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12

Communicating the Politics of Healthcare Systems

Heather Zoller & Shaunak Sastry

When you think about health and politics, what comes to mind? Medical care reform may be your first thought. However, consider the following issues raised in local and state ballots as well as national campaigns during the 2014 U.S. elections: The city of Berkeley, California, voted to tax soda distributors to raise funds to prevent diabetes; Denton, Texas, and two other communities voted to ban hydraulic fracturing gas drilling (fracking) based in part on health concerns; Massachusetts voted "Yes on 4," which allows workers to earn one hour of sick time for every 30 hours they work; Republican candidates continued to campaign against the Affordable Care Act (ACA or "Obamacare"); and governors debated whether and how to quarantine individuals who may have been exposed to Ebola. Across the world, in countries like Spain, Brazil, Greece, and Turkey, individuals, employees, and entire communities participated in mass protests against governmental "austerity" measures designed to shrink public investment in health.

This chapter describes the political complexities of health. What do we mean by politics? You are probably familiar with politics in terms of government policy making, public policy debates, and elections. Governmental policy has a profound influence on public health, including funding Medicaid and Medicare, crafting health and safety regulations, determining the legality of drugs such as marijuana, and mandating caregiver behavior in areas such as physician-assisted suicide. More broadly, governmental economic policy and even international trade agreements affect levels of employment, poverty, and public spending in ways that heavily influence public health outcomes. However, politics also encompasses "private" decision making that takes place in social institutions (e.g., corporations, workplaces, nonprofits, and voluntary associations) and in the negotiation of meaning in our everyday lives. Of course, citizens differ in the degree to which they actively engage in advocating for their own and others' health in medical and public health contexts (Rimal, Ratzan, Arntson, & Freimuth, 1997).

Communication is directly tied to political issues. Political communication is not just about the expression of political interests, although the ability to participate and

have one's voice heard in public decision making is very important. Communication also involves the social construction of ideas and social agreements—often becoming taken-for-granted assumptions—that influence our experiences, our sense of self, and what we consider to count as knowledge. These taken-for-granted assumptions are formed and negotiated in a context of relations of power at governmental, institutional, and interpersonal levels.

In this chapter, we will describe (1) the political complexities of our taken-for-granted assumptions about health and illness causation, (2) the role of power in defining illness and establishing the scope of medical treatment, (3) the influence of economic decision making on health, and (4) the role of communication in medical care reform debates.

The Politics of Defining Health and Attributing Illness

Increasing numbers of employers are charging higher insurance rates or a monthly fee (a surcharge) for employees who smoke, have high cholesterol, have diabetes, or are deemed obese. Take the case of PepsiCo, which rolled out a wellness program that charges employees $50 a month if they smoke or have health issues such as diabetes, hypertension, and high blood pressure that are presumed to be avoidable or resolvable with changes in lifestyle or personal habits. Employees can avoid the surcharge if they attend classes to help them quit smoking or lose weight.

When we decide how to protect health, and how to distribute public health and medical resources, we draw from a set of beliefs about what it means to be healthy and what causes illness. Consider the workplace surcharges described above. When employers start these programs, they assume that (1) these conditions or activities cause illness and (2) these conditions or activities are controllable by individual employees. At first, these might seem like pretty straightforward assumptions, but many factors contribute to our health status. The way that we define health and illness has significant *political* implications.

These issues are political and not just scientific for several reasons. To start, *science is often uncertain* about the biological causes of illness. It is also important to remember that there is a difference between *agents* of disease and *causes* of disease, because multiple factors can lead to different biological vulnerabilities to the manifestation of disease. For example, two people may be exposed to a cold virus (an agent of disease) but only one may come down with the cold (a disease), due to a host of factors that influence the immune system, such as genetics, amount of sleep, adequate nutrition, and the existence of other illnesses. So when we explain what it takes to be healthy and what causes illness, we are selecting from multiple potential causes. When we attribute the cause of illness, we are also attributing *responsibility* for disease—a persuasive and rhetorical process rather than a solely scientific one (Kirkwood & Brown, 1995). These rhetorical choices influence how we treat people who are ill and how we distribute resources to prevent and treat disease. Thus, our theories about health and attributions of disease causation are linked to our beliefs about the proper organization of society (Tesh, 1994).

Thinking about the workplace surcharge, look at the list below of different theories of illness:

- The *lifestyle theory*, which holds that illness is caused by our personal choices, might be used to support employee surcharges for workers who are obese, h

high cholesterol, or smoke. Pr
workers to stop smoking and ea

- *Genetic theories*, on the other ha
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is bad for one's health.)
- *Environmental theories* might en
choices: Does every person ha
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may be contributing to obesity.
- Even *germ theories*, which attribu
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- The *political/structural* perspecti
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Table 12.1 Major Theories of Illnes

Theory	Attribution of Illnes
Lifestyle	Diet, exercise, and ot
Genetic	Genetic make-up
Environmental	Factors in built and n ments
Germ	Microorganisms, viru
Political/Structural	Social and economic

Considering these different theorie
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...ory, which holds that illness is caused by our personal choices, ...support employee surcharges for workers who are obese, have

high cholesterol, or smoke. Proponents argue that higher costs will motivate workers to stop smoking and eat better.

- *Genetic theories,* on the other hand, might be used to question whether the policies discriminate against individuals who are genetically prone to high cholesterol or higher weight. (Generally, it is quite difficult to control cholesterol through behavior choices, and research is mixed about whether high cholesterol is bad for one's health.)
- *Environmental theories* might encourage us to consider the context of health choices: Does every person have equal access to safe and affordable ways to exercise and eat healthy food? Environmental theories also consider that our exposure to endocrine-disrupting chemicals such as bisphenol A and pthlalates may be contributing to obesity.
- Even *germ theories,* which attribute illness to microorganisms, play a role in this debate. Some researchers suggest that our "gut bacteria" might play an important role in our weight, seriously questioning the utility of common advice to just eat less as a way to lose weight (Wendelsdorf, 2013). This theory attributes weight gain to antibiotic use and sugar that may produce less diverse microbes.
- The *political/structural* perspective would point out that income level is the primary predictor of health status. Minority groups and low-income individuals are far more likely to live in places that are unsafe for exercise, have little access to healthy food, and have little time for healthy habits due to difficult work schedules and lack of childcare. Therefore, surcharges blame the individual for widespread social inequalities and further reduce income.

Table 12.1 Major Theories of Illness Causation

Theory	Attribution of Illness Causation	Primary Intervention
Lifestyle	Diet, exercise, and other choices	Individual choice-making
Genetic	Genetic make-up	Genetic therapy
Environmental	Factors in built and natural environments	Ecology, industry, political system
Germ	Microorganisms, viruses	Individual medical care
Political/Structural	Social and economic inequality	Structures supporting social, economic, and political marginalization

Considering these different theories, it becomes evident that questions about what causes illness are very complex. Perceptions about the causes of good health and illness are formed in everyday interactions, media accounts, and through institutional and governmental discourses. However, some people's definitions (such as PepsiCo) become policy because people support their theories of causation and they have power to implement changes (see Theorizing Practice 12.1).

Theorizing Practice 12.1
Insurance Surcharges

Under the Affordable Care Act, insurance companies can charge smokers and other tobacco users up to 50 percent more than nonsmokers for a health insurance policy. If you were the head of Human Resources at PepsiCo, would you support an insurance surcharge for employees who are diabetic or obese? Why or why not? How is your position influenced by different theories of illness causation?

As the surcharge example shows, debates about the causes of illness influence how we distribute resources such as insurance. It also influences how we design health interventions. For example, health communicators may address obesity by drawing from lifestyle theories to create health campaigns to encourage individuals to exercise, or draw from political/structural theories to advocate for safer neighborhoods. Further, by establishing responsibility for illness, these discourses direct blame and moral stigma. Indeed, when we attribute obesity to personal choices, we tend to blame and stigmatize overweight people more than if we emphasized genetic causes. Those who attribute obesity to political/structural factors tend to call out the food industry (such as PepsiCo) for aggressive marketing of cheap calorie-laden and sugary foods, and call for larger changes in our food system.

Heather, one of this chapter's authors, found that these theories of health played a big role during a community debate about a chemical plant that was releasing chemicals of concern in her neighborhood (Zoller, 2012). Some residents drew from envi-

HCIA 12.1

Does the U.S. Have a "Weight Problem"?

Lisa M. Tillmann

At Rollins College, I teach in a program of Critical Media and Cultural Studies (CMC). This major exposes students to pressing challenges like war, climate change, and economic inequality and to movements working for change. Through theory, library and original research, digital art, and social justice documentary filmmaking, CMC students become not only critical consumers of media and culture but critical *producers* as well. I try to model that through my own scholarship and creative work. Since the launch of our program in 2007, I have learned photo, sound, and video editing and have produced or coproduced three documentaries. Students have played important roles in all three films, from consulting on screenplays and music selections to contributing testimony and digital art.

Two of my three films began in sections of a course called The Political Economy of Body and Food. That class covers a lot of ground: from eating disorders and steroid abuse to food insecurity and farmworker justice. When I asked my 2011 student collaborators on what topic they wanted to center our work, they overwhelmingly chose cultural narratives of weight, fat, and "obesity." In other words: What stories circulate in our culture about fat, and how do those stories impact our bodies, lives, relationships, and public policy?

