Critical discourse analysis:
An enabling and challenging research tool for Australian health policy reform

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Abstract

This Working Paper is based on a thesis submitted October 2008 to fulfil the requirements for the degree, Doctor of Philosophy. The researcher began the doctoral study intrigued by the electorate's acquiescent response to the substantial restructuring of Australian health financing. Policy communication offered contradictory, yet often persuasive policy rationales. The conveyed sociopolitical constructs were consistent with the federal Coalition[1] government's political ideology, yet these policy interpretations seemed contrary to the wider community's affinity with Medicare and 'free' (at point of entry) public hospital access. In spite of this, the government's knowledge claims remained unchallenged, or there was a reduction in the power and importance of external policy critique. Federal policy elites became the only 'authoritative interpreters' of policy problems and solutions (Kaati, Sjöström, & Vester, 2004, p. 234). What was clearly observable throughout the policy debates was that the federal government's argumentation either emphasised the importance of the public health system or promoted its retrenchment. This paradoxical but seemingly influential language may provide a pathway to understanding the considerable restructuring of Australia's health financing policy.

This study uncovers one understanding of this phenomenon through Italian philosopher, politician and political theorist Antonio Gramsci's concepts of *hegemony* and *common sense.* His explorations suggest that certain groups exercise cultural and ideological power over other groups (Gramsci, 1971, p. 45). Through consent rather than coercion, the dominant or 'leading' social group's ideas, beliefs, interests and interpretations may become justified and internalised by other social groups (Gramsci, 1971, pp. 161, 244). Gained by 'passive' (acquiescent) or 'active consent', the acceptance of this prevailing *common sense* enables the leading group to exercise and legitimise its social and political control in capitalist societies. The *common sense* ideas mediated through the leading group's elites become the 'popular beliefs' for policy reform (Gramsci, 1971, pp. 45, 244, 335, 413; Birchfield, 1999, pp. 44–45, 48). These Gramscian concepts of *hegemony* and *common sense* provided relevance for understanding political mechanisms that may reduce the democratic representativeness of public policy (Strinati, 2004, p. 149; Navarro et al., 2006, p. 1022). This understanding inspired the researcher to undertake a new approach to health policy analysis to interrogate the ways elected policy elites legitimate and reinforce their policy financing imperatives. Critical theory informed the study and critical discourse analysis underpinned and operationalised the theoretical and conceptual frameworks.

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1 The Coalition government held federal office from 1996 to 2007. The 'Coalition' is a constant alliance between the Liberal Party of Australia and the National Party of Australia at the federal level. Weller & Young (2000, p.177) conclude that the federal Coalition government operates as one rather than two political parties due to its stability, and adherence to the convention of Cabinet solidarity. The researcher concurs with this conclusion. Although National Party backbenchers intermittently express policy discontent in the media, large numbers did not cross the floor opposing Liberal Party legislation during the research time frame. Further, these backbench articulations do not appear to affect Cabinet collectivity or decision-making processes.

This paper further stems from a presentation at the New Zealand Discourse Conference hosted by the Auckland University of Technology, Institute of Culture, Discourse and Communication, Auckland, on 6–8 December 2007. Within the theme, Discourse and Politics, the presentation explored the application of critical discourse analysis to Australian health policy reform. It highlighted the empirical data organisation, whilst addressing the analytical challenges encountered. The research found critical discourse analysis an enabling *and* challenging research tool for Australian health policy reform.

Australian health policy reform on the examining table

The research offers a discursive examination of Australian health policy reform from 1998 to 2004. This period was selected due to its sustained and incremental policy activity motivated by the following policy developments. The first major health policy reform was the taxpayer-funded 30 percent private health insurance rebate initiated in 1998 – 1999. This policy returned to a similar scheme not seen in Australian health financing for more than two decades. The thesis argues that the rebate policy, a non-means-tested deductible private expense, is the most substantial and discrete change to *government funding* of intermediary medical insurance since the 1984 introduction of public universal insurance (Medicare). In 1998 – 1999, a Medicare levy surcharge was also re-introduced to penalise Australians on higher incomes who did not purchase private health insurance.

