UNIVERSITY OF CALIFORNIA

SANTA CRUZ

MEDIA FRAMING OF U.S. HEALTH CARE REFORM: A NEW ERA OR REINFORCING DOMINANT IDEOLOGIES OF HEALTH AND THE HEALTH CARE SYSTEM?

A dissertation submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY

in

PSYCHOLOGY
with an emphasis in FEMINIST STUDIES

by

Beth K. Jaworski

September 2012

The Dissertation of Beth K. Jaworski is approved:

_____
Professor Heather Bullock, Chair

_____
Professor Craig Haney

_____
Professor Eileen Zurbriggen

_____
Tyrus Miller
Vice Provost and Dean of Graduate Studies

Table of Contents

Abstract

March 2010 marked the passage of historic health care reform legislation, the Patient Protection and Affordable Care Act (ACA). The partisan showdown that surrounded the introduction of health care reform, through its passage, captivated the public and dominated news coverage. The media undoubtedly influenced public opinion about key areas of contention as well as policymakers' support or opposition to the ACA. The primary purpose of this study was to investigate how mainstream newspapers framed health care reform from the time that the first version of the ACA was introduced by the Senate Finance Committee through passage of the final legislation. As a highly charged political issue, it is likely that competing frames were emphasized (Chong & Druckman, 2007a; 2007b). A content analysis of 475 articles from seven top-circulating U.S. newspapers was conducted to document the prevalence of competing frames in the following seven domains: (1) the determinants of health; (2) the nature of health care; (3) entitlement to health care; (4) key beneficiaries of health care reform; (5) expense of health care reform; (6) consequences of governmental involvement in health care; and (7) public support for health care reform (limited vs. nearly universal). Support for reform was primarily framed as a health insurance market intervention that would benefit nearly everyone, improve the health care system, and lower costs, whereas, opposition to reform was predominantly described as a costly "government" takeover that would burden individuals and businesses and decrease the quality. Supportive frames about the ACA's key beneficiaries commonly co-occurred with opposing frames about reform

increasing costs. Notably absent were conceptualizations of health care as a human right or public good, even among reform supporters. Future research directions for scholars committed to health care as a matter of social justice are outlined.

Acknowledgments

I am indebted to many people affiliated with the UCSC Psychology Department. I would like to thank my primary advisor, Dr. Heather Bullock, for all her help and guidance. She has provided tremendous support and has been instrumental in my graduate school success. I would also like to thank Dr. Eileen Zurbriggen, my advisor during my first two years of graduate school. Although my research interests shifted, Eileen continued to play a role in important role in my development and served on both my qualifying exam and dissertation committees. Thank you to Dr. Craig Haney for his guidance and service on my qualifying exam and dissertation committees. I had the privilege of taking courses with Drs. Bullock, Haney, and Zurbriggen. They have greatly influenced my perspectives on research and social justice and I feel honored to have worked with them. Thank you also to Drs. Martin Chemers and Barbara Goza. Their mentorship, kindness, and willingness to include me in their work helped me enormously. I would also like to thank Lacey Okonski, Harmony Reppond, Jennifer Rigney, Elisabeth Thompson, Shirley Truong, and Vickie Nam. They have listened to countless practice talks, read drafts of papers, and provided the friendship and support necessary to succeed in graduate school. A special thank you is also necessary for Samantha Bean, Vicky de Monterey Richoux, Richard Enriquez, Philippe Fradet, Stephen Karney, Tyler Wilmoth, and Marta Yushprakh, the outstanding undergraduate research assistants who provided valuable insights for my dissertation and coded all the newspaper articles.

In addition to my mentors, colleagues, and friends at UCSC, there are many other individuals who have contributed to my success. Thank you to Drs. Arthur Glenberg and Simone Schweber. Without them I would have never thought about attending graduate school, nor had the training necessary to succeed. Thank you to my parents, Chris and Arlene Jaworski, who have always provided me with support and encouragement. Many friends have helped me throughout graduate school and I am eternally grateful for the love and support of John Alfsen, Heather Amundson, Catherine Baker, Rachael Behrens, Tomi Brooks, Nick Haen, Kathy Kanazawa, Carlos Konishi, Erin Mews, John Mumma, and Theresa Schriever.

