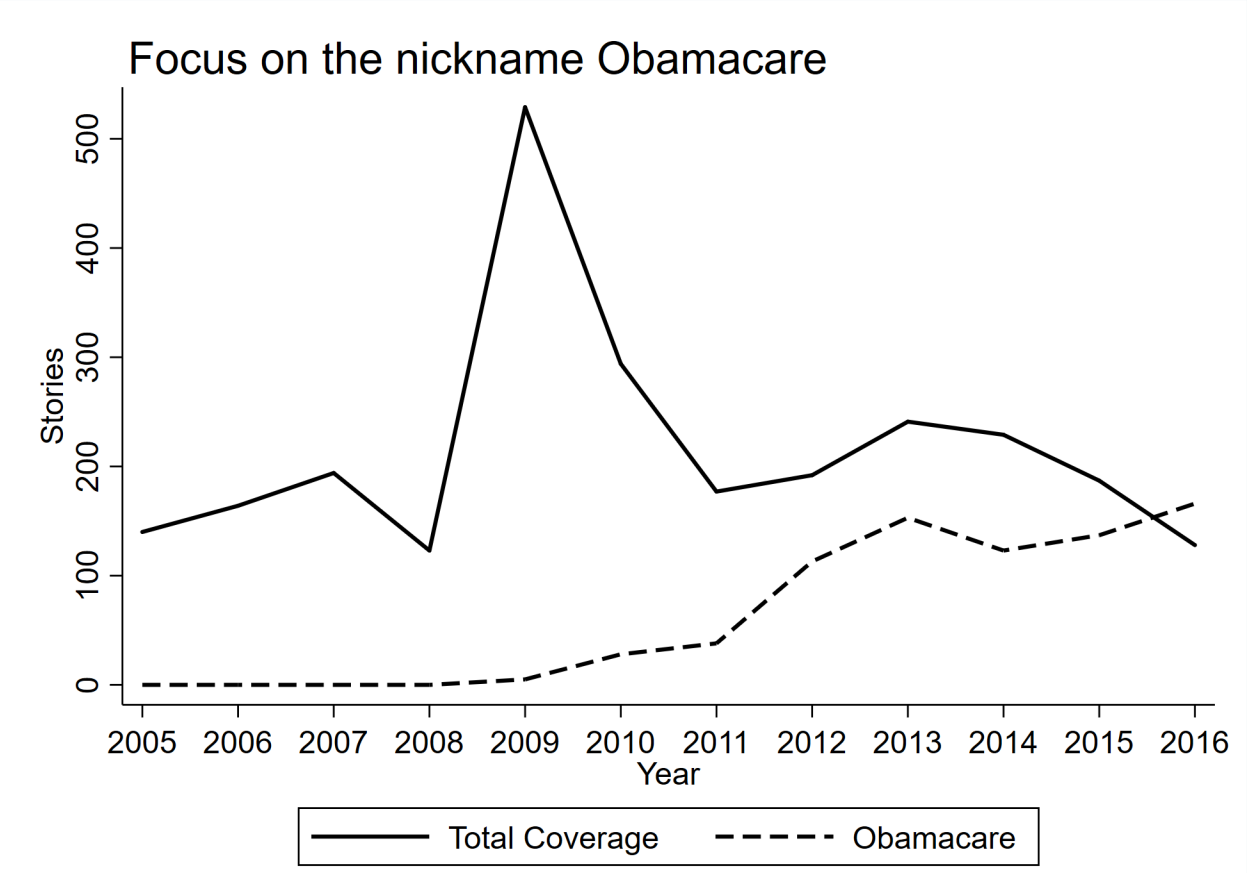
First of all, the American public thinks that most people on welfare are black (Banks 2014: 109). This is not the case, but it means that racial attitudes have a general tendency to dominate opinions on what can be considered welfare policies (Banks 2014: 109). If the policy is also framed or primed in a way that implicitly make race more salient to people, their opinions will become more connected to their racial attitudes rather than ideological considerations (Kinder 2013: 833). This is evident in studies where advertisement on welfare is accompanied by visual depictions of African Americans as the principal recipients of welfare (Kinder 2013: 834).

These appeals to prejudice do not have to be explicit in order to have an effect (Valentino et al. 2018). Actually, in the current American society, any straightforward appeals to racial prejudice are recognized as such and will make people distance themselves from these sorts of messages (Kinder 2013: 834). This was also evident in the same studies on advertisement when the portrayal of African Americans as the principal recipient became too obvious (Kinder 2013: 834).

In the case of the ACA, different aspects surrounding the debate combined to increase the implicit saliency of race without any outright racial frame or references. The spill-over theory put forward by Michael Tesler states that the racial connotations connected to President Obama, due to his skin color, spilled over to the policies he endorsed (Tesler 2012; Banks 2014: 15). When President Obama made the passing of the ACA one of his main goals in his first term as president, health care as an issue thus became racialized (Banks 2014: 105). This connection between President Obama's skin color and the health care reform was further strengthened by the nickname

"Obamacare" that became the opponents' way of referring to the ACA (Banks 2014: 108). The Tea Party framed "Obamacare" as a program that unfairly favored the poor and minorities such as African Americans (Banks 2014: 16). Thus, "Obamacare" was implicitly framed in a way that would make some white Americans perceive the bill as a threat to their "group", which helped increase the saliency of the dichotomy between in-group white Americans and out-group African Americans. As evident in Figure 6, the nickname "Obamacare" was introduced in 2009 and have grown to become a common and widespread way to refer to the bill.

