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**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

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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.

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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 Tennessee 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 Notowidigdo (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, Meunig 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

indicators containing race/ethnicity information, only 24 showed reductions in disparate outcomes and treatments whereas disparities grew in 14 other areas.

More recently, health care disparity research has expanded to include sexual orientation (Conron, Mimiaga, & Stewart, 2010). There too, health care disparities, and differential outcomes are seen among gays and lesbians compared to their heterosexual counterparts. Collectively, the disparities literature paints a picture of a health care system that works significantly better for the white, wealthy, and those with private health insurance. From a social justice perspective, a health care system that primarily serves privileged groups is not a just system and requires significant reform to ensure that quality, affordable health care is available to all.

Consequences of an Unjust Health Care System

Some of the most publicized and controversial components of reform focus on diminishing barriers to care, specifically as they relate to lack of insurance and subsequent inability to access care. Not surprisingly, lack of insurance is one of the strongest predictors of health care disparities (NHDR, 2010, pg. 111). To understand how increasing insurance coverage, and in turn, ability to access care, can reduce health disparities, it is necessary to consider how unequally these health care resources are distributed across the population.

Portraits of the Uninsured and Underinsured. In the United States having health insurance or the ability to pay out-of-pocket for health services is essential to accessing care. Over 50 million people in the United States do not have any health insurance, and over 25 million are underinsured. Since 2003, the rates of uninsured

have steadily increased and the consequences of lacking insurance are grim. The uninsured tend to be less healthy, report poorer physical and psychological health, and have poorer patient-doctor relationships (Bharmal & Thomas, 2005; Cheong et al., 2007). Hadley's (2003) review of over 25 years of research in this area found that the uninsured were less likely to receive preventative care and therapeutic treatments (drug or surgical), and more likely to be diagnosed at more advanced stages of disease and forego recommended treatment because of cost. Not surprisingly, the uninsured also have higher mortality rates than the insured. Better health is positively correlated with greater educational attainment and increased annual earnings, highlighting that health insurance not only predicts better health outcomes but in turn may also play a role in improved educational and economic status.

Not everyone in society is equally likely to be uninsured. In the U.S., the uninsured are more likely to be poor, people of Color, have less education, and be male (Cheong, Feeley, & Servoss, 2007). More specifically, Latinos are significantly less likely than Whites (68.2% compared to 87.4%) to have health insurance, poor people are significantly less likely to have coverage than their high-income counterparts (71.6% compared with 94.4%), those with less than a high school education are a third less likely than their counterparts who have some college education (59.2% compared with 89.0%), and those who speak another language than English in the home are three times less likely than their English-speaking counterparts (11.5% compared with 33.5%; NHDR, 2010).

High out-of-pocket medical costs are a significant barrier to care for the underinsured. The percentage of people whose family's health insurance premiums and out-of-pocket medical expenses were more than 10% of the family's total income was four times as high for poor individuals (family income of less than 100% of the federal poverty level), almost three times as high for individuals at 100%-199% of the federal poverty level), and more than twice as high for middle-income individuals than high-income individuals (NHDR, 2010). Comparing private non-group insurance to private employer-sponsored insurance, a significantly larger percentage of people with private non-group insurance have health insurance premiums and out-of-pocket medical expenses that are more than 10% of the family's total income compared to those with private employer-sponsored insurance (51.5% compared with 16.9%). This is particularly true among women of Color. Even when women of Color are insured, they are less likely to have comprehensive coverage (Kaiser Family Foundation, 2004; Silliman et al., 2004).

Geography also matters. Those living in nonmetropolitan areas are also at a disadvantage compared to their counterparts in metropolitan areas, though the magnitude of the difference was slightly smaller. In nonmetropolitan areas, 22.9% of families had 10% of their income going to medical expenses compared to 16.5% of families in metropolitan areas. Low-income families, even if they are insured, often have to worry about whether their insurance will be accepted by a particular provider, ultimately underscoring that even when one is insured it does not automatically make health care services accessible (DeVoe et. al., 2007).

Lack of Access to Care. In addition to having health insurance, access to a regular source of primary care is critical for preventative care and continuity. Having a “medical home” is associated with better health, lower costs of care, and reduced intergroup disparities (Starfield & Shi, 2004). Having a regular primary care provider is also an important indicator of access to care and is correlated with increased participation in recommended preventative care (Robert Graham Center, 2000). American Indians/Native Alaskans and Latinos are less likely to have a usual source for ongoing care than Blacks, Whites, and Asians although there are differences among Latinos and Asians based upon country of origin (NHDR, 2010). The percentage of poor people with a source for ongoing care is significantly lower than for those with high incomes (79.5% compared with 92.3%), and those with no insurance are also significantly less likely to have a source for ongoing care than those with insurance (53.5% compared with 91.9%; NHDR, 2010). Among those without a usual source of care, Latinos are more likely than Whites to identify lack of finances or insurance as a reason. Not surprisingly, those who are uninsured (compared to the insured) and those that are poor or near-poor (compared to their middle and high income counterparts) indicate that lack of finances or insurance is the reason for not having a usual source of care. Those with less than some college education are also more likely than their counterparts with some college education to indicate that lack of insurance or finances is the reason for not having a usual source of care (NHDR, 2010).

These examples make clear that entry into the health care system via health insurance – a starting point for minimizing health disparities – is unattainable for vulnerable groups. Because health care is so closely linked to full-time employment, those who have part-time or low-wage jobs often do not have health care benefits. People of Color are disproportionately represented among the working poor, have limited access to the health care system, and are unequally served by it. Health care reform and its aim of increasing health insurance coverage represents an important first step toward eliminating barriers to accessing health care and in turn, improving health outcomes.

Fatal Consequences of Unaffordable Care and Unequal Treatment

Disparities in health care quality, clinical conditions (e.g., cancer, diabetes, end stage renal disease, heart disease, HIV/AIDS, mental health and substance abuse, respiratory disease), and care settings (e.g., primary care, home health care, hospice care, emergency departments, hospitals, and nursing homes; NHDR, 2010, p. 8) are amply documented. Across nearly all process and outcome measures, the uninsured fare worse than those with insurance. In nearly all of statistical models, lack of insurance emerges as the single best predictor of quality of care.

Lack of insurance, however, does not explain all racial and socioeconomic differences. Inequalities in access and negative outcomes follow a similar pattern across types of diseases. I use the case of cancer to exemplify how unequal access and care has fatal and unjust consequences for members of marginalized groups. My

discussion is intended to highlight the serious, even fatal consequences of lacking insurance and their unequal distribution in U.S. society.

The Case of Cancer Disparities

The National Cancer Institute (NCI; 2010, para. 1) describes cancer disparities as:

adverse differences in cancer incidences (new cases), cancer prevalence (all existing cases), cancer death (mortality), cancer survivorship, and burden of cancer or related health conditions that exist among specific population groups in the United States. People who are poor, lack health insurance, and are medically underserved (have limited or no access to effective health care) – regardless of ethnic and racial background – often bear a greater burden of the disease than the general population.

To better understand the relationship between cancer and socioeconomic status, the American Psychological Association's, Office on Socioeconomic Status developed the Socioeconomic Status Related Cancer Disparities Program (SESRCDD). The SESRCDD works to develop and promote evidence-based cancer prevention and control specifically for socioeconomically disadvantaged groups (SESRCDD, 2012). During fiscal year 2009, the National Cancer Institute distributed nearly five billion dollars to researchers to help eliminate disparities (NCI Funded Research Portfolio, FY 2009). While progress has been made in identifying disparities, much work remains to eliminate them.

Colorectal Cancer. Colorectal cancer, also called colon cancer or cancer of the large bowel, is the third most common cancer and the third leading cancer-related mortality among U.S. men and women (National Cancer Institute, 2010). However, stage of diagnosis and mortality vary considerably across groups. Black men and women have a higher incidence of cancer compared to White men and women (incidence rate of 62.1 per 100,000 compared with 51.2 per 100,000). Black men and women are also more likely to die from colorectal cancer than White men and women (26.7 deaths per 100,000 compared with 18.9 deaths per 100,000).

Breast and Cervical Cancers. In fiscal year 2009, the National Cancer Institute was allocated almost \$600 million was allocated to fight breast cancer (Office on Budget and Finance, 2009). Breast cancer is the second leading cause of death among U.S. women (National Center for Health Statistics, as cited in National Cancer Institute, 2009). In 2006, the most recent year for which data were available, breast cancer was the number one cause of cancer death among Latinas (Centers for Disease Control, 2010). Although white women have the highest incidence rate of breast cancer compared to all other racial groups, Black women are much more likely to have their breast cancer diagnosed at an advanced stage than white women (111.1 per 100,000 compared with 93.7 per 100,000). This gap is widening and Black women are more likely to die from breast cancer than white women (NHDR, 2010). Recent research from Europe indicates that poor women are 20% more likely to die from breast cancer than wealthier women (Lister, 2010). Ehrenreich (2001, p. 45) has argued that even though breast cancer is the “biggest disease on the cultural map,

bigger than AIDS, cystic fibrosis, or spinal injury,” it has garnered corporate support to market “pink kitsch.” Despite all the money being funneled into breast cancer awareness, white, wealthy women with insurance seem to be the largest beneficiaries. With respect to cervical cancer, Black women and Latinas who reside in low-income areas and rural areas have the highest incidences of cervical cancer as well as the highest mortality rates, though across racial categories, mortality rates rise with decreasing socioeconomic status (Center to Reduce Cancer Health Disparities, 2005).

There are no cures for cancer. However, colonoscopies, mammograms, and pap smears can detect abnormalities and diagnose cancers before they have reached advanced stages. However, people of Color, the poor, the uninsured, and people living in rural areas are significantly less likely to receive preventative health care. Delaying or foregoing care clearly results in a later-stage diagnosis (if care is sought at all), and ultimately, higher mortality rates. Collectively, these disparate rates of cancer and their fatal consequences underscore the need for a health care system that provides affordable, accessible, and timely care for all.

Chapter Three

Key Aspects of the ACA and Public Opinion toward Health Care Reform

Lack of affordable care and its fatal consequences are among the most troubling shortcomings of the U.S. health care system and attempts at reform are not new. Significant reform, particularly the expansion of health coverage, is a challenge that has been undertaken by many different groups throughout the 20th century (Hoffman, 2001; Klein, 2003; Patel & Rushefsky, 1995; 1998; Skocpol, 1996). For this reason, the passage of the Patient Protection and Affordable Care Act is an especially poignant moment in U.S. history. Describing the passage of the Affordable Care Act in the House of Representatives, House Speaker Nancy Pelosi said:

Last night, we made history....we honored the vows of our founders who in the Declaration of Independence talked about life, liberty and the pursuit of happiness. We believe the legislation that we have gives all people in our country the liberty to have healthier lives. (Herszenhorn & Pear, 2010, para. 4)

Although the new law does not address all health inequities, it does seek to fix some of the most broken parts of the system. The U.S. Department of Health and Human Services asserts that the ACA will improve U.S. health care and alleviate disparities by providing preventative care, increasing coordinated care of managing chronic diseases, improving the diversity and cultural competency of health care professionals, increasing the number of health care providers in underserved communities, ending insurance discrimination, and offering affordable insurance through a health insurance marketplace (Healthcare.gov, 2011).

Some reform provisions - providing affordable coverage to adults with pre-existing conditions who have had been uninsured for at least six months, allowing young adults under the age of 26 to remain on their parent's insurance plans, prohibiting insurance companies from denying coverage to children with pre-existing conditions, and barring insurance companies from rescinding coverage for adults if they become sick or made an unintentional error on their application forms - were enacted in September, 2010. However, many others such as state-regulated health insurance markets through which individuals and small businesses can purchase health insurance coverage do not take effect until 2014. The Congressional Budget Office (2011) estimates that the Patient Protection and Affordable Care Act will cover an additional 32 million people when it is fully implemented in 2019. Coverage is estimated to cost approximately \$938 billion from 2010 to 2019, but will reduce the federal deficit by \$124 billion during the same time period by decreasing overall health care costs and generating revenue.

Expansion of Access and Coverage

Expansion of access and coverage is one of the most controversial dimensions of the new law. Commonly referred to as the "individual mandate," most U.S. citizens and legal residents will be required to have health insurance coverage. However, many exemptions will be granted. For instance, exemptions will be considered on the basis of financial hardship, religious objections, short term need (i.e. less than three months). Certain groups, such as American Indians and incarcerated women and men, are also exempt. Undocumented immigrants will be

unable to purchase government-regulated coverage through the exchanges and are ineligible for premium subsidies. These groups will only be able to purchase plans offered outside the exchanges that do not have to meet government standards for comprehensive coverage. States will be responsible for creating American Health Benefit Exchanges - nonprofit or governmental agencies through which individuals, families, and employers can purchase health care plans. Families and individuals earning up to 400% of the federal poverty level will receive subsidies/assistance to help pay for the insurance. Separate exchanges will be created so that small businesses can purchase insurance for their employees and employers will be penalized if their employees receive subsidies to purchase insurance. This is intended to encourage employers to provide health coverage. Medicaid eligibility will be expanded to those who earn up to 133% of the federal poverty level. Medicaid benefits must provide coverage equivalent to the minimum level of health benefits established for health plans available on the exchanges. For children enrolled in Medicaid and SCHIP, states must maintain current income eligibility through 2019.

Employer Requirements

The new law strongly encourages businesses with over 50 employees to provide health insurance. In 2014, these businesses will be fined \$2,000 for each full-time employee who receives tax credits for the exchange. Employers that offer coverage are required to provide free choice vouchers to their employees who earn less than 400% of the poverty level so they are able to choose a plan on the exchange.

Premium and Cost-Sharing Subsidies to Individuals

The government will provide refundable and advanceable income tax credits to eligible individuals and families for purchasing health care insurance. Those eligible would be permitted to keep a portion of their incomes that would normally go to income tax to help pay for their health plan on an exchange. For those earning up to 133% of the poverty thresholds, no more than 2% of their annual incomes can go toward premiums; for those earning 133%-150% of FPL only 3%-4% of their incomes may be used for premiums; for those earning 200%-250% of FPL only 4% – 6.3% of their incomes may be used for premiums; for 250%-300% of FPL only 6.3% - 8.05% of their incomes may be used for premiums; and for 300%-400% of FPL a maximum of 9.5% of their incomes may go toward premiums.

Premium Subsidies to Employers

Beginning in January 2010, the new law provided small employers (i.e., businesses with 25 or fewer employees and employees with an average annual income of less than \$50,000) with a tax credit if they purchase health insurance for their employees. The new law also creates a temporary reinsurance program for employers who provide health insurance coverage to retirees over age 55 who are not eligible for Medicare.

Tax Changes Related to Health Insurance and Financing the Reform

Some of the expenses associated with health care reform will be financed by tax increases and tax penalties. For instance, funds will be generated by increased taxes for higher-income individuals or couples, and by imposing penalties on

individuals and employers who do not comply with the mandate to obtain or provide coverage. Beginning in 2018, additional taxes will be generated by high-priced insurance plans, or the plans popularly referred to as “Cadillac” plans. Additional taxes will be levied against indoor tanning, the pharmaceutical manufacturing industry, and the health insurance sectors.

Health Insurance Exchanges

States will create American Health Benefit Exchanges and monitor all aspects of them including eligibility, the creation of benefit tiers, monitoring rating variation, ensuring renewability of plans, and that all plans meet the exchange requirements. Larger states may have more than one exchange and smaller states will be able to join together and create regional collaborative. The exchanges will be comprised of health plans with the following four benefit levels: (1) bronze under which 60% of the cost of the benefits are covered by the plan; (2) silver in which the plan covers 70% of the cost of the benefits; (3) gold, covering 80% of the cost of the benefits and; (4) platinum, the most expensive plan which covers 90% of the benefits’ costs. Additionally, insurers must offer a lower-cost “catastrophic” plan for people under the age of 30. All insurers need to offer silver and gold tiers to be included in the exchanges.

States will also establish an essential health benefits package which all Medicaid plans and plans on the exchange and individual and small group markets must offer by 2014. As established by HHS, all essential health benefits package must include items and services within at least the following ten categories: ambulatory

patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse services; prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services including oral and vision care (Healthcare.gov, 2012). A website will be developed to help consumers understand their coverage options, a standard format for presenting coverage options will be created, and standards for providing information on benefits and coverage will be established.

Changes to Private Insurance

A temporary high-risk pool will be established for the uninsured with pre-existing conditions. Health plans will need to be transparent about the actual costs of services and rankings of quality. The administration side of the health plans will be required to streamline and simplify their processes. Dependent coverage must be provided for children, up to age 26, on all policies. Individual and group health plans cannot place lifetime dollar limits on coverage, nor can they take away coverage, except in cases of fraud. Beginning in January 2011, insurers of those with individual plans must spend at least 80% of the cost of premiums on medical care, and insurers of employee-based plans must spend 85% of the cost of premiums on medical care.

Cost Containment

Medicare and Medicaid will be restructured to reduce cost. One cost containment strategy includes requiring that pharmaceutical companies can only have exclusive domain of a drug for twelve years before the generic version is introduced. Additional oversight will be put in place to cut down on waste, fraud, and abuse of

public programs, including keeping a database to share data across states and federal government organizations.

Improving Quality/Health System Performance

Research examining the effectiveness of medical practices is supported under the new law. States will be awarded grants to find alternatives to medical malpractice lawsuits and to improve patient safety by reducing medical errors. Primary care services will be provided in-home for high-need Medicare recipients. Hospitals receiving money via Medicare will receive payments based upon quality measures. For those receiving Medicaid and Medicare, receipt of services and benefits will be more coordinated. Medicaid payment rates to primary care providers and doctors will be increased, with bonus payments going to primary care physicians. A national quality improvement strategy will be developed and a community-based Collaborative Care Network Program will be established to coordinate and integrate health services for the low-income uninsured and underinsured populations. Financial relationships between health providers and manufacturers and distributors will need to be disclosed, and enhanced collection and reporting data on race, ethnicity, sex, primary language, disability status, and for underserved rural and frontier population will be required to monitor disparities.

Prevention and Wellness

Under the new law, a National Prevention, Health Promotion and Public Health Council will be established along with task forces charged with facilitating the dissemination of evidence-based research. Preventative care will be improved by

eliminating cost-sharing for those receiving Medicare and Medicaid. Recipients will also receive personalized health risk assessments and prevention plans. Wellness programs created by employers will be supported via direct funding, premium discounts, and waivers of cost-sharing requirements. Beginning in 2011, chain restaurants and food sold from vending machines will be required to disclose nutritional information.

Long-Term Care

A national, voluntary program for purchasing community living assistance services will be established. Medicaid will be expanded to improve assisted living options. Nursing facilities will have to disclose (publicly) information regarding ownership, accountability requirements, and expenditures.

Other Investments

A strategy will be developed and implemented to cultivate diverse, culturally-competent health care providers trained to work with underserved populations. The development of interdisciplinary training programs will be encouraged. Funding for community health centers and school-based health centers will be increased dramatically to \$11 billion over five years. Emergency department and trauma center care will be strengthened and a service corps will be established to respond to national disasters. Non-profit hospitals will be required to conduct community needs assessments and work to meet those needs.

Who and What Is Not Covered by the ACA?

In spite of the many changes established by this historic legislation, two types of coverage are excluded: care for undocumented immigrants and abortion services. While proponents of the legislation touted that coverage would be expanded to an additional 32 million individuals, 11.9 million undocumented immigrants living in the United States remain uninsured (Pew Hispanic Center, 2009). Additionally, women seeking abortion services face new challenges attaining coverage via the exchanges. Under the Hyde Amendment, passed in 1976, abortion is only allowable in cases of rape or incest, or if the mother's life is in danger, and no federal money can be spent on "elective" abortions. Given that the federal government will provide a substantial amount of funding for health exchanges, women seeking abortion will potentially face the added complication and expense of trying to buy additional coverage, finding a plan that might cover abortion, or paying for an abortion out-of-pocket.

In sum, the ACA offers the promise of sweeping changes to the U.S. health care system but only if all components are realized. Health care reform, at least in theory, will provide higher quality, efficient, and less costly care. Yet, even if all provisions of the health care reform law are successfully implemented, it remains to be seen how much will be achieved and some groups (e.g., undocumented immigrants) and services (e.g., abortion) will remain excluded.

How Does the Public View Health Care Reform?

Over the past fifty years, public opinion polls reveal relatively high, stable levels of dissatisfaction with the health care system (Blendon & Benson, 2001),

nevertheless, Republican policymakers and much of the general public expressed mixed views about President Obama's reform initiative (Brodie, Altman, Deane, Buscho, & Hamel, 2010). In a public opinion poll conducted during the end of August and beginning of September 2009, 38% of those polled were in favor of passing health care reform, 40% were opposed, and 22% were unsure (Jones, 2009).

The discrepancy between public dissatisfaction with the current system of care and lack of supportive consensus for various health care reform initiatives is well documented (e.g., Blendon, Benson & DesRoches, 2003; Bundorf & Fuchs, 2007). Blendon and his colleagues (2003) found that the majority of the general public supported expanding health coverage to the uninsured, but rejected increasing taxes to do so, nor was a national, single-payer health plan supported. In poll by the Kaiser Family Foundation (2009), the majority of respondents supported financing health care reform via increased "sin taxes" (e.g., taxes on cigarettes, alcohol, wine, beer, and unhealthy snack foods) and taxes on families earning more than \$250,000 annually, but rejected a national sales tax. Grande, Gollust, and Asch (2011) found that contrary to claims made by reform opponents, support for a government-run public option ranged from 46.5% to 64.6% depending upon question wording.

Attitudes toward health care reform vary by demographic characteristics such as education, gender, political affiliation, and socioeconomic status (e.g., Blendon et al., 1994; Blendon, Benson, & DesRoches, 2003). Men, conservatives, Republicans, wealthy individuals, and those with higher education tend to prefer private-sector solutions for reforming the health care system whereas women, liberals, Democrats,

individuals with lower incomes, and the less well educated favor government run reform (Blendon et al., 1994). Attitudes toward reform likely intersect with pre-existing attitudes and beliefs about fairness and perceived deservingness to impact support for reform (e.g., Lynch & Gollust, 2010). Lynch and Gollust found that perceived fairness about inequalities in access and quality of care strongly influenced support for government-sponsored health insurance.

Brodie and her colleagues' (2010) have identified nine attributes that characterize public opinion toward health care reform:

(1) competing interests (health care is only one issue the public cares about); (2) distrust of government; (3) partisan contradictions (partisan priority assigned to health care and disparate solutions); (4) longstanding support for health reform; (5) views on reform components (certain elements of reform had more support than others); (6) how individuals feel about their own health care coverage; (7) personal impact of health care reform for individuals; (8) lack of awareness of key issues (e.g., the role of media coverage and misperceptions about the legislation); and (9) dislike for personal sacrifice (supportive of reform but disinclined to pay for it). These attributes point to areas that were controversial and highly publicized in the media suggesting that framing of these issues likely contributed to public opinion about the ACA.

Media framing of health care reform is important to explore as a way to understand how opinions may be shaped. According to Nelson, Clawson, and Oxley (1997, pg. 569), "When opinions are ambivalent, the framing of an issue by the mass

media or other communication agent may have an uncommon influence on opinion by shaping the values and other considerations individuals draw on when formulating their own views on the subject.” Mixed support for health care reform and the confusion surrounding its impact may allow media framing to have a greater influence in shaping attitudes and beliefs than if there had been consistent, majority support for all aspects of the reform.

Chapter Four

Media Framing as a Vehicle to Understand the Construction of the ACA

Media has a powerful influence on a range of social issues including affirmative action, crime, the environment, free speech, health care, immigration, social security reform, and welfare reform (e.g., Gollust, Lantz, & Ubel, 2009; Haney & Greene, 2004; Iyengar, 1991; Jerit, 2008; Jerit, 2006; Nelson, Clawson, & Oxley, 1997; Nelson & Kinder, 1996; Shen & Hatfield Edwards, 2005; Shibley & Prosterman, 1998). The majority of research examining the impact of mass media on public opinion focuses on agenda setting, priming, and framing (e.g., Borah, 2011; Entman, 2007; Scheufele & Tewksbury, 2007). Agenda setting (i.e., media emphasis on particular events or issues), priming (i.e., making certain beliefs or concepts more accessible, and in turn, available to use for opinion formation), and framing are often grouped together under the umbrella of mass media effects. However, Borah (2011) asserts that psychological processes involved in framing are distinct because its effects cannot be explained strictly by the accessibility of a particular belief or concept. Framing is of particular import to the current study.

Although the breadth and scope of health care reform is extensive, media coverage has tended to focus on a few select controversial areas. Media framing plays an important role in creating a shared public understanding of the health care system and health care reform. Framing of the perceived flaws of our current system and proposed reform can shape views on how the system should be reformed, who is

viewed as responsible for fixing the system, the perceived beneficiaries of reform, and the potential outcomes of it.