Chapter One

Introduction

> I am not the first President to take up this cause, but I am determined to be the last. It has now been nearly a century since Theodore Roosevelt first called for health care reform. And ever since, nearly every President and Congress, whether Democrat or Republican, has attempted to meet this challenge in some way. A bill for comprehensive health reform was first introduced by John Dingell Sr. in 1943. Sixty-five years later, his son continues to introduce that same bill at the beginning of each session. Our collective failure to meet this challenge -- year after year, decade after decade -- has led us to the breaking point.

("Remarks by the President to a Joint Session of Congress on Health Care," 2009, para. 6-7)

The health care system in the United States costs more than any other industrialized nation, yet ranks very poorly among most health indicators, and U.S. life expectancy ranks close to last among 34 comparison nations (Organization for Economic Cooperation and Development [OECD], 2011). However, large-scale health care reform initiatives in the United States have been largely unsuccessful, and "pessimism is perhaps the best attitude with which to assess national health care reform" (Gray, Lowery, Monogan, & Godwin, 2009, p. 82). Nonetheless, President Barack Obama undertook the challenge of reforming the U.S. health care system and his campaign and presidential term have been marked by this highly publicized, controversial issue. As President Obama's statement makes clear, he was well aware

of his predecessors' unsuccessful national reform initiatives but also optimistic that the outcome of his efforts would be different. He believed the U.S. health care system had reached a "breaking point" and was no longer functional. Although President Obama is unlikely to be the last president to undertake comprehensive health care reform, he was the first to achieve the passage of such legislation.

Despite pessimism about prospects for comprehensive reform, heated debates, and lack of Republican support (characterized by events such as Republican Congressman Joe Wilson shouting "You lie!" during President Obama's address to a joint session of Congress in September 2009), reform legislation was signed into law on March 23, 2010. Together, the Patient Protection and Affordable Care Act (Pub. L. No. 111-148), which was amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152 signed into law on March 30, 2010), constitute what is popularly known as "health care reform."

This legislation addresses some of the most problematic aspects of the current health care system, particularly those related to access and affordability of health insurance and care. In 2009, over 50 million people or 16% of the U.S. population did not have health insurance (DeNavas-Walt, Proctor, & Smith, 2010). Between 2003 and 2010, the number of underinsured people rose 80%, from 16 million to 29 million (Commonwealth Fund, 2011). However, even those with health insurance cannot consistently afford medical care. In a Harvard University study, researchers found that illness, injury, and medical expenses contributed to over 60% of personal bankruptcies, and that nearly three-quarters of those who filed bankruptcy had health

insurance at the time (Robert Wood Johnson Foundation, 2009). Reform legislation seeks to create new insurance marketplaces through which affordable insurance and care can be accessed, with government subsidies provided to those who cannot afford coverage, and Medicaid expanded to provide health up to 133% of the federal poverty level (Goldstein, 2010; Kaiser Family Foundation, 2011).

However, this legislation lacks many of the components needed for comprehensive reform and is less progressive than the universal coverage proposed by President Obama during his campaign. Despite concessions made by President Obama and progressive Democrats in Congress, such as eliminating a "public option," health care reform legislation still failed to generate the bipartisan support desired by President Obama. Neither piece of legislation was supported by a single Republican congressperson or senator. At the March 21, 2010 vote in the U.S. House of Representatives, the Patient Protection and Affordable Care Act (ACA) passed by only three votes over the total needed (219 House Democrats voted in support of the bill with a total of 216 votes needed for its passage).

Partisan objections to health care reform persist. A Kaiser Family Foundation (2010) poll following the 2010 mid-term elections found that eight out of ten self-identified Republican voters hoped for a full or partial repeal of the health care reform legislation and many Republican candidates promised to repeal health care reform. By December 2010, nearly two dozen lawsuits had been filed against the federal government to block the implementation of the health care reform law (Sack, 2010). In November 2011, the Supreme Court decided to hear challenges to health care

reform law. Underscoring the continued controversy surrounding health care reform and the magnitude of its political and legal impact, *New York Times* journalist Adam Liptak remarked that "whatever the outcome [of the case], the tensions running through the case…are likely to give rise to both a political and constitutional blockbuster" (Liptak, 2011, para. 4).