Put into effect in 1999 – 2000, the lifetime rating policy (Lifetime Health Cover) is the most divergent change to the *community rating* system underpinning Australia's private health insurance sector. The policy significantly changed the structure of private health insurance from community rating to an age-related risk policy when purchased. The objective is to encourage people to purchase the commercial product before the age of 31 years (cf. Department of Health & Ageing, 2001).

In 2000, gap-cover schemes were introduced to enable private health insurance agencies to fully indemnify (or indemnify an agreed component) for the medical gap. The medical gap is the difference between the inpatient fee charged by specialist practitioners, the reimbursed Medicare Benefits Schedule fee, and the private health insurance benefit. Previous long-standing restrictions to medical-gap insurance were due to the acknowledged *inflationary* properties to Australia's medical fee-for-service remuneration system (cf. Gray, 1999, 2004; McAuley, 2005).

The final private health insurance policy, higher rebates for older Australians instigated in 2004, is the most mathematically puzzling policy. It *rewards* older Australians for their existing purchase commitments to the private health insurance product, as well as older Australians who newly purchase private insurance. The rebate increased to 35 percent for people aged 65 to 69, and to 40 percent for people aged 70 or older. Yet the previously implemented Lifetime Health Cover policy ensured that older Australians newly purchasing private health insurance would pay 35 per cent *more* than they would have before (Denniss, 2004, p. 9). Whilst the overwhelming majority (91 percent) of Australians aged 65 years and over hold health care concession cards for public health and medical services, strong affordability and life-course barriers to purchasing private health insurance particularly occur in the 75-plus age bracket. These barriers include low income, widowhood and living alone (cf. Temple, 2004, 2006).

Political discourse and the power of political ideas

Ideological standpoints attract some research attention in the Australian literature and provide noteworthy contributions to understanding health policy (cf. Bacchi, 1999; Palmer & Short, 2000; Hancock, 2002; among others). Representatively, Hancock (2002, p. 75) asserts that 'political ideology is a strong driver of policy reform'.

In extending these contributions, this in-depth study investigated the power of argument and persuasion within the disseminated political ideas (Finlayson, 2004, p. 531). Political ideas are spartanly investigated in the social science literature and commonly restricted to the key 'philosophical and political -isms' (van Dijk, 1995a, p. 140) such as

neoliberalism or conservatism. These broad concepts are often perceived or addressed as merely descriptive expressions with a high level of abstraction. However, analysing ideas within political discourse is more complex than categorising by these discrete abstractions. Similarly, with previous research often focused on the rise of technical rationality (evidence-based discourse) in clinical health policy (cf. Bacchi. 1999; Lewis, 2003; Lin, 2003; Willis, 2003), the ideological ideas of political discourse within non-clinical health policy have not been comprehensively addressed.

The ideological discourse of Australian policy elites conveys market-oriented reforms as necessary and inevitable policy ideas for prescriptive action. The 20th century British economist, John Maynard Keynes (1936, p. 383) reached a key conclusion: that dominant ideas, rather than arising intellectually, are sponsored and transmitted to gain the attention of policy elites and/or the wider community.[2] With Australian health policy reform increasingly prioritised by an overarching political ideology that preferences market individualism and centralised federalism, among other tenets, these political ideas warrant closer examination.

Drawing from social constructionist thought, the study explored the socially constitutive function of political ideas and considered the structural relevance of elected policy elites who dominate policy agenda-setting, with the former Health Minister/s and the Prime Minister as the focus. Political ideas influence all aspects of the policy-making and political process. Ideological language is cast in terms of 'truth assertions' and 'ideologies … are penetrated by the mechanisms of discourse' (Freeden, 1998, p. 94; Phillips, 1998, p. 849).

Therefore, the study investigated the policy talk and text within a case study of private health insurance and examined the roles of federal executive government and parliamentary practices. This analysis also included the intergovernmental mechanisms that govern public hospital funding between the Commonwealth and the states. Intergovernmental funding for state public hospitals became fused with the federal government rationale for private health insurance market intervention during the research time frame. The central analytical concern was the *actual* reduction to public hospital funding premised on increased private insurance membership. Concomitantly, the *threatened* reduction of public hospital funding through a recouping ('clawback') mechanism demonstrated that hegemonic politics and centralised federal practices significantly impacted on intergovernmental relations for health policy strategy, funding and service provision.