The average adult in the U.S. consumes approximately 70 minutes of news media each day including newspapers, television, or online news sources, excluding additional time spent viewing news on cell phones or other digital devices (Pew Research Center, 2010c). Health care reform was an important and closely followed news event. Just prior to the introduction of the health care reform bill in the House of Representatives in September 2009, over 25% of the general public identified health care as one of the top problems facing the United States (Jones, 2009). Despite considerable criticism of the media's coverage of health care reform (Pew Research Center for the People & the Press, 2010c) between August 2009 and the passage of the final health care reform legislation on March 30, 2010, one-third to over one-half of the general public reported "very closely following" news about health care reform (Pew Research Center for the People and the Press, 2010a). Thus, regardless of disapproval, media framing of health care reform likely influenced public opinion about many key issues.

Framing Overview

Framing is generally understood as the ways in which meaning is imposed on a particular event, issue, or situation. Goffman describes framing as a way to "provide background understanding for events that incorporate the will, aim, and controlling effort of an intelligence, a live agency, the chief one being the human being" (1974, p. 22). Goffman further draws attention to the fact that frames can be "coaxed,

flattered, affronted, and threatened...motive and intent are involved, and their imputation helps select which of the various social frameworks of understanding is to be applied” (1974, p. 22) and that ambiguities in events/situations are resolved with framing because they not only address, “what could be going on, but also which one of two or more clearly possible things is going on” (1974, p. 302-303).

Goffman’s (1974) definition corresponds with Chong and Druckman’s (2007b; see also Druckman, 2011) conceptualization of *frames in thought* or *individual frames*. This type of frame refers to the way in which an individual processes an issue or event and in turn, how her or his perception of the event or issue shapes attitudes, beliefs, and opinions. Chong and Druckman contrast frames in thought with *frames in communication* or *media frames*. Although the two are related, frames in communication refer to how a speaker (e.g., political elite or media outlet) determines which aspect of an issue or event to highlight for an audience. Both types of frames work in concert to shape attitudes and opinions. Druckman, citing the work of Kinder and Sanders (1996, p. 164) also highlights the dual nature of frames and their importance in political debates:

frames lead a double life...frames are interpretive structures embedded in political discourse. In this use, frames are rhetorical weapons...At the same time, frames also live inside the mind; they are cognitive structures that help individual citizens make sense of the issues...

Frames are an ever-present feature of political discourse, instruct people how to think about complex social policy problems and ultimately “provid[e] a kind of mental

recipe for preparing an opinion” (Nelson & Kinder, 1996, p. 1058). More specifically, frames define problems, diagnose causes, make moral judgments, and suggest remedies (Entman, 1993, p. 52)

Collectively, frames impose a particular meaning on a situation, event, or issue. As such, they can be manipulated to convey the particular desired meaning, agenda, or intent of a person or institution. Understanding how frames are constructed and deployed to gain support for policies that promote health care and well-being as a matter of social justice is essential.

Framing Effects

A large body of social science research illustrates the powerful effects of frames on attitudes and beliefs (e.g., Bullock & Fernald, 2005; Bullock, Wyche, & Williams 2001; Kelly, 1996; Iyengar, 1991; Nelson, Clawson, & Oxley, 1997a; Nelson & Kinder, 1996; Nelson & Oxley, 1999; Nelson et al., 1997b; Sniderman & Theriault, 2004). Research investigating framing effects typically focuses on the use of emphasis frames and equivalency frames (Druckman, 2011; Druckman, 2001). Emphasis frames refer to the way in which a chosen value is highlighted, such as the importance of free speech versus public safety in determining tolerance for a Ku Klux Klan rally (Nelson et al., 1997a). Tversky and Kahneman’s (1981) Asian disease dilemma provides a classic illustration of the power of equivalency frames, which are frames that use different wordings, but have logically equivalent outcomes. The outcomes in the Asian disease scenarios were the same (600 people would die), whether the solution was framed as saving 200 people (success with implicit loss of

600), or the solution would result in 600 people dying (loss with implicit saving of 200 people) determined support for the solution. Even though the same total number of people died in each condition, significantly greater support was found for the solution that was framed as a “success” (the focus was on the number of survivors) instead of a “loss” (the focus was on the number of fatalities). In a related vein, Bigman, Capella, and Hornik (2010) examined the perceived effectiveness of the HPV vaccine on support for a mandate policy. They found that perceived effectiveness and support for the vaccine mandate was greater when the outcomes were framed in terms of its effectiveness (70% effective) than when it was framed in terms of its ineffectiveness (ineffective 30% of the time).

Although the effects of frames are powerful in and of themselves, the fact that people hold pre-existing attitudes and beliefs about complex social issues cannot be ignored. Thus, the interaction between pre-existing attitudes and framing effects must also be considered. For example, Nelson and Kinder (1996) found that modern racism was a stronger predictor of anti-affirmative action attitudes when African Americans were portrayed as having an unfair advantage. In another study, Nelson and Kinder found that antigay attitudes were a stronger predictor of reduced AIDS funding when recipients were perceived as blameworthy. These findings underscore the importance of understanding how social and political attitudes and beliefs intersect with dominant frames to influence policy attitudes.

Pre-existing attitudes may be particularly important when it comes to health care policy. A study by Knowles, Lowery, and Schaumberg (2010) calls attention to

the extent racial attitudes likely played a role in support for President Obama's health care reform plan. Using an experimental paradigm, President Clinton's and Obama's proposed health care reform initiatives were described identically:

In 2009 [1993], President Barack Obama [Bill Clinton] proposed an overhaul to the health care system in the United States. The Obama [Clinton] plan was designed to extend health insurance coverage to all or most Americans.

President Obama [Clinton] stated that the plan would rein in costs by capping individuals' out-of-pocket expenses for health services and prevent denial of coverage based on pre-existing conditions. Most observers agree that the Obama [Clinton] plan would increase the federal government's involvement in the health care sector (Knowles, personal communication).

Implicit anti-Black prejudice was found to be negatively associated with support for health care reform, but only when the plan was attributed to President Obama, and not when it was attributed to President Clinton. Additionally, Rigby and her colleagues (2009) found that when health disparities were framed as varying by income level and educational attainment, racial disparities tended to be minimized, and participants were more supportive of government intervention. Of particular import, Lynch and Gollust (2010) found that the perceived fairness of health inequalities predicted support for a government-sponsored universal health insurance. Even after controlling for self-interest and political affiliation, respondents who viewed inequalities in access and quality as unfair were more likely to endorse a government-run plan over individuals and private insurance. These findings point to the importance of

understanding how attitudes and beliefs about gender, race, and class influence support for health policy. They are also indicative of how stereotypes about perceived beneficiaries influence judgments of fairness and deservingness for health inequities and how individualism and personal responsibility might underlie those determinations. In sum, these studies highlight the interaction of pre-existing attitudes and frames to predict support for health care reform policy. They also point to the need to understand racism in relation to health care (e.g., health disparities) and health care policy and more generally, an-depth exploration of health care reform framing during President Obama's tenure.

The Need to Examine Competing Frames

As Nelson and his colleagues observe:

Mass media coverage of political issues is necessarily selective. Not all sources can be quoted, all angles explored, or all relevant facts cited. The media depend upon frames to help organize and lend coherence to relatively brief treatments of complex subjects. At times, news framing is homogeneous, with the dimensions of mediated public debate confined within the boundaries of a single frame...at other times coverage may be organized by a handful of competing frames (Nelson et al., 1997b, p. 237).

In light of the complexity and scope of the Affordable Care Act, it is likely the mainstream media focused on only a subset of the proposed changes, especially those viewed as most controversial (e.g., Price & Tewksbury, 1997). As a highly charged political issue, it is also likely that *competing* frames were emphasized (Chong &

Druckman, 2007a; 2007b). According to Chong and Druckman (2007a, p.638), although framing effects have been studied across a range of political contexts, “the voluminous literature on framing effects has virtually ignored the most typical communications environment in which competing sides promote alternative interpretations of an issue.”

The polarized discourse surrounding health care reform lends itself to an analysis of the competing frames used by supporters and opponents to justify their positions and can offer insight into how policy alternatives are constructed and debated (e.g., Chong & Druckman, 2007a; 2007b; Druckman, 2011; Jerit, 2009; 2008; Sniderman & Theriault, 2004). Jerit’s (2008) analysis of media framing of the Clintons’ health care reform initiative documents how diverging viewpoints were presented within the same newspaper article (Jerit, 2008). Supporters of reform tended to problematize the current health care system and the potential to achieve health care security via reform. Reform opponents asserted that the government’s role in health care would become too large, that reform would be too costly, that quality of care would decrease, and that the health care system would become too complex. Based on Jerit’s work, it can be hypothesized that news coverage of the health care reform debates during President Obama’s tenure are also characterized by similar competing frames. By focusing on the most debated aspects of health care reform, the media may perpetuate conflicting frames about the impact of health care reform and potentially construct new conflicts.

Competing Frames in the Current Study

Based on previous research examining the framing of U.S. health care reform (e.g., Brady & Kessler, 2009; Jerit, 2008; Winter, 2008), analyses of current health care reform (e.g., Brodie et al., 2010; Eckles & Schafner, 2010; Knowles, Lowery, & Schaumberg, 2010; Nyhan, 2010), public opinion polls examining different aspects of health care reform legislation (e.g., Jones, 2009; Kaiser Health Tracking Poll, 2011; 2010; Newport, 2010), and informal analysis of media reporting of recent health care proposals, it is hypothesized that competing frames in the following seven domains characterized news coverage of health care reform: (1) the determinants of health (personal/individual vs. social determinants); (2) the nature of health care (free market commodity vs. legally-protected public good); (3) entitlement to health care (privilege vs. human right); (4) key beneficiaries of health care reform (very few vs. nearly everyone); (5) expense of health care reform (too costly vs. cost saving); (6) consequences of governmental involvement in health care (a “government takeover” resulting in socialized medicine and loss of choice and quality care vs. an improved system of care and access); and (7) public support for health care reform (limited vs. nearly universal). Independently and collectively, these frames may promote, reinforce, and perpetuate particular conceptualizations of what it means to be “healthy,” services that should be provided, and responsibilities of the health care system

Competing Frame #1: Determinants of Health – Personal Responsibility versus Social Determinants of Health

Health as a Personal Responsibility. The United States is characterized by its focus on individual responsibility for one's actions. This is true across many domains and health is no exception. John McCain, 2008 Republican presidential candidate, exemplified this sentiment in his health care reform campaign platform focusing "on personal responsibility, and the kinds of things that can help you get better outcomes just by taking care of yourself" (Hamby, 2008, para. 8). Interpersonal and institutional practices, from doctor-patient interactions, through hiring policies and Medicaid eligibility, promote personal responsibility (Steinbrook, 2006). Individuals are held accountable for maintaining their own health and preventing illness, and if a person has a health problem her or his behavior is the primary cause of the problem (Wikler, 2002). Thus, "social, political, or economic factors, on the other hand, are deemed irrelevant or only secondary to individual choices and biological makeup" (Kim & Willis, 2007, pg. 360).

Research examining attributions for illness underscores the extent to which individualism informs how health is conceptualized. Certain illnesses such as HIV, lung cancer, skin cancer, and heart disease are more likely to be viewed as the fault of the individual than other illnesses such as Alzheimer's disease or brain tumors (Lucas, Lakey, Alexander, & Arnetz, 2009). Obesity is another health concern that is viewed as a personal responsibility. Crandall (1994) found that people who attributed being overweight to individual causes were more likely to hold anti-fat attitudes and

that anti-fat prejudice is correlated with belief in a just world, political conservatism, general intolerance of others, the Protestant Work Ethic, and internal attributions for poverty.

Research examining attributions for poverty has important implications for policy in the health domain. For example, Bullock, Williams, and Limbert (2003) found that individualistic attributions for poverty predicted support for restrictive welfare policies that focused on punishing the individual and structural attributions predicted support for progressive policies. Content analyses of Type 2 diabetes framing in news media suggest a similar pattern. Researchers found that when Type 2 diabetes was framed in terms of individual or lifestyle factors, articles emphasized individual solutions to the problem, whereas articles emphasized structural solutions when it was framed as socially determined (Gollust & Lantz, 2009; Kim & Willis, 2007). Framing of health as a personal responsibility points to individual-level interventions, rendering invisible the larger structural forces affecting the lives of individuals and communities.

Health as Socially Determined. In contrast to conceptualizing health as a personal responsibility, health can also be understood as a consequence of socio-contextual factors. Public health professionals have long situated the causes of illness outside the individual and more recently, mainstream psychology has adopted this approach (e.g., Adler, 2009; Adler & Stewart, 2009; Phelan, Link, Diez-Roux, Kawachi & Levin, 2004). Director General of the World Health Organization, Margaret Chan, illustrates this perspective in her statement that “the conditions in

which people are born, live, and work are the single most important determinant of good health, or ill health; of a long and productive life, or a short and miserable one” (World Health Organization, 2008, para. 3). Examining the role of contextual factors (e.g., pollution, access to healthy and affordable food, neighborhood violence) shifts focus away from individual responsibility for illness and instead necessitates a structural analysis of strategies to improve health and well-being. This type of framing also points toward policy-level interventions rather than individual behavioral changes and implicates public, corporate, and government responsibility for health (Brownell, Schwartz, Puhl, Henderson & Harris, 2009; WHO Commission on the Social Determinants of Health, 2008). Health care disparity research and government initiatives to reduce health care disparities exemplify the notion that health is, at least in part, socially determined. Examining if and to what degree news media framed health in terms of individual or structural factors can inform the dominant messages that were conveyed about health care reform.

Competing Frame #2: The Nature of Health Care - Health Care as a Free Market Commodity versus Health Care as a Legally-Protected Public Good

Health care as free market commodity. In the United States, health care is frequently regarded as a commodity that can be purchased via the free market.

According to Rudiger (2008, p. 110):

increasing commercialization of health care financing and delivery since the 1980s...pushed by the political muscle of the insurance and pharmaceutical industries and culminating in hospital takeovers by Wall Street

investors...Health care has become a private purchasing "choice," publicly traded on the stock market.

This framing is also illustrated by the Heritage Foundation's Director of Health Policy Studies claim that health care reform should be repealed because, "ACA is utterly incompatible with a health care system based on consumer choice and free markets" (Owcharenko, 2010, para. 1) and that "Congress should block or halt onerous rules and regulations before they do damage to businesses or other sectors of the health care economy" (Owcharenko, para. 7). Owcharenko, further asserts that, "Congress, should consider, after repeal of ACA, to begin moving the system in the right direction and put the country on the right path toward market-based health care change" (para. 10). These remarks epitomize free market conceptualizations of health care.

Free market conceptualizations of health underlie the health care reform strategies of both conservatives and liberals. Patel and Rushefsky (1995) assert that market reformers, who are typically Republicans, prefer market deregulation and increased competition to fix the problems of the health care system. Bureaucratic reformers, who are typically Democrats, blame markets for the problems of the health care system and promote greater regulation as the solution to fix the system. However, both groups of reformers emphasize market solutions and ultimately, regard health care as a free-market commodity. This means it is more readily attainable by those who can afford to buy it and rightfully belongs in the private sector. The conceptualization of health care as a commodity may reinforce attitudes

and beliefs that impede progressive reform. Based on the tenets of President Obama's reform, particularly the market-based strategies for reforming health insurance, it is likely that the ACA may have been described using market-based rhetoric. Thus, it is critical to understand whether health care was framed as a commodity to be bought and sold in the mainstream news media.

Health care as a legally-protected public good. In contrast to free market perspectives of health care, other conceptualizations emphasize health care as a public good worthy of legal safeguards. Explaining this viewpoint, Smith-Nonini (2006, p. 239) states "unlike many other commodities we need in order to live, medical care in a market-driven system presents formidable disadvantages for consumers. Even with competition, the health insurance market doesn't function well, and a sick person is often not in a position to shop for care anyway." Smith-Nonini (2006) argues that framing health care as a commodity is unfair and dysfunctional. During the second presidential debate of the 2008 election, President Obama advanced this perspective in his claim that health care:

should be a right for every American. In a country as wealthy as ours, for us to have people who are going bankrupt because they can't pay their medical bills -- for my mother to die of cancer at the age of 53 and have to spend the last months of her life in the hospital room arguing with insurance companies because they're saying that this may be a pre-existing condition and they don't have to pay her treatment, there's something fundamentally wrong about that. (Linkins, 2008, para. 2)

Not only does President Obama state that health care should be a right, he also indirectly argues against its commodification by asserting that people should not go into bankruptcy due to medical bills. The late Senator Edward M. Kennedy went even further and identified health care as a matter of justice in his claim that “securing quality, affordable health insurance for every American is a matter of simple justice. Health care is not just another commodity. Good health is not a gift to be rationed based on the ability to pay” (John F. Kennedy Presidential Library, 2002, para. 13). Health care as a right and a matter of social justice dictates that the government has a role to play in ensuring that *everyone* has the right.

Approximately three-fifths of U.S. adults regard access to health care as a right but beliefs about the specific government responsibilities are more divided (Galston, Kull & Ramsay, 2009). A Gallup poll (2010) conducted prior health care reform’s passage found strong agreement among proponents for the following statements: “I believe everybody is entitled to it,” “We all deserve to have health care,” and “the American people need health care whether they can afford it or not.” These findings indicate that among proponents of reform support is based on the belief that health care is a public good. However, protecting the right to access health care versus providing health care for people, whether or not they can afford it, suggests that different conceptualizations of rights might be at play. For this reason, it is important to understand whether the media framed health care as a legally-safeguarded public good. This distinction is critical to understanding whether people are guaranteed freedom from government interference, such as in freedom of choice,

or if the government is responsible for ensuring that everyone has access to necessary health care services (e.g., Smyth, 2002). Ultimately, in the words of Farmer (2005, p.175), “we find ourselves at a crossroads: health care can be considered a commodity to be sold, or it can be considered a basic social right. It cannot comfortably be considered both of these at the same time.”

Competing Frame #3: Entitlement to Health Care - Health Care as a Privilege versus Health Care as a Human Right

Health care as a privilege. Implicit in arguments potentially made by reform opponents is the belief that health care is a privilege. This conceptualization is directly related to the framing of health care as a private commodity for those who can afford it (e.g., similar to other luxuries, such as purchasing an automobile, home, or going on vacation). This viewpoint was articulated by former Congressman Zach Wamp (R., Tn.) during an interview, “health care is a privilege...that for some people it is a right, but for everyone, frankly, it’s not necessarily a right. Some people choose not to pay” (“Is health care a ‘privilege’ for some?,” 2009, para. 8-10). Immediately after making this statement, the interviewer interrupted the Congressman and asked him if it would be a privilege for someone with cancer to receive treatment. Congressman Wamp responded that health care is only a right for some people, which neither answered the interviewer’s question nor fundamentally altered his statement that health care is a privilege.

Elite framing of health care as a privilege does not resonate with the public, and conflicts with the advice of Republican rhetorical strategist, Frank Luntz (Allen,

2009; Luntz, 2009). Framing health care as a privilege does not foster “empathy for anyone and everyone struggling right now” (Luntz, p. 4). Following this advice, some health care reform opponents have redirected attention to the “entitlement crisis” by framing health care as the newest “privilege” and likening reform to a new entitlement program (i.e., Social Security; e.g., Carroll, 2008; Smith, 2009). For example, a *Wall Street Journal* editorial opined that health care reform is:

a breathtaking display of illiberal ambition, intended to make the middle class more dependent on government through the umbilical cord of universal health care. It creates a vast new entitlement, financed by European levels of taxation on business and individuals (“The Lords of Entitlement,” 2009, para.4).

By advancing the idea that reform will lead to universal coverage and a dramatic increase in government dependency, a powerful message about entitlement and deservingness is conveyed.

In a similar vein, Brian Blase, a blogger for the Heritage Foundation, denounced health care reform because:

Obamacare pours gasoline on the entitlement fires through enactment of the CLASS Program in addition to insurance subsidies and a massive Medicaid expansion. If Congress allows these measures to take effect, additional millions of Americans will become dependent upon the government. (2010, para. 9)

This message reinforces the notion that health care reform will deepen dependence on government and fuel a burgeoning entitlement crisis. Conceptualizing health care

reform as a new entitlement program, and arguing against it on that basis, ultimately makes depicts health care as a privilege not an entitlement. It also implies underlying hegemonic ideologies of individualism and meritocracy, and the problems of linking health care to employment. From this perspective, obtaining health care is the responsibility of each individual and the health care system is viewed as equally accessible to everyone. Failure to obtain health care is viewed as a reflection of individual faults and not working hard to get a “good” job that provides health benefits. Thus, “handouts” should not be given to people who have not worked hard to “earn” health care. The troubling extension of the meritocratic myth to the domain of health is that death, an unequal outcome, may be viewed as deserved.

Health care as a human right. The belief that health care is a human right is promoted by numerous U.S. scholars and activists (e.g., Padilla, Pingel, Renda, Matiz Reyes & Fiereck, 2010; Rudiger, 2008; Silliman, Fried Gerber, Ross & Gutiérrez, 2004; Women’s Economic Agenda Project, 2008), but is less commonly present in mainstream media framing of health care. It is argued that a progressive vision of health and well-being must go further than consciousness-raising about health injustices and “health disparities.” “Health disparities” is claimed to sanitize alarming statistics about lack of health insurance, lack of quality care, and fatalities. A human rights framework differs dramatically from dominant conceptualizations of health in the United States.

The World Health Organization (WHO) defines health as a “state of complete physical, mental, and social well-being, and not merely the absence of disease or

infirmity” (WHO, 1948). Padilla, Pingel, Renda, Matiz Reyes, and Fiereck (2010, p. 214) trace the conceptualization of health as a human right to the Universal Declaration of Human Rights (UDHR, 1948), which they identify as a “guidepost for the global health and human rights movement.” According to the UDHR:

everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care, and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control (Article 25, UDHR, 1948).

The Declaration also specifies that every individual is entitled to all of the rights and freedoms specified in the Declaration, regardless of any other demographic characteristic or social identity (e.g., race, gender, language, religion, political affiliation) (Article 2, UDHR). This perspective is advanced by Jonathan Mann, the former director of the WHO’s Global Programme on AIDS, and his colleagues (Mann, Gruskin, Grodin, & Annas, 1999b; as cited in Padilla et al., 2010).

WHO’s comprehensive human rights-oriented definition challenges the medicalization of health and what Farmer (2005) terms the “pathologies of power.” This approach allows for the analysis of the political, economic, social, and cultural conditions, and institutional powers that promote or impede achieving health and well-being for everyone. Compared to 18 other industrialized nations, the U.S. has the greatest number of deaths that could be avoided if health care had been accessible (Nolte & McKee, 2008). Ackerly, a feminist human rights scholar, differentiated

between murder as a crime and murder as a human rights violation as the “failure of society to identify, prosecute, and prevent patterns of murder” (2008, p. 14). From a human rights perspective, the U.S. is complicit in an internationally recognized pattern of death and the commission of human rights violations by not ensuring affordable and accessible health care for everyone. The U.S. government is now taking steps to identify health disparities but has done little to stop unequal patterns of death and is regarded by advocates as guilty of violating the human rights of millions.

The human rights perspective, itself, is critiqued for failing to curb human rights violations (e.g., Powell, 2005; Saiz, 2004; Visweswaran, 2004), nevertheless, there is utility and power in framing health as a human right and it appears that President Obama is moving in this direction. Braithwaite identified the following quote by President Obama as exemplifying a human right perspective, “We now face an opportunity and an obligation – to turn the page on the failed politics of yesterday’s health care debates...My plan begins by covering every American” (2008, p. S6). It is important to examine if the media framed health as a human right or to document if United States continues to be one of the few industrialized countries that does not view health as a human right (e.g., Quadagno, 2004).

Competing Frame #4: Key Beneficiaries of Health Care Reform – Very Few People versus Nearly Everyone

Very few people will benefit from health care reform. A public opinion poll conducted shortly before the passage of the ACA provides insight into beliefs about its beneficiaries (Newport, 2010). Respondents were asked whether the

following groups would benefit from reform: “those who currently have no insurance;” “lower-income families;” “the United States as a whole;” “pharmaceutical companies;” “middle-income families;” “hospitals,” “doctors;” “you and your family;” “health insurance companies;” and “upper-income families.” Among those who opposed reform, the uninsured were the group perceived to benefit from proposed policy changes albeit by a small margin.

In a separate poll, respondents who did not support health care reform attributed their lack of support due to reasons such as, “I feel like I would be paying for people who don’t work to get health care,” and “Because why should somebody do nothing and get something for free?” (Jones, 2010). Although documented immigrants have restricted access to public health plans, and undocumented immigrants cannot access care except in emergencies, poll respondents commonly cite benefits to immigrants as a key source of their opposition (Jones). Similarly, although the federal government does not provide money for abortion, health care reform is misperceived as funding these services (Jones).

Among opponents, health care reform is associated with providing benefits to very few people or primarily devalued groups. If health care reform was framed as primarily benefitting unpopular individuals and groups, it may have elicited judgments of deservingness about the perceived beneficiaries. Because of the linkage between health insurance and full-time employment, the uninsured may have been viewed as lazy, irresponsible, and a burden to society. These concerns make clear that

some groups, particularly immigrants and women seeking abortions remain outside the “scope of justice” (e.g., Opatow, Gerson, & Woodside, 2005).