The partisan showdown that surrounded President Obama's reform initiative captivated the public and dominated news coverage. In the final week prior to the passage of the Patient Protection and Affordable Care Act, over one-third (37%) of news coverage focused on health care reform and over half of the public (53%) identified health care reform as the news story that they followed most closely (Pew Research Center, 2010). Between August 2009 and the legislation's passage on March 30, 2010, between one-third and over one-half of the general public reported that they were "very closely following" news about health care reform (Pew Research Center, 2010).

The media undoubtedly influenced public opinion about key areas of contention as well as policymakers' support or opposition to health care reform. Media pundit Jon Stewart identified hyper-partisanship in politics and media reporting as the "nation's curse," suggesting that this polarization makes solving the nation's problems more difficult (Rich, 2010, para. 4). This may be the case for health care, yet media framing of the recent U.S. health care reform debate has been largely unexamined (for an exception, see a special issue of *The Forum,* 2010). The primary purpose of the current study was to investigate how mainstream newspapers framed

reform from the time that first health care reform bill was introduced by the Senate Finance Committee through passage of the final legislation. A content analysis of 475 articles from seven top-circulating U.S. newspapers was conducted to document the types and frequency of frames used to characterize the debate.

Analysis of mainstream news media framing can shed light onto the attitudes and beliefs that may have contributed to support for health care reform during a time marked by high rates of poverty, unemployment, and limited access to health coverage (e.g., DeNavas-Walt et. al., 2010), and provide new insight into relationships among public opinion, media frames, and health care reform legislation. Equally crucial is examining frames that dominated and were absent in media coverage. Doing so can provide a better understanding of public discourse and offer insight into strategies for advancing a more just health care system.

In the following chapters, I provide an overview of relevant history and research related to the health care system, health policy, and media framing, describe the methods employed in the current study, summarize and interpret the findings, and offer suggestions for justice-oriented health research and policy.

Chapter Two

Overview of the U.S. Health Care System and the Need for Reform

Health insurance coverage in the United States, the gateway to health care access, is closely linked to full-time employment. Occupations which offer employee-sponsored health insurance are not equally available to all members of society, nor do all individuals participate in the paid workforce. This clearly has left women (those working in domestic labor, part-time, or not outside the home), low-wage workers (whose employers do not offer health benefits), part-time workers, and the self-employed outside of the health care system. Over three-quarters of the uninsured come from working families (Institute of Medicine, 2003; Kaiser Commission on Medicaid and the Uninsured, 2011) and as the cost of health insurance rises, the number of employers offering health benefits continues to decrease. Large companies with high-wage earners are more likely to offer employee-sponsored insurance than small companies or those with primarily low-wage workers.

Current conceptualizations of U.S. health insurance are rooted in Texas. In 1929, Justin Ford Kimball, a lawyer and professor, developed the foundation of the Blue Cross hospital insurance plan (Cohn, 2007; Minor, n.d.). Teachers who agreed to pay a set monthly or annual rate secured up to 20 days of care at Baylor Hospital, with a set amount paid to the hospital through their plan. Ironically, Texas is now the state with the highest rate of uninsured people in the U.S. (Kaiser Family Foundation on Health Coverage & Uninsured, 2010).

The federal government recognized that these measures did not go far enough and that a safety net was needed for those who were unable to work or were too poor to afford the out-of-pocket costs of health care. As part of the New Deal, President Roosevelt signed the Social Security Act into law in 1935. To address high rates of poverty and unemployment during the Great Depression, the new law provided funds for retirees and the unemployed, a payment to surviving family, assistance for poor families with dependent children, public health programs, and assistance for the blind. However, these initiatives failed to provide equal access. Occupations held by women, particularly women of Color, were largely excluded from the job categories that qualified for unemployment insurance and pensions (Mink, 1995; Quadagno, 1994). In 1939, the law was modified to allow more women to receive pensions, but their receipt was often linked to marital status. Single women received fewer or no benefits (Mink).