Theoretical orientation and underpinnings

A critical theory framework underpinned the study, which drew on these particular insights and concepts of Western Marxism. Gramsci's ideas provided a coherent theoretical framework to strengthen the research. His concepts revealed and reinforced the role of political ideas in the policy process, whilst seeking to explain the policy actors' roles in the ideological struggles and conflicts (Collyer, 2003; Haugaard, 2006, p. 3).

However, Gramsci did not provide a large space for language practices or discourse theory. There is no Gramscian discourse analytical framework as such, although language is a central element in Gramsci's relationship between coercion and consent (Purvis & Hunt, 1993, p. 494; Ives, 2005, p. 455). Gramsci's critical stance on positivism and idealism also clearly demonstrated his discourse theory; particularly that positivist language is pervasive in the 'common sense' of policy decisions. Overall, Gramsci viewed language as a substantial component of social reality (Ives, 2004, pp. 10, 13, 17).

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2 '[T]he ideas of economists and political philosophers, both when they are right and when they are wrong, are more powerful than is commonly understood. Indeed the world is ruled by little else. Practical men [sic] who believe themselves to be quite exempt from any intellectual influences, are usually the slave of some defunct economist' (Keynes, 1936, p. 383).

Regardless, a comprehensive analytical framework was needed to investigate the normalisation and 'efficacy' of political ideology conveyed by policy elites' discourse, and how this discourse may inform policy understandings (Torfing, 1999, p. 29). To explore how the Health Minister/s and the Prime Minister set the health policy reform agenda, a comprehensive research tool was required to examine how the policy elites discursively (re)construct policy reform legitimacy for public dissemination.

Critical discourse analysis

Critical discourse analysis was selected as the analytical scaffold to operationalise critical theory and the writings of Gramsci. The method provided critical insight into the various ideological, political and structural aspects underpinning the power of political ideas espoused by the federal Coalition government.

Providing the empirical framework, critical discourse analysis was used to explore the health policy reform texts and contexts systematically and comprehensively. The method revealed the dialectical (two-way) relationship within the social practice of discourse, a discursive event that is shaped by 'situations, institutions and social structures, but it also shapes them'. Policy elites' language strategies were probed to understand how they performed 'ideological work' (Fairclough & Wodak, 1997, pp. 258, 275). The study recognised that the senior ministry's political ideology greatly influences the selection of policy methods, goals and outcomes in public policy. The framing of policy problems and their solutions may not necessarily emanate from wider community concern, bureaucratic advice, or changes to policy or national indicators (Hay, 2002, p. 46; Kingdon, 2003, pp. 18, 88, 94). Thus, the political discourse of elected policy elites was the primary object of empirical investigation for this research. While Navarro et al. (2006, p. 1033) highlight that there would be a 'severe crisis of democracy' if elected representatives were unable to influence policy reform, my paper foregrounds that the investigation of the *mechanisms* of influence is crucial in a democracy.

The doctoral study blended the ideational theories of change (the role of political ideas and dominant ideologies) with the context of social structures (the agenda-setting strength of the federal executive government) and social practices (the discursive and hegemonic strategies of elected policy elites). A Gramscian conceptual and the critical discourse analysis scaffold assisted the identification of the political ideas and meaning making within political discourse.

Critical discourse analysis: An enabling research tool

The research combined aspects of Teun van Dijk and Norman Fairclough's critical discourse analytical frameworks. These researchers differ in certain theoretical outlooks. A Foucauldian influence is evident within Fairclough's work and van Dijk emerges from a somewhat formal linguistics approach. However, both theorists acknowledge the Gramscian concept of hegemony and incorporate the idea that 'language can be used for self-interested ends by power groups' (Chilton, 2005, pp. 19–20). Not all critical discourse analysts place themselves within a Western Marxist foundation. Nevertheless, it predominantly frames their analysis. The writings of Gramsci, a key figure in Western Marxism, motivated much critical analysis and influenced critical discourse analysis (Fairclough & Wodak, 1997, pp. 260–261).

van Dijk (1993, 1995a, 1995b, 1998) provides a sociocognitive theory and context of ideological discourse's (re)productive and transformative work. His theory distinguishes critical discourse analysis from mainstream policy analyses that do not provide a central exploration of policy reform's political context and ideology (Blommaert & Bulcaen, 2000, p. 450). van Dijk's critical work in ethnic prejudices, racism, and more general issues linked to the abuse of power and (re)produced inequality through ideologies is well known and highly regarded. He critiques many talk and text types (genres) of discourse, including media, political and everyday discourses (Fairclough & Wodak, 1997, p. 265).