Nearly everyone will benefit from health care reform. Reform proponents see reform as benefiting society at large whereas ACA supporters believe that all groups except “health insurance companies” would benefit from reform, especially “those who currently have no insurance” and “lower-income families” (Newport (2010). Representative Pelosi echoed these sentiments when she defended the Affordable Care Act against repeal efforts “as benefiting our middle class, our families, and our businesses, indeed every American. In Congress, we will stand firm against attempts to roll back the law, including the Patient’s Bill of Rights and the critical consumer protections enacted by health insurance reform” (Reuters, 2010a, para. 4). How the media framed perceived reform beneficiaries, particularly in terms of race (e.g., Knowles, Lowery, & Schaumberg, 2009; Rigby et al., 2009), gender (e.g., Grady, 2010; Winter, 2005), class (e.g., Navarro), and immigration status (e.g., Chavez, 2004) merits further investigation. Support for the ACA may have been influenced by beliefs about fairness of unequal access to health care and deservingness of government assistance, depending upon the construction of key beneficiaries.

Competing Frame #5: The Expense of Health Care Reform – Too Costly versus Cost Saving

Health care reform as too costly for individuals and society. Arguments against the high cost and economic impact of health care reform are not unique to the

most recent attempt at reform (e.g., Huebner, Fan, & Finnegan Jr., 1997; Jerit, 2008; West, Heith & Goodwin, 1996). Research examining other policy domains documents that economic frames are particularly strong and persuasive (e.g., Chong & Druckman, 2007a; Druckman, 2011). Given that a major recession was underway when President Obama took office, framing reform as too costly and fiscally irresponsible likely played, and continues to play, an important role in undermining support. Health care reform opponents have focused on individual (e.g., tax increases) and the societal level expenses (e.g., estimated cost to the government and federal deficit increase). The title of Willis's (2011) article "New Health-Care Reform: Taxing Us to Death," in which health care reform is described as an enormous tax burden to individuals and families summarizes this perspective.

Health care reform is not only framed as costly to individuals but also as a burden to society. From the outset of legislative negotiations, Republicans opposed Democratic proposals, calling them "flawed because they sought to decrease health care costs by creating programs that would cost hundreds of billions of dollars," with former Governor Pawlenty of Minnesota comparing health care expenses to "saying you'll balance the checkbook by writing more checks" ("GOP, Blue Dogs Get Health Reform Slowdown They Wanted," 2009, para. 9-10). Detailed explanation or evidence of expenses was rarely provided.

Governor Pawlenty's remarks also exemplify the framing of health care reform as a fiscally irresponsible policy, and ultimately, an illogical solution to problems with the current system. Congressman Cantor's simple statement "We can't

afford this. That is the ultimate problem here” exemplifies this perspective (Cantor, 2010; as cited in Patterson, 2010). Brady and Kessler (2010) argue that the public should support health care reform because over the past decade the cost of health care has outpaced wages. However, overall public dissatisfaction with the current cost of health care may not translate into support for reform. (e.g., Sack & Connelly, 2009). Health care reform framed as a costly burden on individuals and society may lend support to health care reform opposition by capitalizing on the well-documented preference for “loss aversion” (e.g., Eckles & Schaffner, 2010; Jerit, 2008; Tversky & Kahneman, 1981).

Public opinion polls suggest that framing of reform as too costly may have influenced support for health care reform. In a poll conducted prior to the passage of reform, health care opponents provided responses such as “terribly expensive,” “will increase costs for everyone,” “higher costs,” and “increased debt” as reasons for their opposition (Jones, 2010). After the ACA passed, the majority of polling respondents expected increases in personal health expenditures and national spending, and that reform would be too costly for the government (Trumbull, 2010).

Health care reform as cost saving for individuals and society. In contrast to health care reform opponents, supporters may have framed the ACA as cost-cutting for both individuals and society. Supporters likely emphasized the longer-term financial benefits of health care reform, citing the Congressional Budget Office’s estimate that health care reform law would reduce the deficit by \$143 billion over the next ten years (Van de Water & Horney, 2010). The case was made that not passing

health care reform would be more costly than passing it. For example, in a joint address to Congress President Obama (2009) claimed, “We can no longer afford to put health care reform on hold.” In support of this assertion, proponents focus on decreased costs at the individual (e.g., lowering insurance premiums to make coverage affordable) and societal levels (e.g., using technology to decrease overall cost, cutting waste and fraud, decreasing the federal deficit). Framing health care as cost-saving to everyone, debt-reducing, and fiscally responsible is exemplified in President Obama’s address to House Democrats just prior to the passage of health care reform, when he stated:

individuals and small businesses, who right now are having a terrible time out there getting health insurance, are going to be able to purchase health insurance as part of a big group... They are now going to be part of a pool that can negotiate for better rates... and that's why the Congressional Budget Office says this will lower people's rates for comparable plans by 14 to 20 percent... if people still can't afford it we're going to provide them some tax credits... this is the biggest reduction in our deficit since the Budget Balance Act -- one of the biggest deficit reduction measures in history -- over \$1.3 trillion that will help put us on the path of fiscal responsibility. (“Obama Quotes Lincoln to House Dems: I Am Bound to Be True,” 2010, para. 45-49)

Leonhardt (2010, para. 1) identified even broader economic impacts of health care reform when he described the passage of health care reform as “the federal government’s biggest attack on economic inequality since inequality began rising

more than three decades ago.” Despite messages about the fiscal benefits of health care reform, public opinion polls conducted after the passage of health care reform indicated that the majority of people believed that the reform would increase costs for individuals and the government (Trumbull, 2010). Because fears about increased cost undermined President Clinton’s health effort (e.g., Skocpol, 1996), and the Great Recession has made economic concerns particularly salient, it is important to examine how the news media framed the costs of the ACA.

Competing Frame #6: Consequences of Governmental Involvement in Health Care – A “Government Takeover” Resulting in Socialized Medicine and Loss of Choice and Quality Care versus an Improved System of Care and Access

Health care reform as a “government takeover.” To capitalize on public distrust of government and loss aversion preferences, reform opponents may have framed the ACA as a government takeover that would result in socialized medicine and the loss of personal choice. As with claims about the detrimental economic impact of health care reform, assertions about loss of individual choice and benefits are not new (e.g., the Clintons’ proposed health care reform in 1993-1994; Goldsteen, Goldsteen, Swan, & Clemeña, 2001; West, Heith & Goodwin, 1996). Critiques of President Obama’s health care plan as socialized medicine are strikingly similar to those levied against President Truman’s health reform plan nearly 65 years ago (Berkowitz, 2010; Hoffman, 2001). Among the most extreme claims was that reform would lead to health care rationing and “death panels.” The myth of so-called “death panels” charged with performing cost-benefit analyses to determine if patients should

receive life-saving but costly care was popularized by former Governor of Alaska and Vice Presidential candidate Sarah Palin. Ultimately, this claim was voted the “Biggest Political Lie of 2009” by the Pulitzer Prize winning website PolitiFact.com (Malcolm, 2009).

In 2010, the “Biggest Political Lie” award went to health care reform as a “government takeover.” Sargent (2010, para. 2) attributed the effectiveness of this claim to the fact that “it's catchy and packs a lot of fear-mongering into only two words. But the real key to it, I think, is that it's simultaneously *very hard to challenge*.” These myths persisted throughout the health care debates and mainstream media likely perpetuated these beliefs despite repeated efforts to correct these falsehoods (Nyhan, 2010; Sargent, 2010). Repetition may be an especially effective strategy because attempts to refute misperceptions may ultimately reinforce them. For example, among respondents of a March, 2010 public opinion poll opponents expressed strong support for the following rationales: “destruction/take-over of economy;” “government takeover;” “I don’t like the public option;” “doesn’t hit on key issues like affordability” and “I don’t like the idea of socialized medicine” (Jones, 2010). Another poll conducted after the passage of health care reform found that over half (53%) of respondents felt the reform constituted a “government takeover” (Dodge, 2010). Each of these polling examples reflect the strength of myths that associate health care reform with government intrusion and socialism.

Health care reform as an improved system and access. Reform advocates potentially framed reform as a significant and much-needed improvement to the

health care system. Immediately after the passage of health care reform in the House of Representatives, President Obama commented:

we proved that we are still a people capable of doing big things. We proved that this government — a government of the people and by the people — still works for the people. This isn't radical reform, but it is major reform. This is what change looks like (Lee, 2010, para. 11).

President Obama's statement illustrates the view of reform as a great improvement. It also refutes the conceptualization of health care reform as a government takeover and positions it as a government that serves its people. Despite recent GOP arguments that the ACA violates states' rights (e.g., Kaiser Health News, 2010), research demonstrates that the federal government is better equipped than state governments to enhance the institutional capability and economic sustainability of health care (Greer & Jacobson, 2010). Although the ACA would likely lead to greater federal government role in the health care system, it might be a necessary step to ensure that everyone is able to access care.

The government website (www.healthcare.gov) created to disseminate information about health care reform describes the legislation's provisions in direct contrast to opponents' framing. Health care reform is presented as increasing access to affordable care, improving quality, lowering costs, developing new consumer protections, monitoring insurance company practices, and preserving individual choice in providers and health care decisions (www.healthcare.gov).

During President Clinton's reform attempt, loss of choices and care rationing dominated the debate and led to mobilization against the government (Skocpol, 1996). In contrast, President Obama's reform effort passed. Investigating how media coverage of the reform debate framed the consequences of governmental intervention in the health care system might shed light on factors that may have contributed to its successful passage.

Competing Frame #7: Public Support for Health Care Reform – Limited versus Nearly Universal

Health care reform as going against the public's wishes. Opponents likely described the ACA and supportive policymakers as going against the wishes and needs of the American people. This perspective is evident in the title of an article published in *USA Today*, approximately two weeks prior to the reform's passage, "Not that hungry for change; Washington has misread the public. People want problem-solving, not political whiplash" (Medved, 2010). The article conveys a sentiment similar to that expressed by Senator John Cornyn (R., Tx.) when he said, "The American people don't want this bill, but our Democrat friends seem determined to jam it down their throat regardless, and I think there will be serious consequences" (Fox News, 2010). These examples illustrate how reform opponents framed the bill as unhelpful, unwanted, and potentially detrimental. While Brodie and her colleagues (2010) assert that the general public tended to show more support for certain aspects of the reform than the package as a whole, opponents tended to frame the "American people" as not wanting the policy to be passed at all.

Health care reform as generally supported by the public. ACA supporters may have portrayed health care reform as enjoying the support of the American people (e.g., Brady & Kessler, 2009; Sack & Connelly, 2010) and Democrats (Jones, 2010).

Framing public support as strongly against or in favor of health care reform is problematic in that it potentially masks group differences in public opinion that are meaningful or revealing. For example, Wright (2010) found that income was a stronger predictor of support for health care reform than party identification. Additionally, reporting polling results without critical analysis of how polling questions were framed (e.g., Bruine de Bruin, 2011) might contribute to the belief that there is more (or less) support for a particular aspect of reform. For these reasons, it is necessary to closely examine media framing of public support for health care reform, particularly in relation to social groups (e.g., the majority of Republicans are against health care reform) and specific health coverage concerns (e.g., the majority of Americans do not support public funding of abortion) and how public opinion polls are used to justify support or opposition.

Voices in the Media: Key Actors in the Health Care Reform Debate

Mainstream coverage of the health care reform legislation includes complex, multidirectional relationships between the media, policymakers, institutions, interest groups, experts, and public opinion in constructing frames (e.g., Callaghan & Schnell, 2009; 2001; Chong & Druckman, 2007a; 2007b; Goldstein, Goldstein, Swan, & Clemeña, 1996; Iyengar, 1991; Jerit, 2009b; Krause, 2011; Nelson, Oxley, &

Clawson, 1997; West, Heath, & Goodwin, 2001; Quadagno, 2010). In some cases, “frames serve as bridges between elite discourse about a problem or issue and popular comprehension of that issue...the symbolic and rhetorical devices deployed by political elites help the media frame their stories” (Nelson et al., 1997b, p., 224) and news coverage may be a reflection of the frames favored by the media elite.

However, interest groups and thought leaders can shape how political elites frame their messages, and have power to construct their own messages about political issues (Callaghan & Schnell, 2009; Jerit, 2009b; West, Heath, & Goodwin, 2001). Historically, key players in health care reform debates have included the following five groups: (1) health care purchasers (e.g., federal government, state government, employers); (2) health care providers (e.g., hospitals, nursing homes, physicians, nurses); (3) third-party payers (e.g., health insurance companies); (4) health consumers; and (5) interest groups (e.g., Health Insurance Association of America, American Medical Association, organized labor groups, pharmaceutical industry) (e.g., Hoffman, 2011, Patel & Rushefsky, 1995; Quadagno, 2004; Skocpol, 1996).

Although news media often characterize themselves as ideologically neutral and purveyors of factual information, journalists, editors, and the news market play active roles in constructing frames (Krause, 2011). Since the 1980s, media ownership has become consolidated. Through a series of mergers and acquisitions, the top five newspaper companies (Gannett, MediaNews Group, News Corporation, McClatchy Company, and the Tribune Company, respectively) own hundreds of newspapers across the United States, and News Corporation also owns several television news

shows, a major movie studio, and one of the leading websites for online television viewing (Pew Research Center's Project for Excellence in Journalism, 2011). Thus, news media frame information by both constructing the way that information is construed and by limiting the range of information to which people are exposed. Together, political elites, interest groups, experts, public opinion, and the media likely played roles in constructing the competing frames which are hypothesized to characterize the health care reform debate.

Chapter Five

Methodology

Study Purpose and Core Questions

The primary purpose of this study was to investigate how mainstream newspapers framed health care reform from the time that the Patient Protection and Affordable Care Act was first introduced in the U.S. House of Representatives through its passage. The passage of health care reform was highly contested, making an analysis of conflicting frames particularly appropriate (e.g., Chong & Druckman, 2007a; 2007b; Druckman, 2011; Jerit, 2009; 2008). Given the great need for health care and the fatal consequences of lacking access to health care in the United States, understanding dominant framing of health care reform is crucial.

Understanding representations of uninsured individuals and groups is also of great importance. Although supporters and opponents of health care reform differed on many key aspects (e.g., costs, benefits, and consequences of reform), both sides perceived the uninsured as key beneficiaries (Newport, 2010). As Krugman (2011) notes, coverage of the uninsured may be at the heart of health care reform opposition driven, in part, by “trying to appeal to the middle class with an issue – universal coverage – that is really about lower income people and redistribution of resources” (Brown & Zelman, 1998, p. 63). If this is the case, the term “uninsured” may be associated with classist and racist stereotypes (e.g., unemployed, lazy), judgments of deservingness, and concerns about wealth redistribution. Even discourse used by supporters of health care reform may reinforce stereotypical beliefs about health,

health care, and deservingness. Ultimately, understanding the framing of health care reform and uninsured groups may be one way to contribute to the continuous “uphill battles for progressive health care reform” in the United States (Gonzales, 2010, p. 116).

The goals of the current study were threefold: (1) to analyze how mainstream news media framed health care reform, particularly the prevalence of competing frames; (2) to document dominant and “missing” or “absent” frames in mainstream news coverage of health care reform (e.g., health care as a human right); and (3) to assess the role of stereotypes and other beliefs about the uninsured and other perceived beneficiaries in fostering opposition to health care reform.

Research Questions Guiding the Current Study

1. Who were the key actors cited in mainstream news articles? How were their perspectives framed?
2. Based on previous research documenting the use of competing frames in highly contested policy areas (e.g., Chong & Druckman, 2007a; 2007b, Druckman, 2011; Jerit, 2009; 2008), how prevalent were competing frames in news stories published prior to the passage of health care reform? Which frames dominated? Which frames were absent?
3. Which individual frames clustered together? Which supportive frames commonly co-occurred? Which oppositional frames commonly co-occurred? Which framing clusters were used by Republicans and which clusters were favored by Democrats?

4. What potential benefits and negative consequences of health care reform were reported? Which groups were described as “winners” and which groups as “losers” in health care reform?
5. How were uninsured individuals and groups portrayed? Were racist, classist, sexist, and xenophobic stereotypes used to characterize uninsured individuals and groups? Were uninsured groups portrayed as “deserving” or “undeserving” of support?
6. How frequently were public opinion poll findings cited in news stories about reform? How often was public opinion data used to justify opposition to health care reform? How frequently was polling data used to support reform?
7. How frequently were highly contested issues (e.g., abortion, “death panels,” coverage of undocumented immigrants) present in news stories?
8. Overall, was the tone of mainstream news articles favorable, opposed, or neutral toward health care reform?

Newspaper Article Retrieval, Selection, and Sample Characteristics

A content analysis of 475 articles published in seven mainstream newspapers between September 16, 2009 and March 31, 2010 was conducted. These dates were selected to include the window of time in which the first health care reform bill was introduced by the Senate Finance Committee through the passage of the final version of the legislation. To generate a sample of articles focused explicitly on health care reform legislation, a subject search was conducted using the keyword “health care policy.”

Articles were retrieved from the following seven news sources (with overall circulation rank indicated in parentheses): (1) *Wall Street Journal*, (2) *USA Today*, (3) *New York Times*, (4) *Los Angeles Times*, (5) *Washington Post*, (10) *Houston Chronicle*, and (17) *Chicago Sun-Times*. These newspapers were chosen due to their ranking in the top twenty high circulation papers and for geographic diversity (Audit Bureau of Circulation, 2009). See Table 1 for more detailed information about circulation and newspaper ownership. Articles from the *Los Angeles Times* and *Wall Street Journal* were retrieved using the ProQuest database, and LexisNexis Academic was used for all other newspapers. Two databases were utilized because newspapers were archived in different databases.

Searching by the subject “health care policy” yielded a total of 4,186 articles. Nine-hundred and seventy-nine articles were identified as editorials, opinion pieces, or letters to the editor, and were removed from the sample, as were 23 articles that were identified as “corrections.” A total of 3,182 news articles remained from which 15% were selected for coding. To maintain a proportional representation from each news source within the sample of coded articles, every eighth article was selected from each newspaper. This yielded a total of 475 articles with the number of articles from each source as follows: *Wall Street Journal* ($N = 85$), *USA Today* ($N = 46$), *New York Times* ($N = 116$), *Los Angeles Times* ($N = 38$), *Washington Post* ($N = 106$), *Houston Chronicle* ($N = 56$), and *Chicago Sun-Times* ($N = 28$). See Table 2 for information about the number and types of articles from each news source.

The average length of articles was 812 words, but ranged from 67 to 3010 words. A one-way ANOVA, $F(4, 468) = 15.14, p < .001$, indicated that the article length differed significantly by news source. Post hoc comparisons conducted using the Tukey HSD test revealed that articles in the *Chicago Sun-Times* were significantly shorter ($M = 396.25, SD = 51.87$) than articles in all other news sources (*Houston Chronicle*, $M = 653.66, SD = 38.86$; *USA Today*, $M = 699.61, SD = 63.67$; *Wall Street Journal*, $M = 755.69, SD = 36.73$; *New York Times*, $M = 835.76, SD = 35.76$; *Los Angeles Times*, $M = 870.03, SD = 45.48$; and the *Washington Post*, $M = 998.08, SD = 36.24$). Additionally, articles in the *Houston Chronicle* were significantly shorter than articles in the *New York Times* and the *Washington Post*. Also, articles in the *USA Today* were significantly shorter than articles in the *New York Times*, and articles in the *Wall Street Journal* were significantly shorter than articles in the *Washington Post*. However, because only the *Chicago Sun-Times* differed significantly from all other sources, and represented the smallest proportion of articles in the sample (6%, $n = 28$), analyses were conducted across all news sources.

Coding Framework

A coding framework was developed to assess the types and frequency of seven competing frame domains that appeared in newspaper coverage of the health care reform debate under President Obama. Specific coding categories were informed by previous research examining the framing of the Clinton Administration's health care reform initiative (Huebner, Fan, & Finnegan, 1997; Jerit, 2008; Winter, 2005), analyses of the health care reform debate and public opinion surrounding the Obama

Administration's health care reform legislation (e.g., Brodie, Altman, Deane, Buscho & Hamel, 2010; Bundorf & Fuchs, 2010; Eckles & Schaffner, 2010; Knowles, Lowery, & Schaumber, 2010; Nyhan, 2010, Quirk, 2010), and informal analysis of news coverage of the health care reform debate. Democratic and Republican positions for all competing frames were noted. See Appendix A for a detailed description of the coding framework. A summary is provided here.

(1) Key Actors and Groups. To examine influential individuals and groups, key actors referenced or quoted were coded (e.g., President Obama, Nancy Pelosi, Sarah Palin, Democratic and Republican policymakers, scholars, individual health practitioners, health care industry, health insurance industry, pharmaceutical industry, community organizations or groups, average health care consumers) as well as their positions on health care reform.

(2) Determinants of Health. Based on theories of individual and societal responsibility for health (e.g., Adler, 2009; Clarke & Everest, 2006; Ford & Raine, 2008; Kim & Willis, 2007), individual/personal causes (e.g., diet, exercise, self-control) and social determinants of health (e.g., pollution, racial/gender discrimination, unequal distribution of wealth) were coded. Given that some illnesses (e.g., obesity, diabetes) are more likely to be attributed to individual causes (Gollust & Lantz, 2009; Lucas, Lakey, Alexander, & Arnetz, 2009), mention of specific diseases and illnesses were also recorded. Due to the association of health care disparities with social determinants of health (Adler; Braveman, 2006), mention of health care disparities were noted as well as discussion of population groups

identified as facing disparities (e.g., African Americans, women). Whether health care reform was described as decreasing or increasing disparities was recorded.

(3) Nature of Health Care. Criticism of the U.S. health care system largely stems from its governance by “free market ideology” which treats “health care like any other economic good” (Cheong, Feeley, & Servoss, 2007, p.286) rather than a public good (e.g., Karsten, 1995; Quadagno, 2004; Smith-Nonini, 2006). To capture this distinction, articles were coded as to whether health care was described as a free market commodity (e.g., health care as good to be bought and sold by those who can afford it) or a public good or right (e.g., access to health care guaranteed for everyone). Based on coding categories developed by Huebner and his colleagues (1997), specific references to health care reform as too restrictive or unfair to the health insurance or health care industry markets, and health care reform as a needed intervention on those markets were also noted.

(4) Entitlement to Health Care. Articles were coded as to whether health care reform was described as a privilege (e.g., health care is not an entitlement) versus a human right (e.g., guaranteed access regardless of ability to pay or citizenship status; Farmer, 2003; Padilla, Pingel, Renda, Matiz Reyes & Fiereck, 2010; Silliman, Fried Gerber, Ross & Gutiérrez, 2004). Portrayals of health care reform as a new entitlement program were noted (e.g., Jerit, 2006; Jerit & Barabas, 2006; Ku & Pervez, 2010; West, 2003). Mention of existing entitlement programs (i.e., Medicaid, Medicare, Social Security) was also coded.

(5) Key Beneficiaries of Health Care Reform. Whether health care reform was described as benefitting specific groups (e.g., uninsured individuals and groups; Jerit, 2008), and/or very few or a majority of people was recorded. Based on previous research demonstrating the influence of group cues (Lynch & Gollust, 2010; Rigby, Soss, Booske, Rohan, & Robert, 2009) and stereotypes (e.g., Knowles, Lowery, & Schaumberg, 2010) on support for health policy, references to uninsured people were recorded including the presence of racist, classist, sexist and xenophobic stereotypes and judgments of deservingness. Other beneficiaries or non-beneficiaries were also noted along with these representations.

Policies related to immigration and abortion were especially controversial (e.g., Ku & Pervez, 2010; Merola & McGlone, 2011; Wasem, 2010), and highly contested issues during the health care reform debate. Thus, mention of immigrants and abortion was also coded.

(6) Cost of Health Care Reform. Content analyses of media coverage of the Clintons' attempt at health care reform revealed the importance of how the legislation's cost was framed (Huebner et al., 1997; Jerit, 2008; Winter, 2005). Therefore, references to the cost of health care reform were coded. In particular, the impact of health care reform on costs including the federal deficit was coded. Groups described specifically as facing increased or decreased costs were noted.

(7) Meanings of Reforming the Health Care System. The presence of health care reform myths and stereotypes were assessed (e.g., public option, death panels, health care reform as socialism or socialized medicine, and health care reform as a

government takeover). Based on content analyses of the Clinton administration's health care reform initiative (e.g., Huebner et al., 1997; Jerit, 2008; Winter, 2005) mention of the government's ability to implement health care reform was coded as well as references to the limits and responsibilities of the U.S. government. The presence of loss aversion frames (e.g., loss of care, choices, access, or quality of health care) and gain (e.g., increased access, more health care choices, better quality of care) were also coded (Eckles & Schaffner, 2010). Acceptability of the status quo and descriptions of the health care system as broken or unacceptable were coded.