Following a practice encouraged b
Studies, I put "obesity" in quotes to d
supports particular interests, such as th
gest that dominant narratives of "obesi
The student testimony and digital
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has a "weight problem," but in ways th
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The film directly challenges the rhetoric
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Viewers hear from Tomas, who at ag
He responds to criticism and teasing fro
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- Recognize that you have a stake i rent body shape or size. Exposur everyone's self-esteem, undermin and time from civic and communit
- Eat a nutrient-dense diet and enga for weight loss.
- Vote with your wallet. Patronize co everyone, regardless of shape or si tions that sell products and service
- Support antibullying policies inclu ment and bullying on these base more likely to be bullied than thei have been bullied consider, attem who have not.
- Lobby for antidiscrimination prote whelming majority of organizatio refused service in a shop or restaur even fired—on no other basis than
- Advocate for public policies, such a nutrient-dense food and to safe en
- Seek out sources of information inc

Powerful forces wage the war on "obe
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of peace, health, equity, and justice. Lear
For a full-length preview of *Weight Probl*
learn more, please visit the website fo
Serves Justice: http://cinemaservesjustice

Theorizing Practice 12.1
Insurance Surcharges

insurance companies can charge smokers and other tobacco nonsmokers for a health insurance policy. If you were the head would you support an insurance surcharge for employees who y not? How is your position influenced by different theories of

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Following a practice encouraged by scholars in an interdisciplinary field known as Fat Studies, I put "obesity" in quotes to denote that this concept is a social construction that supports particular interests, such as those of the diet and drug industries. The quotes suggest that dominant narratives of "obesity" merit scrutiny, questioning, and critique.

The student testimony and digital art collected in 2011 provided the major building blocks for the film *Weight Problem: Cultural Narratives of Fat and "Obesity."* The U.S. indeed has a "weight problem," but in ways that differ from what we've been led to believe. *Weight Problem* addresses stereotypes and prejudices evident in our homes, with our peers, at primary and secondary schools, on college campuses, in the dating arena, and in mass media. The film directly challenges the rhetoric of the "obesity epidemic," which serves the $50–60 billion-per-year Diet Industrial Complex more than it improves public health.

Viewers hear from Tomas, who at age 15 undergoes a growth spurt in height and weight. He responds to criticism and teasing from his brother and schoolmates with dangerous patterns of self-starvation and weight cycling. Eric speaks of three years of weight-based harassment and bullying. We also meet Roxanne, who despite a hospitalization for anorexia, continues to experience stinging weight-based criticism from her mother.

Weight Problem offers several action items for viewers interested in helping redress the issues raised:

- Recognize that you have a stake in ending antifat prejudice—regardless of your current body shape or size. Exposure to cultural ideals for body shape and size lowers everyone's self-esteem, undermines our relationships with others, and drains energy and time from civic and community engagement.
- Eat a nutrient-dense diet and engage in regular physical activity for your own sake, not for weight loss.
- Vote with your wallet. Patronize companies and organizations that promote health for everyone, regardless of shape or size; withhold support from companies and organizations that sell products and services via antifat prejudice.
- Support antibullying policies inclusive of body shape and size, and interrupt harassment and bullying on these bases. Those classified as "overweight" and "obese" are more likely to be bullied than their so-called "normal"-weight peers, and people who have been bullied consider, attempt, and commit suicide at rates higher than those who have not.
- Lobby for antidiscrimination protections based on body shape and size. In the overwhelming majority of organizations, municipalities, and states, a person can be refused service in a shop or restaurant; denied a hotel room, house, or apartment; and even fired—on no other basis than body shape or size.
- Advocate for public policies, such as a living wage, that facilitate everyone's access to nutrient-dense food and to safe environments conducive to activity and play.
- Seek out sources of information independent of the Diet Industrial Complex.

Powerful forces wage the war on "obesity," and they have a lot to lose if we decide to pursue peace instead of war with our bodies. My student collaborators and I stand on the side of peace, health, equity, and justice. Learn more for yourself, then decide where you stand. For a full-length preview of *Weight Problem*, please email me at: lmtillmann@gmail.com. To learn more, please visit the website for *Weight Problem's* production company, Cinema Serves Justice: http://cinemaservesjustice.com/index.html

(continued)

QUESTIONS TO PONDER

1. Have you ever lost and/or gained a significant amount of weight? If so, did that change in weight alter how you felt about yourself? If so, how? Did it alter how others (a dating partner, family member, friend, doctor, person on the street) treated you? How so?
2. When you hear the word "fat," what words or phrases come to mind first? How do those words and/or phrases reflect our culture's stereotypes about those labeled as "overweight" or "obese"?
3. About one third of people in the U.S. are classified as "overweight" and another one third as "obese." Given these statistics, what explains the fear and hatred of fat we find in mass media and public life?

Source: Tillmann, L. M. (Director, Producer, Writer). (2014). *Weight problem: Cultural narratives of fat and "obesity."* United States: Cinema Serves Justice. http://cinemaservesjustice.com/weight-problem.html

ronmental theories of health to call for reduced emissions from the company, EPA testing, and health department research into the effects of the chemicals. The company, and some residents, opposed such moves, using lifestyle theories of health to argue that research about company emissions was not needed because any increases in cancer and other illness were likely due to individual choices such as smoking and diet. Some residents also argued that cancer is caused by genetics, and nothing can be done about that.

Lifestyle theories of disease are becoming increasingly popular across the globe. During his research on HIV/AIDS risks faced by truck drivers in India, Shaunak, the second author of this chapter, found that most public health campaigns (as well as some truck drivers themselves) talked about AIDS as a "lifestyle" disease, emphasizing risky sexual behaviors and inadequate knowledge about contraception. However, very little attention was paid to the structural and economic context of truckers' lives: the fact that truckers were impoverished migrants forced to live away from their sexual partners for months at a time. Structural theories of health would point out the inequalities embedded in truck drivers' lives that compelled them to engage in risky behavior (Sastry, 2016).

A key issue in these debates is how much our health status is an *individual* and *private* versus *social* and *public* issue. Think about the debates over parents who refuse to vaccinate their children, arguing that it is their individual right to decide what risks their children take. These parents are concerned about their child's individual risk from vaccines. What these parents overlook is that not only are unvaccinated children at significant risk for disease, they are risking the lives of others, including infants who cannot yet get vaccinated and immuno-compromised individuals. Another example can be found in the media discussion of the Ebola Virus Disease (EVD) epidemic concentrated in the three West African nations of Guinea, Sierra Leone, and Liberia. While the spread of the virus may be a result of specific individual behaviors (like inadequate hygiene, or inappropriate disposal of patient waste), the disease is escalated to an epidemic status because of social factors: the lack of adequate public health infrastructure, medical facilities, hospitals, and so forth. In resource-poor countries like the ones mentioned above, the lack of adequate medical resources is a telling

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Learning to

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...and/or gained a significant amount of weight? If so, did that change in ... you felt about yourself? If so, how? Did it alter how others (a dating ...ember, friend, doctor, person on the street) treated you? How so?

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example of how health is determined through social causes. We will return to the Ebola example later in the chapter.

Although we may fall into the trap of thinking of individual and social causes as either-or, Levins and Lopez (1999) remind us to think about how these overlap:

> Consider the two propositions: (a) we are each responsible for our own health, and (b) health is socially determined. Both are claims about reality, and about the causes of disease. Both are also normative: each person should take responsibility for her or his own health, or our society should take collective responsibility for the health of all of us. Each proposition is separately false, but together they are jointly true. . . . When stated by policymakers, the first proposition blames the sick (or their parents) for being sick and justifies the denial of public resources for health improvement. The second, accepting social responsibility, would propose actions to improve healthcare, make it more available, or reduce environmental insults to our health such as pollution, but it leaves the individual out of the equation or as a passive onlooker. (p. 270)

We have described the political implications of defining health and naming responsibility for illness. In the next section, we describe how some conditions become "medicalized" and treated within the medical system.

HCIA 12.2

Learning to Talk about HPV "Like a Girl"

Jennifer A. Malkowski

When I was a teenager I tested positive for a high-risk strain of the human papillomavirus (HPV), a sexually transmitted disease known to cause cervical cancer. To care for the condition, I followed the doctor's orders and underwent some rigorous, painful treatments. At the time, I was not informed about the nature of HPV, nor how I might have been exposed to the virus in the first place. Most significantly, I left the doctor's office unclear about what an HPV-positive status meant for my future sexual health. WebMD and other e-health sites did not exist at the time. For the next two years, every three months I returned for an exam. Each report came back "clean." For the next decade, I remained uncertain about how to disclose my HPV status to sexual partners. What did a "clean" HPV-positive diagnosis mean for sexually responsible behavior?

Many years after my initial diagnosis, a public health awareness campaign was launched that urged me to "tell someone" about the link between HPV and cervical cancer, a link that I had not known about despite my HPV-positive status. The advertisements did not mention the sexual nature of transmission nor the male contribution to the problem. These omissions suggested some ground rules for discussion: I could talk about HPV in terms of cancer, but should I remain silent about its classification as a sexually acquired condition?

In June 2006, the approval of GARDASIL®, a vaccine that blocks infection by four strains of the HPV virus, became of interest to public health agencies, political institutions, and advocacy organizations that understood HPV to be the cause of 70% of all cases of cervical cancer and 90% of all cases of genital warts. The next wave of advertising, dubbed "One Less," promoted the vaccine as *the* method for ensuring that each vaccinated girl would become

"one less" cancer victim. In this way, the new medical vaccination technology provided women with an opportunity to proactively intervene and protect themselves against a deadly condition, if they elected to get vaccinated. Moreover, the vaccination offered women a way to talk about HPV as a public health issue.

