RESPONSIBILITY FOR HEALTH CARE: AUTOWORKERS AND MORALLY LEGITIMATE CLAIMS TO HEALTH INSURANCE AT A TIME OF COMPANY RESTRUCTURING, ECONOMIC CRISIS, AND HEALTH REFORM IN THE UNITED STATES

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ABSTRACT

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Employer-sponsored health insurance is the leading source of health insurance for non-elderly Americans, reflecting a historical tendency in the United States for health coverage to be accessed through employment. Over the past 65 years, General Motors autoworkers have had access to increasingly comprehensive health insurance plans, which have set the standard for employer-based health coverage in the United States. However, as part of GM's 2009 bankruptcy and restructuring measures, GM and the United Auto Workers (UAW) union agreed to cuts to coverage, illustrating not only the strain of the financial crisis on auto industry employees, but also hinting at larger shifts within the American economy, whereby millions of newly unemployed were loosing their health insurance altogether. The financial crisis also coincided with the passing of the Affordable Care Act (ACA). This dissertation explores GM workers' ideas about health insurance within the context of these economic and political circumstances. Specifically, it examines the ways in which GM employees were constructing ideas of merit and responsibility for health insurance at a time in which popular assumptions about the responsibilities of the individual, the employer, and the state, in the provision of health insurance, were being challenged by the material realities of economic instability, and debate surrounding health reform and the ACA.

This study is set at two General Motors manufacturing plants in mid-Michigan, from 2009 to 2011, following the company's restructuring, and the passage of health reform. Using qualitative methods of semi-structured interviewing and participant observation, as well as discourse analysis of the ACA, this dissertation examines emerging health policy, and the opinions of production workers and managers to understand: 1) notions of deservedness, or moral worthiness, for health insurance; 2) how conflicting ideas about responsibility and merit for health insurance are expressed; and 3) the ways that ideas regarding responsibility for health insurance are manifested in emerging health care policy. I found that for those interviewed, there was an insistence that deservedness for, and morally legitimate claims to, health insurance, are predicated on one's ability, or willingness, to work. I argue that this reflects not only the structure of employer-sponsored benefits at GM, but also neoliberal understandings of the self and of the state. I further illustrate that participants viewed the individual as responsible for the provision of health insurance, with employers and the state acting as facilitators or regulators of this access. I argue that the ACA reinforces this configuration of responsibilities, reaffirming the role of the individual and the employer in the provision of insurance coverage, while simultaneously divesting the state of the bulk of the responsibility for health insurance. Ultimately, this dissertation shows that, combined, an insistence on the importance of work as a prerequisite to morally legitimate claims to health insurance, the perception that health insurance is an individual responsibility, and the ACA's reinforcement of the individual and the employer as the primary bearers of responsibility for health insurance, further strengthen and normalize the link between health insurance and employment in the United States.

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CHAPTER 1: INTRODUCTION

Maps for and of Health Care Systems

In 2004, I moved from Canada to the United States to begin graduate studies in a small Midwestern city. I chose to study there because I was intrigued by the idea of a country as wealthy as the United States that effectively denied certain segments of its population basic needs such as health care. As a Canadian, I had spent most of my life fully immersed in a medical system that seeks to make health care universally accessible to the country's residents. Canada's National Health Insurance is a taxpayer-funded hospital and medical insurance program. The law that establishes the public system is collectivist in spirit, and strives to ensure that all Canadians, regardless of income, have access to medical care. "Universality", or the requirement that all residents have the same access as everybody else to health care, is among the five key principles that form the framework for the Canada Health Act (Canada Health Act 1984). Although it has, in recent years, been criticized for inadequate funding, doctor shortages, and long wait times for medical procedures, the public health care system remains popular among Canadians (Reid 2009). In fact, it remains a dominant theme in the cultural identity of Canadians; in 2004, they (overwhelmingly) voted Tommy Douglas, the founder of Canadian Medicare, the winner in the national broadcaster's country-wide contest for the "Greatest Canadian" (Canadian Broadcasting Corporation 2014).

As Kleinman (1980) notes, a health care system meets Geertz's (1973: 3-30) definition of a cultural system: it is both a map "for" and "of" a special area of human behavior (p. 26). It was with a collectivist, universally-oriented map "for" and "of" a

health care system that I moved from Canada to the United States. This dissertation is inspired by the differences in the maps of the Canadian and American health care systems, which slowly became visible to me as I lived and conducted fieldwork in Michigan. It is not a comparison of the cultural dimensions of the two health care systems; rather, it is an interrogation of the cultural assumptions that inform the Unites States health care system. However, because I come to this research with a particular set of assumptions regarding health care that are deeply ingrained, they necessarily inform my inquiry, inspire the questions I ask, and to a certain extent, influence my perspective on the results of my research. As such, they require acknowledgement.

When I moved to Michigan in 2004, I had wanted to examine migrant Mexican laborers' access to health care. In my mind, these workers epitomized a paradox that I found perplexing: people within the United States borders who, due to their specific circumstance, did not have consistent, systematic access to adequate health care. This lack of guaranteed medical treatment seemed random and capricious, and – to someone who had only experienced a universal public system – outrageous and exotic. After a few months living in Michigan, however, I began to understand that this lack of access to health care was not limited to a specific subpopulation, and that lack of health insurance, and being underinsured, were problems that spanned the entire United States population. Migrant Mexican workers do, indeed, face specific obstacles in attempting to seek health care (Azevedo and Hilda in Aguirre-Molina, Molina, and Zambrana 2001; Chavez, Flores, and Lopez-Garza 1992; Montemayor 2014; Quesada, Hart, and Bourgois 2011), however, they represent a subgroup of a much larger population of uninsured. In 2004, when I moved to the United States, 45.8 million Americans were uninsured (Department

of Health and Human Services 2005); by 2013, that number stood at 41 million (Kaiser Family Foundation (KFF) 2014a). In 2007, 25 million Americans were underinsured – inadequately covered because of high cost sharing or limits on coverage – ultimately leading to similar outcomes associated with lack of insurance: the postponement of medical care and medical debt (KFF 2002; Schoen, Collins, Kriss, and Doty 2008). I quickly learned that I was surrounded by people who did not have adequate - or any - health insurance. As I wrote this in 2014, even after the implementation of key health reform provisions designed to expand insurance coverage, lack of health insurance remained a challenge faced by millions of Americans, with racial and ethnic minorities overrepresented on the rolls of the underinsured and uninsured (Hunt, Kreiner, and Rodriguez-Mejia 2013; KFF 2014a).

I began my fieldwork in June 2009, a time of tremendous economic upheaval in the United States. The country was 18 months into a recession that had also triggered fiscal problems on a worldwide scale. In September 2008, President Bush declared that the country was "in the midst of a serious financial crisis" (The White House 2008: 575). The economic, social, and cultural developments surrounding the recession helped frame my inquiry into health insurance in the United States. As banks and corporations teetered on the brink of failure, as thousands of Americans lost jobs, and as the housing market failed, the economic crisis challenged popularly held assumptions in the United States about the capacity of unregulated markets to adequately meet the needs of the country's citizenry. In response to this fiscal crisis, the American state intervened in unprecedented ways, taking dramatic action in the regulation of private industry, infusing billions of dollars into the financial sector, taking partial ownership of publicly traded financial

institutions, and requesting the resignation of the CEO of one of the country's largest private employers, General Motors. The boundaries that delineated the responsibilities of the state, the private sector, and the individual in meeting the needs of the country's citizens were in flux.

Understandings of state, business, and individual responsibility are salient in the study of the American health care system. Americans have, traditionally, obtained health insurance through their employer, and although, for the period between 1998 and 2009, fewer Americans were being offered health insurance at work, it remained the primary vehicle through which Americans are insured (KFF 2011); in 2010, employer-sponsored insurance covered approximately 157 million non-elderly Americans (KFF 2010). However, as increasing numbers of Americans lost their jobs during the financial crisis, they were also loosing their health insurance, drawing greater attention to some of the problems inherent in a primarily private, employer-based health insurance model. In 2009, in the lead up to my fieldwork, the newly appointed Obama Administration indicated that health care reform was a priority in its domestic agenda. Heated public and political debate surrounded the passage of health reform, before, during, and after the signing of the bill in the spring of 2010, and at the time of my fieldwork. This dissertation explores ideas about health insurance within the context of these emerging economic and political processes. Specifically, I examine the ways in which a group of General Motors employees were constructing ideas of merit and responsibility for health insurance at a time in which popular assumptions about the responsibilities of the employer, the individual, and the state were being challenged by the material realities of economic instability.