(8) Support for Health Care Reform. Public opinion polls indicate that a national health insurance enjoys strong support (Blendon & Benson, 2001), but supporters and opponents of reform distort poll findings to justify their position (e.g., Brodie et al. 2010; Contandriopoulos & Bilodeau, 2009; Shapiro & Jacobs, 2010). Articles were coded as to whether health care reform was described as having broad or limited public support. Justifications used by Democrats and Republicans via public polling data were also noted. Additionally, any population group (e.g., those over the age of 65, health care industry, medical practitioners) described as supporting or opposing health care reform was noted.

(9) Overall Tone. Based on previous framing analyses (e.g., Bullock et al., 2001; Collins, Abelson, Pyman, & Lavis, 2006; Iyengar, 1994), articles were categorized as being favorable, opposed, or neutral toward health care reform. Judgments of the main problem with the current health care system, portrayals of

reform as capable of fixing the health care system, alternate solutions, and the most powerful frame within the article were noted.

Coding Procedure

A team of six undergraduate researchers was trained to work with the coding framework. Drawing from the same newspapers as the primary investigation, pilot coding was conducted with articles published between August 1, 2009 and August 31, 2009. This time period was selected because articles contained similar types of messages and key actors. Results of the pilot coding were assessed for intercoder reliability, to clarify questions, and refine the coding framework. After adequate intercoder reliability was reached, two undergraduate researchers independently coded each article. To reduce order effects, research assistants coded groups of articles from all seven news sources across publication dates rather than chronologically by publication date. To protect the integrity of the data, excel spreadsheets containing the coding for each article were shared between the author and each coder via an online, password-protected, file sharing service. Each researcher could only view her or his coded text.

All articles were analyzed for the occurrence of each code. “Presence” (yes = 1) and “absence” (no = 0) for each coding category was recorded. To contextualize the findings, text associated with a “presence” code was recorded. The number of times that each code appeared within a single article was not counted. The author resolved coding disagreements. After the resolution of all coding disagreements, data were imported into SPSS 16.0 for analysis.

Intercoder Reliability

Percentage agreement was used to assess intercoder reliability in the current study. Although this approach has been called into question (Krippendorff, 2004; Lombard, Snyder-Duch, & Campanella Brackman, 2002), percentage agreement is considered appropriate when evaluating categorical data. According to standards proposed by Lombard, Snyder-Duch, and Campanella Brackman (2010), the overall percentage agreement across all coding categories and coders was acceptable (91.3%).

The percentage agreements for each of the nine coding categories and the question about overall tone were also calculated. Percentage agreements for each coding category were also acceptable (percentage agreement ranged from a low of 88.0% to a high of 96.8%). The percentage agreement for judgments about article tone (favorable, neutral, or against health care reform) was unacceptably low (54.1%) and was not analyzed further. Please see Table 3 for detailed information about intercoder reliabilities for each coding category and coding pairs.

Chapter Six

Results and Discussion

Overview of Findings

Newspaper coverage of the ACA reflected the partisan and contentious nature of the debate. Frames used by Democratic and Republican policymakers set the terms of the debate and newspaper coverage served as a “conduit” through which messages of the political leaders could flow (Jacoby, 2000, p. 751). Support for reform was primarily framed as a needed intervention in the health insurance market 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 of the existing system. Frames about cost and key beneficiaries competed with each other. Notably absent were conceptualizations of health care as a human right or public good.

Presentation of the findings is organized into three sections. My discussion begins with descriptions of key actors in the health care reform debate. This is followed by an overview of frames within each of the seven competing frame domains, along with portraits of the supportive, opposing, and competing frame clusters. The chapter concludes with an analysis of the most contested aspects of the health care reform debate including government-run insurance, the individual mandate, coverage of undocumented immigrants, and abortion.

Key Actors in the Health Care Reform Debate

Consistently supportive actors and groups

Pro-reform Democratic policymakers received the greatest newspaper coverage. President Obama's support for reform was mentioned in nearly two-thirds of articles (61.1%, $n = 290$) and Speaker of the House Nancy Pelosi's (Ca.) support was mentioned in 21.7% of articles ($n = 103$). Other Democrats were referenced in 57.5% of articles ($n = 273$) including Senate Majority Leader Harry Reid (Nv.), and Chairman of the Senate Finance Committee Max Baucus (Mt.). The following excerpt highlights how coverage of supportive Democrats was characterized:

Despite the criticism, there were growing indications Democrats would prevail on an initial Senate showdown set for Saturday night, and Majority Leader Harry Reid crisply rebutted the Republican charges. The bill "will save lives, save money and save Medicare," he said. (Espo, 2009, p. A3, para. 2)

Specifically, coverage focused on why Democrats supported health care reform as well as the legislative process, challenges to passing reform, and the partisan nature of the legislation.

Community, trade, and professional organizations that supported reform were also represented in news coverage ($n = 47$, 9.9%), but received substantially less coverage than political elites. Among these diverse groups were the American Cancer Society, American Heart Association, American Association of Retired Persons (AARP), Catholic nuns, Catholics United, Families USA, Health Care for America Now, and organized labor unions (e.g., American Federation of Labor and Congress

of Industrial Organizations [AFL-CIO], American Federation of Federal, State, County, and Municipal Employees [AFSCME], and Service Employees International Union [SEIU]). Although organized labor unions have declined in power, their support of Democratic health care reform initiatives has historically been strong and remains so (e.g., Klein, 2003; Quadagno, 2004). Organized labor opposed a proposed tax on high-cost insurance “Cadillac Plans,” successfully negotiating a delay in the tax and a higher tax threshold. Information about supportive organizations typically included a brief statement of support and how constituents stood to benefit from the ACA. Additionally, for the first time in U.S. health care debate history, the American Medical Association (AMA) endorsed reform efforts (Quadagno, 2011), although their support was referenced infrequently. Scholars, universities, or think tanks were referenced in less than 5% of all articles ($n = 21$, 4.4%). The opinions of supportive health consumers also appeared in less than 5% of the articles. Detailed frequency information concerning supportive key actors is presented in Table 4.

Contested support

Although the majority of moderate Democrats supported health care reform, both progressive and conservative Democrats took issue with certain provisions and threatened to withhold their support for the overall bill. Fiscally conservative Blue Dog Democrats opposed the public option and threatened to veto reform if the overall cost of implementing the legislation couldn’t be lowered. Conversely, progressive Democrats such as Representative Dennis Kucinich (D., Oh.), initially withheld support because a public option was not included.

Abortion was also hotly contested with Representatives Bart Stupak (D., Mi.) and Joseph Pitts (R., Pa.) threatening to block reform if abortion restrictions were not tightened. In response, the Congressional Pro-Choice Caucus, co-chaired by Representatives Diana DeGette (D., Co.) and Louise Slaughter (D., Ny.) pledged to vote against reform if it restricted abortion access. Coverage of immigrants further divided Democrats. The Hispanic Caucus objected to a provision that “illegal” immigrants be barred from purchasing health insurance through government-run exchanges.

Special cases of limited support

Considerable media attention chronicled limited legislative support from Representative Anh “Joseph” Cao (R., La.) and Senator Olympia Snowe (R., Me.). During the first vote in the House of Representatives, Cao supported reform but he withdrew his support in the final vote. Similarly, Snowe was portrayed as an ally and courted by the Democrats, but she also voted against reform.

Opposing key actors and groups in the debate

Republican policymakers dominated oppositional coverage. Nearly half of the articles cited Republican policymakers as against reform ($n = 221$, 46.5%). Commonly mentioned Republican opponents included House Minority Leader John Boehner (Oh.), Senate Minority Leader Mitch McConnell (Ky.), second-ranking House Republican Eric Cantor (Va.), Senator Charles Grassley (Ia.), and Senator Scott Brown (Ma.). The following passage illustrates how Republican opposition was portrayed in newspaper coverage of the debate:

Republicans, led by Minority Leader Mitch McConnell of Kentucky, argued that the bill will worsen the recession by increasing insurance premiums and taxes on individuals and business owners. "We're spending trillions we don't have on legislation Americans don't even want," he said. (Kiely, 2009, p. 1A, para. 10)

Both overall and specific opposition was voiced. Specific refutations focused on Democrats' claims about the benefits of reform and objection to their perceived tactics for passing the legislation (e.g., reconciliation process). Strategies for using reform opposition to upset Democrats during the midterm elections were also discussed as were threats of legal action against reform, including repealing the entire law.

Anti-reform community, trade, and professional organizations received approximately the same amount of coverage as did pro-reform groups. Coverage of opposing groups appeared in less than 10% of the articles ($n = 36$, 7.6%) and included organizations such as the 60 Plus Association, Americans for Prosperity, Conservatives for Patients' Rights, FreedomWorks, Health Care Freedom Coalition, Heritage Foundation, National Right to Life Committee, National Small Business Association, Students for Life of America, Tea Party Patriots, and the U.S. Chamber of Commerce. America's Health Insurance Plans (AHIP), a national trade association group that represents the health insurance industry, was presented in about 5% of articles ($n = 25$, 5.3%). Coverage of anti-reform groups was brief and typically included the name of the group, the basis of their opposition, and in some cases, their

policy preferences. Slightly more than 5% of articles ($n = 25$, 5.3%) included the views of anti-reform consumers who opposed reform. References to scholars, think tanks and universities were rare ($n = 12$, 2.5%).

Similar to the AMA, pharmaceutical and hospital industries fought against health care reform throughout the twentieth century (Patel & Rushefsky, 1995). The pharmaceutical industry was instrumental in turning the tide of support against President Clinton's reform attempt (Skocpol, 1996). To avoid repeating missteps, President Obama brought these industries into the reform negotiation process from the beginning (Jacobs & Skocpol, 2010). The pharmaceutical and hospital industries agreed to some concessions that would help fund reform, but ultimately, they are able to keep much of their new revenue generated from the law. According to Hacker (2011), the underlying meaning of these deals was that:

the White House promised to protect hospitals and drug manufacturers from those who believed that government should play a stronger countervailing role. In return, the industries wouldn't kill reform. The up-front concessions were substantial: they limited the law's ability to deliver tangible benefits to the middle class and largely took off the table tools of cost control used in other nations, such as provider rate setting and government negotiations for lower drug prices. (p. 439)

After negotiations early on in the debate, these industries remained largely out of the debate. An exception occurred when Senator Byron Dorgan (D., Nd.) introduced an amendment to allow the U.S. to re-import drugs from Canada. The pharmaceutical

industry came out strongly against this proposal, and it was defeated in the Senate. For more detailed frequency information about opposing key actors, see Table 5.

Overview of Framing Domains: A Description of Dominant, Absent, and Co-Occurring Messages

Seven competing frames were expected to be present in news coverage of health care reform. Findings for each framing domain are reported from most to least frequent: (1) key beneficiaries of health care reform (very few vs. nearly everyone); (2) expense of health care reform (too costly vs. cost saving); (3) government involvement in health care (a “government takeover” resulting in socialized medicine and loss of choice and quality care vs. an improved system of care and access); (4) the nature of health care (free market commodity vs. legally-protected public good); (5) public support for health care reform (limited vs. nearly universal); (6) the determinants of health (personal/individual vs. social determinants; and (7) entitlement to health care (privilege vs. human right).

A summary of findings is provided here. See Tables 6 through 12 for frequencies of each code, by framing domain.

(1) Key “winners” and “losers” in health care reform

Overall, articles emphasized key beneficiaries slightly more frequently than potential “losers.” Support for health care reform was framed in terms benefits for specific individuals or groups in 37.5% of the articles ($n = 178$). Explicit mention of the uninsured as key beneficiaries occurred in nearly one-third of the articles (32.5%, $n = 152$). These beneficiary categories co-occurred in 86 articles. Descriptions of

individuals or groups potentially facing some type of loss due to the reform occurred in over one-quarter of the articles (29.3%, $n = 139$). In 20% of the sample ($n = 95$), portrayals of the potential beneficiaries co-occurred with portrayals of those who potentially faced losses.

Health policy scholars argue that the health care reform law, “for the vast majority of Americans is *more benefits, greater security, less cost*” (Jacobs & Skocpol, 2010, p. 123, emphasis in original). Overall, the news media represented beneficiaries in a manner consistent with this assessment. A wide range of beneficiaries were identified: “Average Americans,” people with pre-existing conditions, the uninsured, young adults allowed to stay on their parents’ plans, Medicare recipients, low-income and middle-income individuals and families, union members, doctors, hospitals, small businesses, large employers, pharmaceutical companies, health insurance companies, and the government. The primary benefit was affordable, accessible, quality health care with advantages to small and large health-related industries and the government framed in terms of economic gains (e.g., more “customers” who are able to pay, controlling health care costs for employees, reduced government spending on Medicare). Focusing on the range of benefits and beneficiaries and emphasizing how nearly everyone stood to benefit may have been a strategy for appealing to U.S. beliefs in equality of opportunity. The number of times that each beneficiary group occurred within an article was not recorded

The uninsured were described as key beneficiaries of reform, yet they were described as a monolithic group. No mention of race, almost no reference to class or

gender, and no explanation as to why coverage of the uninsured was an important goal of reform was provided. General goals of improved access were cited, including President Obama's objective to "slow the fast growth in health-care costs while extending coverage to many of the 46 million Americans who lack insurance" (Fletcher, 2010, p. A01, para. 5). Such statements mask the inequitable distribution of access to insurance. The consequences of being uninsured, such as greater risk of poor health and bankruptcy than their insured counterparts (e.g., Cheong et al., 2007; Hadley, 2003; NHDR, 2010), were also ignored. Identifying "the uninsured" as just one of the many reform beneficiaries may reinforce power imbalances that privilege elite interests and minimize the deleterious effects of being uninsured. This approach is not surprising when considered in relation to research showing that policymakers are most responsive to the preferences of the wealthy (e.g., Gilens, 2005).

Missing discourse surrounding the uninsured may be an intentional political strategy to garner public support for reform. Analysis of private intra-administration memos from the Clintons' health care reform initiative reveals the decision not to discuss the uninsured "since most American's have insurance, they think of the uninsured as 'them' – this creates an 'us versus them' mentality. We should not even talk about '37 million uninsured' because that is not who the proposal is designed to protect (Skocpol, 1996, p. 118). Uninsured people were overtly discussed in news coverage of Obama's reform initiative, but a similar political strategy may have been employed. In Connolly's (2010) analysis of the ACA, she described four "ground rules" established by President Obama's team to avoid the mistakes of the Clinton

presidency. Notably, the second rule was “Do not emphasize the problems of the uninsured. Focus on the rising costs that worry middle-class voters and the corporate world” (Connolly, 2010, p. 16). This strategy implies that the “uninsured” may have been code for low-income individuals and groups and their health needs were less concerning than their higher-income counterparts. Attention to uninsured individuals and groups may have been sacrificed to gain broader support for reform because “the uninsured” may have been perceived as undeserving of assistance.

Supporters and opponents identified different groups as health care reform’s “losers.” Reform opponents focused on groups of people that would be negatively impacted by the ACA’s passage including the “American people,” the young and healthy (who would be “forced” to purchase insurance they didn’t need), the elderly, the middle class, people who didn’t purchase insurance, and men. Opponents also highlighted the negative impacts of reform for tanning salons, businesses (both large and small), and hospitals. Commonly reported losses included “liberty” (i.e. being required to purchase unwanted health insurance), health benefits, and money (e.g., increased taxes, loss of profits). Reform’s impact on businesses and hospitals were typically described in terms of monetary losses (e.g., increased taxes, profit losses, or fines for non-compliance with the law).

Reform advocates identified distinctly different “losers” and included: women (i.e. restricted abortion access), immigrants (i.e. barred from purchasing insurance through the new health insurance exchanges), union members (i.e., proposed tax on their “high-end” insurance plans), and the working poor (i.e., insufficient government

subsidies would render insurance unaffordable). In general, advocates voiced concerns about how particular provisions undermined goals of improved access, quality, and affordability. Ultimately, only organized labor succeeded in both delaying and decreasing the proposed tax. Their success may, in part, be attributed to perceived deservingness. News coverage portrayed union members as having negotiated better health benefits in lieu of increased wages and therefore, earned their relatively comprehensive health benefits. Coverage of women seeking abortion, immigrants, and the working poor rarely provided the same type of justification or explanation of deservingness. Political support for these groups was used as a divisive tool by reform opponents and may have undermined overall support for the ACA. Limited coverage of the need for comprehensive benefits serves to justify the status quo of limited health care access. Coverage focusing on the controversial nature of these issues in particular may also contribute to the idea that members of these groups are breaking society's "moral code" and therefore deserve exclusion, which Opatow (2000, p. 354) characterizes as an "unwillingness to extend fairness, resources, or make sacrifices on behalf of others."

(2) Expense of health care reform: Costly to society yet deficit-reducing

Overall, articles emphasized increasing expenses for certain individuals and groups, and society, more generally. Reform's impact on the federal deficit was mentioned less frequently.

In over one-third of all articles (34.3%, $n = 163$), health care reform was described as increasing expenses, while half as many articles highlighted the potential

for reduced costs (15.2%, $n = 72$). Businesses, employers, and wealthy taxpayers were identified as facing rising health care expenses, whereas low and middle-income individuals and families, the elderly, hospitals, and small and large business were expected to pay less for medical care. In approximately 10% of articles, discussion of increased and decreased costs co-occurred.

More generally, nearly one-quarter of the articles (23.2%, $n = 110$) associated health care reform with increasing costs for society via higher taxes, rising health insurance premiums and care-related expenses, job loss, and economic downturn. Interestingly, these articles did not identify individuals or groups who would be impacted and instead framed reform as posing a general threat. In comparison, fewer articles characterized health care reform as decreasing overall costs to society (17.1%, $n = 81$). These conflicting messages co-occurred in 28 articles. The following passages show this oppositional framing:

The Harvard-USC report could be a boost for President Obama, who has made the economic benefits of health reform a top selling point in his administration's efforts to forge public support for the overhaul. The president's Council of Economic Advisors said health care reform would increase domestic growth, raising family incomes substantially and leading to significant new hiring. (Helfand, 2010, p. B1, para. 14-15)

But conservative economists and many business leaders contend that the proposed legislation would drive up costs by imposing billions of dollars in

new taxes and penalties, killing jobs and hurting the economy as the financial burden of health care shifts to employers and workers. (Helfand, 2010, p. B1, para. 5)

This example highlights how health care reform was directly linked to the health of the economy. Opponents of reform focused on possible negative economic consequences and supporters communicated the opposite message. President Obama made the economic benefits of reform a top selling point but in spite of this effort, negative financial effects received greater attention.

Reform's impact on the federal deficit was discussed less frequently than other possible financial consequences. However, articles that mentioned the federal deficit contradicted messages about increased costs to individuals and groups. Health care reform was described as deficit-neutral or decreasing the federal deficit in twice as many articles (10.5%, $n = 50$) as increasing the deficit (5.3%, $n = 25$). Conflicting messages about the impact of health care reform on the federal deficit occurred in 11 articles. The following example illustrates this type of competing messages:

The Senate hasn't released a cost estimate of the public plan. But Mr. Obama and Democrats have pledged the health bill will be fully supported by tax increases and spending cuts, and won't add to the deficit. If the plan pays health-care providers at lower rates than private insurers, it could put pressure on health costs and, eventually, help save government money by driving down costs of medical services. But government insurance programs have historically cost more than planned. Medicare had modest cost expectations

when it was created in 1965. It is now one of the biggest contributors to the federal budget deficit. (Adamy, 2009, p. A6, para. 11)

In light of the economic recession, consideration of both personal and societal costs may have been an important aspect in determining support for reform and arguments centered on decreased costs for middle and low-income individuals and families may have unintentionally (or intentionally) cast the ACA as a redistributive policy and triggered negative attitudes toward wealth redistribution (Kluegel & Smith, 1986). Furthermore, focusing only on the economic costs of health care minimizes the human costs faced by those who are unable to access care.

(3) Consequences of governmental involvement in health care: An improved system of care

Despite some mixed coverage, government involvement in reform was described favorably in one-third of the articles (e.g., improved quality and access, increased affordability, preservation of choices for care). Many of these articles focused on eliminating barriers to access, primarily by helping people obtain health insurance. Although the ACA contained many provisions to improve the quality of care including grants for preventative care and research, developing best-practices to improve health outcomes, and ensuring that insurance plans on the new marketplaces offer comprehensive health benefits, these improvements were rarely mentioned. The following examples typify how reform was described as improving the health care system:

The Democrats' health care bill would preserve, and broadly expand, the existing system of private, employer-sponsored health insurance, while also offering subsidies to help moderate-income Americans buy private coverage through new government-regulated markets. (Herszenhorn, Kirkpatrick, & Chan, 2010, p. A13, para. 2)

"We are right on the brink of passing historic legislation to provide quality, affordable, accessible health care for all Americans," Pelosi told reporters. Asked whether she had the votes to bring the bill to the House floor, the California Democrat pledged, "We will." (Murray & Montgomery, 2009b, p. A01, para. 5)

The \$848-billion measure that will now be laid before the full Senate is designed to expand coverage to an additional 31 million Americans over the next decade, while still restraining federal deficits and making the health care system more efficient and reliable for patients. (Levey, 2009, p. A1, para. 10)

In contrast, half as many articles characterized reform as diminishing access, care, choices, or quality (14.9%, $n = 71$). This differs from media portrayals of President Clinton's health care reform plan in which depictions of losses in care and choice were common and are widely recognized as contributing to his initiative's failure (Skocpol, 1996; West et al., 1996). Arguments that reform would be detrimental typically focused on the potential loss of choice in care, reduced benefits,

and failure of the supply-demand chain (i.e., a shortage of physicians after new clients flood the health care system). These three passages exemplify how the perspectives of opponents were represented in news coverage of reform:

Senate Minority Leader Mitch McConnell (R., Ky.) dismissed the Congressional Budget Office cost estimate of the Finance Committee plan as "irrelevant" and insisted the legislation "will never see the light of day." He said "the real bill" will bust the federal budget and limit "the health-care choices Americans now enjoy." (Hitt & Adamy, 2009b, p. A3, para. 4)

"As this bill moves across the [Senate] floor, I am concerned that it will not move more in the direction of more choice and lower cost, but one that will lurch to the left and result in higher cost and less choice for the American people," said Sen. John Cornyn (R-Texas). (Hook & Levey, 2009a, p. A18, para. 10)

Republicans -- and many Democrats -- have complained that the health legislation would add up to 15 million people to state Medicaid rolls at a time when many current recipients are struggling to find doctors willing to see them. (Montgomery & Murray, 2010, p. A01, para. 15)

These passages show how anti-reform policymakers tried to capitalize on public distrust of government and fears about losing current health care benefits to foster opposition.

Contradictory messages regarding the impact of reform on the health care system co-occurred in 27 articles. Positive references to government intervention ($n = 77$, 16.2%) occurred more frequently than negative references to “government takeover” ($n = 56$, 11.8%). Competing messages about the consequences of government intervention in the health care system co-occurred in 13 articles. The following example, drawn from an article in which these messages co-occurred, illustrates these contrasts:

"It is more important that we begin this debate to improve our nation's health care system for all Americans, rather than just simply drop the issue and walk away," Sen. Blanche Lincoln of Arkansas, one of the last Democratic holdouts, said Saturday in announcing her support for the parliamentary vote.

"That is not what people sent us here to do." (Levey, 2009, p. A1, para. 4)

Two paragraphs later it was noted that “not one Republican backed the motion, which GOP lawmakers declared would pave the way for a federal takeover of health care and drive up the national debt” (Levey, 2009, p. A1, para. 7). As this example shows supporters emphasized government responsibility for ensuring that everyone has health care while opponents labeled the government as overstepping its bounds. By framing reform as “government takeover,” opponents may have been able to capitalize on the “worst political climate for Democrats since ’94...[and] at its core is distrust of government, which is only stoked by the prospect of a bigger federal role in the one-sixth of the economy represented by health care” (Calmes, 2009, p. A21, para. 19). Despite positively characterizing government intervention, a “takeover”

frame may resonate deeply with a public that has grown increasingly distrustful of the federal government since the passage of the Civil Rights Act in 1964 (Jacobs & Skocpol, 2005).

The U.S. health care system was not described as functioning well ($n = 4$, 0.8%). Fourteen percent of the articles ($n = 67$) identified the health care system as broken:

Piecemeal reform is not the best way to effectively reduce premiums, end the exclusion of people with pre-existing conditions or offer Americans the security of knowing that they will never lose coverage, even if they lose or change jobs," Obama wrote. "Both parties agree that the health care status quo is unsustainable. And both should agree that it's just not an option to walk away from the millions of American families and business owners counting on reform." (Montgomery & Murray, 2010, p. A01, para. 15)

Both political parties acknowledged problems with the current health care system. However, it was also recognized that "by trying to kill the Democratic effort at reform and reposition themselves as defenders of Medicare, Republicans are in essence fighting for an unpalatable status quo" ("As medical costs take over government, Dems duck," p. 11A, para. 9). Opposition to reform may have been interpreted as tacit acceptance of the status quo, despite not explicitly being framed as such.