Once again, though, it appeared as if women were equipped and encouraged to talk about HPV only in terms of cancer prevention. Omission from public messaging of HPV's method of transmission and an overemphasis on cervical cancer as its health consequence (rather than focus on genital warts, a condition also caused by HPV that affects both women *and men*) implied an association between women, "responsible" behavior, and health "consequences." If individual women decided not to heed the advice of medical professionals to get vaccinated and share their HPV knowledge with others, then, at least in part, an HPV-positive status implied a connection between "irresponsible" behavior and "deserved consequences." As someone already carrying the virus, how was I to talk about HPV? More importantly, how could I ensure that I, too, would be "one less" cancer victim?

Since GARDASIL®'s introduction to market, understanding how women successfully communicate about HPV status has, thankfully, grown as an issue of concern among health scholars, professionals, and advocates alike. Indeed, many communication scholars, including myself, now study the ways public communication about health and medicine contributes to the adoption of individual health behaviors, the reputation of particular medical conditions, and the political and cultural responses to different types of disease prevention and treatment. Because my personal awareness about HPV was initiated by public health messaging about the condition, I have elected to focus on pharmaceutical advertisements as a mode of communication designed to inspire particular public responses to individual health conditions. Pharmaceutical giants, such as Merck, have raised much needed awareness about previously misunderstood or stigmatized health conditions, such as HPV. However, as communication critics, it is our job to think about the consequences of for-profit authorship of public health messages to ensure that the overall quality of individual lives—and especially those dealing with difficult health situations—are enhanced by public health communication.

Almost four years after its initial introduction to market, GARDASIL® launched the third installment of its national awareness campaign entitled "My Voice." Unlike the other waves of advertisements, this campaign claimed to represent the voices of people living with HPV. I decided to investigate the campaign materials from a rhetorical perspective to evaluate Merck's claims. Through close textual analysis, with attention to a history of women in medicine, I identified storytelling as a mode of persuasion used by Merck to gain the attention of female audiences more broadly and identified voice as the means by which Merck convinced female consumers to trust that GARDASIL® was the only way to resolve the HPV story. I concluded that Merck's use of contradiction and tension to tell that story appeared to encourage complacency, or inaction, among female health participants. As such, Merck's campaign may be functioning to keep women in a state of anxiety about HPV, a state that, perhaps intentionally, preserves problematic notions of both women and health. With this possibility in mind, how might we as communication scholars help to re-story health narratives in ways that empower women across health contexts and offset problematic patterns in public talk? Can we compete and/or partner with Big Pharma to improve everyday health experiences? As health communication specialists, I think we can and hope we do.

Questions to Ponder

1. Based on your experiences, why do you think men and women experience health differently *even if the health condition is the same?*
2. Think about a pharmaceutical advertis
or on television. Describe what feature
that you find problematic about the ad
3. In your opinion, whose responsibility i
public know about contagious health c
in particular?
4. What makes talking about sexually tra
eases so difficult? Do you think public h
to talk about these types of issues more

Source: Malkowski, J. A. (2013). Confessions of
dered dialectics in the case of Gardasil. *Health Co*

■ The Politics of Medicalizatio

How many absences are allowed in the cours tor allow for "excused absences?" If you were proof of illness? This is an important exampl tioned weight of a "sick note." Only a doctor reason for not participating in our social lives reduced, and doctors have been vested the res

The Western medical establishmen health, illness, and our bodies. If aske chances are that most people would rely grams in school textbooks that reveal di an assembly line. Are our bodies actual our knowledge of our bodies has been spectives like anatomy? How did medici

Michel Foucault (1975), a French investigated the development of professi the confluence of knowledge and power. ine, classify, and create categories of heal as the "medical gaze." The medical ga extends through the growth in professio habits, bodily routines, social interaction tise deepens the reach of their profession often have a monopoly over diagnosis ba cal expertise. Medical sociologists like De ern medicine has emerged as a site for the wherein it propagates ideas that justify t ideas. For instance, until the early 1970s, sexuality mirrored the general social atti

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experiences. Why do you think men and women experience health differ- e health condition is the same?

2. Think about a pharmaceutical advertisement that you have recently seen either in print or on television. Describe what features of the ad make it persuasive. Is there anything that you find problematic about the advertisement? What and why?
3. In your opinion, whose responsibility is it to ensure that members of the general U.S. public know about contagious health conditions? Why this person, institution, or group in particular?
4. What makes talking about sexually transmitted infections and sexually transmitted diseases so difficult? Do you think public health advertisement campaigns help individuals to talk about these types of issues more easily? Why or why not?

Source: Malkowski, J. A. (2013). Confessions of a pharmaceutical company: Narrative, voice, and gendered dialectics in the case of Gardasil. *Health Communication, 29,* 81–92.

The Politics of Medicalization

How many absences are allowed in the course you are enrolled in right now? Does your instructor allow for "excused absences?" If you were too sick to work, would you be fired unless you had proof of illness? This is an important example of medicine as a site of social control: the unquestioned weight of a "sick note." Only a doctor has the power to decide whether one has a genuine reason for not participating in our social lives. Truancy, in school or at the workplace, must be reduced, and doctors have been vested the responsibility to make those judgments.

The Western medical establishment has come to dominate our thinking about health, illness, and our bodies. If asked to describe their bodies from the inside, chances are that most people would rely on anatomical descriptions. Think of the diagrams in school textbooks that reveal discrete, linear organs working in sequence like an assembly line. Are our bodies actually arranged like those diagrams? Or is it that our knowledge of our bodies has been completely formed by Western medical perspectives like anatomy? How did medicine develop this sort of legitimacy?

Michel Foucault (1975), a French philosopher, historian, and social theorist, investigated the development of professional control among the sciences, describing the confluence of knowledge and power. Professionals have gained the power to examine, classify, and create categories of health and illness, which is sometimes referred to as the "medical gaze." The medical gaze defines normality and abnormality, and extends through the growth in professional surveillance of the public and its health habits, bodily routines, social interactions, and mental status. Communicating expertise deepens the reach of their professional control. Western biomedical professionals often have a monopoly over diagnosis based on perceptions of objectivity and technical expertise. Medical sociologists like Deborah Lupton (2012) have argued that Western medicine has emerged as a site for the control and distribution of social ideologies, wherein it propagates ideas that justify the status quo and seeks to rectify dissonant ideas. For instance, until the early 1970s, the medical establishment's views on homosexuality mirrored the general social attitudes, and it was considered to be a form of mental illness. As a matter of fact, the Di

which categories the different kinds of mental illnesses, had an entry for homosexuality, which included a set of diagnostic criteria, prognoses, and treatment options.

Medicalization is a contested process by which social, health, or behavior issues come to be defined and treated as medical problems. Processes that were once thought of as natural such as childbirth, breastfeeding, and aging are now treated as medical events. Foucault argues that medicalization was a historical process that accompanied (and continues today) the development and professionalization of allopathic medicine in society. Broad-based changes in the economic, political and social organization of 19th-century European society were central to the development of professional medicine. In the backdrop of the industrial revolution and the great demand for industrial labor, social institutions began to differentiate between the sick and the poor (which up to this point were jointly regarded as "destitute"). Medicalization helped demarcate bodies that could be productively used as labor. Foucault notes that the process of medicalization, the regular surveillance of bodies and the maintenance of hygiene, was made possible by the development of the nuclear family, which subsequently emerged as the locus of responsibility for an individual's health.

Medicalization defines normality and deviance, for instance, in deciding whether a child is "rambunctious" or has attention deficit/hyperactivity disorder (ADHD). Gays and lesbians organized for many years to contest the American Psychiatric Association's classification of homosexuality as a mental illness, as mentioned above. Medicalization brings important benefits such as the legitimation of a diagnosis, reduction in personal blame, access to care, insurance benefits, social support, and other resources, as well as allowances from school, work, and social burdens (think about how medicalization has helped people with post-traumatic stress disorder (PTSD). On the other hand, medicalization may also increase stigmatization, and brings behavior into the purview of the medical care system. It may promote unneeded treatments that can lead to *iatrogenic disease* (illness caused by medical treatment). Furthermore, the process of medicalization may act politically to adapt individuals to currently dysfunctional social arrangements rather than changing those social circumstances. For example, giving children ADD medication allows them to fit into existing school structure rather than adapt those structures to the children (e.g., smaller class sizes, more time for exercise). Lynn Payer (1992) described attempts to make well people feel sick as *disease mongering*. Health professionals and marketers may invoke very broad definitions of illness to include more people in diagnoses, or inflate the risk of relatively minor disorders. Pharmaceutical marketing has worked with the American Psychiatric Association to develop new disorders in its Diagnostic and Statistical Manual and then marketed those disorders to promote drug sales such as Sarafem for "premenstrual dysphoric disorder" (Frances, 2013; Koerner, 2002). Medicalization is apparent through the constant creation of new medical conditions and categories, like "restless leg syndrome" and "chronic fatigue syndrome," among others, that make increasing sections of the population dependent on pharmaceutical drugs.

These issues show how deeply personal the politics of medicine can be. The discussion also points out how business concerns such as pharmaceutical marketing influence health. Next, we describe linkages between public health and the economy. But first, consider theories of policy making in Theorizing Practice 12.2.