Although this dissertation does not take, as its main focus, the 2010 Patient Protection and Affordable Care Act – or Affordable Care Act (ACA), as it is now most commonly known – the debate surrounding health reform provided an inextricable background to the interviews I conducted. By the summer of 2009, the various manifestations of a reform bill were being hotly debated in town hall meetings and on the airwaves. As I wrote this, in 2014, the constitutionality and legality of the ACA had been challenged repeatedly at the federal and state levels for the past four years, and the October 2013 rollout of the online health insurance exchanges – essentially the vehicle through which millions of Americans will gain access to more affordable health insurance – had been marred with colossal technical difficulties. The implementation of the ACA has been high profile and contentious. Furthermore, the form of the bill was amorphous and constantly shifting in the early stages of my fieldwork, and the autoworkers I interviewed were not all equally informed on the ongoing debate about health reform, nor clear on what health reform might actually look like. Even once it was signed into law, participants were unsure as to how the ACA might affect them, as it was almost impossible to be, at the time, given the Act's various components and staggered implementation timeline. Thus, although the ACA forms an important backdrop to this study, this dissertation is not, in and of itself, about the ACA. This dissertation is about the cultural assumptions, as expressed by a group of Mid-Michigan autoworkers, surrounding the private, employer based health insurance model that so dominates the United States health care system. However, it is impossible to ignore the manifestations, within policy, of concepts of merit and responsibility for health insurance. For example, although the ACA expands eligibility for Medicaid (and thus extends state responsibility

for health insurance to a larger population within the United States), its overarching policy objective of making health insurance more affordable, and more systematically available through the employer, reinforces the private, employer based system through which Americans obtain health insurance, and individual and employer obligations to procure health insurance. I will turn to the ACA, and how it illustrates key themes explored within my analysis of ideas of merit and responsibility for health insurance, in Chapter Five.

This dissertation is set in Lansing, Michigan, the center of health policy making for the state of Michigan, and the site of two manufacturing plants for General Motors, a company that occupies a unique place in the landscape of employer sponsored health insurance in the United States. General Motors' health insurance plans have set the standard for employer sponsored health coverage in the United States for the past 65 years. These plans are considered the benchmark for employer-based health insurance, and changes to GM health coverage suggest possible changes for other corporate and industry related health plans. GM was highly impacted by government intervention during the financial crisis, and has experienced recurring layoffs, as well as the fiscal and administrative challenges inherent in the employer-based health insurance model. Because of their unique relationship with employer-based health insurance (production workers are often described as receiving "Cadillac plans", a term used to describe some of the most comprehensive insurance policies available in the United States), and the scrutiny under which this insurance fell when General Motors was declaring bankruptcy and then restructuring (several categories of employees faced a reduction in health benefits as a direct result of government sponsored restructuring, a topic explored in

Chapter Three), I chose to interview GM production workers and managers about their ideas regarding health insurance. At the time of my fieldwork, Michigan also exhibited one of the highest rates of unemployment in the United States (between 11.7 and 14.3%) (National Conference of State Legislatures 2010), and as such, represented the individual and corporate challenges that have characterized the economic crisis. Laid off production workers were being faced with the possibility of losing their health insurance, and salaried employees were experiencing ever dwindling levels of coverage.

Using qualitative methods of open-ended interviewing and participant observation, this dissertation explores the ways in which workers and managers in the automotive sector construct ideas of merit and deservedness for health insurance. In addition, it explores how they perceive the appropriate roles of the individual, the employer, and the state, in the procurement and the provision of health insurance, at a time when these ideas were in flux, and being challenged by the material realities of economic instability. This project also consists of the discourse analysis of policy portrayals of responsibility and deservedness for health insurance. The specific aims of this dissertation are to examine emerging health policy, and the opinions of auto workers to understand: 1) current and emerging notions of responsibility and merit for health insurance, including constructions of morally legitimate access to health care 2) how conflicting ideas about responsibility and merit for health insurance are expressed and rationalized; and 3) the ways that ideas about responsibility and merit for health insurance are echoed in emerging health care policy, and may reflect American understandings of the self and of the state.

Situated within medical anthropology, this research adopts a critical interpretive approach, and provides a response to Rylko-Bauer and Farmer's (2002) call for anthropologists to make market-based health care a topic of ethnographic enquiry. The impact of a market-based health care system on access to health care in the United States is well-documented by anthropologists (Abraham 1993, Carillo et al 2001, Rylko-Bauer & Farmer 2002, Farmer 1999, Sered & Fernandopulle 2005). However, the *cultural assumptions* that inform private, employer-based health care in the United States have not been well explored. This research provides an anthropological investigation into American attitudes towards market-based health care, with a focus on the construction of ideas of deservedness and responsibility for health insurance.

Exploring ideas about merit and responsibility as they pertain to health insurance serves the following theoretical and practical purposes: It provides insight into the way in which moral responsibility for the provision of health insurance is being understood by a group of Americans – specifically, a set of individuals employed in the auto industry – at a time of economic and corporate restructuring, and in a period in which the relative roles of the individual, the employer, and the state, in insurance provision, are in flux. In addition, it elucidates the ways by which the state, corporations, and the popular media attribute responsibility and merit for the provision of health insurance. This dissertation also provides insight into the nature of the cultural assumptions - as embedded in ideas about health insurance - about the self, employment, and the state, that circulate in American society. In so doing, it provides insight into the process of subject-formation in the United States, and further contributes to scholarly investigations of the way in which the self and the state are defined in western neoliberal society. Furthermore, by

elucidating the cultural assumptions inherent in popular ideas about who bears responsibility for the provision of health insurance, this research contributes to a better understanding of the cultural logic of the American health care system. It provides insight into the cultural resilience of the private, employer-based health insurance system, and thus offers an expanded perspective on reasons for the continued support of a health insurance model that poses economic and health-related problems for millions of Americans. Ultimately, this research contributes to the ongoing dialog on health care reform in the United States.

Merit, Responsibility, and Health

The concepts of merit, deservedness, and responsibility are culturally salient in the United States, and bear particular influence on ideas about health and access to health care. I will elaborate on these concepts in Chapter Two, but I would like to provide an initial clarification of their use within this dissertation from the outset. By "merit", I am referring to one's relative deservedness of a reward or a punishment, whether material or moral. By "deservedness", I am referring to moral worth (Willen 2012). The concepts of merit and deservedness are strongly associated with work and employment in the United States. It is part of the ideology of meritocratic individualism, which suggests that economic success or misfortune is the individual's responsibility (McNamee and Miller 2004). In his analysis of the origins of the rise of modern capitalism, Weber (2002) explains that early Protestant sects in the United States placed greater emphasis on work than on other aspects of human life, and interpreted wealth as an illustration of one's moral worth, providing the early cultural underpinnings for Americans' emphasis on

merit and the association of work with moral value. Merit, as a cultural concept, is deeply rooted in the United States, and continues to manifest itself in contemporary ideas about morality and worth. Responsibility, here, refers to one's duty or obligation, whether legal or moral. Contemporary American approaches to health and health care emphasize individual, as opposed to state, responsibility for ensuring one's health. Key neoliberal values – independence, freedom, entrepreneurship, autonomy, and self-reliance – reinforce this emphasis on individual health management. Donahue and Maguire (1995) note that in the United States, with its marketplace strategy towards health policies, individual responsibility for health is defined in terms of consumer and lifestyle behavior, and the dominant biomedical paradigm presents the causes of disease as individual, rather than social or political-economic in nature. Bearing in mind the cultural salience of the concepts of merit and responsibility, the guiding research question for this study is "How are Americans constructing notions of responsibility and merit for health insurance at a time of national economic crisis?" I explore how a group of autoworkers are defining legitimate access to, and responsibility for, health insurance, and attempt to determine whether these ideas are changing due to the current economic crisis.