(4) The nature of health care: A commodity in need of greater regulation, not a right

In nearly one-third of the articles, health care (29.1%, $n = 138$) was likened to a product or service for purchase, and only rarely as a legal right or public good ($n = 9$, 1.9%). Health care consumers were frequently referred to as customers and the ability to “shop” for coverage in the health care marketplace was a dominant topic. Both supporters and opponents of reform relied on free market terminology to advance their positions. For example, Senator John D. Rockefeller (D., Wv.) drew a parallel between “shopping” for health insurance and cars saying that “an individual shopping for a health insurance policy would benefit from information about the relative value of the plans available, just as someone purchasing a car finds information about gas mileage helpful in choosing models” (Abelson, 2009, p. B1, para. 12).

Greater transparency is important, nonetheless, likening obtaining health insurance to shopping for a car reinforces the problematic construction of health care as a luxury item and neglects differences between necessities and conveniences. Helen Darling, leader of the National Business Group of Health, opined “Americans have really changed their buying behavior, and health care is a part of that, since a lot of health care is really a consumer good” (Adamy & Johson, 2010, p. A4, para. 12). Implying that much of health care is elective and non-essential is a privileged viewpoint. Although not a dominant perspective, one health “consumer” stated that

he and wife “don't believe health care is a right. It's a service, just like anything else” (Bendavid, 2010, p. A6, para. 14).

In slightly over one-quarter of articles (26.7%, $n = 127$), reform was described as necessary to regulate the health care and insurance industries. These arguments centered on unfair insurance practices, most notably the denial of coverage to people with pre-existing conditions, dropped coverage due to illness, premium increases, and benefit caps. The five largest health insurance companies, WellPoint Inc., UnitedHealth Group, Cigna Corp., Aetna Inc., and Humana Inc., were widely criticized after it became known they earned more in 2009 than 2008, even though 2.7 million people were forced to drop coverage due to the recession. The following passage exemplifies this anger and the framing of health care reform as a “solution:”

The companies' 2009 profits are nonetheless fueling attacks on an industry already criticized for raising premiums and denying coverage to millions of Americans. “That's why we need health insurance reform today in this country and why we are going to continue in the Congress to work on this until we see it through,” said Rep. Rosa DeLauro (D-Conn.), a leading advocate of the health legislation being pushed by Democrats on Capitol Hill. (Levey, 2010, p. B1, para. 7-8)

In contrast, health care reform was seldomly described as an unfair regulatory burden on the insurance and health care industries (6.9%, $n = 33$), but when they were present, it was to defend corporate interests. For example, the chief of strategy at WellPoint, the largest U.S. health insurance company by membership, stated the

“move [to create a federal agency which would review premium increases and block those deemed unreasonable] could create instability, prompt bankruptcies and oblige some insurers to leave regions where they can't operate profitably” (Johnson, 2010, p. A8, para. 6).

Among all articles that referred to health as a commodity ($n = 138$) or references the need for regulation ($n = 127$), nearly one-quarter (22.2%, $n = 59$) contained both types of frames. This type of message juxtaposition is illustrated in the following pair of statements which occurred consecutively in the same article:

Lawmakers liken the marketplaces, or "exchanges," to travel Web sites where consumers buy airline tickets after seeing side-by-side comparisons of prices and schedules. (Adamy & Hitt, 2010, p. A4, para. 2)

Congressional Democrats and insurance companies both say they want robust regulation of the exchanges to prevent deceptive marketing of health plans and to ensure that customers can exercise the rights guaranteed by the bills, including the right to buy coverage even if they have a pre-existing medical condition. (Adamy & Hitt, 2010, p. A4, para. 3)

The co-occurrence of these frames reinforces the idea that health care is a good and that market-based reforms are the solution to structural inequalities, without contesting that health insurance and care might be qualitatively different. As such, the provision of care is framed as a private rather than public responsibility. This solution is based on the assumption of equality of opportunity rather than equality of outcomes.

The prevalence of messages that both commodified health care and presented it as needing greater regulation, even among ACA supporters, stands in contrast to progressive conceptualizations of health and to public beliefs about the nature of health care. Patel and Rushefsky (1995, pg. 114) draw attention to the distinction between health and other types of commodities, noting that:

Health care and health insurance are not automobile insurance. People in good health can do more, can realize more of their potential, than those in poor health. Health care is instrumental in the sense that it enables one to do other things.

Health may be viewed as a unique “good” because of its relationship to societal opportunities (e.g., educational attainment, career success) and accordingly, takes on a special moral importance (Daniels, 2008). However, the majority of the public tends to view health as a qualitatively different domain than “commodity,” and is distinguished from other public goods, such as education or political voice (Lynch & Gollust, 2010). Lynch and Gollust (2010, p. 861) found that individuals who place a high priority on health care do so because they believe that “to be in decent health” is a right in itself, not just because good health affords more opportunities to get ahead in life. In a similar vein, a public opinion conducted by the Brookings Institution and Worldopinion.org (2009) after the Senate Finance Committee introduced its version of the health care reform legislation revealed that 60% of the public viewed health care as a right, not a privilege. This finding are indicative of a disconnect between news coverage of reform and how the public views health care.

(5) Opinion toward health care reform: Public portrayed as unsupportive

Although data from opinion polls were infrequently referenced, the public was characterized as unsupportive of reform, with three times as many articles discussing disapproval ($n = 61$, 12.8%) than support ($n = 20$, 4.2%). These contradictory characterizations co-occurred in 10 articles. Opponents of reform often made broad generalizations about lack of public support for reform such as Senate Minority Leader Mitch McConnell claim, "I do not believe there will be any Republican support for this 2,700-page bill that the American people are so opposed to" (Wolfe & Fritze, 2010, p. 6A, para. 5). Public support for reform was described less broadly and tended to occur in conjunction with statistics such as "more than half of Americans say they trust the president to change the [health care] system, compared with 37% expressing the same for congressional Republicans" (Fritze, 2009a, p. 5A, para. 5).

Additionally, 6.5% of articles ($n = 31$) contained public opinion data tangentially related to health care reform such as confidence ratings in Democratic and Republican policymakers, support for reform as a function of political affiliation, group membership, and attitudes toward different aspects of the reform (e.g., cost, personal impact). Of the 20 articles in which the public was described as generally supportive of reform, nearly half ($n = 9$) contained additional types of polling data. In articles that described the public as anti-reform, 13 contained additional types of polling data. The following excerpts demonstrate how opinions, beyond support or opposition, were reported in coverage of reform:

The poll found only 38% approve of the job Mr. Obama is doing on health care, lower than his overall approval rating and lower than his grades for the economy, foreign policy and the war on terrorism. People are even less happy with Republicans in Congress on this issue, with just 26% approving of the job they've done on health. (Meckler, 2010, p. R5, para. 5)

Harvard University pollster Robert Blendon said public opinion remains mixed. "Most people are afraid these bills are going to raise their costs, so this could raise public anxiety," he said. "At the same time, the health insurance industry is at the bottom of the scale of people's trust." (Connolly, 2009, p. A06, para. 24)

Mrs. Obama targeted two important groups in her meeting. Women, like the public overall, are generally split on the health care legislation. Polls have shown people age 65 and older have had the most negative views about President Barack Obama's attempt to overhaul health care. ("First lady attempts to assure seniors on health care overhaul," 2009, p. A8. para. 12)

Although public opinion data was infrequently cited, articles were more likely to reference polls cited by reform opponents than supporters. This misrepresents highly nuanced attitudes toward health care and encourages the perception that fewer people support reform than actually do. Unfortunately, warnings about how to handle conflicting statistics, such as "Beware of politicians quoting poll numbers -lawmakers

in both parties cherry-picked survey results, ignored contrary findings and presented public opinion, which is highly nuanced on these questions, as a slam-dunk” (Woodward & Drinkard, 2010, p. A20, para. 1-2) rarely accompanied polling data.

(6) Determinants of health: Lack of “health” in health care reform

Determinants of health and the potential impact of reform on individual and population health were mentioned infrequently. Specific disease or illness was mentioned in 10.1% of the articles ($n = 48$). Asthma, autism, cancer, diabetes (particularly Type 2), high blood pressure, leukemia, and multiple sclerosis were most commonly mentioned.

Individual ($n = 8$, 1.7%) and socially determined causes ($n = 8$, 1.7%) of illness were virtually nonexistent in coverage of reform, and these frames did not co-occur. Without a broader discussion of health, including attributions for health status, there is limited context for understanding the significance of health care reform. Attributions for health are also important because of their relationship to blame and responsibility. The following example illustrates how personal responsibility is connected with health and health care costs:

A study in the January-February 2009 issue of the journal *Health Affairs* concluded that 75 percent of the country's \$2.5 trillion in health care spending has to do with four increasingly prevalent chronic diseases: obesity, Type 2 diabetes, heart disease and cancer. Most cases of these diseases, the report stated, are preventable because they are caused by behaviors like poor diets, inadequate exercise and smoking. (Warner, 2009, p.1, para. 20)

Individuals and their “poor” health habits were blamed for the majority of health care spending, suggesting that the possibility of reductions if individuals improved their diet, exercised, and stopped smoking. First Lady Michelle Obama echoed this sentiment when she said “health costs would continue to soar if children continued to stuff themselves with salty, high-fat foods that contributed to obesity -- and to a higher risk of diabetes, high blood pressure and heart disease” (Pear, 2010, p. 16, para. 13.)

In contrast, health attributed to social causes directs attention to structural changes needed to solve health care problems. For instance, a “Scorecard” released by the Commonwealth Fund ranked health in each of the 50 states based on measures such as access to care, insurance coverage and avoidable hospital admissions. Summarizing the findings, Schoen stated, “Where you live matters for how long you live and how healthy you live” (Rubin, 2009, p. 10B, para. 3) and co-author Davis added, “States cannot go it alone. Health reform is needed on a national level” (Rubin, 2009, p. 10B, para. 14). Together, these remarks speak to the importance of social factors and the need for national level reform.

Health disparities were rarely discussed, but when they were reform was twice as likely to be described as potentially decreasing ($n = 24$, 5.1%) than increasing health disparities ($n = 12$, 2.5%). Articles about reduced disparities focused on improved health for women, the elderly, and individuals with pre-existing conditions. The following passage exemplifies these discussions:

Women's health groups, legal organizations and some female senators are fighting for a host of little-known provisions in the health care legislation being debated in Congress that they say will dramatically improve health care and insurance coverage for women. From a ban on insurance companies charging women more for the same policies as men to a requirement that companies provide maternity coverage as part of their basic plans, advocates say the provisions would correct long-standing inequities and offer more coverage to women at lower costs. (Hall, 2009, p. 5A, para. 1-2)

Claims of increased disparities were often predicated on specific reform provisions rather than reform as a whole:

those on the losing end are criticizing the provision as a brazen money grab. They predict that, instead of saving taxpayer money, it will simply take funding from areas with more poverty and racial minorities and send it to more homogenous communities that tend to have fewer health problems. (MacGillis, 2010, p. A04, para. 6)

Opponents of the Medicare payment restructuring argued that valuable health resources would be redistributed to healthier, more privileged groups at the expense of low-income individuals and people of Color with poorer health.

Many provisions of the ACA, such as extending coverage to people with pre-existing conditions, increasing preventative care services for women, and strengthening community-based health centers could alleviate health disparities (Kaiser Family Foundation Facts on Health Reform, 2010). Lack of news coverage

undermines the U.S. government's emphasis on eliminating health disparities (HealthyPeople.gov, 2010). The National Partnership for Action to End Health Disparities (NPA), sponsored by HHS Office of Minority Health, defines health equity as the "attainment of the highest level of health for all people." They state that "valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities" is necessary to achieve health equity (NPA, 2011, para. 1).

Limited discussion of health care reform's potential to advance these goals, even among supporters, may reflect racist, sexist, and classist beliefs and lack of commitment to addressing health injustices. It may also have been a political strategy to avoid racializing the ACA and gain broad public support. This approach was likely successful because it is consistent with research demonstrating that policies are more likely to be supported when nearly everyone is perceived as a potential beneficiary, not just certain groups (e.g., Shibley & Prosterman, 1998).

(7) Entitlement to health care: Neither a privilege nor an entitlement

Discussions of entitlement to health care were notably absent in the newspaper coverage of health care reform. Health care was never explicitly identified as a privilege, and was rarely identified as a human rights or a matter of social justice ($n = 12$, 2.5%). In one of the few examples of this perspective, Representative Alan Grayson (D., FL.) defended his vote in support of health care reform saying that a "just society is one that shelters the homeless, feeds the hungry, that heals the sick"

(as cited in Nagourney, 2010, p. A1, para. 8). Only the Roman Catholic Church explicitly identified health care as a human right.

Health care reform was neither praised for nor criticized as creating new entitlement programs ($n = 2$, 0.4% and $n = 7$, 1.5%, respectively). However, existing entitlement programs (e.g., Medicaid, Medicare, Social Security) were mentioned in more than half of the articles (56.4%, $n = 268$). These discussions focused on reform's potential impact on funding for existing programs (e.g., cuts to Medicare to fund subsidies for purchasing insurance, expansion of Medicaid), wastefulness and fraud within these programs, and comparisons to the passage of health care reform with the adoption of Social Security, Medicare, and Medicaid. Criticism of deal-making to ensure favorable votes (e.g., Senator Ben Nelson's "Cornhusker Kickback" to secure federal money to pay for Medicaid expansion in Nebraska) was also common. The following excerpts typify the juxtaposition of existing entitlement programs with the current health care reform initiative:

A small group of senators and staffers is expected to gather Monday with the Senate parliamentarian to determine whether a tax on high-cost insurance policies would affect the Social Security trust fund, and whether that would violate prohibitions against altering Social Security through the reconciliation process. (Kane, 2010, p. A12, para. 5)

Medicaid, the state-federal health-care program for the poor, would be expanded to cover people making 133% of the federal poverty level, starting

in 2014. (The federal poverty level is about \$10,800 for an individual and \$22,000 for a family of four.). (Matthews, 2009, p. A4, para. 5)

White House health-care adviser Nancy-Ann DeParle said the administration was pleased with the House bill and the one emerging in the Senate. She described the Medicare savings in both bills -- about \$500 billion under the Senate approach and \$400 billion in the House version -- as the first serious effort to restrain the entitlement program's growth since the 1997 Balanced Budget Act. (Murray, 2009b, p. A04, para. 3)

For hours, Democrats sought to woo Republicans by citing areas of agreement, such as going after Medicare fraud and insurance company abuses. (Wolf & Fritze, 2010, p. 6A, para. 10)

Democrats said throughout the day they were making history and that hostility also confronted earlier Congresses that passed landmark Social Security, Medicare and civil-rights laws. (Bendavid, 2010, p. A6, para. 18)

Ultimately, a range of messages from both supporters and opponents connected existing entitlement programs to the current health care reform debate. This provides a context for understanding the ACA, but may also be problematic if the public misunderstood reform as creating a new entitlement program.

These mixed messages likely reflect ambivalence toward health care as an entitlement as well as conflicting attitudes toward entitlement programs more

generally. This ambivalence is summarized in Levitsky's (2008, p. 552) claim that "as President Clinton's health security plan subsequently unraveled, it became clear that the American public was in fact deeply ambivalent about bestowing 'entitlement' status to health care" (2008, p. 552). She observes that there is strong public support for federal spending and yet, lack of trust in the government's ability to play a larger role in health care provision. Recent polling documents the persistence of this ambivalence. A survey conducted by the Pew Research Center for the People and the Press (2011a) found that the majority of respondents believe that Social Security, Medicare, and Medicaid need to be rebuilt or undergo major changes, but that they have also have been good for the country and that benefits should not be reduced.

Attitudes and beliefs about Medicaid, Medicare, and Social Security are more nuanced than general polling results reveal. Medicaid and Medicare were created at the same time, yet Medicare enjoys greater popularity and its recipients are viewed as more deserving than Medicaid which is stigmatized as a "welfare" program (Patel & Rushefsky, 1995 p. 52). President Clinton attempted to "recast Medicaid as a broad social entitlement that incorporated the middle class" (Grogan, 2003, p. 844) but his success in doing so is questionable. Medicaid recipients are closely scrutinized and regulations to combat fraud are widely supported, despite evidence that fraud is not a significant problem (Ku & Pervez, 2010).

Although Social Security provides financial benefits, not medical care, it is viewed similarly to Medicare in terms of its beneficiaries ("deserving") and access (based on age, not need). Furthermore, Social Security is viewed as a "white"

program, and subsequently, racially conservative whites feel more positively about it than do racially liberal whites (Winter, 2006). Collectively, these studies suggest that mention of existing entitlement, in conjunction with debate about health care reform may have activated beliefs about deservingness. However, based on differences in beliefs about the program, it is not clear exactly how these mixed messages impacted understanding of the ACA or support for it.

Framing Clusters

Supportive Health Care Reform Frame Clusters

News coverage of reform support was characterized by arguments from the following three framing domains: nature of health care, key beneficiaries and losers, and meanings of reforming the health care system. More specifically, arguments about reform as a needed government intervention, as improving the health care system, and helping beneficiaries, most frequently co-occurred ($n = 61$, 12.8%). Discussions of beneficiaries frequently co-occurred with descriptions of reform as improving the health care system ($n = 135$). Emphasis on beneficiaries also frequently co-occurred with messages about the importance of the government stepping in to curb unfair health industry practices ($n = 82$, 17.3%). The following paragraphs drawn from the same article typify these co-occurrences:

Summoned to success by President Obama, the Democratic-controlled Congress approved historic legislation Sunday night extending health care to tens of millions of uninsured Americans and cracking down on insurance

company abuses, a climactic chapter in the century-long quest for near universal coverage. (Espo, 2010, para. 1)

The nonpartisan Congressional Budget Office said the legislation awaiting the president's approval would extend coverage to 32 million Americans who lack it, ban insurers from denying coverage on the basis of pre-existing medical conditions and cut deficits by an estimated \$138 billion over a decade. If realized, the expansion of coverage would include 95 percent of all eligible individuals under age 65. (Espo, 2010, p. 12, para. 5)

Although pro-reform advocates did not comment on the cost of reform as frequently as opponents, supporters described reform as decreasing costs (including the federal deficit). Supporters were also more likely than opponents to describe the current health care system as “broken” or “unacceptable” and health care reform as having the potential to decrease health disparities. Democrats were also more likely to make positive comparisons between health care reform and existing entitlement programs. This is evident in the statement that President Obama made about the ACA urging “others to see the glass as half-full, emphasizing that the legislation, like the landmark 1965 law that created Medicare, would be a foundation for further improvements later” (Hook & Levey, 2009b, p. A1, para. 30). Clearly, Democrats hoped to gain support by comparing the current reform effort to popular existing programs.

Opposing Health Care Reform Frame Clusters

The mostly commonly occurring opposing frame clusters included arguments from the following three framing domains: cost of reform, key beneficiaries and losers, and meanings of reforming the health care system. Concerns about increased health care costs, “losers” under reform, and “government takeover” of health care most commonly occurred together, yet even so, their co-occurrence was infrequent ($n = 38$, 8.0%). Far more frequent were the pairings of increased cost with discussion of groups who faced potential losses under the ACA ($n = 106$, 22.3%) The following paragraphs exemplify how these messages co-occurred:

The insurers, however, showed no sign of being chastened. America's Health Insurance Plans, an industry trade group, opened a fresh line of attack with a multistate advertising campaign warning that senior citizens enrolled in private Medicare plans could lose benefits under the legislation. (Connolly, 2009, p. A06, para. 7

Sen. Joseph I. Lieberman (I-Conn.) said Tuesday that he would not support the finance panel's bill because of cost concerns. "I'm afraid that in the end the Baucus bill is actually going to raise the price of insurance for most of the people in the country," he said on Fox Business Network's "Imus in the Morning" program, referring to Finance Chairman Max Baucus (D-Mont.). (Connolly, 2009, p. A06, para. 26-27)

Increased cost claims also occurred relatively frequently with reform described as a “government takeover” ($n = 68$, 14.3%).

Additionally, opponents were more likely than supporters to characterize health care reform as imposing unfair regulations, to describe reform as increasing the federal deficit, to question the federal government's ability to successfully implement health care reform, and to justify their positions using public opinion data. Although opponents were more likely to cite public opinion data, the findings they cited were often taken out of context or used to make sweeping generalizations.

Notable exceptions to the supportive and opposing framing cluster patterns included Blue Dog, anti-choice, and progressive Democrats. Fiscally conservative Blue Dog Democrats were portrayed as dubious of reform's capacity to reduce costs; anti-choice Democrats aligned with Republicans in using health care reform as a platform to restrict abortion access; and some progressive Democrats drew attention to omitted groups and services (e.g., immigrants, abortion, government-run option).

Dominant Competing Frames

News coverage of health care reform was dominated by framings of its cost and key beneficiaries and losers. Frames most commonly in competition with each other involved increasing costs and benefits to individuals and groups. Opposition to reform was characterized as being too costly to individuals, groups, and businesses, while support for reform was characterized in terms of its benefits to a wide range of groups, and to the United States as a whole.

More broadly, competing frames of losses and gains characterized the health care reform debate. Opponents of reform primarily focused on potential losses related to higher individual costs (e.g., increased taxes, increased health insurance premium

costs), health care access, benefits, quality, and liberty (e.g., reform as a “government takeover”), whereas supporters emphasized gains such as heightened control over unfair practices and spiraling costs, fewer uninsured Americans, and an improved system of care via increased access and quality. Reform opponents capitalized on the public’s aversion to loss and resistance to changes in the status quo while reform supporters worked to “neutralize the loss averse predispositions of the American public” (Eckles & Schaffner, 2010, p. 4) by focusing on how people might face increased costs if no reform was enacted and how those who already had insurance would keep their existing coverage. Findings from their analysis of public polling data indicate that reform opponents successfully portrayed the ACA as financially costly to individuals, but advocates effectively highlighted some of the most popular “gains” such as coverage for pre-existing conditions and the removal of lifetime insurance limits. In doing so, supporters were able to effectively counter frames about financial losses by framing reform in terms of benefits to many different groups even if they already had coverage.

Framing of Highly Contested Issues

During the summer of 2009, fierce opposition from Tea Party activists was evident at town hall meetings held across the U.S. Among the most dramatic claims was that “death panels” would be charged with conducting cost-benefit analyses to determine which seniors would receive end-of-life care. Interestingly, the original proposition for voluntary end-of-life consultations (i.e. “death panels”) was generated by a Republican senator but was subsequently attributed to the Democrats (Jacobs &

Skocpol, 2010). Despite sensationalistic coverage throughout the summer, in the six months prior to the ACA's passage death panels were almost never mentioned in the articles analyzed ($n = 6$, 1.3%). However, other highly contested issues received substantial attention: government-run insurance, the individual mandate, coverage of undocumented immigrants, and abortion.

A government-run insurance plan, or the “public option”

Although the initial reform legislation passed by the House of Representatives in 2009 included a public option, the Senate rejected this initiative. Yet, nearly one-quarter of the articles mentioned public support for a government-run plan to compete with private plans (24.8%, $n = 118$). Opposition to a government-run plan was discussed in slightly fewer articles (18.7%, $n = 89$). Support and opposition co-occurred in 59 articles. The following passage typifies sentiments about the public option:

Supporters of a public insurance program, including President Obama, have argued it would lower health care costs by offering competition to private insurance companies. Most Republicans counter that a government-run plan would drive private insurers out of business. "It is a slow walk toward government-controlled, single-payer health care," said Iowa Sen. Chuck Grassley, the Finance panel's ranking Republican. "A government-run plan is not the answer." (Fritze, 2009b, p. A4, para. 4-5)

Notably, news coverage of the public option reflected a switch in the framing preferences of supporters and opponents. In this case, supporters of the public option

focused on costs (i.e., that it would help lower costs). Opponents, who included Democrats and Republicans, countered with claims about key beneficiaries (i.e., that a public option would hurt insurers and put them out of business). Opponents also focused on the negative consequences of “too much government” and how the public did not want it.

Claims that the public did not want government-run insurance was a misrepresentation of polling data. A June 2009 New York Times-CBS news poll revealed that 87% of Democrats, 73% of Independents, and 50% of Republicans supported a public-option to compete with private insurance plans (Sack & Connelly, 2009, para. 8). Similarly, a Washington Post-ABC News poll conducted in the middle of the debates about the public option revealed that the majority of respondents (57%) supported a public option (Balz & Cohen, 2009, para. 8-9). Even among Republicans, there was majority support (56%) for a public option if control was located at the state-level. Explaining why progressives failed to gain support for a public option, Lakoff (2009) asserts:

As for language, the term "public option" is boring. Yes, it is public, and yes, it is an option, but it does not get to the moral and inspiring idea. Call it the American Plan, because that's what it really is. The American Plan. Health care is a patriotic issue. It is what your countrymen are engaged in because Americans care about each other. (para. 24-25)

Although making health care an issue of patriotism could be problematic, Lakoff's point underscores the need for framing that draws attention to underlying issues of morality in the provision of health care.