Fairclough's (1989, 1995, 2001, 2003) sociocultural work elucidates how the creative combination of ordinary and political discourse restructures, establishes and maintains political and institutional relationships. Fairclough's work in the commodification of British public services and the rhetoric of political parties is also well known and held in high esteem. He analyses genres including advertising, marketing, media and political discourses (Fairclough & Wodak, 1997, pp. 260, 264–265).

This study's atypical combination of van Dijk and Fairclough discourse categories provided space to specifically tailor the codes to health policy discourse and form an analytical map of the policy debates. To the researcher's knowledge, the analytical mapping is unique to this doctoral study. Nevertheless, the research design enabled analysis and contextualisation of a large corpus of policy communiqués within one case study framework. The policy elites' institutional processes and language strategies were considered by reviewing 1172 documents to interrogate the ways in which communicative practices and political strategies attempted to secure hegemonic consent for policy reform. This in-depth examination accessed official documents as political discourse genres to retrieve the policy talk and text relevant to the policies of analytic interest. These documents included:

- Proposed Bills (first, second and third readings), assented Acts (legislation), and policy debates and parliamentary responses sourced from the transcripts of the Commonwealth House of Representatives and Senate parliamentary proceedings (Hansard). Assented Acts were sourced from the Australasian Legal Information Institute database; and

- Ministerial media releases, speeches, interviews and statements of the Health Minister/s and the Prime Minister (referred to collectively as 'ministerial communiqués', unless the context required otherwise).

The analysis was mapped chronologically, legislatively (that is, the Bill's passage through the Parliament) and contextually. Chronological presentation was crucial to the case study, as each sequential policy builds on the Coalition government's private health insurance market intervention. Legislative analysis also included an overview of public debate for each policy. This format established a contextual analysis of the participants, relationships and institutional mechanisms to provide insight into the highly political context of health policy reform (van Dijk, 1998, pp. 255–256). Contextualisation is prominent in critical discourse analysis to study the sociopolitical properties and power of discourse (van Dijk, 1993, pp. 249–250). Discourse is unequally 'loaded' and therefore reliant on *what is said, where, and by whom* that may have a power when spoken or written at another place or time, or by another speaker or writer (Hodge & Kress, 1993, p. 210). The contextual framework of critical discourse analysis provided the link to explore context-specific hegemonic ideas and processes through this specific analytical mapping.

The study then explored the ideological dimension communicated within policy talk and text associated with each key reform initiative. After data collation, data exemplars were drawn from extracts that employed a variety of ideological strategies to avoid repetition or inconsequential detail. The discourses and political context linked to intergovernmental mechanisms were organised somewhat differently by conditionality, negotiation and ministerial context. However, all sections explored the ideological dimension communicated within policy talk and text and were further organised by the critical discourse analysis codes. The instrumental rationality of economic/positivist, market/consumerist and medical/technical discourses were also examined, to assist in the identification of how these constructs were used to promote particular ideological positions and political objectives (Fine & Sandstrom, 1993, pp. 23–24; Fischer, 2003, pp. 13–14; Sindall, 2003, p. 81). The selected critical discourse analysis codes are tabled below.

Critical discourse analysis balanced its challenges (discussed later) as it provided an opportunity to present a comprehensive contextual analysis to complement the hegemonic underpinning of the research. Critical discourse analysis provided methodical insights into the presentations, strategies and structures of discourse that may

otherwise be obscured, opaque, repressed, over-generalised or selectively observed (Fairclough, 2001, pp. 122–123). Through the scrutiny of talk and text, the claims and processes within policy were analysed for constructed and (re)produced power (Hodge & Kress, 1993, p. 159).

As Fairclough (1989, p. 90) argues, the interest is more than 'mere words'. Critical discourse analysis highlights that 'power relations are exercised and negotiated in discourse' (Fairclough & Wodak, 1997, p. 272). It elucidates the hegemonic dominance of sociopolitical structures that legitimise policy and reveals how language plays a part in ideological and hegemonic struggles by linking 'the *surface* of talk and text to *underlying* ideologies' (Hodge & Kress, 1993, p. 157 [original emphasis]).