Theorizing Pra
Theories of Pol

In democratic countries, citizens elect officials t
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ment (the U.S. president, for example) and enfo
agencies and police. Among political scientists, s
there are long-standing, competing theories about
interests it serves. Read and consider the following

- **Elite theories** (Mills, 1956; Schattschneider, 1
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and influence to dominate policy processes.
officials and other policy makers, they prefer
agenda, in order to maintain their control. Th
make policies such as tax breaks that benefit
connected groups.
- **Pluralist theories** (Dahl, 1958) suggest that
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- **The Punctuated Equilibria Model** (Baumgar
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Which theory best describes the U.S. political
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Theorizing Practice 12.2
Theories of Policy Making

In democratic countries, citizens elect officials to represent their interests when creating public policies (the U.S. Congress, for example) and executing laws by appointing heads of government (the U.S. president, for example) and enforcing laws through federal and enforcement agencies and police. Among political scientists, sociologists, and communication researchers there are long-standing, competing theories about how our political system operates and whose interests it serves. Read and consider the following positions on how public policies occur:

- **Elite theories** (Mills, 1956; Schattschneider, 1960) argue that political elites (wealthy, well-connected people, often with big business interests) have the information, political skills, and influence to dominate policy processes. Because these groups can influence elected officials and other policy makers, they prefer to keep debates private, that is, off the public agenda, in order to maintain their control. This theory suggests that policy makers tend to make policies such as tax breaks that benefit the interests of powerful, wealthy, politically connected groups.
- **Pluralist theories** (Dahl, 1958) suggest that because different social and political interests can organize to represent their interests, and may work together in coalitions to gain strength, no single interest group dominates the process. Rather than a political process controlled by a few, this theory suggests that our political system represents a wide variety of public interests and concerns. (This theory would suggest that college students, for instance, could organize to pressure state governments to offer financial aid and reduce tuition.)
- **The Punctuated Equilibria Model** (Baumgartner & Jones, 1993; Conrad & McIntush, 2003) suggests that long periods of policy consensus (that is, times when policy does not change) are punctuated by sudden social change (for example, problems of lack of access to medical care mounted for years until anyone proposed significant changes in how we offer health insurance). The model argues that elite individuals and groups, often from large business interests, are tightly organized and have more money and prestige, which allows them to influence the political process better than fragmented non-elite groups such as students or consumers. However, non-elite publics can play a role in the political process. Nonelites are likely to participate at moments when they believe their interests are affected and they feel they have a voice. (For example, as we mentioned, public concern about water quality has led some communities to fight larger energy companies by passing local bans on fracking.)
- **From a communication perspective**, Conrad (2004) reminds us that in order for an issue to be addressed in the policy process, long-standing issues must be defined as problems important enough to require action, apparent solutions must be made available, and political pressure from the public must be adequate to overcome policy elites' desire for keeping debates behind closed doors. Groups must frame benefits and costs through their rhetorical skills. Conrad reminds us that politics is emotionally contentious rather than a rational process as different groups mobilize support for their positions (Conrad & McIntush, 2003). Which theory best describes the U.S. political system? Is our political system dominated by wealthy elites or is it open to public participation by everyday people? Whose interests are reflected in government policies?

HCIA 12.3

Gender Stereotypes, Media Portrayals, and the Prophylactic Mastectomy Narrative

Tasha Dubriwny

Narratives about health in the media offer us information not only about the health issue at hand but also about who we are, and who we can be, in relation to a given health issue. In one recent project, I analyzed how women's health issues are represented in popular media texts (news, films, and bestselling books), and I suggested that these representations coalesce into dominant narratives that construct a specific identity for women: the "vulnerable empowered woman." This identity positions women both as *vulnerable* to the female body's supposed frailty and as *empowered* to make choices about their medical care. However, it is important to think critically about the health information we receive in the media, especially in terms of how such information may be reproducing harmful gender stereotypes. For example, in the media narrative about prophylactic mastectomies, the representation of the vulnerable empowered woman as empowered to choose prophylactic surgery is concerning because the narrative positions all women as mothers and frames prophylactic mastectomies as a cosmetic procedure that can give women perfect breasts.

By "prophylactic mastectomies," I am referring to the procedure of removing healthy breasts as a way to reduce one's risk for eventually developing breast cancer. In the media coverage I explored, most women that elected the procedure had also received positive results from a genetic test for the breast cancer gene mutations BRCA1 and BRCA2. Women with these gene mutations have up to an 85% chance of developing breast cancer in their lifetime.

The narrative that develops in media coverage about prophylactic mastectomies emphasizes the high risk that women with the BRCA1 and BRCA2 gene mutations face, to the extent that the risk of cancer is often equated with actually having cancer. For example, in *Gossip Girl*, writer/producer Jessica Queller's memoir about her experience with prophylactic mastectomies, she describes finding herself literally in the position of a breast cancer patient; she is sitting in the waiting room in an oncology office, filling out forms with women who had lost their hair from chemotherapy treatments. The difference between testing positive for a gene mutation and having cancer disappears, and breast cancer is depicted not as a possibility but as her destiny. The media narrative also routinely emphasizes the horrors of breast cancer. Coverage of actress and mother of six Angelina Jolie's decision to remove both breasts after receiving a positive result from a genetic test, for example, included information on Jolie's mother Marcheline Bertrand whose eight-year battle with breast and ovarian cancer resulted in her death. Stories of the pain caused by cancer and its treatments combined with a sense of "cancer as destiny" propel the vulnerable empowered woman of the prophylactic mastectomy narrative to remove her breasts in an effort to remain cancer-free.

Such a choice is understandable given the fear and uncertainty of a breast cancer diagnosis, but I critique the narrative that develops in the media for positioning the choice as compulsory. What makes the choice compulsory is the connection between the vulnerable empowered woman's pursuit of a cancer-free life and her position as a mother (or, as often, a potential mother). Women, according to this narrative, must do all they can to rid themselves of the risk of cancer for the sake of their children. Moreover, the promise of a *future* family works as well to support the framing of the choice as compulsory; in Jessica Queller's case, her memoir ends with details about her plans to become pregnant. Reducing women to the position of mothers is problematic, as not all women are or will be mothers. Positioning women's health decisions as driven by motherhood reproduces stereotypes about what

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QUESTIONS TO PONDER

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Source: Dubriwny, T. N. (2013). *The vulnerable
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Health and the Economy

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it means to be a woman in contemporary society (women are first and foremost seen as nurturers of *others*, with care for the self coming in a distant second place).

If the narrative about prophylactic mastectomies in the media is problematic because it reduces women to their status as mothers, it is also problematic because in the end the narrative reproduces cultural standards about what women's bodies should look like. For example, Queller's memoir details how her "new" breasts are better and more suited to her than her old breasts. Coverage of Jolie has unabashedly examined her bust line, using words such as "fuller" and "perkier" to describe her new appearance. Prophylactic mastectomies and the often grueling procedures of reconstructive surgery are thus aligned with the growing culture of body modification through cosmetic surgery. In this narrative, interest in women's long-term health is displaced by a focus on the vulnerable empowered woman maintaining an appropriately feminine appearance.

Health narratives can be thought of as tools for helping us work through life situations. However, as I have suggested here, some narratives are problematic because they reduce the complexity of health events and propel medical choices that depend on gender stereotypes.

Questions to Ponder

1. Can you think of other examples of media narratives about health issues that rely on gender stereotypes about women and/or men?
2. How do you see health narratives as influencing your own health decisions? Can you think of an example of (for instance) a celebrity's story that has influenced your approach to health?
3. Thinking critically about health narratives means being aware that narratives often offer only one perspective on a given health issue. Outside of mainstream media sources, where can we find alternative health narratives that may not reinforce gender stereotypes?

Source: Dubriwny, T. N. (2013). *The vulnerable empowered woman: Feminism, postfeminism, and women's health.* New Brunswick, NJ: Rutgers University Press.

Health and the Economy

Although we may not always realize it, economic decisions are an important part of the politics of healthcare. Economic development is important to public health. Advances in nutrition and sanitation that resulted from improved standards of living played a larger role in improving the health of the public in Europe and the U.S. than developments in medicine (McKeown & Brown, 1976). Unfortunately, there are also long-standing conflicts between business interests and public health. Early conflicts included business resistance to quarantining ships to prevent the spread of contagious disease in the 1800s (Tesh, 1994). Today, some of the most significant influences on health are corporate policies. Corporations are responsible for resource depletion and environmental pollution, as well as occupational injury and disease in Western countries and are compounded in "sweatshop" conditions in the Global South. The production, sales, and marketing of harmful products such as tobacco, fast food, and dangerous chemicals puts corporate interests in conflict with public he... berg, 2014).

For example, concentration among food companies means that a handful of very large corporations determine what we eat. Popular author and journalist Michael Pollan, in the film *Food Inc.* (Kenner, 2008), argues that the grocery store gives only the appearance of variety. Because of massive government spending on corn subsidies for large agricultural businesses, we have made junk food appear to be very inexpensive. Companies can buy this corn for an artificially low price. As a result, it is difficult to find products without high fructose corn syrup. Hidden sweeteners in our food contribute to obesity, diabetes, and other costly health problems. Cattle eat inexpensive corn instead of grass, which makes the price of meat cheaper at the store but raises the risk of E. coli contamination and antibiotic resistance. Livestock raised in concentrated animal feeding operations produce millions of gallons of liquid manure that run off into neighboring wells and cause gastrointestinal illness, fatal respiratory illness in babies, and is associated with miscarriage and developmental defects (Pojda, 2010). Workers are exposed to pesticides and face high rates of occupational injury in agricultural work and in meatpacking plants. These practices increase profits for the companies, but they do so by "externalizing" the costs and risks, which means shifting them to the public—taxpayers, workers, consumers, and neighbors.

Corporate public relations and issue management are central to this system. Food companies lobby elected officials to maintain government subsidies (that is, government payments for commodities like corn) (Nestle, 2013). "Veggie libel laws" (food disparagement laws) passed in several states are a good example of this corporate influence. These laws allow food manufacturers to sue members of the public for making disparaging comments about their food. Oprah Winfrey was famously sued by a Texas beef company for suggesting that she would no longer eat hamburgers because of the Mad Cow Scare, resulting in lower beef sales. Although the company lost the suit, the high cost of her defense had a chilling effect on other advocates (Kenner, 2008). Food companies avoid stricter regulations and enforcement through the *revolving door,* in which corporate leaders move from their positions with food companies to head the agencies such as the USDA and FDA that are supposed to regulate those companies. This system can lead to *regulatory capture,* wherein the agencies that are supposed to police an industry actually come to advocate for the profitability of those companies instead.