Individual mandate

Controversy surrounding the individual mandate was not part of the original coding framework but emerged as an important point of contention approximately two months prior to the reform's passage. Pro and anti-reform attitudes toward requiring the purchase health insurance are exemplified in the following passages:

Advocates of a coverage mandate say it is needed to ensure that young, healthy people get insurance and contribute to the system. They say this will ease costs associated with an influx of less-healthy people who are expected to get coverage under the Baucus legislation. (Hitt & Adamy, 2009a, p. A6, para. 3)

Iowa Sen. Charles Grassley, the Finance Committee's senior Republican, said the mandate is among the reasons that he couldn't support the bill despite months of negotiations with Mr. Baucus. "Individuals should maintain their freedom to chose health-care coverage, or not," he said. (Hitt & Adamy, 2009a, p. A6, para. 5)

Virginia State Senator, Phillip Puckett, a Democrat who represents a rural county echoed the sentiments of Republicans saying, "I don't believe someone

should be forced to buy something they don't want to...It's un-American. And it might be unconstitutional.” (Helderman, 2010, p. A01, para. 11)

Supporters of the mandate highlighted the necessity of reducing costs by spreading “risk” among the insurance pool and how this practice would enable the success of other reform provisions. Opponents framed the individual mandate as an unconstitutional attack on liberty.

Republican opposition to the individual mandate is particularly intriguing. The core tenets of the ACA - expansion of Medicaid, income-based subsidies, health insurance exchanges, insurance reform, and the individual mandate - were modeled after 2006 Massachusetts reform law, a bipartisan effort spearheaded by former Republican Governor Mitt Romney (Brown, 2011). However, the individual mandate, which became one of the most contested provisions of the reform and the basis for legal efforts to overturn reform, has conservative and Republican roots (Morone, 2011). This point received little media attention. The individual mandate is rooted in individualism and provides a market-based, individualized “solution” to health care, but was reframed by Republicans as a loss of liberty. In this case, Republicans appealed to the value of freedom and Democrats countered by explaining how insurance pools work, supporting Lakoff’s (2004) position that Republicans are more effective at framing than Democrats.

Coverage of undocumented immigrants

Coverage of undocumented immigrants was one of two issues identified as “sticking points” of health care reform (Murray, 2009a, p. A07, para. 1). The

Hispanic Caucus fought to allow undocumented immigrants to purchase health insurance through the new exchanges. In contrast, President Obama assured Congress that benefits would not be extended to undocumented immigrants. Despite these public assurances, concerns about extending any health benefits persisted, even among reform supporters. The following passage illustrates the fear that pro-reform Democrats felt about extending access to “undeserving” undocumented immigrants:

As the hours ticked away, Democrats scrutinized the House bill for other potential landmines that could haunt them on the campaign trail next year. Immigration, and the prospect that Republicans will identify a loophole that could be construed as benefiting people who live in the United States illegally, is one area that is receiving a great deal of attention. Rep. Gerald E. Connolly (Va.), president of the Democratic freshman class, said he wants to be able to assure his constituents that people "who are here illegally cannot avail themselves of the infrastructure that we're creating." (Murray & Montgomery, 2009b, p. A01, para. 10-11)

Progressive groups such as ColorLines have campaigned to remove the word “illegal” from public discourse but nearly all articles that discussed permitting undocumented immigrants to purchase health insurance through the exchanges, referred to immigrants as “illegal.”

Deliberate exclusion of undocumented immigrants from the benefits of health care reform mirrors policy trends at both the state and national levels. Over the past several years, policymakers have intensified efforts to identify, detain, and deport

undocumented immigrants and adopted policies to restrict access to public services and employment (Casas & Calorera, 2011). The term “illegal immigrants” has become synonymous with Mexico, regardless of whether immigration was sanctioned by the U.S. government (e.g., Stewart, Pitts, & Osborne, 2011). These punitive policies reflect both anti-immigrant attitudes and stereotypes about Latinos (e.g., Brader, Valentino, & Suhay, 2008; Welch, Payne, Chiricos, & Gertz, 2011).

Stereotypes about Latina immigrants likely fueled resistance to including undocumented immigrants in health care reform. Since the 1960s, myths about high fertility rates among Latinas have informed legislation that limits immigrant women’s access to critical health services for themselves and their children (Chavez, 2004; Chapkis, 2003). Immigrant women are stereotyped as “criminals” and as coming to the United States to have “anchor babies.” Although immigrant women, particularly those who are undocumented, have limited access to public services, they are stereotyped as draining public funds (Lindsley, 2002).

Analysis of health care reform coverage revealed that Democratic supporters took steps to ensure the exclusion of undocumented immigrants and subsequently, used their opposition to gain favor with their constituents. This stands in stark contrast to supporters’ focus on benefits and beneficiaries. In this case, the exclusion of undocumented immigrants was used as a “selling point” to garner support, reinforcing dominant perceptions of immigrants as undeserving outsiders.

The power of one highly contested issue: Abortion and the near derailment of health care reform

Abortion was discussed in over one-quarter of the articles ($n = 122$, 25.7%). Both Republicans and Democrats threatened to veto any bill if abortion access was not explicitly restricted. In one of the few bipartisan efforts, the Stupak-Pitts Amendment guaranteed that any government-run insurance plans offered through the exchanges could not cover abortion, nor could any other health plan receiving a federal subsidy. The final version of the bill “dictated that federal premiums or subsidies could not be used for the purchase of abortion coverage and had to be segregated from private premium payments or state funds” (Quadagno, 2011, p. 451).

News coverage of abortion typically focused on conflict between pro and anti-choice policymakers. Ultimately, anti-choice policymakers pitted abortion against health care reform, and pro-choice supporters were forced to choose between supporting health care reform or abortion access. Instead of fighting for expanded reproductive and abortion health services, pro-choice supporters worked to preserve existing coverage. Articles reflected the gendered nature of attitudes toward abortion, with women opposed to restricted abortion access and men supporting greater restrictions. Opponents’ concerns about the complex process by which federal money could cover abortion was oversimplified, and in doing so, implied that abortion is a federally-funded procedure:

While support for a "robust" public option is strong, they [Democrats] said, other issues are muddying the waters. For example, as many as 20 votes hinge

on resolving a battle over abortion that has pitted an unyielding abortion-rights faction against anti-abortion Democrats who want to make sure no federal money is used to pay for the procedure. (Murray & Montgomery, 2009b, p. A01, para. 17)

Anti-choice (e.g., the U.S. Conference of Catholic Bishops, National Right to Life) and pro-choice groups (e.g., Catholic nuns, NARAL Pro-Choice America) also received coverage. Anti-choice groups were simply quoted as stating they did not support federal funding of abortion, with the exception of activist Randall Terry, who suggested that protesters should “burn effigies of House Speaker Nancy Pelosi and Senate Majority Leader Harry Reid this Halloween, as part of a ‘Burn in Hell’ video contest to protest the health-care legislation in Congress” (Sanner, 2009, p. 18, para. 1). In contrast, Catholic nuns issued a progressive statement:

“Despite false claims to the contrary, the Senate bill will not provide taxpayer funding for elective abortions. It will uphold long-standing conscience protections and it will make historic new investments -- \$250 million -- in support of pregnant women,” wrote the nuns. “This is the REAL pro-life stance, and we as Catholics are all for it.” (Sweet, 2010, p. 4, para. 16)

This progressive perspective stands in contrast to how abortion debates are typically characterized. The “pro-life” perspective is often framed in terms of morality and the “pro-choice” position as a matter of individual rights and freedoms (Rohlinger, 2002). These competing frames, to a large extent, portray abortion as being about two mutually exclusive issues. However, both perspectives emphasize the

role of choice (e.g., a woman choosing life or protecting an individual woman's right to choose). This conceptualization fails to acknowledge the larger economic, social, and political conditions in which individual choice takes place and the institutional barriers that stand in the way of "free" will (Smith, 2005). The anti-choice position was presented as common sense, thus, explanations for why abortion access should be restricted were rarely provided. Conversely, pro-choice positions almost always included some form of justification. Abortion was the only area that conservative policymakers wanted the government directly involved in medical decision-making, and was not considered a governmental intrusion. It is also striking to note that abortion, but not health care, was identified as a right.

The contested nature of abortion during the health care reform debate is part of a broader, escalating assault on women's sexual and reproductive health. In the year following the ACA's passage, policymakers from 24 states enacted a record-setting 92 provisions to restrict abortions including mandatory waiting periods, required ultrasounds, and limiting insurance coverage of abortion (Guttmacher Institute, 2011). These initiatives were enacted despite two decades of research showing that abortions do not negatively affect mental health (Major et al., 2009). The ACA's contraception coverage also caused conservative outcry (e.g., Aizenman & Helderman, 2012). Collectively, the attack on abortion during the health care reform debate, attempts to block contraceptive coverage, and other initiatives to undermine women's reproductive and sexual health are just several facets of

reproductive oppression, a larger, systematic effort to control women's bodies, sexuality, and reproduction (Silliman et al., 2004).

Concluding Thoughts

In summary, Democratic and Republican policymakers dominated newspaper coverage of the health care reform debate, reinforcing the partisan nature of the debate. Newspapers, taking their cues from political elites, framed the health care reform debate as a matter of key beneficiaries versus costs. Supporters emphasized the wide range of benefitting groups, while opponents argued that reform would be too costly. Supporters also made a compelling case for greater market regulation, and assured the public that reform would improve care. Opponents stressed who would lose out if reform was passed and portrayed reform as “government takeover” that would reduce consumer choice. Both supporters and opponents reinforced the notion of health care and health insurance as free market commodities. Notably absent were portrayals of health care as a public good or a human right. Overall, readers were presented with politically polarized, conflicting narratives about the costs, benefits, and consequences of reform, which is consistent with the findings from framing analyses of prior reform efforts (e.g., Huebner et al., 1997, Jerit, 2008, Skocpol, 1996; Patel & Rushefsky, 1995).

Possible consequences of conflicting media messages on public understanding of the ACA: Confusion reigns. The news media is a primary source of information about health and health policy (Brodie, Hamel, Altman, Blendon, & Benson, 2003). The ACA is an extremely complex law, yet newspaper coverage

focused on the same general talking points used by supporters and opponents, and detailed information about the legislation was not provided. Moreover, the viewpoints of supporters and opponents frequently contradicted one another. This likely contributed to confusion and a general lack of understanding about the health care reform law.

Assessments of public understanding of the ACA support this assertion. Public opinion polls conducted immediately after the passage of reform found that 56% of respondents did not understand key provisions of the law. After a year of government messages to educate the public about reform, 52% of those polled described themselves as “confused about the law” (Kaiser Family Foundation, 2011), and a majority reports lacking sufficient information to understand how the ACA will impact them personally (Kaiser Health Tracking Poll, 2012). Low-income households and those without insurance are even more likely than their higher income and insured counterparts to report that they do not understand the reform law. This is especially troubling since these are the most underserved groups and the key beneficiaries of reform.

Missing voices. Newspapers are able to include and exclude certain perspectives. Policymakers were the most frequent voices in mainstream media coverage of health care reform. The views of anti and pro-reform interest groups, academics, and consumers appeared in approximately equal numbers of articles. However, relative to policymakers, they occurred infrequently and lacked depth and diversity of viewpoints. Furthermore, the voices of average health care consumers,

health care professionals, and progressive organizations, such advocates for health as a human right, or a single-payer health care system were noticeably absent.

Absent frames, missed opportunities, and the perpetuation of existing ideologies: A critique of the construction of reform support. The current investigation extends literature on health care reform debates by incorporating a social justice and human rights perspectives and assessing the presence of frames related to the social determinants of health (e.g., Gollust & Lantz, 2009; Farmer, 2005; Reid, 2010; Rudiger, 2008). In general, Republicans are less supportive of major changes, less likely to be uninsured, more satisfied with their insurance, and more likely to believe that reform will have a negative impact (Blendon et al., 1994). Thus, it served Republican interests to frame health in ways that preserve the status quo. Alternatively, Democrats led the reform effort, and were therefore burdened with justifying their plan. This leadership role may have also provided unique opportunities to reframe the debate. Newspaper coverage of the ACA relied heavily on frames used by political elites, yet neither political party framed reform in ways that fundamentally challenged how health is conceptualized.

It is likely that framing reform in terms of stricter regulation on the insurance industry resonated with a public tired of insurance industry abuses. Moreover, during a sociohistorical time of great of economic instability and high rates of poverty (DeNavas-Walt et. al., 2010), focusing on the ACA's economic consequences may have addressed a legitimate public concern. It may also have been an effective strategy to counter messages put forth by reform opponents. However, framing health

as a commodity is unlikely to foster beliefs about collective responsibility for promoting well-being or ensuring equality of health outcomes. Reform advocates did not take advantage of an opportunity to fundamentally change the way health is viewed in the U.S. Support for reform was almost never framed in terms of health as a human right or public good, and failed to acknowledge existing health disparities and their root causes.

One of the aims of the current study was to illuminate possible reasons for public opposition to health care reform. Public opposition, in part, may stem from how supportive political elites framed the “causes” of problems within the health care system and where they located “moral responsibility” for these problems. Reform advocates defined the health care crisis as predominantly economic (i.e., lack of affordable health care) and argued that lowering costs for individuals and businesses would benefit “everyone.” However, other possible root causes of unaffordable health care were neglected (e.g., societal devaluation of health, race, class, and gender inequities). Importantly, media coverage of reform did not include analyses of power and privilege. ACA supporters did not draw attention to how the health care system works better for the wealthy, nor did they foster a sense of moral outrage about health inequalities and unnecessary deaths from lack of medical care. As noted by Marmor:

one of the most striking features of [the] debate is how little attention was paid to general philosophical principles and what conception of social justice the reform was meant to serve. There was little discussion of what fundamental

fairness was at stake, let alone what solidarity should mean in this context.

(2011, p. 567)

Marmor's critique resonates with the current findings. Pro-reform policymakers had the responsibility and power to incorporate social justice arguments into their explanations of why reform was important, yet they failed to reframe health or the health care system to acknowledge health as a human right. Both supporters and opponents of reform promised market-based solutions that commodified health care.

Although supporters emphasized how reform could decrease costs for individuals and groups, broader connections between economic justice and health justice (e.g., Women's Economic Agenda Project, 2008) were not made. Particularly egregious was the deliberate exclusion of certain groups (i.e., immigrants) and services (i.e., abortion) from reform. Doing so likely serves to strengthen existing stereotypes and beliefs about deservingness. The oft-repeated claim of "affordable care for everyone" coupled with the exclusion of undocumented immigrants implies these groups are somehow less than human. Even those who favored including undocumented immigrants, having a public option, or retaining abortion access did not reframe their arguments to focus simply on equality or fairness, strategies advocated by social justice-oriented scholars (e.g., Limbert & Bullock, 2009). Collectively, the dominant frames used by policymakers and represented in news coverage of reform did not reflect a strong and consistent commitment to social justice.

Chapter Seven

Making Health a Matter of Social Justice

Major health care reform efforts have eluded presidents, senators, and other progressive groups for nearly a century. The passage of the Affordable Care Act marks a victory for reform advocates. The ACA will help many gain access to affordable health coverage. Newspaper coverage of the debates portrayed reform as highly partisan. Competing frames and contradictory messages, particularly about the potential costs and beneficiaries of reform, characterized mainstream news coverage. Although reform passed, it was less progressive than originally hoped. Reform supporters, themselves, may have reinforced the conceptualization of health as a commodity, an idea that pervades ongoing conflict about the individual mandate. Moreover, health care was rarely framed as a human right or public good in mainstream coverage of reform. Ultimately, news coverage did not frame health or reform in a ways that promoted a social justice perspective toward reform or fostered support for progressive health policies.

News coverage of the debate focused on the most divisive issues, often in superficial ways, and continues to do so. Commenting on the fierce opposition to the ACA, Morone observes:

Health care has always been jarringly partisan. It has always stretched beyond public policy and stirred up questions of national identity. However, despite all the drama of past debates, there are not many precedents for a conflict that rages on, practically unabated, after the final congressional

votes are taken and a bill is signed. (2011, p. 384)

Public opinion reflects the partisan nature of the debate. A Kaiser Family Foundation (2010) poll conducted prior to the ACA's passage found that 80% of Republicans opposed reform (66% strongly opposed), 75% of Democrats supported reform (52% strongly supportive), and Independents divided with 36% supporting it and 48% opposed. These trends, including more intense Republican opposition than Democratic support, have persisted for the past two years (Kaiser Health Tracking Poll, 2012).

Despite the public's reliance on news media as a primary source for news about health and health policy (Brodie et al., 2003), "news" about the ACA contains little information about the content of the reform, and the information provided is often conflicting. In a study of partisan identity, framing, and public opinion, Slothuus and de Vreese (2010) found that frames used by participants' own political party were more influential than those used by the opposing party, and these effects were more pronounced for contested than consensual policy issues. They argue that highly partisan issues increase the salience of one's own political loyalties, thus increasing acceptance of frames employed by one's own party. In a similar vein, Dancey and Goren (2010, p. 697) found that "party identification dynamically constrains issues attitudes when the media environment is awash with explicit cues about where parties stand on the issue."

News coverage of the health care reform provided ample information about each party's stance, thus regardless of frames, support for the ACA could be

predicted by party affiliation. Nonetheless, beliefs about reform's impact on the federal deficit supports the argument that media messages are experienced through a partisan filter. In newspaper coverage of the ACA, Democrats emphasized reform as deficit neutral or decreasing the federal deficit, while Republicans claimed the opposite. Results from the Kaiser Family Foundation poll (2010) suggest that Republicans may have given more credence to Republican policymakers. Over three-fourths (76%) of Republicans thought reform would increase the deficit, while only 42% of Democrats thought it would.

Findings from the current study document the presence of contradictory, competing messages, but also some points of convergence. Both Democrats and Republicans framed health care as a commodity and emphasized the importance of individual cost considerations. Supporters and opponents both drew on dominant beliefs about individualism and personal responsibility to justify their positions. The effectiveness of individualism in garnering support for conservative policies is well documented (e.g., Bullock, Williams, & Limbert, 2003; Limbert & Bullock, 2005). Importantly, reform supporters did not reframe health as a human right or a matter of social justice, and the news media did not seek out voices that represent these perspectives.

Directions for Future Research

The outcome of the Supreme Court's decision about the ACA does not change the need to eradicate disparities and interrogate the powers and institutions that create health disparities. This study contributes to several different fields. Health scholars,

political scientists, psychologists, and individuals from fields that wish to study health care reform will need to address the frames that continue appearing during health care reform debates. From a social psychological perspective, this study provides a starting point for examining the relationship between frames and public opinion such as how people process competing frames and makes sense of competing information. For social justice advocates, the challenge of how to disseminate the perspective that health and access to health care are matters of social justice remains.

A critical social psychological perspective is uniquely suited to investigate how health is currently understood in the U.S. and how frames can influence attitudes and beliefs about health, fairness, and deservingness. A research agenda based on the following three areas is recommended: (1) expanding and refining a health justice framework within social psychology; (2) systematically investigating the use of frames in media coverage of health and health policy; and (3) understanding how attitudes and beliefs about fairness, deservingness, and responsibility relate to support for socially just health policies. Collectively, research in these areas can contribute to the adoption of a health justice framework, the development of frames that promote health care as a human right and foster collective responsibility for ensuring quality health care for everyone, and to promote socially just health policies.

Adopting a health justice framework. A health justice framework is needed to analyze existing health care problems and promote equitable health policies. An important way to institutionalize the perspective of health care as a human right is to collaborate with grassroots and advocacy organizations to develop a critical

perspective rooted in lived experiences. Organizations such as California Latinas for Reproductive Justice, the Women's Economic Agenda Project, and Families Together (formerly Asian Communities for Reproductive Justice) have been instrumental in locating health within a human rights-based social justice framework and giving voice to women from marginalized groups. A reproductive justice framework situates women's sexual and reproductive rights within a social justice paradigm and focuses on "what women of Color have done for themselves, rather than what has been done to them" (Siliman et al., 2002, p. 2). In doing so, this movement moves away from a position of "victimhood" and encourages critiques of domination and systems of power (Smith, 2005). Expanding this vision to health, more broadly, and developing a critical framework based on human rights would be a way to involve people across social groups (e.g., based on race, class, gender, immigration status), social issues (e.g., health care access, immigration, welfare), and disciplines (e.g., law, medicine, public policy, public health, social psychology) in an effort to end health injustices.

Experimental investigations of health care reform frames. Given the exploratory nature of the current study, additional experimental research is needed to understand the effects of competing frames on attitudes toward health care reform. Specifically, researchers should experimentally assess the impact of competing frames and framing clusters on support for comprehensive health care reform. Strength of frame (e.g., Chong & Druckman, 2007a) and messenger (e.g., Callaghan & Schnell) likely affects the impact of frames. However, the strength of various

frames or frame clusters used during the health care reform is unknown. Experimental research can lend insight into the impact of human rights framing on support for comprehensive health care reform. This area is currently underexamined.

Analysis of how the health care reform debate was represented in different types of media is also needed. The current study examined how reform was framed in mainstream newspapers. Documenting framing patterns in overtly liberal and conservative media outlets can advance our understanding of how media preference contributes to differential understandings of health care as a human right and the meanings of health care reform. Opinion pieces and editorial cartoons also play a role in political domains, such as conveying racial or gender stereotypes about policymakers (e.g., Zurbriggen & Sherman, 2010). President Obama and Speaker of the House Nancy Pelosi were likely targets of editorial cartoons, and stereotypes could have undermined support for reform. Additional research is needed to delineate the effects of media source, frame type, and messenger to determine how media frames could be used to develop messages that help eliminate health inequities and promote progressive policies.

Understanding the role of pre-existing attitudes and beliefs in health care reform framing. Investigating the attitudes and beliefs that mediate or moderate relationships between frames and support for progressive health policies are also important next steps. Of particular interest is how pre-existing attitudes and beliefs interact with health framed as human right to impact support. Correlates of the framing domains examined in this study could be measured such as attributions for

health, attributions for poverty, and sexist, racist, and xenophobic attitudes. An extensive body of research documents that individual attributions for poverty are related to support for individualistic solutions and structural attributions related to support for structural solutions (e.g., Iyengar, 1991). Limited research in the public health domain mirrors this finding. Framing illness in terms of its social determinants increases support for social policies to alleviate the problem, as opposed to individual solutions (Gollust et. al., 2009). However, this finding only held for self-identified Democrats, not Republicans. Among Republicans, highlighting social determinants of health led to decreased support for proactive social policies. Focusing on the social determinants of health may not be a universally effective strategy for promoting health justice and framing health as a human right might not resonate with all groups.

Opotow's (1990) work on the scope of justice seems particularly relevant to understanding support for health care policies. According to Opotow, psychological boundaries influence what actions and outcomes are viewed as fair. Those who are morally 'included' are perceived as deserving just treatment, whereas those who are morally 'excluded' are seen as outside the scope of justice and undeserving. Moral exclusion can be overt or more subtle, and is characterized by: 1) viewing excluded groups as unconnected from one's own groups; 2) an absence of moral obligation toward excluded groups; 3) viewing excluded groups as non-human, or non-entities and undeserving of community resources; and 4) approving procedures and outcomes for those excluded that would be unacceptable for people included within the scope of justice (Olson, Cheung, Conway, Hutchison & Hafer, 2011; Opotow, Gerson,

Woodside, 2005). Opatow (2001) argues that moral exclusion helps justify human rights violations and genocide. News coverage of the health care reform debate clearly cast undocumented immigrants and women seeking abortions outside the scope of justice. This moral distancing or “othering” allows these groups to be seen as less than human and thus, undeserving of health care. Future work should investigate how beliefs about responsibility for health and the perceived fairness and deservingness of health inequalities might be important mediators or moderators in determining support for progressive health policies. It is also important to examine stereotypes about race, class, and gender may intersect and inform how boundaries are drawn around who is entitled to health care.

Conclusion

In summary, the ACA was an important step forward in repairing the U.S. health care system, a system that works far better for wealthy, white, insured groups. The passage of reform was highly contested and the debate continues. Mainstream newspaper coverage of reform reinforced frames used by political elites. Reform supporters focused on the key beneficiaries of reform, the need to regulate the health insurance industry, and how the ACA could decrease costs for most Americans, ranging from the currently uninsured to businesses to employers. Opponents framed the ACA as a costly “government takeover” that would result in a loss of choices and a poorer quality system of care.

Despite deeply divided attitudes toward the ACA, reform supporters and opponents reinforced and perpetuated the uniquely American perspective that health

care is a commodity and an individual responsibility. Democratic policymakers failed to acknowledge that health can be, and already is in many other countries, considered a human right and a matter of social justice. Media coverage repeated this omission and did not publicize alternate perspectives on health and health care. The ACA offered the possibility for its supporters to reframe the core tenets of the debate, yet policymakers did not seize that opportunity. Yet, describing health care reform using conventional frames that directly competing with opponents' frames may be why the ACA passed.