Chapter Two provides an in depth discussion of the overall context and relevance, in practical and theoretical terms, of my research. It expands on the history of concepts of merit and deservedness in the United States. It also elaborates on the social, economic, and political context of the research as introduced in this chapter, and explains why the study of ideas about health insurance is timely. It provides a review of the literature relevant to this study – including, but not limited to, health inequalities in the United States, the anthropology of policy, and risk and responsibility for health – and situates

this research within these bodies of literature. It also explains the importance of providing a uniquely anthropological perspective on attitudes towards health insurance, and describes the ways in which this study provides a response to the call, within anthropology, for studies of market-based health care.

Chapter Three focuses on the setting and methodology for my research. It provides an overview of the presence of GM in Lansing, and the industrialization, deindustrialization, and reinvestment in Lansing by the company. This chapter also provides a detailed summary of the history of employee health coverage at GM, from its early introduction as a hard-won benefit by the United Auto Workers to the ever shrinking packages of the company's salaried employees. It also describes the differences between insurance plans at GM, according to employee status. This information provides the necessary background for understanding the shifting context of GM health benefits, and interviewees' ideas about responsibility for health insurance. Finally, this chapter addresses the research methods used for this project, including the sampling strategy, the types of fieldwork conducted, and the methods used for data analysis.

Chapter Four explores one of the key themes that emerged in my analysis of interviewees' ideas about merit and deservedness for health insurance: the importance of "work" in defining legitimate access to health insurance. It examines the various ways in which ideas about work manifest themselves in interviewees' ideas about health insurance, including the assumption that health insurance is not a right but a privilege that is "earned" through paid or volunteer work, and the suggestion that coverage for the newly unemployed should be indexed to the amount of time spent in the workforce. I also explain that the personal work ethic described by employees provides insight into the

salience of work in defining legitimate access to health insurance for those interviewed. This chapter also explores the idea of the deserving and undeserving poor, which finds its roots in eighteenth and nineteenth century Christian responses to poverty and unemployment, and which provides a template onto which interviewees project ideas of merit and deservedness for health insurance. I provide a historical overview of this culturally specific concept, and examples of its application in assessments of legitimate access to health insurance in the view of the autoworkers I interviewed. Furthermore, I examine the role of personal sacrifice, through physically and mentally challenging work on the production line, as well as personal savings and financial planning, in legitimizing one's access to health insurance. I analyze the sense of fairness that guides individuals' assessment of legitimate access to health insurance, and the specific metaphors of morality, such as accounting and reciprocity, used to define and assess legitimate access to health insurance.

Chapter Five examines participants' ideas about rights and responsibilities for health insurance, with a focus on the relative obligations of the individual, the employer, and the state in the provision and procurement of health insurance. Because concepts about responsibility for health insurance necessarily have policy implications, this chapter also situates these ideas within a policy context, namely that of the ACA. It examines how the ACA – signed into law immediately prior to this fieldwork – assigns responsibility for health insurance. It also suggests that this legislation not only reinforces the employer based model for health insurance and market-based medicine, as well as an interpretation of rights and responsibilities based on consumer choice, but that it in fact reflects and reinforces the values and norms discussed by study participants regarding

merit and responsibility for health insurance. Chapter Six summarizes the dissertation's arguments, situates it within existing scholarship in medical anthropology, identifies areas of future research, and suggests ways in which research such as this can contribute to policy development.

CHAPTER 2: BACKGROUND AND THEORETICAL CONTEXT

A New Era of Responsibility

Although ideas of merit and responsibility for health are intrinsically relevant to an understanding of the American health care system, at the time that this dissertation was conducted, these themes were central to national discussions on health care. For example, the economic downturn drew increased attention to popular assumptions about the appropriate roles and responsibilities of the individual, the private sector, and the state in meeting the needs of the country's citizenry; health care reform had become increasingly recognized as an economic necessity for the individual, the private sector, and the state; and the state, as represented by the Obama administration, had undertaken major national health reform as a priority for the domestic agenda.

These issues were brought into high relief at a specific moment in American history, as multiple factors were coalescing to create a unique social, political, and economic context that had the potential to influence attitudes towards personal, private sector, and state responsibility and merit in the United States. As the economic crisis unfolded, Americans were reexamining ideas of personal, business, and state responsibility and merit. Unregulated private enterprise, most visibly represented by large financial institutions, was depicted in the popular press as both irresponsible and undeserving of the financial relief it had received from the state. The state, as represented by President Obama and members of his administration, had publicly condemned the fiscal irresponsibility of large financial institutions such as American International Group (AIG). The American state had also made clear its intention to increase regulation in the

financial industry. This decision challenged one of the central tenets of neoliberalism, which holds that the primary responsibility of the state is to remove restrictions so that labor and financial markets may flourish. As testimony to the cultural importance of ideas of responsibility and merit during the economic downturn, the government's 2009 budget was titled *A New Era of Responsibility: Renewing America's Promise* (OMB 2009). Such notions of responsibility and merit, whether implicit or explicit, pervaded popular and political discourse about the economic crisis.

At the time of my research, notions of responsibility and merit were also being examined at the personal level. The popular press carried innumerable condemnations by confused and angry callers and bloggers of "irresponsible" homeowners who had taken on loans for houses they could not afford, and testimonials that "responsible" Americans, who did not financially overextend themselves, were more "deserving" of "bailouts" from the government than were the financial institutions that played such a key role in the economic crisis. Ideas about personal responsibility and merit proved to be especially salient when public dialogue turned to health insurance. Millions of "responsible" and "deserving" Americans were loosing their jobs, and thus their health insurance, calling into question the cultural assumption that hard work ensures prosperity and access to resources such as health care (McNamee and Miller 2004). Massive job losses were challenging the notion that responsibility for the cost of health care must be the obligation of either the employer or the individual. Notions of personal responsibility were being reexamined in the economic crisis both at a general level, and with respect to specific issues, such as health care. However, a consensus on responsibility for health care had yet to be reached. Conservative interest groups began placing ads on television in favor of

the maintenance of the private, employer-based health insurance system, arguing that personal responsibility for, and control over, health signifies a key patient right (Conservatives for Patients' Rights 2009). Yet millions of Americans found themselves without private or employer-based health insurance. As if to highlight the conflicting logics and ambivalence pervading the question of responsibility for health insurance, President Obama stated that health care is a "right for every American" (New York Times 2008), but also that government-run health care "is wrong". Ideas about merit and responsibility, as they pertain to health insurance, as well as the notions of morality that inform them, were being brought to the fore during the economic downturn. They emerged in analyses of personal fiscal responsibility, and in discussions about the feasibility of the private, employer-based health insurance model. The unfolding financial crisis, as well as the state, private sector, and personal responses to it, were replete with references to, and questions about, merit, responsibility, and morality.

At the time of my fieldwork, research into Americans' ideas about merit and responsibility for health insurance was relevant not only because Americans were reflecting on popularly held notions of responsibility and merit, but also because the material realities of the cost of health care in the United States placed health reform near the top of Americans' agenda. The high and growing cost of health insurance was - and remains - a significant issue for government, business, and individual Americans. In 2008, health care costs rose at twice the rate of inflation, and according to the Centers for Medicare and Medicaid Services, the United States was projected to spend over $2.5 trillion on health care, or $8160 per United States resident (KFF 2009a) in 2009. Health spending in 2009 was projected to account for 17.6% of GDP (Ibid.), and the Centers for

Medicare and Medicaid predict that by 2018, health care spending will be over $4.3 trillion, or $13 100 per resident, and account for 20.3% of GDP (Ibid). The high cost of health insurance acts as a barrier to access to health care for millions of individual Americans (KFF 2014a). It also remains a key issue for the private sector. It is especially relevant to the auto industry; in 2005, General Motors divested itself of responsibility for retiree health insurance (Wieland 2005). In recognition of the effects of health care costs on the fiscal stability of the United States, President Obama made health care reform a priority for his administration, stating to Congress in 2009 that "Health care reform cannot wait, it must not wait, and it will not wait another year" (The White House 2009). Health reform was, and remains, a key issue in America for individuals, employers, and the state. This health reform necessarily requires debating the boundaries that delineate the appropriate responsibilities of the state, the private sector, and the individual in the provision of health care. As such, this research was both timely and necessary.