It is also important to remember that by failing to educate ourselves about what is in our food, and allowing the price we see on the fast-food menus and store shelves to guide our choices, we *consent* to the hidden costs of tax subsidies to corporations, increased disease, obesity, animal cruelty, low wages, and environmental damage.

Despite the power and influence of the food industry, there are signs of public *resistance* as groups advocate for regulating and reforming the industry, and develop alternatives to factory farming. Movies such as *Food, Inc.* and *Fed Up* shine a light on the government policies and corporate practices hidden behind the packaging. Many communities are supporting local food by hosting farmers' markets, and allowing urban residents to raise chickens and goats. More people are learning to garden and grow their own food. The Slow Food movement (versus "fast food") is a global network that seeks justice in the food system by advocating for better food policies, as well as by encouraging changes in the way we eat. As Slow Food USA website

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nine what we eat. Popular author and journalist Michael Pol-
(Kenner, 2008), argues that the grocery store gives only the
ecause of massive government spending on corn subsidies for
sses, we have made junk food appear to be very inexpensive.
corn for an artificially low price. As a result, it is difficult to
gh fructose corn syrup. Hidden sweeteners in our food con-
es, and other costly health problems. Cattle eat inexpensive
ich makes the price of meat cheaper at the store but raises the
nation and antibiotic resistance. Livestock raised in concen-
erations produce millions of gallons of liquid manure that run
ls and cause gastrointestinal illness, fatal respiratory illness in
d with miscarriage and developmental defects (Pojda, 2010).
pesticides and face high rates of occupational injury in agri-
atpacking plants. These practices increase profits for the com-
by "externalizing" the costs and risks, which means shifting
payers, workers, consumers, and neighbors.

lations and issue management are central to this system. Food
d officials to maintain government subsidies (that is, govern-
nmodities like corn) (Nestle, 2013). "Veggie libel laws" (food
assed in several states are a good example of this corporate
llow food manufacturers to sue members of the public for mak-
ents about their food. Oprah Winfrey was famously sued by a
r suggesting that she would no longer eat hamburgers because
resulting in lower beef sales. Although the company lost the
her defense had a chilling effect on other advocates (Kenner,
s avoid stricter regulations and enforcement through the *revolv-*
orate leaders move from their positions with food companies to
as the USDA and FDA that are supposed to regulate those
m can lead to *regulatory capture,* wherein the agencies that are
industry actually come to advocate for the profitability of those

t to remember that by failing to educate ourselves about what is
ing the price we see on the fast-food menus and store shelves to
consent to the hidden costs of tax subsidies to corporations,
sity, animal cruelty, low wages, and environmental damage.

r and influence of the food industry, there are signs of public
vocate for regulating and reforming the industry, and develop
farming. Movies such as *Food, Inc.* and *Fed Up* shine a light on
ies and corporate practices hidden behind the packaging. Many
porting local food by hosting farmers' markets, and allowing
se chickens and goats. More people are learning to garden and
The Slow Food movement (versus "fast food") is a global net-
ce in the food system by advocating for better food policies, as
ing changes in the way we eat. As Slow Food USA website
odusa.org/) describes, "A better, cleaner and fairer world begins

with what we put on our plates—and our daily choices determine the future of the environment, economy and society." They add, "If you care about local farmers, ranchers, fishers; animal welfare; the joy of a shared meal; preserving food culture; protecting the environment or avoiding GMOs, we have a place for you at our table." The Equitable Food Initiative (EFI) is a partnership of nonprofits such as Oxfam, agricultural unions, large produce farming operations, and grocery chains such as Costco to create a certification system that guarantees the produce was harvested and packed by workers who have been trained to identify and address potential food safety threats, that workers and consumers are exposed to fewer pesticides, and that workers receive fair wages. The project demonstrates that workers, consumers, and food companies can all benefit from safer food practices that reduce food-borne illness and recalls, and reduce environmental impact.

Earlier in this chapter, we mentioned the Ebola Virus Disease (EVD) epidemic that was declared as a "health emergency of international concern" by the World Health Organization in August 2014. Concentrated in the three West African countries of Sierra Leone, Guinea, and Liberia, the disease has resulted in more than 11,300 deaths (Centers for Disease Control and Prevention, 2016). It is known that bats are carriers of the virus, and at some point, bats entered the food chain in one of the three countries, leading to the human spread of the virus.

While media reporting on the epidemic has focused on the dangers of eating bats and other "bush meat" (a term that technically only means meat that is not recognized as food in mainstream Western cultures), we encourage you to think about the economic aspects of Ebola. Until recently, why were these three countries, despite significant international efforts, unable to effectively prevent, manage, and treat the cases of Ebola? Another way to ask this question is to ask why these particular countries reached epidemic status while neighboring countries like Ivory Coast, Benin, and Mali did not. The lack of adequate public health infrastructure to deal with an epidemic may lie in the economic arrangements in the affected countries. It is common knowledge that underdeveloped countries in Africa receive aid and financial support from the United Nations (UN) and the World Bank (WB). Why, then, were these countries unable to effectively apply quarantine and prevention measures to isolate the virus, as was done in the United States, Spain, and other countries?

Resource-poor countries like those in West Africa have historically depended on loans and financial support from Western countries and international organizations like the World Bank, the World Trade Organization (WTO), the International Monetary Fund (IMF), as well as influential governmental organizations like the United States Agency for International Development (USAID). These organizations provided huge loans to impoverished nations, in the name of "developing" their economies. However, these loans come at a high cost, often accompanied by the condition that they be used to develop markets, private enterprise, and free trade at the cost of public infrastructure like hospitals, clinics, and schools. Recipient countries are required to reduce spending on public infrastructure in favor of repayment of interest on the loan, often with devastating consequences on health. These *neoliberal* economic policies promoting deregulation, austerity (minimal government spending on public goods), and privatization (the transfer of public functions

Medical anthropologist and physician Paul Farmer described how neoliberal economic policies in Haiti exacerbated the economic deprivation of poor Haitians, making them more vulnerable to contracting HIV/AIDS (Farmer, 2006). The construction of large hydroelectric dams in central Haiti flooded several villages there and displaced hundreds of indigenous Haitians. In Haiti, as in many underdeveloped countries, basic infrastructure like continuous electricity is not guaranteed. Hydroelectric energy (tapped by damming major waterways) has commonly been used by international agencies in the developing world. As it turns out, the lucrative contracts for these dams were awarded to private Western construction companies who then instituted local offices and branches in Haiti, hiring engineers, laborers, and other local employees. Hydroelectric dams require large reservoirs of stored water, which, in Haiti, were created over existing agricultural villages.

Forced out of their lands, which were now inundated by the reservoir, many rural Haitians had to leave and go to urban centers to survive. But jobs were not easy to come by, and some Haitians had no recourse but to take to sex work in order to sustain themselves and their families, putting them at higher risk for HIV/AIDS. Here, an infrastructural project purportedly undertaken for the development of Haiti ended up ravaging the health of large sections of its population. Activists seek to put these development policy issues on the public health agenda and question whose voices are heard in the formation of these policies and whose definition of development is applied.

We now turn to the role of health politics closer to home: the much-debated history of medical care reform in the United States.

Politics and Communicating Medical Care Reform

Since Congress passed the Affordable Care Act (ACA) or "Obamacare" into law in 2011, it has become the focus of attention of all health policy-related discussions in the United States. Its proponents have endorsed it, given that the U.S. is the only developed country without universal health coverage, whereas opponents have consistently tried to repeal it. A political commercial paid for by a group called "Generation Opportunity" urges young college-age students to "opt out of Obamacare." The commercial opens with a typical scene: a young woman going in for a regular check-up at an obstetric/gynecologic (Ob/Gyn) clinic. The nurse notices that she has "signed up for Obamacare" and asks her to change into a gown and wait for the doctor. The doctor asks a few routine questions and then prepares the patient for a vaginal exam, saying, "Okay, let's take a look." However, instead of proceeding to examine the patient, the doctor leaves the room. The patient is confused by this turn of events, when suddenly, she sees an oversized, caricatured Uncle Sam emerge from under the stirrups. As the patient screams in shock, the commercial cuts to text that reads: "Don't let the government play doctor." The commercial ends with cutting back to Uncle Sam, complete with eerie grin and speculum in hand, followed by the message, "Opt out of Obamacare."

Critics of Obamacare have propagated the idea that medicine is a "private" transaction between doctor and patient, and this commercial suggests that the government is now literally interested in the citizen's private parts. This sort of childish (and rather patriarchal) depiction of the government's role in health has been the most prominent mode of public debate around

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The U.S. Healthcare Systen

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Americans often tout our reputation for having "the best healthcare in the world." The U.S. does provide innovative, life-saving interventions. However, high costs, uneven access, and medical mistakes contribute to the U.S. ranking poorly compared with the healthcare systems of other nations. The "healthcare trilemma" (Conrad & McIntush, 2003) involves managing trade-offs among cost, access, and quality. From a communication perspective, arguments about reform tend to emphasize different parts of that equation.

The U.S. Healthcare System

The Affordable Care Act (ACA) requires that individuals have health insurance coverage. Thus the U.S. medical care system is a mix of private (nongovernmental) and public (governmental) options. Private insurance may be self-financed but is often offered through the workplace. Congress offers employers tax breaks (public money) to offer health insurance to employees (Morone & Ehlke, 2013). Public financing includes Medicaid for a percentage of low-income people, Medicare for the elderly, and state-by-state Child Health Insurance Programs. The U.S. also has a patchwork of public hospitals and clinics that provide some treatment for low-income and uninsured individuals.