The passage of the ACA offers social justice and critical scholars new challenges and opportunities in the pursuit of eliminating health injustices. Critical scholars need to gain a better understanding of why opinion toward the ACA was so divided how the public conceptualizes health and well-being. Research is a tool for social change and it is necessary to “think through how to interrupt/dismantle oppression and how to sustain justice in the face of ongoing political assaults” (Fine, 2006, p. 83). Scholar-activists committed to health justice have a responsibility to understand the roots causes of oppression related to health. It is also important to understand how framing health care as a human right health might be useful in changing the attitudes and beliefs that legitimize health inequities in the United States, and how media frames can foster support for progressive health policies.

Table 1

Circulation Rank, Source Ownership and Total Number of Coded Articles by News

Source for the Six-Month Period Ending March 31, 2010

News Source	Circulation Rank	Daily Circulation	Ownership
<i>The Wall Street Journal</i>	1	2,092,523	(Dow Jones) News Corporation
<i>USA Today</i>	2	1,826,622	Gannett Company
<i>The New York Times</i>	3	951,063	The New York Times Company
<i>Los Angeles Times</i>	4	616,606	Tribune Company
<i>The Washington Post</i>	5	578,482	The Washington Post Company
<i>Houston Chronicle</i>	10	494,131	Hearst Corporation
<i>Chicago Sun-Times</i>	17	266,803	Sun-Times Media Group

Table 2

Number of Articles, by News Source

News Source	Circulation Rank	Total Number of Articles	Total Number of News Articles	Total Number of Articles in Study Sample
<i>The Wall Street Journal</i>	1	718	569	85
<i>USA Today</i>	2	336	331	46
<i>The New York Times</i>	3	1036	778	116
<i>Los Angeles Times</i>	4	284	255	38
<i>The Washington Post</i>	5	1066	710	106
<i>Houston Chronicle</i>	10	424	373	56
<i>Chicago Sun-Times</i>	17	322	186	28

Table 3

Intercoder Reliability, Overall, and by Coding Pair and Coding Category

Coding Category	Overall Agreement	Coding Pair 1 Agreement	Coding Pair 2 Agreement	Coding Pair 3 Agreement
Overall	.913	.896	.910	.932
Category B	.949	.942	.932	.973
Category C	.893	.884	.907	.888
Category D	.968	.951	.970	.983
Category E	.906	.870	.916	.932
Category F	.880	.866	.886	.888
Category G	.899	.875	.887	.932
Category H	.964	.962	.955	.975
Category I	.914	.900	.912	.930
Category J	.541	.679	.373	.570

Table 4

*Presence of Supportive Key Actors and Groups in Newspaper Coverage of Health**Care Reform Articles*

Key Actors and Groups	Total Number of Articles with Code Present	Percentage of Total Number of Articles
1. Is President Obama quoted or referred to in support of health care reform?	290	61.1%
2. Is Nancy Pelosi quoted or referred to in support of health care reform?	103	21.7%
3. Are Democratic policymakers (excluding President Obama and Nancy Pelosi) quoted or referred to in support of health care reform?	273	57.5%
4. Are Republican policymakers quoted or referred to in support of health care reform?	46	9.7%
5. Are scholars referenced or quoted as supporting health care reform (e.g., professors, think tanks, universities)?	21	4.4%
6. Are health care industry groups referred to or quoted as supporting health care reform?	21	4.4%
7. Are health insurance industry groups referred to or quoted as supporting health care reform?	13	2.7%
8. Are any pharmaceutical industry groups referred to or quoted as supporting health care reform?	14	2.9%
9. Are any community groups/organizations referred to or quoted as supporting health care reform?	47	9.9%
10. Are any health care consumers referred to or quoted as supporting health care reform?	21	4.4%
11. Are any health care professionals referred to or quoted in support of health care reform?	16	3.4%
12. Are any other key actors/groups referred to or quoted in support of health care reform?	34	7.2%

Note. N = 475. Percentage of total number of articles is based on this number.

Table 5

*Presence of Opposing Key Actors and Groups in Newspaper Coverage of Health**Care Reform Articles*

Key Actors and Groups	Total Number of Articles with Code Present	Percentage of Total Number of Articles
1. Is Sarah Palin quoted or referred to in opposition to health care reform?	0	0.0%
2. Are Democratic policymakers (excluding President Obama and Nancy Pelosi) quoted or referred to in opposition to health care reform?	85	17.9%
3. Are Republican policymakers quoted or referred to in opposition to health care reform?	221	46.5%
4. Are scholars referenced or quoted as opposing health care reform (e.g., professors, think tanks, universities)?	12	2.5%
5. Are health care industry groups referred to or quoted as opposing health care reform?	16	3.4%
6. Are health insurance industry groups referred to or quoted as opposing care reform?	25	5.3%
7. Are any pharmaceutical industry groups referred to or quoted as opposing health care reform?	4	0.8%
8. Are any community groups/organizations referred to or quoted as opposing health care reform?	36	7.6%
9. Are any health care consumers referred to or quoted as opposing health care reform?	25	5.3%
10. Are any health care professionals referred to or quoted in opposition to health care reform?	8	1.7%
11. Are any other key actors/groups referred to or quoted in opposition to health care reform?	34	7.2%

Note. N = 475. Percentage of total number of articles is based on this number.

Table 6

Determinants of Health (Individual versus Social) Coding Category Frequencies

Code	Total Number of Articles with Code Present	Percentage of Total Number of Articles
1. Is health attributed to individual causes?	8	1.7%
2. Is health attributed to socially determined causes?	8	1.7%
3. Are any specific diseases or illnesses mentioned?	48	10.1%
4. Are health disparities mentioned?	29	6.1%
5. Is health care reform described as potentially increasing health disparities?	12	2.5%
6. Is health care reform described as decreasing health disparities?	24	5.1%
7. Is Republican support for health care reform justified using any of the codes in Category B?	3	0.6%
8. Is Republican opposition to health care reform justified using any of the codes in Category B?	1	0.2%
9. Is Democratic support for health care reform justified using any of the codes in Category B?	8	1.7%
10. Is Democratic opposition to health care reform justified using any of the codes in Category B?	1	0.2%

Note. N = 475. Percentage of total number of articles is based on this number.

Table 7

*Nature of Health Care (Commodity versus Public Good) Coding Category**Frequencies*

Code	Total Number of Articles with Code Present	Percentage of Total Number of Articles
1. Is health care described as a private resource or good that is purchased?	138	29.1%
2. Is health care described as a legal right or public good?	9	1.9%
3. Is health care reform described as an unfair regulation or burden on the health insurance or health care industry?	33	6.9%
4. Is health care reform described as needed to control/regulate the health insurance or health care industry?	127	26.7%
5. Is Republican support for health care reform justified using any of the codes in Category C?	5	1.1%
6. Is Republican opposition to health care reform justified using any of the codes in Category C?	8	1.7%
7. Is Democratic support for health care reform justified using any of the codes in Category C?	54	11.4%
8. Is Democratic opposition to health care reform justified using any of the codes in Category C?	4	0.8%

Note. N = 475. Percentage of total number of articles is based on this number.

Table 8

*Entitlement to Health Care (Privilege versus Human Right) Coding Category**Frequencies*

Code	Total Number of Articles with Code Present	Percentage of Total Number of Articles
1. Is health or health care described as a privilege?	0	0.0%
2. Is health or health care described as a human right or matter of social justice?	12	2.5%
3. Is attention brought to the fact that health care is not treated as a human right in the United States?	1	0.2%
4. Are any other entitlement programs mentioned (e.g., Medicaid, Medicare, or Social Security)?	268	56.4%
5. Is health care reform criticized because it is described as creating a new entitlement program?	7	1.5%
6. Is health care reform praised because it is described as creating a new entitlement program?	2	0.4%
7. Is Republican support for health care reform justified using any of the codes in Category D?	0	0.0%
8. Is Republican opposition to health care reform justified using any of the codes in Category D?	9	1.9%
9. Is Democratic support for health care reform justified using any of the codes in Category D?	16	3.4%
10. Is Democratic opposition to health care reform justified using any of the codes in Category D?	3	0.6%

Note. N = 475. Percentage of total number of articles is based on this number.

Table 9

*Key Beneficiaries and “Losers” in Health Care Reform Coding Category**Frequencies*

Code	Total Number of Articles with Code Present	Percentage of Total Number of Articles
1. Is health care reform described as benefitting most people?	74	15.6%
2. Is health care reform described as being beneficial to very few people?	21	4.4%
3. Is health care reform described as benefitting the uninsured?	152	32%
4. Is health care reform described as not benefitting the uninsured?	8	1.7%
5. Are uninsured people described as undeserving of assistance?	2	0.4%
6. Are uninsured people described as deserving assistance?	9	1.9%
7. Is the race/ethnicity of uninsured groups mentioned?	3	0.6%
8. Is the gender of uninsured groups mentioned?	0	0.0%
9. Is the social class of uninsured groups mentioned?	18	3.8%
10. Is health care reform described as benefitting specific individuals or groups?	178	37.5%
11. Is health care reform described as not benefitting specific individuals or groups?	139	29.3%
12. Is health care reform described as benefitting immigrants or undocumented immigrants?	2	0.4%
13. Is health care reform described as not benefitting immigrants or undocumented immigrants?	22	4.6%
14. Is abortion mentioned?	122	25.7%
15. Is abortion mentioned as being covered under health care reform?	37	7.8%
16. Is abortion mentioned as being not covered by health care reform?	63	13.3%
17. Is Republican support for health care reform justified using any of the codes in Category E?	6	1.3%
18. Is Republican opposition to health care reform justified using any of the codes in Category E?	42	8.8%

19. Is Democratic support for health care reform justified using any of the codes in Category E?	107	22.5%
20. Is Democratic opposition to health care reform justified using any of the codes in Category E?	50	10.5%

Note. N = 475. Percentage of total number of articles is based on this number.

Table 10

*Cost of Health Care Reform (Too Costly versus Cost Saving) Coding Category**Frequencies*

Code	Total Number of Articles with Code Present	Percentage of Total Number of Articles
1. Is health care reform described as increasing costs?	110	23.2%
2. Is health care reform described as decreasing costs?	81	17.1%
3. Is health care reform described as increasing the federal deficit?	25	5.3%
4. Is health care reform described as decreasing the federal deficit or deficit neutral?	50	10.5%
5. Is health care reform described as being too costly to undertake?	27	5.7%
6. Is health care reform described as being too costly to not undertake?	26	5.5%
7. Are any specific groups described as facing increased costs?	163	34.3%
8. Are any specific groups described as facing decreased costs?	72	15.2%
9. Is Republican support for health care reform justified using any of the codes in Category F?	6	1.3%
10. Is Republican opposition to health care reform justified using any of the codes in Category F?	64	13.5%
11. Is Democratic support for health care reform justified using any of the codes in Category F?	78	16.4%
12. Is Democratic opposition to health care reform justified using any of the codes in Category F?	17	3.6%

Note. N = 475. Percentage of total number of articles is based on this number.

Table 11

Meanings of Reforming the Health Care System (Government Takeover versus Needed Intervention) Coding Category Frequencies

Code	Total Number of Articles with Code Present	Percentage of Total Number of Articles
1. Is a government-run insurance option or “public option” mentioned?	179	37.7%
2. Is support for a government-run insurance plan or “public option” present?	118	24.8%
3. Is opposition to a government-run insurance plan or “public option” present?	89	18.7%
4. Does the article mention that a government-run insurance plan or “public option” is not included in health care reform?	60	12.6%
5. Are “death panels” (or “end of life” care) mentioned?	6	1.3%
6. Is it reported that “death panels” will not be established?	4	0.8%
7. Is health care reform referred to as “socialism” or “socialized medicine?”	4	0.8%
8. Is information challenging the idea of health care reform as socialized medicine provided?	1	0.2%
9. Is health care reform described as a “government takeover?”	56	11.8%
10. Is information presented that challenges the idea that health care reform is a government takeover?	6	1.3%
11. Is the government’s ability to successfully implement reform questioned?	36	7.6%
12. Is health care reform described as a positive government intervention?	77	16.2%
13. Is health care reform described as resulting in a loss of care, fewer choices, reduced access to care, and/or quality of care?	71	14.9%
14. Is health care reform described as an improvement to health care, health care choices, access to care, and or/quality of care?	160	33.7%
15. Is the current health care system described as acceptable?	4	0.8%

16. Is the current health care system described as broken or unacceptable?	67	14.1%
17. Is Republican support for health care reform justified using any of the codes in Category G?	10	2.1%
18. Is Republican opposition to health care reform justified using any of the codes in Category G?	69	14.5%
19. Is Democratic support for health care reform justified using any of the codes in Category G?	122	25.7%
20. Is Democratic opposition to health care reform justified using any of the codes in Category G?	36	7.6%

Note. N = 475. Percentage of total number of articles is based on this number.

Table 12

*Support for Health Care Reform (Limited versus Nearly Universal) Coding Category**Frequencies*

Code	Total Number of Articles with Code Present	Percentage of Total Number of Articles
1. Is the public described as supporting health care reform?	20	4.2%
2. Is the public described as not supporting health care reform?	61	12.8%
3. Is public opinion data cited by Republicans to justify support for health care reform?	0	0.0%
4. Is public opinion data cited by Republicans to justify opposition to health care reform?	35	7.4%
5. Is public opinion data cited by Democrats to justify support for health care reform?	7	1.5%
6. Is public opinion data cited by Democrats to justify opposition to health care reform?	1	0.2%
7. Is public opinion data cited by any individuals or groups (besides Republicans) to justify opposition to health care reform?	2	0.4%
8. Is public opinion data cited in the article but not associated with a particularly support or opposing viewpoint (e.g., just cited as factual information)?	31	6.5%

Note. N = 475. Percentage of total number of articles is based on this number.

Appendix

Coding Framework for Media Framing of 2010 Health Care Reform

A. Identifying Information	
A1.	Coder name
A2.	Newspaper source
A3.	Article number (from Dropbox)
A4.	Article title
A5.	Date of article publication
A6.	Number of words in article
B. Determinants of Health – Personal Responsibility and Social Determinants	
B1.	<p>Is health attributed to individual causes? (Yes/No)</p> <p>(e.g., exercise, diet, self-control)</p> <ul style="list-style-type: none"> • No one knows, but possible explanations include: (a) many uninsured are fairly healthy – about two-fifths are age 18 to 34; (b) some are too sick to be helped or have problems rooted in personal behaviors --smoking, diet, drinking or drug abuse • He says he eats right, doesn't smoke and exercises -- efforts he hopes will keep him healthy until he qualifies for Medicare in four years.
B2.	If “Yes” to B1, please provide an illustration from the text
B3.	<p>Is health attributed to socially determined causes? (Yes/No)</p> <p>(e.g., pollution, unequal distribution of power or resources)</p> <ul style="list-style-type: none"> • The two-story clinic in Humboldt Park, until the mid-1980s, housed a Walgreen's on the first floor and doctors' offices upstairs when the clientele was predominantly white and Eastern European. But the neighborhood changed, and by the '80s, gangs were rampant and the infant mortality rate was akin to that of a developing country, at 17 per 1,000 live births, said Dr. Lee Francis, the president and chief executive officer of Erie. Now the rate is down to about 8 per 1,000 live births.

B4.	If “Yes” to B3, please provide an illustration from the article.
B5.	<p>Are any specific diseases or illnesses mentioned? (Yes/No)</p> <ul style="list-style-type: none"> • Last April 24, their world collapsed: Jan was diagnosed with late-stage stomach cancer.
B6.	If “Yes” for B5 – which diseases/illnesses? Please list all.
B7.	<p>Are health disparities mentioned? (Yes/No)</p> <p>(e.g., “Blacks and Latinos have less access to care,” “Women are more likely to pay increased health care premiums”)</p> <p>*ALSO: Disparities in access to care, quality of care, health outcomes, health insurance payments</p> <ul style="list-style-type: none"> • More than half of the uninsured are minorities
B8.	If “Yes” to B7, please provide an illustration from the article?
B9.	Is health care reform described as potentially <u>increasing</u> health/health care disparities? (Yes/No)
B10.	If “Yes” to B9, please provide an illustration from the article.
B11.	Health care reform described in terms as potentially <u>decreasing</u> health/health care disparities? (Yes/No)
B12.	If “Yes” to B11, please provide an illustration from the article.
B13.	<u>Is Republican support</u> for health care reform justified using any of the codes in Category B? (Yes/No)
B14.	<p>If “Yes” to B13, please list each code category and provide an illustration from the article for each code listed.</p> <p>*If a specific Republican is cited, please provide the name after the text, in</p>

	<p>parentheses.</p> <p>e.g., (Sarah Palin)</p>
B15.	<p><u>Is Republican opposition</u> to health care reform justified using any of the codes in Category B? (Yes/No)</p>
B16.	<p>If “Yes” to B15, please list each code category and provide an illustration from the article for each code listed.</p> <p>*If a specific Republican is cited, please provide the name after the text, in parentheses.</p> <p>e.g., (Sarah Palin)</p>
B17.	<p><u>Is Democratic support</u> for health care reform justified using any of the codes in Category B? (Yes/No)</p>
B18.	<p>If “Yes” to B17, please list each code category and provide an illustration from the article for each code listed.</p> <p>*If a specific Democrat is cited, please provide the name after the text, in parentheses.</p> <p>e.g., (President Obama)</p>
B19.	<p><u>Democratic opposition</u> to health care reform justified using any of the codes in Category B? (Yes/No)</p>
B20.	<p>If “Yes” to B19, please list each code category and provide an illustration from the article for each code listed.</p> <p>*If a specific Democrat is cited, please provide the name after the text, in parentheses. e.g., (President Obama)</p>
C. Nature of Health Care	
C1.	<p>Is health care described as a private resource or good that is purchased? (Yes/No)</p> <p>(e.g., something that should be bought or sold, described in terms of “shopping around” for the best price, responsibility of consumer to do her/his “homework” to get the best price)</p> <p>*Could you substitute another “good” in the sentence (e.g., shoes, car, home,</p>

	vacation) – if so, it is likely being described as a commodity.
C2.	If “Yes” to C1, please provide an illustration from the article.
C3.	<p>Health care described as a legal right or public good? (Yes/No) (e.g., health care is a right or everyone should have access to health care)</p> <ul style="list-style-type: none"> • Health care in America ought to be a right, not a privilege
C4.	If “Yes” to C3, please provide an illustration from the article.
C5.	<p>Is health care reform described as unfair regulation or burden on the health insurance or health care industry? (Yes/No) (e.g., health care reform would destroy health insurance or industry markets, not fair to people who work in those industries, individual mandate is unconstitutional)</p> <ul style="list-style-type: none"> • I don't want a big government, Washington-run operation that would undermine the private insurance that 200 million Americans now have," he said.
C6.	If “Yes” to C5, please provide an illustration from the article.
C7.	<p>Is health care reform described as needed to control/regulate the health insurance or health care industry? (Yes/No) (e.g., health insurance industry is out of control, people can't get health insurance or health care and the government should step in and help)</p> <ul style="list-style-type: none"> • With the upset victory of Republican Scott Brown in the Massachusetts special election last month, Democrats lost their 60-40 filibuster-proof Senate majority, which poses major problems for the timely passage of a much-needed health care overhaul. But with or without a final bill, one aspect of health care cries out for swift reform: the unconscionable gouging of consumers by Big Pharma, as the giant pharmaceutical industry is known. • The health care status quo is not an option for our states. If we do nothing, by 2019 the number of uninsured people will grow by more than 30 percent in 29 states and by at least 10 percent in every state. The amount of uncompensated care provided will more than double in 45 states. Businesses in 27 states will see their premiums more than double.'

C8.	If “Yes” to C7, please provide an illustration from the article.
C9.	<u>Is Republican support</u> for health care reform justified using any of the codes in Category C? (Yes/No)
C10.	<p>If “Yes” to C9, please list each code category and provide an illustration from the article for each code listed.</p> <p>*If a specific Republican is cited, please provide the name after the text, in parentheses.</p> <p>e.g., (Sarah Palin)</p>
C11.	<u>Is Republican opposition</u> to health care reform justified using any of the codes in Category C? (Yes/No)
C12.	<p>If “Yes” to C11, please list each code category and provide an illustration from the article for each code listed.</p> <p>*If a specific Republican is cited, please provide the name after the text, in parentheses.</p> <p>e.g., (Sarah Palin)</p>
C13.	<u>Is Democratic support</u> for health care reform justified using any of the codes in Category C? (Yes/No)
C14.	<p>If “Yes” to C13, please list each code category and provide an illustration from the article for each code listed.</p> <p>*If a specific Democrat is cited, please provide the name after the text, in parentheses.</p> <p>e.g., (President Obama)</p>
C15.	<u>Is Democratic opposition</u> to health care reform justified using any of the codes in Category C? (Yes/No)
C16.	<p>If “Yes” to C15, please list each code category and provide an illustration from the article for each code listed.</p> <p>*If a specific Democrat is cited, please provide the name after the text, in parentheses. e.g., (President Obama)</p>

D. Entitlement to Health Care	
D1.	<p>Is health or health care described as a privilege? (Yes/No)</p> <p>(e.g., health care access is something you have to work for or earn; the government is not responsible for making sure that everyone has health care)</p>
D2.	<p>If “Yes” to D2, please provide an illustration from the article.</p>
D3.	<p>Is health or health care described as a <i>human</i> right or a matter of social justice? (Yes/No)</p> <p>(e.g., everyone should have access to quality health care, regardless of ability to pay).</p> <p>*Note: Please read the text carefully to distinguish between articulations of health care as a right (e.g., everyone should have the right to health care vs. health care is a fundamental human right that should be guaranteed to everyone, regardless of ability to pay)</p> <ul style="list-style-type: none"> • The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.
D4.	<p>If “Yes” to D3, please provide an illustration from the article.</p>
D5.	<p>Is attention brought to the fact that health care is not treated as human right in the United States? (Yes/No)</p> <p>(e.g., other countries treat health care as a human right, the US is one of the only countries that doesn’t view health care as a human right)</p> <ul style="list-style-type: none"> • We are the only democracy ... the only wealthy nation that allows such hardship for millions of its people," President Obama told a joint session of Congress on Sept. 9, in an effort to jump-start his revamp of the health care system • Real health care reform must come to grips with two fundamental issues. First, with 46 million Americans uninsured, 60 million lacking regular access to a doctor and 45,000 dying every year because of that lack of access, we must join the rest of the industrialized world and guarantee health care to every man, woman and child in our country.

D6.	If “Yes” to D5, please provide an illustration from the article.
D7.	Are other entitlement programs such as Medicaid, Medicare, or Social Security mentioned in the article? (Yes/No) (also includes state versions of Medicaid, such as Medi-Cal)
D8.	If yes to D7, which one(s)? Please list all.
D9.	<p>Is health care reform <u>criticized</u> because it is described as creating a new entitlement program? (Yes/No)</p> <p>(e.g., Social Security is already in trouble, we don’t need another entitlement program)</p> <ul style="list-style-type: none"> • What people need to know is that Obama's plan evades health care's major problems and would worsen the budget outlook. It's a big new spending program when government hasn't paid for the spending programs it already has.
D10.	If “Yes” to D9, please provide an illustration from the article.
D11.	<p>Is health care reform <u>praised</u> because it is described as creating a new entitlement program? (Yes/No)</p> <p>(e.g., health care reform is good because it is creating a program that ensures access to care, and very few people can be excluded)</p>
D12.	If “Yes” to D11, please provide an illustration from the article.
D13.	<u>Is Republican support</u> for health care reform justified using any of the codes in Category D? (Yes/No)
D14.	<p>If “Yes” to D13, please list each code category and provide an illustration from the article for each code listed.</p> <p>*If a specific Republican is cited, please provide the name after the text, in parentheses.</p> <p>e.g., (Sarah Palin)</p>
D15.	<u>Is Republican opposition</u> to health care reform justified using any of the codes

	in Category D? (Yes/No)
D16.	<p>If “Yes” to D15, please list each code category and provide an illustration from the article for each code listed.</p> <p>*If a specific Republican is cited, please provide the name after the text, in parentheses.</p> <p>e.g., (Sarah Palin)</p>
D17.	<p><u>Is Democratic support</u> for health care reform justified using any of the codes in Category D? (Yes/No)</p>
D18.	<p>If “Yes” to D17, please list each code category and provide an illustration from the article for each code listed.</p> <p>*If a specific Democrat is cited, please provide the name after the text, in parentheses.</p> <p>e.g., (President Obama)</p>
D19.	<p><u>Is Democratic opposition</u> to health care reform justified using any of the codes in Category D? (Yes/No)</p>
D20.	<p>If “Yes” to D19, please list each code category and provide an illustration from the article for each code listed.</p> <p>*If a specific Democrat is cited, please provide the name after the text, in parentheses. e.g., (President Obama)</p>
E. Key Beneficiaries and “Losers” in Health Care Reform	
E1.	<p>Is health care reform described as benefitting <u>most people</u>? (Yes/No) (e.g., “most Americans will benefit”)</p> <ul style="list-style-type: none"> You have a health plan that’s meant to benefit everybody...[but it’s being paid for by only 2.1 million taxpayers], said Rosanne Altshuler, co-director of the non-partisan Tax Policy Center.
E2.	<p>If “Yes” to E1, please provide an illustration from the article.</p>
E3.	<p>Health care reform described as being beneficial to <u>very few people</u>?</p>

	(Yes/No) (e.g., only very few Americans will benefit from reform)
E4.	If “Yes” to E3, please provide an illustration from the article.
E5.	<p>Is health care reform described as <u>benefitting</u> the uninsured? (Yes/No)</p> <p>*Note: “low-income” does not necessarily mean uninsured</p> <ul style="list-style-type: none"> • The bill would extend insurance to about 29 million Americans who now lack it. Most of the features in the measure wouldn't take effect until 2013. • States with the largest uninsured populations, like Texas and California, might be considered by its backers the biggest winners to emerge from the law, because so many additional residents will have access to health insurance.
E6.	If “Yes” to E5, please provide an illustration from the article.
E7.	<p>Health care reform described as <u>not benefitting</u> the uninsured? (Yes/No)</p> <ul style="list-style-type: none"> • Ralph Neas, head of the National Coalition on Health Care, a group that includes businesses, labor and providers, slammed the bill for leaving an estimated 17 million Americans, not including illegal immigrants, still uninsured in 10 years because they won't buy insurance.
E8.	If “Yes” to E7, please provide an illustration from the article.
E9.	<p>Are uninsured people described as <u>undeserving</u> of assistance? (Yes/No)</p> <p>(e.g., benefits would reward people who are lazy, choose not to work, choose not to purchase insurance)</p>
E10.	If “Yes” to E9, please provide an illustration from the article.
E11.	<p>Are uninsured people described as <u>deserving assistance</u> (Yes/No)</p> <p>(e.g., benefits would be received by hard working people who deserve help)</p>
E12.	If “Yes” to E11, please provide an illustration from the article.
E13.	Is the race/ethnicity of uninsured groups mentioned? (Yes/No)
E14.	If “Yes” to E13, were any negative racial comments made? Please provide an illustration from the article.