Analysis of Private, Employer-based Health Care

The overarching research question for this study is "How are Americans constructing notions of responsibility and merit for health insurance at a time of economic crisis, company restructuring, and health reform?". Ultimately, however, this research represents an examination of the private, employer-based health insurance model, and the cultural assumptions that reinforce and reproduce it. By examining the attitudes of a group of autoworkers, this dissertation seeks to elucidate the ideas that have informed and replicated the private, employer-based health care system, and to determine whether the current economic crisis has altered this specific population's ideas about

merit and responsibility for health insurance. To date, much of social science research into the private, employer-based health care system has examined why Americans have chosen private, individually-oriented models of health insurance over nationalized health care. From a political science perspective, researchers have suggested that the structure of the U.S. political system is responsible for the persistence of a private health care system (Maioni 1998; Steinmo and Watts 1995). They posit that characteristics specific to the U.S. legislative system, including a structure of checks and balances, and a lack of party discipline, have prevented the passage of bills supporting universal health reform. Labor and industrial relations historians attribute the employer-based health care system to a desire by early twentieth century industrialists to preempt the formation of unions and to wartime wage restrictions that encouraged the compensation of employees through benefits (Jacoby 1997; Tone 1997). Other scholars have focused on the effect of private interests such as pharmaceutical companies, insurance companies, and investor-owned hospitals in ensuring the continued presence of a private health insurance system in the U.S. (Ehrenreich 1970; Maioni 1998; Rayack 1967). Still others (Lipset 1989) cite ideological factors as the primary influence on the maintenance of a private, employment-based health insurance structure. According to these scholars, a popular preference for small government, and a strong sense of individualism in American society, reinforce the private, employer-based health care system in the United States.

Although there has been considerable investigation into political science, labor relations, and ideological explanations for the existence of this system, there has been little anthropological investigation into Americans' attitudes towards the private, employer based health insurance system. While examinations of the ideological reasons

for the support of the system touch on cultural assumptions about the way in which health insurance should be obtained and distributed, there is a lack of anthropological literature exploring this topic. This study, therefore, attempts to fill a gap in existing literature regarding the private, employer-based insurance system in the United States by providing a uniquely anthropological investigation into Americans' ideas about health insurance. Specifically, it investigates the way in which a group of Americans construct notions of deservedness and responsibility for health insurance. This project attempts to elucidate the *cultural assumptions* that reinforce and reproduce the private, employer-based health insurance model, and questions whether these assumptions were being challenged during a period of economic downturn, company restructuring, and health reform.

Health Inequalities in the United States

This study is informed by research into the health inequalities that result in the United States from the private health insurance system. The negative health effects that result from limited access to health care in this type of system are well documented (Becker 2007; Becker 2004; Carillo et al 2001; Davis 2003; Horton et al. 2001; Rylko-Bauer and Farmer 2002; Sered and Fernandopulle 2005). These scholars have also illustrated that the assumptions on which the U.S. health care system are based, that most working-age Americans receive health insurance through their employer or through insurance purchased on the open market, and that those who do not are covered through Medicaid or Medicare, do not always hold true in the United States, and often result in poor health outcomes for Americans. Lack of health insurance is a major factor contributing to poor health outcomes and death in the United States (Becker 2004;

Becker 2007; Davis 2003; KFF 2014a). In their "ethnography of the uninsured", Sered and Fernandopulle (2005) illustrate that the unemployed quickly loose access to private health insurance, resulting in poor physical and mental health outcomes, and often do not qualify for Medicaid until all personal financial safety nets have been exhausted. Abraham (2003) highlights the challenges faced by those who do rely on Medicaid for health insurance, including limited access to physicians willing to accept those insured by Medicaid, and strict income and monthly health spending regulations. As these studies illustrate, anthropologists have argued that the United States' market-based health care system contributes to health inequalities. This dissertation expands upon existing anthropological literature regarding market-based health care and its resulting health inequalities by examining Americans' opinions about the private, employer-based health care system. It explores the cultural assumptions that inform popular and political support for market-based health care in the United States, and attempts to determine whether these cultural assumptions are being challenged by the current economic downturn.

Merit, Self-Responsibility, and Morality

This study is also influenced by research into concepts of meritocratic individualism, self-responsibility, and morality, as they are constructed in the United States. Meritocratic individualism refers to the idea that individuals are rewarded materially for the effort that they invest and the work that they do. This is the fundamental assumption that informs the positive moral value placed on financial independence and self-reliance in the United States, and the moral condemnation that accompanies economic dependence and need (Katz 1990). Ideas of merit, responsibility,

and morality were especially salient at the time of this research, as Americans attempted to make sense of the economic downturn. As previously noted, the state, private sector, and personal responses to the economic crisis were replete with references to, and questions about, merit, responsibility, and morality. This is especially important in the examination of ideas about health insurance. The private, employer-based health care system reflects a historical tendency within the United States to associate moral worth with economic productivity, reinforcing the cultural assumption that deservedness for health care is determined by employment and moral "worthiness" for material rewards such as health insurance. The western association of work with morality dates to Elizabethan times (Friedlander and Apte 1974; Handler 2004), and was cemented by the Puritan sects in early America. Weber (2002) explains that early Protestant sects in the United States placed greater emphasis on work than on other aspects of human life, and interpreted wealth as an illustration of one's moral worth, providing the early cultural underpinnings for Americans' emphasis on merit and the association of work with moral value. In her history of individualism in the United States, Coontz (1992) notes that the government's relative unwillingness to contribute to social programs "forces each family to think first of its own savings, its own standard of living, and its own competitive position" (p.89), which in turn reinforces the positive value placed on individualism and economic productivity, and the negative value placed on dependence, in the United States.

While significant research has been conducted into the salience of meritocratic individualism in the United States (Bellah et al. 1996; Durrenberger 2005; Ehrenreich

1989; McNamee & Miller 2004; Newman 1999; Putnam 2000), few, if any, scholars have examined the way in which ideas about merit correspond to understandings about who is "deserving" of health insurance, and whether the state, the employer, or the individual bears ultimate responsibility for its provision. Willen (2012) argues that there is an urgent need for a "robust, multi-disciplinary conversation about how health-related deservingness is reckoned in different social and political contexts and in relation to different groups of people", and that "broader questions of health- related deservingness remain poorly understood" (p. 813). While Becker (2004) provides an introduction to the way in which ideas about merit, individualism, work, and morality bear upon opinions about health insurance and health care, an extensive anthropological investigation into the role of such ideas in shaping attitudes towards health insurance remains to be conducted. This research seeks to fill this gap in anthropology, and broaden the literature on meritocratic individualism, by examining how individuals construct ideas of merit and responsibility with respect to health insurance. The existing literature would suggest that Americans reckon deservedness for health insurance according to employment and economic productivity. It also suggests that Americans would accord responsibility for health insurance to the employer or the individual. However, with the current economic downturn, and resulting job losses, the employer-based health care system that supports the cultural logic of deservedness and responsibility for health insurance is being weakened. This research explores how a group of Americans – a set of mid-Michigan autoworkers in particular – define legitimate access to, and responsibility for, health insurance, and attempts to determine whether these ideas are changing due to the current economic crisis.