Figure 6. Focus on the nickname "Obamacare"[5] (2005-2016)



[5] The figure shows that the number of times "Obamacare" was used in NY Times articles surpassed the total coverage of national health insurance in 2016. This is of course not the case seeing as that would be illogical. The reason for

On the basis of how the manner in which a health care proposal is referred to can be considered a frame in and of itself, I would expect the same kind of links to be present throughout the history of health care proposals. Indeed, even the categorization of health care proposals as either "voluntary" or "compulsory", which was the common and seemingly neutral way of distinguishing between different types of proposals throughout much of the 20th century, seems intuitively to be linked to ideas of freedom of choice or coercion, very much in favor of "voluntary" insurance proposals. Similar considerations apply to the modern way of distinguishing between "private" and "universal" or "for all" health care plans. This is an interesting aspect of the framing of the national health care debate, which is not thoroughly examined in this paper.

5.0 Conclusion

Throughout the last century the predominantly private health care system has grown increasingly expensive for the U.S. as a whole and for its citizens. Multiple health care reform proposals have been put forward by different U.S. presidents but to no avail. This paper has identified four frames – three negative and one positive – which have dominated the debate on national health care in the U.S. although to different extents. The positive "moral compassion" frame, which focused on the deservingness of recipients of national health care, has at all times throughout the century been the

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this is that my search for "Obamacare" did not have the same number of restrictions as the regular search had, seeing as Obamacare naturally would refer to national health insurance, which is what I wanted to look at, while search terms like "health insurance" and "health coverage" had to have complimentary keywords such as "national" or "government" to make sure the searches were valid. This observation means that the percentage of "Obamacare"-related articles are overestimated in the figure, which is something I have to account for in my analysis of the trend.

single most used frame, while the negative "Un-American" and "Free market" frames, which focused on American exceptionalism and free market principles respectively, were almost as widespread as the moral frame in the debate before 1965 ("Un-American") and after 1993 ("Free market"). A net result of the four frames revealed that positive stories had generally outnumbered negative stories since 1965. Public opinion surveys from 1950-2000 told somewhat the same story, but also showed how Americans had become satisfied with the erstwhile health care system, how they generally distrusted government involvement in health care, and how negative frames therefore have had better conditions throughout this period. Lastly, I identified an implicit link between the nickname "Obamacare" and the racialized opinions on the Affordable Care Act of 2010 and argued that the same kind of implicit frames might apply to other ways in which earlier health care reform proposals have been referred to, which is not captured by the frames I have found.

In summary, the Overton window has not shifted significantly, in terms of what kinds of health care the American citizenry would find acceptable, in part because of a constant contest between strong competing frames. However, it should be noted that this paper has focused mainly on the time period from 1910-2010. Since the AFA was signed into law in 2010, it seems as if parts of the debate have taken a massive leap, and that terms like "universal health care" and "medicare for all" have become household terms, especially within the Democratic Party. Time will tell if a potential Democratic President elect will be able to shake off more than a century's worth of failed attempts, and create a universal health care system in the U.S.

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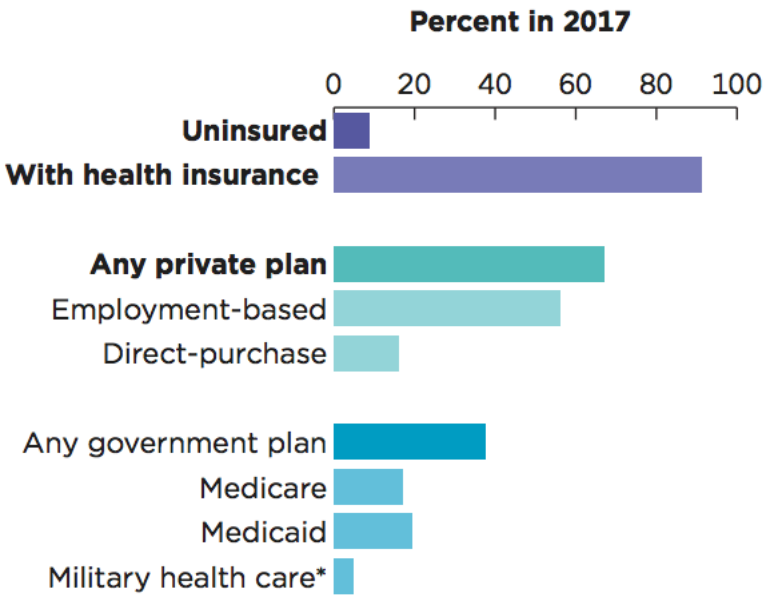
Appendix

A) Percentage of People by Type of Health Insurance Coverage and Change From 2013 to 2017



Source: U.S. Census Bureau, Current Population Survey, 2014, 2017, and 2018 Annual Social and Economic Supplements.