Data generally show that although the U.S. has the highest per capita spending on healthcare, it has poor health outcomes compared with other economically developed countries. In 2014, we spent roughly 17% of our Gross Domestic Product (GDP), or about $8,895 per person on healthcare, and our life expectancy was 78.7 years. Hong Kong, by contrast, spent 5.3% of its GDP ($1,944 per person), and its life expectancy was 83.5 years. Japan spent 10.2% of its GDP or $4,752 and had an 83-year life expectancy and universal health coverage (Bloomberg Best [and Worst], n.d.a).

In 2010, prior to the ACA, 48.2 million adult Americans were uninsured, or roughly 18% of the adult population (Ward, Clarke, Freeman, & Schiller, 2015). Lack of insurance was most common among young adults. Over the last two decades, employers have been reducing benefits and employing part-time and temporary workers who do not qualify for employer-based insurance (Kaiser Commission on Medicaid and the Uninsured, 2010 in Weitz, 2013). Prior to the ACA, insurance companies could deny coverage to people with preexisting illnesses or other conditions. Estimates suggest that roughly 25 million Americans were underinsured, not having enough coverage to pay for their medical expenses (Weitz, 2013).

A lack of health insurance leads to a lack of preventive care, which creates increased costs for more advanced problems in emergency care. Approximately 18,000 deaths each year can be attributed to insufficient or no care due to lack of insurance (Morone, Litman, & Robins, 2008). Lacking insurance also leads to loss of work days and jobs, bankruptcy, and homelessness. In 2005, researchers found that at least 46% of bankruptcy filings were triggered by healthcare bills (about 2 million medical bankruptcies each year) (Himmelstein, Warren, Thorne, & Woolhandler, 2005). Of those who filed for bankruptcy, 56% were classified as middle class. In a process called *rescission*, many people diagnosed with illness found their insurance company cancelled their coverage or refused to pay for treatment based on minor discrepancies in paperwork or because prior illnesses were determined to be a ing condition." For

> The day before she was scheduled to undergo a double mastectomy for invasive breast cancer, Robin Beaton's health insurance company informed her that she was "red flagged," and they wouldn't pay for her surgery. The hospital wanted a $30,000 deposit before they would move forward. Beaton had no choice but to forgo the life-saving surgery. She had never missed a payment, but that didn't matter. Blue Cross cited two earlier, unrelated conditions that she hadn't reported to them when signing up—acne and a fast beating heart—and rescinded her policy. (Potter, 2009a)

Ms. Robin Beaton at a press conference after her surgery and insurance cancellations. (Image source: https://flic.kr/p/6Mttf3)

In addition to access and cost, quality is another important piece of the healthcare trilemma. The Institute of Medicine estimated that 44,000 to 98,000 people die annually from medical errors (cited on "How Common Are," 2016), although others put the number much higher at 225,000 deaths per year (Starfield, 2000). Hospital infection rates may be as high as 2 million cases per year. Prescription drugs save lives, but they can also be dangerous. Between 1969 and 2002, 75 drugs were removed from market for safety reasons (Egilman & Ardolino, 2010). Research techniques frequently underreport side effects and overreport potential benefits (Egilman & Ardolino). These numbers remind us that *more* care is not always *better* care. As we will discuss, these statistics are important when we consider how different healthcare reform proposals address the "trilemma" of cost, access, and quality healthcare. Next, we discuss some of these healthcare reform debates.

History of U.S. Reform Attempts

There have been many attempts to reform U.S. healthcare. Each attempt shows us how different interest groups have framed the debates and negotiated the policy process.

- In 1912, presidential candidate Theodore Roosevelt proposed national health insurance.
- In 1942, President Franklin Roosevelt supported national health insurance

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S. Reform Attempts

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presidential candidate Theodore Roosevelt proposed national health

President Franklin Roosevelt supported national health insurance ocial Security (to ward off calls for socialism) (Weitz, 2013). Fearing

that health insurance would jeopardize social security, he did not strongly endorse the proposal (Marmor, 2000).

- In 1943, the Murray-Wagner-Dingell bill proposed a comprehensive insurance system. Congress refused to hold hearings on the bill. President Truman shifted his attention to coverage for the aged population (Medicare).

The American Medical Association played a major role in defeating these proposals, due to concerns that national programs would reduce incomes or autonomy for its physician members (Weitz, 2013). Some labor unions such as the American Federation of Labor also opposed national health insurance because offering insurance was a major benefit of joining a union. Conservatives equated national insurance with socialism (and later communism), and the growth in access to Blue Cross and Blue Shield insurance in the 1930s meant middle-class people who were covered were not motivated to create a national plan.

- In 1964, President Lyndon Johnson campaigned on health issues. Medicare (elderly) and Medicaid (percentage of the poor) legislation passed in 1965, accompanied by massive Democratic victories in Congress, despite the efforts of hospital and physician groups.
- In 1993, President Bill Clinton proposed the Health Care Security Act. The proposal maintained private insurance and private medical care but created purchasing options for lower-cost insurance. The insurance and pharmaceutical industries along with many large employers lobbied hard against the program, fearing it would affect their profits. The groups outspent supporters four to one (Weitz, 2013) and used growing fears of "big government" to defeat the plan.

You can see from this discussion that a number of different groups play a role in healthcare reform debates. Figure 12.1 lists some of these groups. As we describe the policy process, consider the stake that these groups have in different proposals.

The following organizations represent groups with a significant stake in healthcare reform policies and often seek to influence debates about the issue:

- The American Medical Association represents physicians.
- The American Hospital Association, Federation of American Hospitals, and other groups represent hospital interests.
- The Pharmaceutical Research and Manufacturers of America (PhRMA) is the lobbying arm for the pharmaceutical industry.
- American Health Insurance Providers (AHIP) is a lobbying and advocacy group for the health insurance industry.
- Big business has a number of associations that participate in healthcare debates, such as the Chamber of Commerce, Business Roundtable, and the American Legislative Exchange Council.
- Patients and healthcare consumers are represented through smaller, often fragmented organizations, such as American Association for Retired Persons, Families USA, Public Citizen, and other advocacy groups.

Figure 12.1 Interest Groups

Communication and the U.S. Policy Process

Morone and Ehlke (2013) describe four stages of the governmental policy process: (1) agenda setting, (2) policy formation, (3) policy adoption, and (4) policy implementation. Strategic and everyday discourses interact at each stage to influence the possibilities for medical care reform.

Agenda setting involves gaining enough attention for an issue to create policy debates. Agenda setting determines which issues are debated and brought into the realm of policy making and which go unaddressed. For example, medical care reform often receives more attention than public health spending unless the public is concerned about the spread of a high-profile contagious disease.

From a communication perspective, agenda setting is not only about which issues get discussed, but also *how* they are talked about. *Framing,* or providing interpretive "structures that render events and occurrences subjectively meaningful, and thereby function to organize experience and guide action" (Snow & Lessor, 2010, p. 285), is powerful because it influences how discourses are understood. For example, opponents of universal healthcare coverage often framed the U.S. system as "the best medical care system in the world," which obscured problems in an effort to persuade the public that no reform was needed. Opponents also framed healthcare reform as expensive, something that we cannot afford given our rising deficit. Prior to the passage of Obamacare, *proponents* of healthcare reform framed the need for healthcare reform by comparing the amount of money the U.S. was spending on the Iraq war ($12 billion per month in 2008 according to the *Huffington Post*; see Hanley, 2008) versus what it would spend insuring all Americans. They also framed healthcare reform as "deficit-reducing" because it would control healthcare costs and increase preventive care.

Problem definition is a key means of influencing the policy agenda. Often, problems are defined and communicated in ways that fit the solutions interest groups already want to promote (Conrad & McIntush, 2003). For example, you've probably heard of Health Maintenance Organizations (HMOs). Advocates first promoted the use of "gatekeeper" physicians in HMOs to solve the problem of overseeing medical quality, and then as public priorities shifted to concerns about healthcare costs, they promoted HMOs to solve the problem of medical cost overruns. Other examples:

- Insurance companies discuss the problem of high costs from medical providers, but rarely address the problem of access to health insurance.
- Physicians groups tend to promote the problem of access to care rather than cost. When physicians do address the problem of medical costs, they blame them on the rising price of malpractice insurance. The American Medical Association's (AMA) solution proposes limiting consumers' ability to sue caregivers (tort reform).
- Groups who advocate for universal healthcare coverage often define wasteful duplication and bureaucracy of our mixed public and private system as the problem, and propose government negotiation of healthcare costs (sometimes called a Single Payer system) in order to reduce overhead costs and create universal access to care.

Groups often use *narratives* to influence the policy agenda. Proponents of reform

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the U.S. Policy Process

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services. During the debates over the ACA, commercials by those opposed to reform highlighted problems in the Canadian medical system. Stories are powerful because they give us a personal and emotional connection to the issue (Sharf, Harter, Yamasaki, & Haidet, 2011).

Policy formation is the process through which solutions are defined and policies written and introduced into the legislative process. Although elected officials introduce legislation in Congress and in state legislatures, policies are formed through a process of negotiation among political parties and interest groups.