Risk and the Responsibility for Health

Risk and self-responsibility are increasingly prevalent themes in American discourse, and are especially salient in the realm of personal health and health care. Foucault (1995) has noted that since the eighteenth century, western individuals have come to internalize the ideal of self-surveillance, resulting in the constant monitoring of their bodies. This is a key concept in the analysis of the construction of the responsible individual. Turner (2005) suggests that the insecurity that characterizes the national and global political and economic realms has been internalized by westerners and is reflected in a sense of risk about personal health, which is controlled through the self-monitoring of one's body. Donahue and McGuire (1995) assert that the United States' market-based strategy towards health policy defines individual responsibility for health in terms of consumer and life-style behavior, and the dominant biomedical paradigm presents the causes of disease as individual, rather than social in nature. Scholars across the social sciences (Conrad 1995; Donahue & McGuire 1995; Greco 1993; Lupton 1995; Minkler 1999; Nettleton 1997; Rockhill 2001; Rose 1992) posit that key values of neoliberalism – independence, freedom, entrepreneurship, autonomy, and self-reliance – inform the assumption that Americans are expected to govern their health at an individual level, and note that this assumption also divests the state of an active role in the provision of health care to its citizens. According to neoliberal rationality, the state exists to ensure that the ambitions of the individual can flourish unimpeded by excessive regulatory policy (Rose 1992), and neoliberal anti-state rhetoric ensures that expectations of the state in the realm of welfare policy and other redistributive roles are dampened (Hartman 2005). These observations about neoliberal rationality and rhetoric are especially relevant to an

analysis of ideas about responsibility for health insurance; anti-state rhetoric is regularly used by conservative media and commentators to denounce health reform. The persistence of a market-based health insurance system also allows Americans to fulfill their "right" to individual choice as health insurance consumers, free from government "intervention", reflecting the neoliberal rationality that stresses freedom from state intervention and the maximization of individual choice and self-fulfilment (Rose 1992).

While there has been substantial anthropological exploration of the nature and context of the concept of "personal responsibility for health", this has focused largely on self-monitoring and behavioral choices, such as those relating to diet and exercise, which influence health. A focused study has yet to be conducted on the way in which ideas of responsibility manifest themselves in attitudes towards health insurance, and in ideas about the relative roles of the individual, the employer, and the state in ensuring access to health care. Through ethnographic interviews, as well as content analysis of health care policy, this dissertation provides new information regarding the ways in which responsibility for health are conceived of and constructed in the United States, with a specific focus on the way in which legitimate access to health insurance is defined, and the way in which responsibility for health insurance is constructed.

Work and Productivity

This study is also influenced by, and seeks to extend, research into the role of economic productivity in defining legitimate access to government social programs and claims to social citizenship. Social rights and benefits, such as welfare and access to health care, are conferred by citizenship in most industrialized countries, and in many

cases outside the United States, even non-citizens are provided access to basic health care and treatment (Quesada, Hart, and Bourgois 2011). However, access to social services and health insurance in the United States are contingent not only on citizenship, but must be also be earned (Olsen 2002). The link between social benefits and employment in the United States finds its roots in the American association of work with morality. The idea that to work is to be moral and that to be idle represents personal failure dates to Elizabethan times (Friedlander and Apte 1974; Handler 2004), was reinforced by the Puritan sects in early America (Weber 2002), and continues in contemporary times as evidenced by contemporary welfare policy that promotes the perception that the unemployed are morally flawed (Gans 1995; Handler and Hasenfeld 1991 ; Katz 1990). Neoliberal rationality, which promotes market-oriented assumptions about social value, reinforces and amplifies the assumption that social worth and cultural citizenship are predicated on the ability to be economically productive.

All western industrialized nations except the United States provide a universally accessible health care system to their citizens (Becker 2007; Laham 1993, Navarro 1992); furthermore, employment is not a prerequisite for obtaining access to this health care (Olsen 2002). The current American health care system is based on a historical tendency for employers to provide health insurance to employees (Tone 1997), on the assumption that most employers do, in fact, offer health insurance to their employees, and on the theory that all working age adults can afford to purchase health insurance through their employers (Carillo et al. 2001). While statistics reveal that these assumptions are flawed (KFF 2014a, Tone 1997), the association between work and health insurance is strong in the United States, and the employer remains a common means by which individuals

obtain health care. Work and economic productivity are key components of American society and culture (Ehrenreich 1989, Newman 1993, Newman 1999, Schor 1991), and employment is a salient theme in any discussion of health insurance in the United States. As Diamond explains in his discussion of interviews regarding health care, "Invariably, people will talk about employment, because that's the intervening institution – people need to be employed or connected to someone employed to have health insurance" (in DeVault and McCoy 2002: 26). This dissertation explores the way in which the groups studied understand notions of work and productivity, as they relate to ideas about responsibility for, and legitimate access to, health insurance. It pays particular attention to the role of morality in defining the relationship between work and legitimate access to, and responsibility for, health insurance. At the time that this dissertation was conducted, this focus was especially important in light of unfolding social, economic, and political processes, including the economic downturn, and the implementation of the Affordable Care Act. What is the relationship between ideas about work and legitimate access to, and responsibility for, health insurance in the United States? As the number of individuals receiving employer-sponsored health insurance was declining, was the cultural logic that supports the link between employment, the market, and the provision of social benefits being challenged? How do cultural assumptions about work bear upon national receptivity to ideas, such as universal health insurance, that challenge the work-health insurance paradigm?

Scholars in the social sciences have explored the cultural significance of work in the United States, and elsewhere in the world where neoliberalism occupies a dominant political, economic, and philosophical place in the understandings of the value of the

individual and in constructions of the self. Biehl's (2005) ethnographic investigation into the lives of the mentally ill, homeless, and sick in Brazil finds that personhood and value are intimately associated with economic productivity in that country; those who are no longer economically productive are branded as socially deviant and relegated to "zones of abandonment". Similar perceptions are reflected in attitudes towards the poor in the United States; Katz (1990) finds that policy and discourse about poverty in the United States focus on the concepts of productivity, cost, and eligibility, reflecting the cultural tendency within America to measure people by their ability to produce wealth. Heelas and Morris (1992) explain that in societies in which neoliberalism forms the dominant political and economic rationality, the individual's central role is that of a producer; wealth creation and making a profit become the yardstick by which individual self-worth is measured. Scholars have, therefore, explored the cultural importance of work in defining the value of the individual and constructions of the self. However, there is a gap in the literature exploring the ways in which ideas regarding health insurance might reflect American constructions of the self. What is it that American attitudes towards merit and responsibility for health insurance can tell us about the nature of the construction of the self in the United States? What role do ideas about economic productivity, as manifested in ideas about health insurance, reflect about the ways in which subjectivities are formed in the United States? This dissertation explores just such insufficiently answered questions.

Anthropology of Policy

This research takes inspiration from, and attempts to expand the scope of, anthropological investigations into public policy. Given the role of the state in creating health policy and in defining the parameters by which Americans have access to health insurance, this study pays particular attention to the role of policy as a tool of government. It examines policy as an instrument of power used to communicate ideology and to shape individuals (Shore and Wright 1997). Anthropology has deep roots in the exploration of the nature of the state and the means by which it attains its power (Althusser 2006, Comaroff & Comaroff 1991, Foucault 1991, Gramsci 1971, Mitchell 1991, Sharma & Gupta 2006, Trouillot 2001). It has also taken public policy as a topic of anthropological investigation, situating various policies within the larger ideological and political-economic context in which they operate, and highlighting the role of policy as a political tool. This is particularly evident in ethnographic investigations into the relationship between public policy and the construction of the responsible citizen. These studies highlight the role of public policy in divesting the state of responsibility for economically and socially detrimental policies and material conditions, and placing it on the shoulders of individual citizens. For example, Goldstein (2001) and Dunk (2002) have explored the way in which government-sponsored job retraining programs aimed at former employees of the industrial sector situate personal economic success or failure in terms of individual character, rather than in the structural realities of the economy. They note that this tactic divests the state of responsibility for its role in contributing to difficult economic conditions, and in failing to mitigate their effects. Hyatt (1997) argues that such policies represent a new mode of governance that promotes the values of

choice, self-responsibility, and empowerment by enlisting poor individuals to manage their own welfare, while simultaneously divesting the state of its role in ensuring the welfare of its citizens. Taking health policy as a tool of government, this dissertation explores the ways in which the responsible individual is defined by health insurance legislation and other forms of government discourse. While anthropologists have investigated the relationship between state policy and the construction of personal responsibility with respect to economic and housing programs (Goldstein 2001; Dunk 2002; Hyatt 1997), the role of state health insurance policy in defining constructions of the responsible individual remains insufficiently explored. This project examines the way in which state policy about health insurance defines and encodes legitimate access to health care, and the ideas communicated by public policy as to whether the state, the employer, or the individual bears ultimate responsibility for the provision of health insurance. It pays particular attention to current, and emerging state constructions of responsibility for health insurance, with a focus on the ways in which the Affordable Care Act constructs responsibility for health insurance. It also extends a focus on the role of values and norms in health care policy formation (Ruger 2007).