As the United States moved out of the Great Depression, and into the more prosperous World War II era, higher rates of employment strengthened the health insurance-employment connection. During this time period, the federal government issued wartime wage controls, but excluded fringe benefits, such as health insurance, from regulation. Thus, health benefits became one way to attract competitive job candidates. The federal government also decided that employees would not have to pay taxes on any income that they contributed to health insurance from their employers (Cohn, 2007) nor would employers have to pay taxes on money they contributed to health insurance for their employees (Blumberg & Nichols, 2004).

In spite of the relative prosperity and low unemployment rate during World War II, President Truman attempted to overhaul the U.S. health care system. Although President Roosevelt was the first U.S. president to identify "adequate medical care and the opportunity to achieve and enjoy good health" as rights guaranteed to all members of society "regardless of station, race, or creed" (Franklin D. Roosevelt Library & Museum, n.d.), President Truman was the first to try to establish the federal government's role in helping individuals achieve those rights. In 1945, President Truman proposed a national health care program funded by the federal government for all who wanted to participate (Harry S. Truman Library & Museum, n.d.). In his address to Congress, he stated that every American citizen should have the

> right to adequate medical care and the opportunity to achieve and enjoy good health…millions of our citizens do not now have a full measure of opportunity to achieve and enjoy good health and [they] do not now have protection or security against the economic effects of sickness. The time has arrived for action to help them attain that opportunity and that protection. (The American Presidency Project, as cited by Harry S. Truman Library & Museum, n.d., para. 2)

Democratic members of Congress and large labor unions supported Truman's plan, but the American Medical Association strongly opposed it, invoking claims of communism and socialized medicine (Harry S. Truman Library & Museum, n.d.). Berkowitz (2010, p. 7) describes 1935-1965 as the "Lost Years" in terms of working

toward establishing national health coverage run by the federal government. In fact, the increasing availability of private insurance from the 1940s and until the 1980s, is seen as one of the main reasons for lack of political support for a national health care plan (Klein, 2003).

The next step forward in expanding health care access did not occur until 1965 when the Social Security Act was amended to include funding for the newly created Medicare and Medicaid programs. These programs still exist today, albeit in modified form. Medicare, a federal program funded primarily through payroll taxes, was created to provide health insurance for those ages 65 and older or those who meet other special criteria (Centers for Medicare & Medicaid Services, 2011). Medicaid was created for low-income individuals and families and people with disabilities to receive medical care. It is jointly funded by federal and state governments, and is administered at the state level. Although not required by law to do so, all states currently operate Medicaid programs. These programs often use state-specific names such as TennCare in Tennesee and Medi-Cal in California.

Under President Clinton, the Health Insurance Portability and Accountability Act (HIPAA) passed with overwhelming bipartisan support. HIPAA aimed to increase the protection of confidential patient data, increase the portability of health insurance when people changed jobs, and decrease costs by reducing fraud. After President Clinton's defeated health reform initiative, HIPAA reflected a move toward incremental changes in the private health insurance market as a way to solve the large-scale problems of the health care system (Hacker & Skocpol, 1997). As its

name and aims imply, HIPPA reflected ideologies of individualism and personal responsibility for reforming the health care system. Additionally, the Social Security Act was amended once again in 1997 to include the State Children's Health Insurance Program (SCHIP). SCHIP was designed to cover uninsured children whose families earn above Medicaid thresholds but who lack sufficient earnings to pay for health coverage for their children. During his presidency, George W. Bush twice vetoed expanding SCHIP. In February 2009, President Obama passed legislation which expanded health insurance to an additional four million children and pregnant women. Importantly, legal immigrants were eligible for the program without a waiting period.

The Centers for Medicaid and Medicare estimate that 98 million adults and children are covered by Medicare, Medicaid, or the SCHIP (U.S. Department of Health & Human Services [HHS], 2009). These programs provide basic assistance to some of the most vulnerable groups; however, given the high number of uninsured and underinsured people as well as longstanding disparities in access to health care and health outcomes, it is clear that the needs of many remain unmet (National Healthcare Disparities Report, 2009). Presidents Truman and Clinton, and Senator Edward M. Kennedy attempted to initiate major health care reform but each of their efforts was defeated.