When different plans are introduced, proponents and opponents seek to frame the legislation for the public. Groups who successfully frame policies in ways that resonate with dominant social values have an advantage in policy debates. For example, the ACA requires that everyone be covered by health insurance or pay a fine. (The plan requires that businesses with more than 50 employees offer insurance, creates health exchanges to buy private insurance at more affordable prices, and expands access to Medicaid for low-income citizens.) The *mandate* requiring insurance coverage was (and remains) a hot political topic during debates. Republicans and other opponents framed the mandate as government intrusion into the public's lives. Interestingly, when Republicans proposed an individual healthcare mandate in 1993, it was framed in terms of the need to require individuals to take personal responsibility to get coverage (Roy, 2012).

Naming and word choice are central to policy formation debates. Proponents of comprehensive medical care reform such as Physicians for a National Health Plan describe their Canadian-style proposal, in which the government sets prices as the single purchaser of healthcare, as "single payer" whereas critics use the label "socialized medicine." (A single-payer system does have a significant government role, but it is not socialized medicine. Although healthcare payments come from the government, healthcare is delivered through the private sector.) Indeed, the term "socialized medicine" is now used for almost any attempt to reform healthcare.

These buzzwords are an example of what Richard Weaver called *ultimate terms*, which include *god terms*—those terms that merit the highest cultural respect and often go unquestioned—and *devil terms*—those terms that merit cultural revulsion. "Choice" is a god term often used to ensure that any plan must promote consumer choice of physicians. Other god terms may include "efficiency" and "free market." The name of President Obama's plan—"The Patient Protection and Affordable Care Act"—includes god terms like "protection" and "affordable." It is difficult to argue against affordability, for example.

Devil terms like "socialism" and "communism" have long plagued attempts to provide national health insurance in the U.S. "Government-run" healthcare was often used as a devil term in debates about the Affordable Care Act. Wendell Potter, the former vice president of communication at Cigna Insurance, shared a memo with journalist Bill Moyer:

> I have a memo written by Frank Luntz who we discovered, in the spring, has written the script for opponents of healthcare reform. "First," he says, "you have to pretend to support it. Then use phrases like, 'government takeover,' 'delayed care is denied care,' 'consequences of rationing,' 'bureaucrats...

These terms are designed to short-circuit thoughtful debate and create negative impressions for the public. For example, the devil term "rationing" sounds like a threat to our access to care. This is a fallacy, however, because all care is rationed in some way (in the U.S., we ration care by ability to pay).

Although it was played for laughs, late night television host Jimmy Kimmel highlighted the importance of terminology when he interviewed people on the street, many of whom said they supported the Affordable Care Act but not Obamacare. Some people knew they were the same thing, but many people shown had a preference for one or the other.

Policy adoption entails Congressional lawmaking. Public debate may influence this process, as does interest group lobbying and other strategies. *Corporate lobbying, political donations,* and *advertising* play a significant role in which legislation is passed, particularly in the wake of the Citizens United vs. the Federal Election Commission decision that allows for unlimited corporate donations to political candidates. CNN estimated that groups spent $600 million on lobbying, campaign contributions, and television ads in 2008, with $400 million of that coming from the healthcare industry (Liberto, 2009). In addition, AHIP, the health insurance lobby, gave the U.S. Chamber of Commerce more than $86 million in 2009 to oppose the legislation on their behalf without disclosing the source (Armstrong, 2010). Among Democrats, those individuals that opposed the public option in the Patient Protection and Affordable Care Act received the largest political donations from insurance companies (Renick Mayer, 2009).

Many well-funded industry groups know that the public will mistrust information they provide because it appears biased. So instead, they promote their viewpoints using *front groups*: apparently neutral research or advocacy groups that actually serve some other interest, whose sponsorship is hidden.

- Wendell Potter (former vice president of communications for Cigna Insurance) described the Healthcare Leadership Council as a front group for the insurance industry that sought to defeat reform (Potter, 2009b). The group lobbied members of Congress, providing talking points to elected officials and conservative talk show hosts and editorial page editors.
- The Center for Medicine in the Public Interest also sought to prevent healthcare reform. Although it sounds like a consumer group, it is a project of the Pacific Research Institution, itself a front group that Philip Morris used to create academic support for the tobacco industry (Fang, 2009).
- The National Federation of Independent Business (NFIB) appears to represent small business. However, it lobbies for issues that serve the interests of larger corporations, and it receives millions in contributions from large corporate interests without revealing these sources (Center for Media and Democracy, n.d.b).

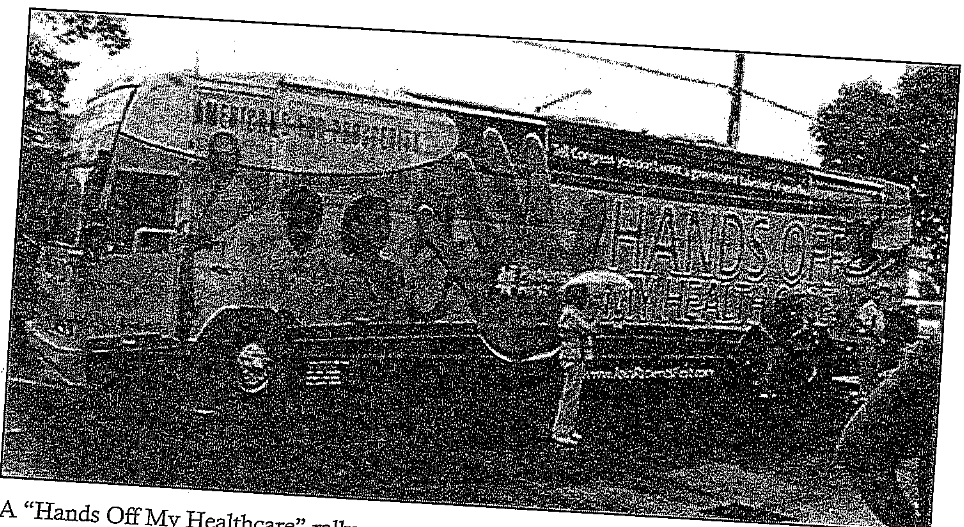
Astroturf is paid corporate PR that appears to be grassroots organizing. In other words, groups are funded and formed by corporate interests but appear to be everyday citizens who care enough to express their views through protest. For example, many advertisements during the most recent healthcare debate were aired in the name of groups like "Patients United Now," which sounds like a patient advocacy group but was actually funded by Americans for Prosperity, an organization led by the heads of

A "Hands Off My Healthcare"

designed to short-circuit thoughtful debate and create negative impres-
blic. For example, the devil term "rationing" sounds like a threat to our
This is a fallacy, however, because all care is rationed in some way (in
ion care by ability to pay).
t was played for laughs, late night television host Jimmy Kimmel high-
portance of terminology when he interviewed people on the street,
n said they supported the Affordable Care Act but not Obamacare.
new they were the same thing, but many people shown had a prefer-
the other.
tion entails Congressional lawmaking. Public debate may influence this
s interest group lobbying and other strategies. *Corporate lobbying, political*
advertising play a significant role in which legislation is passed, particu-
ke of the Citizens United vs. the Federal Election Commission decision
unlimited corporate donations to political candidates. CNN estimated
ent $600 million on lobbying, campaign contributions, and television
ith $400 million of that coming from the healthcare industry (Liberto,
ion, AHIP, the health insurance lobby, gave the U.S. Chamber of Com-
an $86 million in 2009 to oppose the legislation on their behalf without
source (Armstrong, 2010). Among Democrats, those individuals that
ublic option in the Patient Protection and Affordable Care Act received
tical donations from insurance companies (Renick Mayer, 2009).
l-funded industry groups know that the public will mistrust information
because it appears biased. So instead, they promote their viewpoints
ups: apparently neutral research or advocacy groups that actually serve
terest, whose sponsorship is hidden.
l Potter (former vice president of communications for Cigna Insurance)
ed the Healthcare Leadership Council as a front group for the insurance
y that sought to defeat reform (Potter, 2009b). The group lobbied mem-
Congress, providing talking points to elected officials and conservative
ow hosts and editorial page editors.
enter for Medicine in the Public Interest also sought to prevent healthcare
. Although it sounds like a consumer group, it is a project of the Pacific
ch Institution, itself a front group that Philip Morris used to create aca-
support for the tobacco industry (Fang, 2009).
ational Federation of Independent Business (NFIB) appears to represent
business. However, it lobbies for issues that serve the interests of larger
ations, and it receives millions in contributions from large corporate inter-
ithout revealing these sources (Center for Media and Democracy, n.d.b).
is paid corporate PR that appears to be grassroots organizing. In other
ps are funded and formed by corporate interests but appear to be everyday
 care enough to express their views through protest. For example, many
nts during the most recent healthcare debate were aired in the name of
Patients United Now," which sounds like a patient advocacy group but
funded by Americans for Prosperity, an organization led by the heads of

for by Americans for Prosperity. But they appeared to be just angry citizens who chose to protest at representatives' town hall meetings (Center for Media and Democracy, n.d.c).

Protestors against the ACA sometimes held signs reading "Hands Off My Healthcare." These signs framed healthcare reform as unnecessary government intervention. Notice what this draws our attention to, and what it draws our attention away from. For example, "our healthcare" assumes that viewers have health insurance coverage and would continue to do so, despite rising costs. It also draws our attention away from the control of our healthcare by health insurance companies and medical providers.



A "Hands Off My Healthcare" rally.

The *implementation* step often receives less attention, but it is a key phase where governmental departments write and enforce rules. For example, in the United States, the AMA fought against the creation of Medicaid in 1965 by labeling it socialized medicine. During implementation, however, the AMA negotiated highly lucrative "standard fees" for physicians (http://kff.org/health-reform/issue-brief/national-health-insurance-a-brief-history-of/), meaning that healthcare providers themselves set the prices with little oversight, and were paid by public dollars. The Hill Burton Hospital Survey and Construction Act in 1946 provided $12 billion to fund hospital construction. Although liberals in Congress included a requirement that these hospitals treat people who could not afford to pay, this requirement was never enforced (Morone & Ehlke, 2013).