Discourse

This study is influenced by the discourse theories of Fairclough (2003, 2001), Foucault (2004), and Apthorpe (1997). They posit that power both informs, and manifests itself in, discourse. Apthorpe (1997), Hajer (1995) and Shore and Wright (1997) note that public policy communicates ideology and acts as a tool of government that shapes subjectivities and delineates appropriate parameters for the behavior and rationalities of

citizens. As such, public and political discourse about health care policy is an appropriate object of study for an investigation into the way in which the American health care system is reproduced. Public and political discourse has the potential to both reflect and reproduce ideas about merit and responsibility for health insurance, and it is an important factor in the formation of ideas about who is "deserving" of health insurance, who should be responsible for its provision, and what type of health insurance, whether public, private, or employer-sponsored, is deemed legitimate in the United States. Consider the role of political speeches in describing responsibility with respect to health care. In his 2006 State of the Union Address (*The Washington Post* 2006), President George W. Bush promoted the use of private health savings accounts, and asserted that "a life of personal responsibility is a life of fulfillment", enjoining Americans to take individual responsibility for health and well-being. With the unfolding implementation of health reform, there has been increasing discussion of merit and responsibility for health insurance in the print and electronic media, in communications from government agencies, and in presidential addresses and news conferences. This makes political discourse an appropriate object of study for this dissertation.

Deindustrialization and Class Consequences in the United States

This study is situated within the context of global industrial reorganization, and the local deindustrialization that results from the movement of American manufacturing plants to countries outside the United States. Deindustrialization in the American auto industry is of key concern to this study because the lack of economic resources that results from job loss limits an individual's access to health insurance, health care, and

well-being. Deindustrialization in the auto industry is also of key importance to this study because the domestic car manufacturing sector has, until recently, been a reliable and consistent source of employer-sponsored health insurance for Americans. However, this is now changing; America's Big Three car manufacturers are slowly but steadily reducing the scope of health insurance coverage provided to their employees. General Motors is a leader in the recent reduction of retiree health care benefits (Weiland 2005), and as the current economic crisis unfolds, the company is making dramatic changes to its business plan. The future of employee health benefits appears uncertain; government-mandated corporate reforms, and the threat of bankruptcy, imply that further cuts to employee benefits may lie ahead. General Motors has been vocal about the burden that health insurance places on the company's economic viability. The company claims that the cost of health care adds $1500 to the price of each vehicle it produces (Will 2005), thereby making its product less competitive against vehicles produced in countries in which health insurance is provided by the state, or vehicles produced in the United States by companies that do not provide health insurance to employees, and ultimately leading to financial losses (Ibid). Health insurance is a key facet of the current economic crisis, and the job losses that it is producing. This project explores a group of GM employees' ideas about responsibility and merit for health insurance within the context of these emerging processes.

Scholars have written extensively about the effects of deindustrialization and downward mobility on individuals and their communities in the United States (Dudley 1994, Milkman 1997, Newman 1999, Newman 1993, Zippay 1991). Given the extent of

deindustrialization experienced in Michigan since the 1970s, this state has been the focus of several descriptions of the effect of deindustrialization and the decline of the Michigan auto industry on Michigan communities (Dandeneau 1996, Feldman & Betzold 1988, Fine 2003, Kearns 1990, Rubenstein 1992). These studies document the way in which economic disorder affects the family lives, political attitudes, and personal identities of downwardly mobile white-collar professionals and skilled blue-collar workers. However, little attention appears to have been paid to the way in which unemployment or downward mobility affect ideas about access to social programs. This dissertation explores the way in which economic instability, both past and present, and the persistent threat of unemployment, combined with the reduction of employer-sponsored health care benefits, affect opinions about who "deserves" health insurance, and who (the individual, the employer, or the state) bears ultimate responsibility for the provision of health insurance. The recession rendered the exploration of these topics especially relevant and timely. The relative roles of the employer, the individual, and the state, in the provision of health insurance were in flux, and foregrounded interviewees' ideas about health care.

Critical Interpretive Anthropology

This project adopts a critical interpretive theoretical approach. Critical interpretive medical anthropology emphasizes the effects of local, societal, and global class-related power imbalances on health, as well as the subjective ways in which these imbalances are lived and experienced. It considers the way in which individuals' experiences and encounters with health, illness, and medical systems reflect larger political and economic forces (Baer, Singer and Susser 2003). This approach has been especially useful in

exploring the ways in which ideas about responsibility for health are internalized and expressed by Americans. In particular, it has offered insight into the ways in which notions of the self reflect larger political and economic forces. Researchers have argued that ideas about self-responsibility for health in fact reflect neoliberal ideas about the self and the state (Conrad 1994; Minkler 1999; Donahue and Maguire 1995; Lupton 1995). They suggest that contemporary American ideas about health behavior mirror a neoliberal focus on independence, self-reliance, competition, and market-oriented assumptions about social value. They note that the rigorous self-monitoring of personal behavior choices surrounding diet and exercise help individuals to fulfill the neoliberal ideal of autonomy and self-reliance. This behavior also divests the state of direct responsibility for the health of its citizens, reflecting a key neoliberal value of shifting costs from the state back onto individuals and the market (Gamble 2001).

This dissertation uses a critical interpretive theoretical approach to explore how responsibility and merit for health insurance are conceived of and constructed in the United States by a group of mid-Michigan autoworkers. It pays particular attention to possible reflections of neoliberal rationality in understandings of the self and of the state, as they are expressed in attitudes towards health insurance. It also probes whether or not neoliberal subjectivities normalize the link between economic productivity and individually-oriented health insurance models, such as private and employer-based health insurance, and denaturalize the notion that the state should be responsible for health care. Ultimately, this investigation into attitudes about health insurance allows for insight into the nature of subject formation in the contemporary neoliberal United States. This dissertation explores what it is that ideas about responsibility and merit for health

insurance might tell us about notions of the self and subject formation, as well as the state, in the United States, as well as the political economic factors that affect these understandings of the self and the state. This project explores these topics at a time in American history that is at once characterized by the prevalence of neoliberal values such as self-responsibility, meritocracy, and government deregulation, on the one hand, and the failure of the markets, economic destabilization, government intervention, increasing unemployment, declining employer-sponsored health insurance coverage, and unfolding federal health care reform, on the other. With its focus on both political and economic factors affecting health, and on the subjective experience of these, critical interpretive medical anthropology is an appropriate theoretical approach for exploring attitudes towards responsibility and merit for health insurance.

The literature reviewed in this chapter represents a diverse range of themes that inform a better understanding of the way in which the autoworkers interviewed conceptualize deservedness for health insurance in the United States. It covers topics that provide the context for an anthropological investigation into the intersection of global industrial reorganization, local deindustrialization, social stratification, the state, and health policy creation in the United States in general, and Lansing, Michigan, in particular. It pays special attention to the concepts of individualism, responsibility, and meritocracy, recurrent themes that inform not only micro-level understandings of health and deservedness, but also macro-level political and economic philosophies, including neoliberalism, that drive health policies and influence the degree to which the state partakes in the provision of health insurance to Americans. The themes covered by this literature provide the conceptual framework from which to investigate the way in which

individuals in both the Lansing and Michigan auto industries, and the state and federal health policy sphere, conceptualize who should receive health insurance in the United States, and who should provide this insurance.

CHAPTER 3: THE GM CONTEXT: SETTING, EMPLOYEE HEALTH COVERAGE, AND METHODOLOGY

This chapter provides an overview of the context to my research. It begins with an overview of the history of the auto industry in Lansing, addressing the industrialization, deindustrialization, and reinvestment in Lansing by auto manufacturers. Understanding the long and, at times, tumultuous history of GM and auto making in Lansing provides the necessary context to appreciate notions of personal sacrifice and work in participants' ideas about morally legitimate access to health insurance. This chapter also provides a brief overview of labor relations between the United Auto Workers and General Motors, both at the national, and local levels, which is necessary to understand the different types of health benefits afforded different employees. It then offers a summary of employee health coverage at GM, and the differences between insurance plans according to employee type, including hourly and salaried employees. This information provides the necessary context for understanding shifts in participants' health benefits, and interviewees' ideas about responsibility for health insurance. Finally, this chapter addresses the methods used for my project, including how I gained access to my field sites, a description of the field sites themselves, my sampling strategy, the types of fieldwork I conducted, and how I conducted my analysis of the data.