E15.	Is the gender of uninsured groups mentioned? (Yes/No)
E16.	If “Yes” to E15, were any negative gender comments made? Please provide an illustration from the article.
E17.	Is the social class of uninsured groups mentioned? (Yes/No)
E18.	If “Yes” to E17, were any negative comments about low-income individuals or groups made? Please provide an illustration from the article.
E19.	Is health care reform described as <u>benefitting</u> specific individuals or groups? (Yes/No) <ul style="list-style-type: none"> • Low-income families would receive government subsidies to help pay for the insurance.
E20.	If “Yes” to E19, which individuals or groups? Please list and provide illustrations for each individual and/or group.
E21.	Is health care reform described as <u>not benefitting</u> specific individuals or groups of people other than the uninsured? (Yes/No). (e.g., young, elderly, taxpayers, businesses) <p>*Note: other than the uninsured</p> <ul style="list-style-type: none"> • Republicans in the House have been more blunt. “The taxes are onerous during a recession,” said Rep. Dave Camp, R-Mich. “They’re going to fall on families, small businesses, manufacturers—and they’re going to cost us millions of jobs.”
E22.	If “Yes” to E21, which groups? Please list.
E23.	Is health care reform described as <u>benefitting</u> immigrants or undocumented immigrants? (Yes/No)
E24.	If “Yes” to E23, please provide an illustration from the article.
E25.	Is health care reform described as <u>not benefitting</u> immigrants or undocumented immigrants? (Yes/No)
E26.	If “Yes” to E25, please provide an illustration from the article.

E27.	Is abortion mentioned? (Y/N)
E28.	If “Yes” to E27, please provide an illustration from the article.
E29.	Is abortion mentioned as <u>being covered</u> under health care reform? (Yes/No)
E30.	If “Yes” to E29, please provide an illustration from the article.
E31.	<p>Is abortion mentioned as being <u>not covered</u> by health care reform? (Yes/No)</p> <ul style="list-style-type: none"> • The Senate bill, approved Thursday morning, allows any state to bar the use of federal subsidies for insurance plans that cover abortion and requires insurers in other states to divide subsidy money into separate accounts so that only dollars from private premiums would be used to pay for abortions.
E32.	If “Yes” to E31, please provide an illustration from the article.
E33.	<u>Is Republican support</u> for health care reform justified using any of the codes in Category E? (Yes/No)
E34.	<p>If “Yes” to E33, please list each code category and provide an illustration from the article for each code listed.</p> <p>*If a specific Republican is cited, please provide the name after the text, in parentheses.</p> <p>e.g., (Sarah Palin)</p>
E35.	<u>Is Republican opposition</u> to health care reform justified using any of the codes in Category E? (Yes/No)
E36.	<p>If “Yes” to E35, please list each code category and provide an illustration from the article for each code listed.</p> <p>*If a specific Republican is cited, please provide the name after the text, in parentheses.</p> <p>e.g., (Sarah Palin)</p>
E37.	<u>Is Democratic support</u> for health care reform justified using any of the codes in Category E? (Yes/No)

E38.	<p>If “Yes” to E37, please list each code category and provide an illustration from the article for each code listed.</p> <p>*If a specific Democrat is cited, please provide the name after the text, in parentheses.</p> <p>e.g., (President Obama)</p>
E39.	<p><u>Is Democratic opposition</u> to health care reform justified using any of the codes in Category E? (Yes/No)</p>
E40.	<p>If “Yes” to E39, please list each code category and provide an illustration from the article for each code listed.</p> <p>*If a specific Democrat is cited, please provide the name after the text, in parentheses. e.g., (President Obama)</p>
F. Cost of Health Care Reform	
F1.	<p>Is health care reform described as <u>increasing</u> costs? (Yes/No)</p> <p>(e.g., taxes, health care costs, health insurance premiums)</p> <p>Note: Increasing costs <u>except</u> federal deficit – see coding category F5)</p> <ul style="list-style-type: none"> Negotiations over separate versions of the legislation in the Senate and House have stalled in recent weeks as lawmakers sought ways to pay for the \$1-trillion-plus cost.
F2.	<p>If “Yes” to F1, please provide an illustration from the article.</p>
F3.	<p>Is health care reform described as <u>decreasing</u> costs? (Yes/No) (e.g., taxes, health care costs, health insurance premiums, fewer bankruptcies due to medical bill debt – “no one should have to go bankrupt because of medical bills”)</p> <p>Note: Decreasing costs except federal deficit – see coding category F7)</p>
F4.	<p>If “Yes” to F3, please provide an illustration from the article.</p>
F5.	<p>Is health care reform described as <u>increasing</u> the federal deficit? (Yes/No)</p>
F6.	<p>If “Yes” to F5, please provide an illustration from the article.</p>

F7.	<p>Is health care reform described as <u>decreasing</u> the federal deficit or deficit neutral? (Yes/No)</p> <ul style="list-style-type: none"> • The added revenues and cost savings are projected to grow more rapidly than the cost of the coverage expansion," the report said. Consequently, CBO expects that the proposal, if enacted, would reduce federal budget deficits [beyond 2019] relative to those projected under current law by as much as one-half of 1 percent of the nation's gross domestic product -- savings that could total hundreds of billions of dollars.
F8.	If "Yes" to F7, please provide an illustration from the article.
F9.	<p>Is health care reform described as being <u>too costly</u> to undertake? (Yes/No) (e.g., the economy is struggling – the U.S. can't afford health care reform)</p> <ul style="list-style-type: none"> • Republicans such as House Minority Leader John Boehner of Ohio argue that the government can't afford to spend up to \$1 trillion on health care changes.
F10.	If "Yes" to F9, please provide an illustration from the article.
F11.	<p>Is health care reform described as being too costly to <u>not</u> undertake? (Yes/No) (e.g., health care costs are already out of control – something needs to be done now)</p>
F12.	If "Yes" to F11, please provide an illustration from the article.
F13.	<p>Are any specific groups described as facing <u>increased</u> costs? (Yes/No)</p> <ul style="list-style-type: none"> • Fee on drug makers: \$17.2 billion. • Fee on health insurers: \$40.5 billion.
F14.	If "Yes" to F13, which groups? Please list and provide an illustration from the text for each group.
F15.	<p>Are any specific groups described as facing <u>decreased</u> costs? (Yes/No)</p> <ul style="list-style-type: none"> • Subsidies to help low-income people buy insurance: \$463 billion • Tax credits to help small employers insure their workers: \$24 billion

	<ul style="list-style-type: none"> • Paying more for prescription drugs for seniors under Medicare: \$17.4 billion
F16.	If “Yes” to F15, which groups? Please list and provide an illustration from the article for each group.
F17.	<u>Is Republican support</u> for health care reform justified using any of the codes in Category F? (Yes/No)
F18.	<p>If “Yes” to F17, please list each code category and provide an illustration from the article for each code listed.</p> <p>*If a specific Republican is cited, please provide the name after the text, in parentheses.</p> <p>e.g., (Sarah Palin)</p>
F19.	<u>Is Republican opposition</u> to health care reform justified using any of the codes in Category F? (Yes/No)
F20.	<p>If “Yes” to F19, please list each code category and provide an illustration from the article for each code listed.</p> <p>*If a specific Republican is cited, please provide the name after the text, in parentheses.</p> <p>e.g., (Sarah Palin)</p>
F21.	<u>Is Democratic support</u> for health care reform justified using any of the codes in Category F? (Yes/No)
F22.	<p>If “Yes” to F21, please list each code category and provide an illustration from the article for each code listed.</p> <p>*If a specific Democrat is cited, please provide the name after the text, in parentheses.</p> <p>e.g., (President Obama)</p>
F23.	<u>Is Democratic opposition</u> to health care reform justified using any of the codes in Category F? (Yes/No)
F24.	If “Yes” to F23, please list each code category and provide an illustration

	<p>from the article for each code listed.</p> <p>*If a specific Democrat is cited, please provide the name after the text, in parentheses. E.g., (President Obama)</p>
G. Meanings of Reforming the Health Care System	
G1.	Government-run insurance option or “Public option” mentioned? (Yes/No)
G2.	If “Yes” to G1, please provide an illustration from the article.
G3.	Was <u>support</u> for a government-run insurance plan or “public option” present? (Yes/No)
G4.	If “Yes” to G3, please provide an illustration from the article.
G5.	Was <u>opposition</u> to a government-run insurance plan or “public option” present? (Yes/No)
G6.	If “Yes” to G5, please provide an illustration from the article.
G7.	<p>Does the article mention that a government-run insurance plan or “public option” is not included in health care reform? (Yes/No)</p> <ul style="list-style-type: none"> • But the bill fails to fulfill President Obama's aim of creating a new government-run insurance plan -- or option – to compete with the private market. It proposes instead a system of nonprofit member-owned cooperatives, somewhat akin to electric co-ops that exist in some areas of the country. That was one of many concessions meant to win over Republicans.
G8.	If “Yes” to G7, please provide an illustration from the article.
G9.	<p>Are “death panels” (or “end of life care”) mentioned? (Yes/No)</p> <ul style="list-style-type: none"> • Then Betsy McCaughey entered the fray. A former lieutenant governor of New York, Ms. McCaughey had gained notoriety in the 1990s by attacking the Clinton health plan. In a radio interview, she attacked the end-of-life provisions in the health care legislation, claiming it "would make it mandatory, absolutely require, that every five years people in Medicare have a required counseling session that will tell them how to end their life sooner.

G10.	If “Yes” to G9, please provide an illustration from the article
G11.	<p>Is it reported that “death panels” will not be established? (Yes/No)</p> <p>(e.g., a description of what the legislation actually stated, or that death panels would not exist)</p> <ul style="list-style-type: none"> • There is, of course, nothing even remotely like this in the bill, yet other politicians joined the death panel chorus. On "This Week With George Stephanopoulos," the former Republican House speaker, Newt Gingrich, refused an opportunity to set the record straight. Instead, Mr. Gingrich noted "the bill's 1,000 pages," as if the number of pages was an excuse for his misrepresentation, and then declared, "You're asking us to trust turning power over to the government, when there clearly are people in America who believe in establishing euthanasia." The Speaker Gingrich I served with a decade ago would have been appalled at the blatant and repeated falsehoods of the Newt Gingrich of 2009.
G12.	If “Yes” to G11, please provide an illustration from the article.
G13.	<p>Is health care reform referred to as “socialism” or “socialized medicine?” (Yes/No)</p> <ul style="list-style-type: none"> • “Socialism” is now an active part of the Republican lexicon, among the litany of routine charges to be trotted out whenever they cannot come up with a substantive critique of policy initiatives they oppose. Beginning with a steady drumbeat from the far-right blogosphere during last year’s Democratic primary campaign, Republicans have attacked health care reform and modest progressive tax reform proposals as somehow “un-American,” “European,” and, God forbid, “socialist!”
G14.	If “Yes” to G13, please provide an illustration from the article.
G15.	<p>Is information challenging the idea of health care reform as socialized medicine provided? (Yes/No)</p> <p>(e.g., a description of what socialized medicine actually is or why the reform would not be socialized medicine or care, how the reform would not lead to care rationing)</p>

	<ul style="list-style-type: none"> All this Republican chatter is letting me make a living telling people that Obama and his administration are not socialist – and as National Director of Democratic Socialists of America (DSA), the United States’ largest socialist organization, I ought to know. Just like the New Deal-era Roosevelt haters, these Republicans erroneously term a president who is trying to save capitalism from itself a socialist. -Frank Llewellyn
G16.	If “Yes” to G15, please provide an illustration from the article.
G17.	<p>Is health care reform described as a “government takeover?” (Yes/No)</p> <ul style="list-style-type: none"> President Obama's ability to shape the debate on health care appears to be eroding as opponents aggressively portray his overhaul plan as a government takeover that could limit Americans' ability to choose their doctors and course of treatment, according to the latest New York Times/CBS News poll.
G18.	If “Yes” to G17, please provide an illustration from the article.
G19.	<p>Is information presented that challenges the idea that health care reform is a government takeover? (Yes/No)</p> <p>(e.g., people would still retain their choice of care providers, not everything would be controlled by the government)</p>
G20.	If “Yes” to G19, please provide an illustration from the article.
G21.	<p>Is the government’s ability to successfully implement reform questioned? (Yes/No)</p> <p>(e.g., the government can’t handle reforming the health care system)</p>
G22.	If “Yes” to G21, provide an illustration from the article.
G23.	<p>Is health care reform described as a positive government intervention? (Yes/No) (e.g., the government needs to step in and fix the mess that the health care system is in)</p> <ul style="list-style-type: none"> “When history calls, history calls,” Snowe said, declaring that Congress must address rising health costs before they send the system into a "death spiral" that will see the average employer-

	provided insurance plan cost nearly \$31,000 within a decade.
G24.	If “Yes” to G23, provide an illustration from the article.
G25.	Is health care reform described as resulting in a <u>loss</u> of care, fewer choices, reduced access to care, and/or quality of care? (Yes/No)
G26.	If “Yes” to G25, please provide an illustration from the article.
G27.	Is health care reform described as an <u>improvement</u> to health care, health care choices, access to care and/or quality of care? (Yes/No)
G28.	If “Yes” to G27, please provide an illustration from the article.
G29.	Is the current health care system described as acceptable? (Yes/No) (e.g., the system is fine now and works for most people, status quo is ok)
G30.	If “Yes” to G29, please provide an illustration from the article.
G31.	Is the current health care system described as broken or unacceptable? (Yes/No) (e.g., millions of people don’t have health care and that needs to be fixed)
G32.	If “Yes” to G31, please provide an illustration from the article.
G33.	<u>Is Republican support</u> for health care reform justified using any of the codes in Category G? (Yes/No)
G34.	If “Yes” to G33, please list each code category and provide an illustration from the article for each code listed. *If a specific Republican is cited, please provide the name after the text, in parentheses. e.g., (Sarah Palin)
G35.	<u>Republican opposition</u> to health care reform justified using any of the codes in Category G? (Yes/No)
G36.	If “Yes” to G35, please list each code category and provide an illustration from the article for each code listed.

	<p>*If a specific Republican is cited, please provide the name after the text, in parentheses.</p> <p>e.g., (Sarah Palin)</p>
G37.	<p>Is <u>Democratic support</u> for health care reform justified using any of the codes in Category G? (Yes/No)</p>
G38.	<p>If “Yes” to G37, please list each code category and provide an illustration from the article for each code listed.</p> <p>*If a specific Democrat is cited, please provide the name after the text, in parentheses.</p> <p>e.g., (President Obama)</p>
G39.	<p>Is <u>Democratic opposition</u> to health care reform justified using any of the codes in Category G? (Yes/No)</p> <ul style="list-style-type: none"> <p>We need to fix health care," Mary Bevering, a Democrat from Fort Madison, Iowa, said in a follow-up interview, "but if the government creates the system, I'm afraid the quality of care will go down and costs will go up: We will pay more taxes." "It's going to come down to regulation," Ms. Bevering said. "What also worries me is whether we will be told what physician we can have." (Mary Bevering)</p>
G40.	<p>If “Yes” to G39, please list each code category and provide an illustration from the article for each code listed.</p> <p>*If a specific Democrat is cited, please provide the name after the text, in parentheses. e.g., (President Obama)</p>
H. Support for Health Care Reform	
H1.	<p>Is the public described as <u>supporting</u> health care reform? (Yes/No)</p> <p>(e.g., “general public,” most Americans, the majority of Americans)</p> <ul style="list-style-type: none"> <p>The general public believes that, too. The latest New York Times/CBS News poll of 1,042 adults found that only 15 percent believe changes under consideration would make the Medicare program better, while 30 percent think they would make it worse.</p>

	Health and Human Services Secretary Kathleen Sebelius and Sen. Arlen Specter, D-Pa., are heckled and booed at a town-hall-style meeting in Philadelphia on health care
H2.	If “Yes” to H1, please provide an illustration from the article.
H3.	Is the public described as <u>not supporting</u> health care reform? (Yes/No)
H4.	If “Yes” to H3, please provide an illustration from the article.
H5.	Is public opinion data cited by Republicans to justify <u>support</u> for health care reform? (Yes/No)
H6.	If “Yes” to H5, please provide an illustration from the article.
H7.	Is public opinion data cited by Republicans to justify <u>opposition</u> to health care reform? (Yes/No)
H8.	If “Yes” to H7, please provide an illustration from the article.
H9.	Is public opinion data cited by Democrats to justify <u>support</u> for health care reform? (Yes/No)
H10.	If “Yes” to H9, please provide an illustration from the article.
H11.	Is public opinion data cited by Democrats to justify <u>opposition</u> to health care reform? (Yes/No)
H12.	If “Yes” to H11, please provide an illustration from the article.
H13.	<p>Is public opinion data cited by any individuals or groups (besides Republicans) to justify <u>opposition</u> to health care reform? (Yes/No)</p> <ul style="list-style-type: none"> • When we started this health care debate a year ago, 85 percent of the American people had health insurance, and 95 percent of the 85 percent were happy with it," Will said during the show's round table discussion. "So there was no underlying discontent that you now postulate to drive this radical change."health care debate a year ago, 85 percent of the American people had health insurance, and 95 percent of the 85 percent were happy with it," Will said during the show's round table discussion. "So there was

	no underlying discontent that you now postulate to drive this radical change."
H14.	If "Yes" to H13, please provide the name of the individual or group and an illustration from the article.
H15.	Is public opinion data cited in the article but not associated with a particular supportive or opposing viewpoint (e.g., just cited as factual information in the article)? (Yes/No)
H16.	If "Yes" to H15, please provide the quote.
I. Key Actors and Groups	
I1.	Is President Obama quoted or referred to in support of health care reform? (Yes/No)
I2.	If "Yes" to I1, please provide an illustration from the article.
I3.	Is Nancy Pelosi quoted or referred to in support of health care reform? (Yes/No)
I4.	If "Yes" to I3, please provide an illustration from the article.
I5.	Is Sarah Palin quoted or referred to in opposition to health care reform? (Yes/No)
I6.	If "Yes" to I5, please provide an illustration from the article.
I7.	Are Democratic policymakers (excluding President Obama and Nancy Pelosi) quoted/referred to <u>in support</u> of health care reform? (Yes/No)
I8.	If "Yes" to I7, please provide an illustration from the article, including <i>who</i> was quoted.
I9.	Are Democratic policymakers (excluding President Obama and Nancy Pelosi) quoted/referred to <u>in opposition</u> to health care reform? (Yes/No)
I10.	If "Yes" to I9, please provide an illustration from the article, including <i>who</i> was quoted.

I11.	Are Republican policymakers quoted/referred to <u>in support</u> of health care reform? (Yes/No)
I12.	If “Yes” to I11, please provide an illustration from the article, including <i>who</i> was quoted.
I13.	Are Republican policymakers quoted/referred to <u>in opposition</u> to health care reform? (Yes/No)
I14.	If “Yes” to I13, please provide an illustration from the article, including <i>who</i> was quoted.
I15.	Are scholars referenced/quoted in the article <u>as supporting</u> of health care reform? (e.g., professors, “think tanks,” universities) (Yes/No)
I16.	If “Yes” to I15, please provide an illustration from the article.
I17.	Are scholars referenced/quoted in the article <u>as opposing</u> health care reform? (e.g., professors, “think tanks,” universities) (Yes/No)
I18.	If “Yes” to I17, please provide an illustration from the article, including <i>who</i> was quoted.
I19.	Are health care industry groups referred to/quoted in the article <u>as supporting</u> health care reform? (Yes/No)
I20.	If “Yes” to I19, please provide an illustration from the article, including <i>who</i> was quoted.
I21.	Are health care industry groups referred to/quoted in the article <u>as opposing</u> health care reform? (Yes/No)
I22.	If “Yes” to I21, please provide an illustration from the article, including <i>who</i> was quoted.
I23.	Are health insurance industry groups referred to/quoted in the article <u>as supporting</u> health care reform? (Yes/No)
I24.	If “Yes” to I23, please provide an illustration from the article, including <i>who</i> was quoted.

I25.	Are health insurance industry groups referred to/quoted in the article <u>as opposing</u> health care reform? (Yes/No)
I26.	If “Yes” to I25, please provide an illustration from the article, including <i>who</i> was quoted.
I27.	Are pharmaceutical industry referred to/quoted in the article <u>as supporting</u> health care reform? (Yes/No)
I28.	If “Yes” to I27, please provide an illustration from the article, including <i>who</i> was quoted.
I29.	Are pharmaceutical industry referred to/quoted in the article <u>as opposing</u> health care reform? (Yes/No)
I30.	If “Yes” to I29, please provide an illustration from the article, including <i>who</i> was quoted.
I31.	Community groups/organizations referred to/quoted in the article <u>as supporting</u> of health care reform? (Yes/No)
I32.	If “Yes” to I31, please provide an illustration from the article, including <i>who</i> was quoted.
I33.	Community groups/organizations referred to/quoted in the article <u>as opposing</u> health care reform? (Yes/No)
I34.	If “Yes” to I33, please provide an illustration from the article, including <i>who</i> was quoted.
I35.	Health care consumers referred to/quoted in the article <u>as supporting</u> health care reform? (e.g., average people) (Yes/No)
I36.	If “Yes” to I35, please provide an illustration from the article, including <i>who</i> was quoted.
I37.	Health care consumers referred to/quoted in the article <u>as opposing</u> health care reform? (e.g., average people) (Yes/No)
I38.	If “Yes” to I37, please provide an illustration from the article, including <i>who</i>

	was quoted.
I39.	Are any health care professionals referred to/quoted in the article <u>in support</u> of health care reform (e.g., doctors, nurses)? (Yes/No)
I40.	If “Yes” to I39, please provide an illustration from the article, including <i>who</i> was quoted.
I41.	Are any health care professionals referred to/quoted in the article <u>in opposition</u> to health care reform (e.g., doctors, nurses)? (Yes/No)
I42.	If “Yes” to I41, please provide an illustration from the article, including <i>who</i> was quoted.
I43.	Any other key actors/groups referred to/quoted in the article <u>in support</u> of health care reform? (Yes/No)
I44.	If “Yes” to I43, which individual/group? Please list and provide an illustration from the article for each.
I45.	Any other key actors/groups referred to/quoted in the article <u>in opposition</u> to health care reform? (Yes/No)
I46.	If “Yes” to I45, which individual/group? Please list and provide an illustration from the article for each.
J. Summary Analysis and Overall Tone	
J1.	What is identified as the primary problem with the current health care system?
J2.	Illustration.
J3.	What is the primary problem that health care is described as solving?
J4.	Illustration.
J5.	Are alternatives other than the proposed health care reform offered as solutions?
J6.	If “Yes,” please provide an illustration.

J7.	<p>Overall, was the tone of the article supportive, opposed or neutral toward health care reform?</p> <p>“Favorable,” “Against,” or “Neutral”</p> <p>Note: If you cannot determine the tone, please list “unable to tell”</p>
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