Table 1: Critical discourse analysis codes; Source: Fairclough (1989, 1995, 2001, 2003); van Dijk (1993, 1995a, 1995b, 1998)

Argumentation	Political strategy
- Authority - Evidentiality - Generalisation - Illustration - Number Game	- Consensus - Obfuscation - Populism
Ideological square	**Instrumental rationality**
- Positive self-presentation - Negative other-presentation - Polarisation	- Economic / positivist - Market / consumerist - Medical / technical
Rhetoric	**Lexicalisation**
- Hyperbole - Metaphor - Moral statement	- Description levels - Degree of completeness - Disclaimer - Functionality - Presupposition - Proposition

Critical discourse analysis: A challenging research tool

Critical discourse analysis is not commonly used to analyse Australian health policy reform. In this study, coding was the primary research challenge. There was minimal research design precedence, particularly within health legislation and other policy talk and text. The analytical codes selected are distinct to this research; however, the coding selected regularly connects with the investigation of ideology in talk and text through critical discourse analysis.

Firstly, the study required analytical codes that were relevant and important for the research objectives. As van Dijk (2001, p. 19) states, the codes must be at least interesting. Not all of the codes listed in the table were abundant in the data, however there were exemplars of each code within the large volume of data analysed. The codes were kept to a minimum to avoid becoming lost in the data.

Secondly, the many discursive strategies and structures used in political and legitimation discourse were intentionally avoided (see Hodge & Kress, 1993; van Dijk, 1993; and Jäger, 2001 for examples). Often used within Parliament and legislation, paths not travelled included syntax and analytical strategies, such as, the study of pronoun and formal structures. Other political science discourse analyses too numerous to list here were also avoided (cf. Chilton & Schäffner, 2002). These strategies unnecessarily complicated and elongated the critical discourse analysis framework without benefit for an ideological analysis. In this research, detail was considered crucial but complexity was not. This direction was chosen as critical discourse analysis is not a linguistic theory.

Finally, parliamentary debates have many structures at many levels, and again, to avoid being swamped by the data, the researcher avoided many specific argumentation and discourse strategies, speech acts, and interactional and other strategies. As parliamentary debates are typically argumentative and use various political strategies to 'sell' their ideas (Keating & Weller, 2000, p. 59), the analysis is most concentrated in argumentation and political strategies.

Analysis of political ideas

Using the most distinctive health policy reform of the 30 percent rebate (accompanied with the Medicare levy surcharge), this paper provides an exemplar below that demonstrates the study's application of critical discourse analysis. The political strategy of consensus was the most repeated and forceful argument underpinning the ideological shaping of the rebate and Medicare levy surcharge reforms. This strategy combined with risk privatisation narratives throughout most debates and ministerial communiqués to underpin policy objectives, means and outcomes statements.

After the strategy of consensus, the most frequent communicative strategies adopted for the rebate policy were ideological square, metaphor and the number game. These strategies inextricably linked the rebate initiative to power, conflict and contestation for the construction and interpretation of meaning. The exemplar follows.

> This continued decline (of private health insurance membership), although *smaller* than what we've *seen throughout most of the 1990s underscores the importance* of the new tax rebate and benefit … [ideological square, proposition and consensus]
>
> … I will be announcing further action to *tackle* some of the problems with private health insurance and *address key consumer concerns*. [common language and consensus]
>
> *Nobody should doubt our commitment* to put value back into health insurance and *make it a more affordable choice* and *to relieve pressure on our public hospitals …* [proposition, moral statement and functionality]
>
> Labor's *do-nothing* approach, having *ignited* the premium hikes that started the big *exodus* of members, was *responsible* for the problems the industry is still experiencing today. [ideological square and metaphor]

<div align="right">(Wooldridge, 1998)</div>

Research findings

The dominant communicative strategies manufactured consensus for the rebate and Medicare levy policies. The data demonstrates that the consensus claimed by the Cabinet ministers was not achieved through democratic processes such as wide public consultation and debate, engagement with a broad range of academics and policy analysts, or the presentation of evidence-based or comparative analysis to the wider community. The Coalition government's political communication throughout 1998 did not address calls for quantified evaluations. Instead, the

political discourse promoted ideological homogeneity through the tenets of market individualism and risk privatisation. No evidentiary analysis accompanied this promotion.