Project Setting: Industrialization, deindustrialization, and reinvestment in Lansing

Lansing, the state capital, is located approximately 90 miles northwest of Detroit, in southern lower Michigan. It is a mid-sized city with a population of approximately 114, 000 (U.S. Census Bureau 2010), and a greater metropolitan area of approximately 537, 000 (U.S. Census Bureau 2011). Lansing's larger social history and context are deeply enmeshed with its industrial past and present, and any anthropological investigation into the ideas of today's autoworkers requires an understanding of the industrialization, deindustrialization, and reinvestment of auto manufacturers in the city. As Deborah Hortstik, director of the Lansing-based R.E. Olds Transportation Museum explains, "Our Oldsmobile legacy is the single most important part of Lansing's long history, and it shouldn't be ignored" (Scott 2002). Ultimately, understanding GM's history in Lansing allows the reader to contextualize participants' ideas about merit and deservedness for health insurance. Understanding the omnipresence of car manufacturing in the city, and the effort expended by the Lansing area community to ensure that GM remained a local employer, affords insight into the importance participants place on work and personal sacrifice as prerequisites for morally legitimate claims to health insurance. It is also important to understand the history and timeline of the opening and closings of these plants because many of the workers at Lansing's existing plants, and indeed several of the participants I interviewed, were raised in the Lansing area, have family who worked in the original GM plants, may have worked in the original plants themselves, and are certainly aware of the various shifts in plant openings and closings during their lifetime, as they were often directly affected by these changes.

The stable, then precarious nature of GM's presence in Lansing, and the extreme effort exerted by local government, labor leaders, and GM employees alike, in order to retain GM as a local employer, as well as the current intense competition for well-paying blue collar jobs in the area, forms an important backdrop to understanding workers' ideas of merit and deservedness for health insurance, one of the benefits local employees have fought so hard to maintain through their continuing work with GM. Furthermore, without understanding the evolution of plant openings and closings in the Lansing area, conversations with workers, and especially those with a long history in Lansing, would prove confusing and difficult to follow. References to "LCA", "Fisher Body", "Plant Six", and other acronyms or shorthand names for the plants were common during my interviews with GM employees. A large percentage of workers at the newer Lansing Grand River Assembly (LGRA) and Lansing Delta Township Assembly (LDTA) plants transferred from GM's original Lansing plants, and as such, the history of the original plants forms a key component of their institutional memory and knowledge of GM in Lansing. Given the importance of the history of plant openings and closings to the emotional and material lives of the participants I interviewed, and possibly their ideas about hard-won benefits such as health insurance, not to mention the practical project of understanding references to the local plants where they might have once worked, and the closing of which would have created labor shifts, it is important to understand the evolution of GM's manufacturing facilities in Lansing.

Lansing's industrial history begins in the late nineteenth century, when the area was predominantly rural and the vast majority of the area's early settlers migrated seeking farmland (Fine 2004). The first major manufacturing activities in Lansing

centered on farming, and the area quickly became a leader in the manufacture of agricultural implements, tools, and machines (Ibid). Staffed by skilled machinists and engineers, these early manufacturing workshops became the site for experimenting with "horseless carriages", first with steam, and then with gasoline. One of the first local businesspeople to do so was Ransom E. Olds, who, in 1897, founded Olds Motor Works; August 21, 1897 is generally accepted as the birth of Oldsmobile (Early and Walkinshaw 1996). The late nineteenth and early twentieth centuries saw a quick succession of auto manufacturing plants being established in Lansing. Ransom E. Olds left Olds Motor Works in 1904 and went on to found REO Motor Company (Fine 2004); Oldsmobile was purchased by the fledgling General Motors in 1908 (Lansing State Journal 2008a), and Lansing became the headquarters of the Oldsmobile division of GM (Block and Berg 1999). Throughout the twentieth century, Olds Motor Works, REO Motor Company, and General Motors, as well as suppliers of key elements in auto manufacturing, such as Fisher Body Corporation (which initially supplied the bodies of horseless carriages to various manufacturers, and then became integrated into GM) and Delphi Corporation, provided manufacturing jobs to the residents of Lansing and the surrounding area.

Beginning in the 1920s, General Motors organized itself around distinct brand divisions, each of which designed, manufactured, and marketed its own vehicles. These brands were designed to capture a different price segment of the market; in order from lowest to highest priced, they were: Chevrolet, Pontiac, Oldsmobile, Buick, and Cadillac (Block and Berg 1999). From 1908, when it was purchased by GM, until a corporate restructuring in 1983-84, Oldsmobile was headquartered in Lansing, and maintained the facilities required to fully manufacture an Oldsmobile vehicle, including the powertrain,

sheet metal, parts, and assembly facilities needed to do so (Ibid). During the 1970s and early 1980s, Oldsmobile manufactured mid-size and full-size cars in Lansing, including the Oldsmobile Cutlass Supreme, the Oldsmobile 88, and the Oldsmobile 98. General Motors employment in Lansing facilities peaked in 1980, with 15 000 hourly and salaried employees at facilities represented by Local 652, the UAW local which then represented the largest number of GM workers in the area (Block and Berg 1999).

Over the course of forty years, beginning in the 1970s, the plants that provided a strong economic base in the Lansing area began to shut down. In 1975, Reo Motor Company, which by then had been sold and absorbed into larger corporations three times, closed (Fine 2004). In 1983-84, GM underwent a corporate reorganization that decoupled the Oldsmobile brand from the Lansing manufacturing facilities. The Lansing plants, which could no longer be guaranteed to produce Oldsmobiles (but could also be allocated the production of other GM brands), had to compete with other GM plants for production work (Ibid). Exacerbating the diminished presence of GM in Lansing, in 1995, the company moved engineering and marketing employees to Detroit, reducing the local GM workforce. In 1998, Lansing lost the Oldsmobile headquarters to Detroit altogether (Lansing State Journal 2008a). Although now faced with the uncertainty of having to compete for assembly work each time a vehicle line was dropped, Lansing continued to produce automobiles for General Motors; the company invested US$40-60 million by building a new paint plant, a new assembly plant, and by remodeling its fabrication facilities. From the mid-1980s through the late 1990s, GM Lansing assembled the Pontiac Grand Am, the Buick Skylark, the Oldsmobile Calais, the Chevrolet Cavalier, and the Oldsmobile Achieva (Ibid).

Beginning in the early to mid-2000s, GM began closing various components of its Lansing production facilities. Until then, GM's Lansing operations included a number of parts and assembly facilities. The oldest of these original manufacturing plants was Lansing Car Assembly (LCA), also known as "Plant One". This had been the original site of the Olds Motor Works, and in 1908 became GM's headquarters for the production of Oldsmobile. In 1935, GM purchased an existing plant located in the west of the city near the intersection of North Verlinden Avenue and West Michigan Avenue, where it opened the Lansing Car Assembly Body Shop, also known as "Plant Six", and moved its Fisher Body operations to an adjacent site (Lansing State Journal 2008a). These sites produced car bodies that were then shipped to LCA's Plant One for assembly. In 1940, GM bought an additional site next to Plant Six, which initially served as a munitions factory and foundry. In 1988, it was converted for automobile assembly, and it produced a small number of specialty vehicles. It was named the Lansing Craft Center, or "Plant Two" (Lansing State Journal 2008b). In 1952, GM built a sheet metal plant, the Lansing Metal Center, or "Plant Three", on Saginaw Avenue, near the LCA Plant Six, to stamp major automobile parts. GM also added a service parts warehouse in Delta Township in 1959 (Lansing State Journal 2008a). This extensive network of production facilities began to disintegrate in the 2000s, as numerous sites began to close under economic pressures and the effects of corporate restructuring.