The New York Times reported that after the passage of the Affordable Care Act in 2010, health insurance companies shifted from trying to defeat the legislation to lobbying federal and state officials over how it would be implemented. In particular, they wanted to avoid regulation of premium costs and profits

sions require rules of enforcement; for example, one provision bars insurance companies from unreasonable premium increases without justifications to regulators, but does not define unreasonable.

This is the stage where laws are put into practice. Implementation for the ACA has been uneven. The rollout of healthcare.gov, the website used to enroll in a health insurance exchange, was stymied by major technical problems so that the deadline for enrolling had to be pushed back. However, the required number of people did eventually enroll. At the time of this writing, 17 states have refused federal money to expand access to Medicaid, barring affordable healthcare coverage for thousands of qualified citizens ("Where States Stand," 2016). In 2014, Freedomworks and Americans for Prosperity ran ads persuading the public not to get covered by highlighting citizens who claimed to have increased costs or lost coverage under the ACA (fact-checkers showed that most people telling their stories actually saved money under the ACA). Generational Opportunity, also funded by the Koch brothers, launched a campaign to discourage college students from gaining insurance through the exchanges. In addition to the Uncle Sam ad described earlier, they rolled out parties on campus with games, pizza, and free giveaways, where organizers asked college students to sign a pledge that they would not enroll in insurance through "Obamacare" (Moody, 2013).

Debate during ACA passage has led to a great deal of confusion about the law. In 2015, a significant number of people opposed Obamacare and were unaware that they were enrolled in the program through their state exchange, and were happy with their insurance. State governors who created the exchanges through which insurance is purchased have sought to hide the connection and take credit for the insurance program. These debates are so heavily influenced by interest groups that they often distract us from some very basic questions: How should we distribute healthcare? Should healthcare be distributed by the ability to pay? Is it a public right? Is it a public good that we should promote? See how well you know the ACA in Theorizing Practice 12.3.

Theorizing Practice 12.3
How Well Do YOU Know the Affordable Care Act (ACA)?

Take the following quiz, using items adapted from the Henry J. Kaiser Family Foundation (http://kff.org/quiz/health-reform-quiz/):

1. Does the health reform law require nearly all Americans to have health insurance or else pay a fine?
2. Does the health reform law establish a government panel to make decisions about end-of-life care for people on Medicare?
3. Does the health reform law give states the option of expanding their existing Medicaid program to cover more low-income, uninsured adults?
4. Does the health reform law allow undocumented immigrants to receive financial help from the government to buy health insurance?
5. Does the health reform law increase the Medicare payroll tax on earnings for upper income Americans?

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9. Does the health reform law cre
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Answers: 1. Yes, 2. No, 3. Yes, 4. No, 5. Yes, 6.
The Kaiser Family Foundation also has a h
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Conclusion

The political complexities c
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reform law increase the Medicare payroll tax on earnings for upper
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6. Does the health reform law require employers with 50 or more employees to pay a fine if they don't offer health insurance?
7. Does the health reform law provide financial help to low- and moderate-income Americans who don't get insurance through their jobs to help them purchase coverage?
8. Has the health reform law created a government-run insurance plan to be offered along with private plans?
9. Does the health reform law create health insurance exchanges or marketplaces where small businesses and people who don't get coverage through their employers can shop for insurance and compare prices and benefits?

Answers: 1. Yes, 2. No, 3. Yes, 4. No, 5. Yes, 6. Yes, 7. Yes, 8. No, 9. Yes
The Kaiser Family Foundation also has a helpful video that explains the law: http://kff.org/health-reform/video/youtoons-obamacare-video/

Conclusion

The political complexities of public health and medical encounters also include many other issues, including the rise of the AMA and the regulation of competition among caregivers, patients' rights issues such as right-to-die controversies, and debates about technology and wrongful birth. Medical research has been marked by a history of racism, sexism, and nationalism, and there are ongoing concerns that these biases may influence debates about how to manage genetic testing and interventions. As this chapter has demonstrated, in everyday interactions, institutional settings, and policy making, communication constitutes public perceptions of health, illness, and ideal social relations in ways that profoundly influence how we organize and address health issues. The politics of health play out through the communicative construction of knowledge regarding how to achieve health and manage illness, access decision making, and have a voice in the policy process.

Discussion Questions

1. Are you concerned about environmental sources of illness? If so, how does that affect your behavior? If you found that an organization was polluting your neighborhood with potential carcinogens, what would you do? Do you believe the government does too much, too little, or about the right amount to regulate polluters? Should companies adopt more environmentally sustainable practices voluntarily?
2. Consider a diagnosis such as attention deficit disorder. Do you think we are diagnosing too many children with this label? Or, do children benefit from the diagnosis? Should we address problems by making changes, such as reducing class sizes allowing more time for physical activity at school, or by using medication?
3. Should soda companies and others who sell highly sugary foods have responsibility to pay for medical care costs due to obesity, diabetes, and other resulting health problems?
4. We discussed the political-economic basis of the Ebola epidemic. Can you describe

5. Is some level of healthcare a basic right of all humans? Is providing healthcare to all citizens a sign of a strong nation or an intrusive government? Or, do you believe that healthcare should be distributed by the ability to pay? Do you think that insurance companies, hospitals, and other healthcare providers should operate as for-profit or not-for-profit institutions?
6. Do you find it difficult to talk with people who have different positions from yours regarding healthcare? How have your own experiences with healthcare (for example, whether you have always had insurance coverage, whether your family experienced any major illnesses or injuries, whether your family is middle-class or working two jobs to get by?) influenced your position on healthcare reform? Consider talking with someone who has had very different healthcare experiences. How have those experiences shaped his/her political positions?

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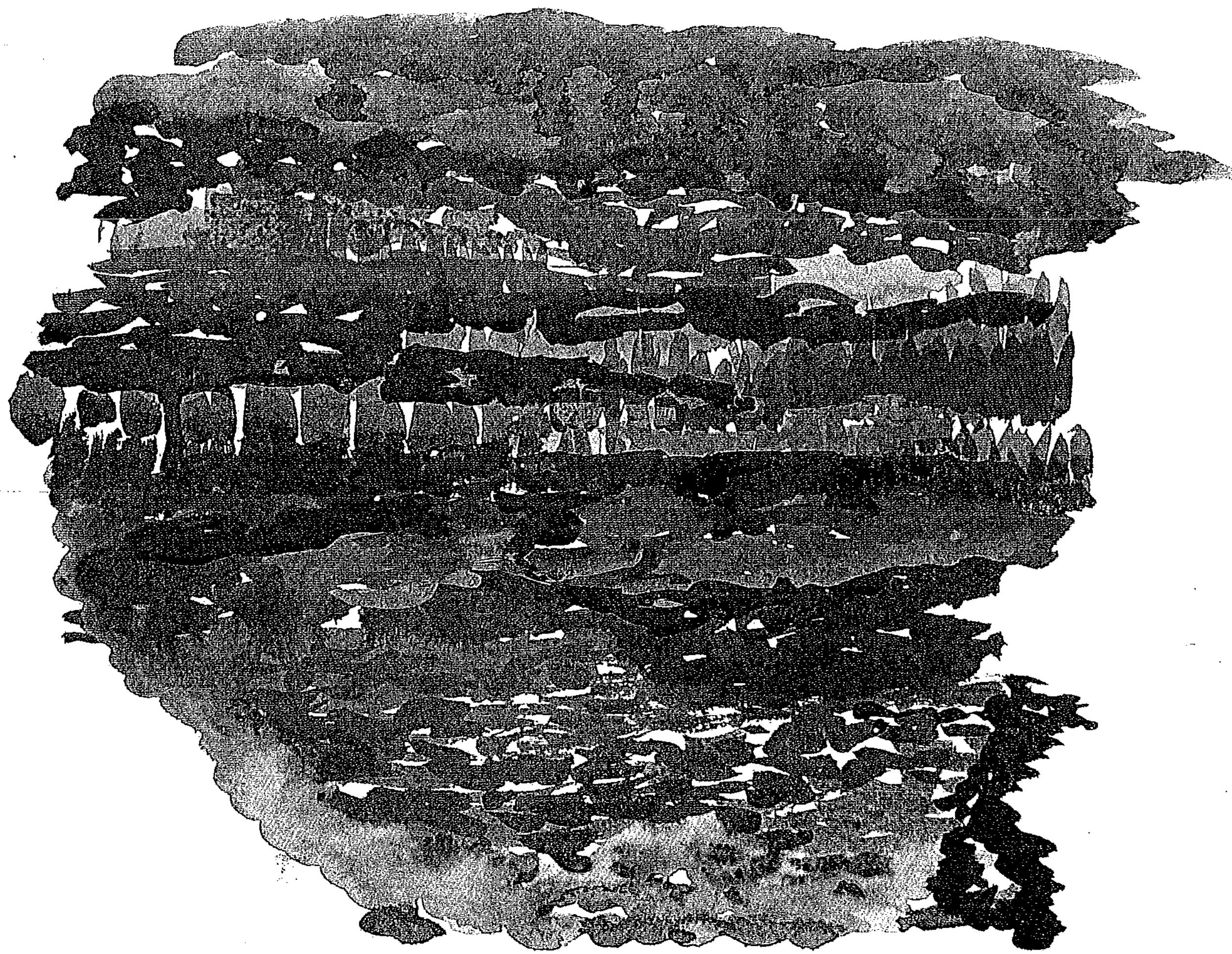

Jill Yamasaki
Patricia Geist-Martin
Barbara F. Sharf