With each passing year, U.S. health care has become less about "care" and more about cost control (Berkowitz, 2010). From the 1980s onward, employers have cut health care benefits and coverage to control costs (Cohn, 2007). However, the

need to rein in costs is, at least in part, based on the rapidly increasing health insurance premiums. Researchers at Kaiser Family Foundation found that between 1998 and 2008, employee-sponsored health insurance premiums rose four times more than the inflation rate (Rowland, Hoffman, McGinn-Shapiro, 2009). Moreover the percentage of companies offering health insurance benefits dropped from 69% to 63% between 2000 and 2008. At the same time, co-pays and deductibles paid by employees steadily increased. Currently, employer sponsored health insurance provides health care coverage to 61% of the population under the age of 65, and 16% of the U.S. population is covered through Medicaid, Medicare, and SCHIP (Rowland, Hoffman, McGinn-Shapiro). However, Medicaid, Medicare and SCHIP were never designed to fully meet the health care needs of those who require assistance and due to rising costs of co-pays and deductibles even those with employee-sponsored health insurance struggle to afford health costs. For these reasons, people with government health insurance face difficulties obtaining affordable, quality health care.

Public support is strong for improving national health and decreasing the number of uninsured but majority support for increasing taxes to expand health insurance coverage or viable alternatives to the current system remain elusive (Blendon & Benson, 2001; Blendon, Benson, & DesRoches, 2003). Soaring health care costs and shrinking health care coverage have, however, contributed to a potential climate for change. A *New York Times/CBS News* public opinion poll conducted during the 2008 presidential campaign found that the majority of respondents across party lines believed that the federal government should guarantee

health insurance to every American and supported pay higher taxes to ensure access (Toner & Elder, 2007). Additionally, eight out of ten respondents rated universal access to health care as more important than extending Bush administration tax cuts (Toner & Elder).

By the time President Obama took office, economic conditions were worse than during his presidential campaign. The Great Recession was underway, the unemployment rate doubled, and the number of uninsured people skyrocketed. From December 2007 to June 2010, Medicaid enrollment increased by almost 20% and for the first time exceeded 50 million enrollees (Kaiser Commission on Medicaid Facts, 2011).

The Consequences of a Broken System and the Need for Health Care Reform

The consequences of repeated reform failures are reflected by skyrocketing medical expenses, the high number of uninsured and underinsured individuals and families, and poor outcomes on national health indicators. In 1975 approximately 8% of the U.S. gross domestic product (GDP) went toward health care spending (Orszag & Ellis, 2007), by 2009 this figure rose to 17.4% (OECD, 2011), and by 2020 health care spending is estimated to reach 20% of the GDP (Orszag & Ellis). Further evidence is provided by comparative analyses. A study of health care spending in 34 industrialized nations revealed that average per capita spending in the United States ($8,000) is over twice as much as the average spending of all other countries, including wealthy European nations such as France, Belgium, and the United Kingdom (OECD). In an investigation of twelve industrialized nations (Australia,

Canada, Denmark, France, Germany, Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States), Squire (2011) found that private health care spending was highest in the United States, and the U.S. ranked second for the most government spending on health care and out-of-pocket money spent on health care expenses.

The costliness of U.S. health care contributes to personal bankruptcies. Researchers at Harvard University found that illness, injury, and medical expenses contributed to over 60% of personal bankruptcies, and that nearly three-quarters of those who filed bankruptcy had health insurance at the time (Robert Wood Johnson Foundation, 2009). Gross and Notowidigo (2011) estimated that out-of-pocket medical expenses account for 26% of bankruptcies among low-income households. The costliness of the U.S. health care systems has grave consequences for businesses, government, and individuals, and in the words of civil rights activist, Reverend Jesse Jackson (2011, para. 6), if there is no change, "health care will bankrupt everything -- federal and state governments, private businesses, and families."