For all health policy reforms within the research time frame, the research found that political discourse presented market individualism and risk privatisation as the universal answer to the question of improving hospital access. Authoritative claims and insistences for reform consensus permeated the language of all policy communications. Political discourse conveyed a hegemonic order built around perceived and actual consent for legislative restructuring, with the Coalition government communicating a taken-for-granted acceptance of selective knowledge claims in shaping health policy reform. Debates predominantly contained values, principles and beliefs. Powerful representations of individual 'choice', self-reliance and other moral statements of individual behaviour and social organisation dominated policy rationales. Discursive representations of 'choice' and consensus constrained the reform debate to the inevitability and necessity of privatised medical insurance and hospital services. The public health sector was consigned a residual and 'safety-net' role. These claims connected with insurance risk discourse, with the political idea revolved around uncritical assertions of 'consumer' autonomy and sovereignty. Policy elites promoted private insurance as a dedicated pathway to the 'choice' and immediate access to private hospitals and specialist practitioners. Substantial insurance subsidies and other supportive resources from the public purse reinforced this promotion.

Redressing knowledge gaps

Gramscian concepts and the method of critical discourse analysis allowed the thesis to resolve some analytical gaps in health policy reform. It contributes to health policy knowledge and widens policy research in several interconnected ways. Firstly, the work contributes to policy analysis by investigating the policy language that presents and promotes the 'idea' and understanding of reform. This in-depth examination of Hansard, assented Acts and ministerial communiqués uncovered the rich problematic of policy reform language. Political discourse and strategies revealed their constitutive functions, which were to (re)produce and (re)construct senior Cabinet ministers' legitimacy and political power in problem interpretation and policy direction. An analysis through mainstream policy approaches would not have produced the richness of data this research provides.

Secondly, political ideology is widely recognised as the keystone in health policy. However, the power of political ideas in health policy attracts minimal research attention. The little research undertaken is viewed predominantly through broad ideological concepts, with studies more descriptive than analytic. The study reverses this trend. It offers a fresh approach to policy analysis that recognises attempts to manufacture consent for substantive social change. The ideological discourse of policy elites is underpinned with a comprehensive methodology and transdisciplinary methods. The study reveals the relevance of Gramscian applications and critical discourse analysis to contemporary democratic concerns.

Finally, to accommodate the lack of public access to Cabinet decision making, the study applied an interpretive agenda-setting or 'entrepreneurial' theory to policy elites. Tools were imported from political science and adapted aspects of economic theory were incorporated with contextual discourse interpretations. This 'entrepreneurial' theory provided a way to understand the policy elites' privileged voices in policy development, parliamentary practices, legislative strategies and public communications. Overall, the research contributes to the understanding that policy analysis cannot move forward without addressing the power of political ideas and the examination of ideologically-prescriptive values in policy making.

Methodological reflections

It would be prudent to assume that the influence of political communication in policy reform varies. However, as Schmidt & Radaelli (2004, pp. 184, 192) clarify, when discourse wields a causal influence on policy reform or

provides a pathway for the legitimation of new ideas, values and practices, it becomes an object for empirical investigation.

The Coalition government required not only the discursive strategies of political discourse but also other techniques of modern hegemonic politics. The latter included particular forms of economic or access incentives and disincentives, for example 'carrot and stick' approaches in the rebate and Medicare levy surcharge policies; an allegedly powerful economic and access incentive in Lifetime Health Cover; and economic rewards in both the gap-cover schemes and the higher rebates for older Australians.

This study took an uncommon methodological approach to health policy analysis, attempting to uncover implicit, unrecognised or unarticulated hegemonic institutional and ideational processes. Considering that the enacted policy reforms may not be in the interest of all social groups, the study attempted to understand if the communication of political ideas was shaped to gain hegemonic consent from the wider community.

Critical discourse analysis provided added depth to the understanding of private health insurance policy and intergovernmental funding mechanisms. It revealed the communicative practices and political strategies that powerfully legitimate and reinforce the former federal government's policy imperatives, and therefore powerfully influence social and political outcomes.

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