The U.S. health care system also fails to cover a substantial portion of the population. In 2009, over 50 million people, more than 16% of the U.S. population, did not have health insurance (DeNavas-Walt et. al., 2010). This does not include the large group of people who are considered "underinsured." "Underinsured" is typically defined as having health insurance but: a) medical expenses exceeding 10% of annual income; b) an annual income of 200% of the federal poverty level and medical expenses greater than 5% of annual income; or c) health plan deductibles greater than

or equal to 5% of annual income (Short & Banthin, 1995). Over 25 million people between the ages 19 to 64 are estimated to be uninsured (U.S. News & World Report Health, 2008). This figure reflects a 60% increase since 2003 (Schoen, Collins, Kriss, & Doty, 2008).

Despite being the most expensive health care system in the world, U.S. residents continue to have embarrassingly poor health outcomes, particularly in relation to other industrialized nations. Compared to Australia, Canada, Germany, the Netherlands, New Zealand, and the United Kingdom, the United States places last in access to care, efficiency of the system, and the ability of residents to lead long, healthy, productive lives (Commonwealth Fund, 2010; Squires, 2011). The U.S. health care system performs poorly across many domains including: infant mortality and childhood obesity rates, primary and preventative care, preventing hospitalizations for those in nursing homes, rehospitalizations for standard procedures, safe care (e.g., correct medications prescribed), health disparities, and patient-centered, timely, coordinated care (Commonwealth Fund, 2011). To address critics who claim that it is unfair to compare the United States, an ethnically and racially diverse country, to more homogeneous nations, Meunnig and Glied (2010) compared life expectancy rates of White women in the U.S. to twelve other industrialized nations with populations over seven million and a gross domestic product of at least 60% of the United States. They found that white women in the U.S. had a lower fifteen year survival rate than all other comparison countries,

indicating that even among relatively privileged groups the U.S. health care system performs poorly.

Understanding U.S. Health Care System Failures – Health as a Matter of Social Justice

Critiques of the health care system in the United States abound. The fact that access to high quality, affordable health care is so limited resonates with those who see health care reform as a matter of social justice. A social justice lens draws attention to group-level inequalities and promotes structural analyses that examine how health and well-being are undermined by unfair policies and practices. Social psychologists have an important role to play in expanding the definition of what constitutes "good health" and understanding the attitudes and beliefs that contribute to health injustices.

One way to examine the unequal distribution of health care and differential health outcomes is through the lens of health disparities. Although meanings of the terms "health disparities," "health inequalities," and "health inequities" vary in the domestic and international research literature (see Braveman, 2006), most "definitions share an emphasis on avoidable and unjust aspects of health" (Adler, 2009, p. 664). Adler notes that while health behavior research focuses on the individual as the locus of control, disparity research focuses on the social context and has "increasingly been used to emphasize the injustice of differences in health among groups" (2009, p. 664). Importantly, Braveman (2006, p. 180) also identifies the need to address social advantage (or disadvantages) of particular groups, and defines it as

"one's relative position in a hierarchy determined by wealth, power, and/or prestige." She points not just to the need for addressing health differences between racial and ethnic groups, which is how health disparities is typically conceptualized in the U.S., but also the importance of interrogating power and privilege. Thus, from a social justice perspective, the consequences of unaffordable and inaccessible health care are outlined using the lens of "health disparities."

The U.S. Department of Health and Human Services (HHS) and the Office of Disease Prevention and Health Promotion manage the *Healthy People Initiative,* a set of national health objectives for improving health in the United States. Reducing disparities in health care access and outcomes among diverse groups is a major aim of this initiative. Initial work on health disparities focused primarily on racial and ethnic group differences (e.g., Smedley, Stith, & Nelson, 2003), however, socioeconomic disparities are also common, and in some cases racial/ethnic disparities in health can be accounted for by socioeconomic status (Adler, 2009). In 2003, the Agency for Healthcare Research and Quality (housed within HHS) released its first set of reports on health care disparities and the quality of U.S. health care. Their work documents major disparities in care and health outcomes based on race/ethnicity, class, gender, and geographic location (National Healthcare Disparities Report, 2003; National Healthcare Quality Report, 2003). Nearly a decade later, little progress has been made. According to their most recent report (NHDR, 2010), disparities are still widespread and are increasing in some areas. In Adler's (2009) review of progress toward meeting the *Healthy People Initiative* objectives, she found that of 195