The Lansing plant closures of the 2000s have their origin in GM's corporate decisions of the 1990s and economic pressures that continued into the 2000s. In 1996, GM announced that Lansing would produce the Oldsmobile Alero over a product cycle of five to six years, scheduled from 1998 to 2003 (Lansing Business News 2013).

Significantly, accompanying the announcement that Lansing would be building the Alero was the news that the end of the production of the car would also mark the end of GM production in Lansing (Ibid). In response, city, community, and labor leaders launched a campaign called "Lansing Works! Keeping GM", in order to persuade GM to maintain manufacturing operations in Lansing (Ibid). The campaign was successful, in part because of the "favorable tax abatements, corporate perceptions of the well-qualified labor force, and very good labor relations in the region" (Fine 2004). GM committed to building two new plants and a metal stamping plant in the Lansing area. The company agreed to build one of the new assembly plants on the existing site of Lansing Car Assembly Plant One after the demolition of some unused buildings (Chicago Tribune 2013). In keeping with this plan, in 2001, it opened the Lansing Grand River Assembly (LGRA) plant. In 2003, the company opened the Lansing Regional Stamping (LRS), designed to provide LGRA and the soon-to-be-opened second plant with metal parts for vehicle production. In 2006, GM opened the second new assembly plant in the Lansing area, Lansing Delta Township Assembly (LDTA). Although these plants have ensured GM's continued presence in the Lansing region, the company has since closed its original facilities. In 2004, GM produced the last Oldsmobile in Lansing, and in 2005 and 2006, the company closed its facilities at Lansing Car Assembly Plant One, Lansing Car Assembly Plant Six, the Fisher Body shop, Lansing Craft Center (Plant Two), and the Lansing Metal Centre (Plant Three), to offset production at the two new plants and the new metal stamping plant (Lansing State Journal 2008b).

The LGRA and LDTA plants have a history of producing high quality products and of being highly productive. In its first three years of operation, LGRA became a

leader in luxury nameplate quality production, receiving numerous quality and production efficiency awards by research firms such as J.D. Power and Associates and The Harbor Report (Brondo and Baba 2010). The LDTA facility is considered the most modern domestic plant in GM's portfolio (General Motors n.d.a) and at the time of the interviews, the plant operated at maximum capacity. The plant's 3896 workers were divided into three eight hour shifts, and frequently worked six days a week. A "hot handoff", in which tools and equipment were passed directly from employees on one shift to the next, meant that the line did not stop running over the course of the work week (General Motors n.d.a). In October 2010, GM announced its intention to spend $37 million on new tooling and equipment at the plant (Wieland 2010). At the time of my fieldwork, LGRA was not operating at maximum capacity. It employed only one shift of workers, who worked 40 hours per week, and several hundred workers had been laid off from LGRA in the previous months. Yet in late October 2010, GM announced its intention to invest $190 million in the plant to facilitate the assembly of a new Cadillac model, adding over 600 jobs to the plant's workforce (Domsic 2010). At the time of my fieldwork, LGRA produced the Cadillac CTS, and the LDTA plant produced the GMC Acadia, the Buick Enclave, and the Chevy Traverse.

Labor Relations and Health Insurance at General Motors

In order to appreciate participants' ideas about health insurance, it is necessary to have a basic understanding of labor relations at GM, and to understand how the provision of health benefits has evolved for hourly and salaried workers. The contract for hourly workers at GM plants is negotiated by the United Auto Workers (UAW), which is the

union that represents production employees, and General Motors. General Motors and the UAW have, since the late 1930s, negotiated a master agreement for all GM plants and their employees (Block and Berg 1999). That contract, known as the UAW-GM National Agreement, provides the basic terms and conditions of employment for all GM hourly employees, including wages, benefits, and working conditions, as negotiated by both parties (UAW-GM Center for Human Resources 2010: 1-21). Contracts are negotiated and renewed every four years. At the time of my fieldwork in 2010, hourly workers were covered by the 2007 UAW-GM National Agreement. The contract consists not only of the National Agreement, but also of Supplemental Agreements that regulate and outline benefits such as life insurance, Supplemental Unemployment Benefits, and health care. In addition to the National Agreement, GM-Lansing and Locals 602 and 652 – as is the case with all GM facilities – negotiate a local agreement covering plant level issues such as seniority, job transfer rights, shift preferences, and work practices (Block and Berg 1999). Production workers at the LDTA plant are represented by UAW Local 602, and the hourly workers at the LGRA plant are represented by UAW Local 652.

Under the UAW-GM agreement, health insurance benefits are negotiated at both the national and the local levels. Employer-based health insurance is not a union invention; it arose during the Second World War as a means to compensate employees at a time of government-imposed wage restrictions. For some companies, it was part of a paternalistic form of welfare capitalism, designed to promote employee satisfaction and thus hedge against union formation (Fine 2004, Jacoby 1997, Tone 1997). However, it has been a focus of unions since the 1930s, when organized labor first began campaigning for universal health insurance. Historically, the UAW has supported

national health insurance from the time of the union's formation in 1935 (Jacobs 1987, Lichtenstein 1995), arguing that health insurance is both a right and that national health insurance is financially advantageous for corporations, and for union membership. In the absence of such reforms, and "as round after round of collective bargaining enhanced the attractiveness of the UAW's own private welfare state" (Lichtenstein 1995: 297), the UAW maintained the pragmatic approach of bargaining for its members' health benefits. The UAW first successfully bargained with General Motors for employee health benefits in 1950; the company and the employee each shared 50% of hospital and medical costs for employees and their dependents. In 1961, the company began to fully cover hospital and medical costs, with no cost to the employee (UAW-GM Center for Human Resources 2010). In 1967, the first prescription drug plan was introduced. In 1973, dental care was introduced, and in 1976, a vision care plan was offered to hourly employees (Ibid). By the mid-1980s, production employees could choose from a traditional health insurance plan, a plan offered through a Health Maintenance Organization (HMO), or a Preferred Provider Organization (PPO). Throughout the 1980s and 1990s, health benefits expanded to include chiropractic care, substance abuse treatment, and mental health care (Ibid). By the late 1990s, UAW-represented GM employees had what has popularly become known as "Cadillac" plans, health insurance plans offering extensive coverage and small or non-existent co-pays or co-insurance costs, low deductibles and out-of-pocket maximums.

Despite the fact that health benefits are negotiated at a national level, and that UAW represented employees enjoy a certain degree of shared, uniform benefits, in reality, there is variation in the health benefits afforded different production employees. The Supplemental Agreement for health insurance ensures that uniform levels of

coverage are provided for the medical, dental, and vision plans, but health insurance plans also exhibit some variation at the local level. This variation is due, in large part, to the fact that plant locations, and thus employees, are clustered in different parts of the country, and are, therefore, served by health plans that draw on health care providers physically bound to those geographical regions. Because the locations of the plants vary, employees have a limited number of providers – who are bound by geography – from which to seek services, and the health insurance companies with which these providers are associated are also geographically based.

The implications of this variation in plans can be quite difficult to understand, reflecting a level of complexity one Union Benefits Representative (a UAW employee whose job is to provide hourly employees with information about UAW-GM benefits) described as "mind numbing". What follows is an attempt to provide a simplified summary of health benefits provided to General Motors employees at the LDTA and LGRA plants, based on the information available to me in the field. This overview provides the context necessary to understand the comments made by various participants – many of whom had widely varying levels of health insurance benefits – about merit and deservedness for health insurance.

Types of General Motors employees and their corresponding health benefits can, at a very general level, be classified into two groups: UAW represented employees (also referred to as production or hourly employees) and salaried employees. These two groups of employees receive vastly different health benefits. This section describes production employees' health benefits, and the following section will address those received by salaried employees. In general, the benefits afforded production employees are

differentiated according to whether one is actively employed, retired, or recently laid off. Amongst those "active" employees, benefits are further differentiated by the date on which one was hired; those employees hired before October 15, 2007, are known as "traditional" employees, while those hired on or after that date are considered "Entry Level" employees. While Entry Level employees receive one set of health benefits, traditional employees receive another set, and the benefits of traditional employees are further differentiated according to where the employee resides.

Traditional hourly employees at Lansing's plants may choose from three types of health insurance, "Blue Cross Blue Shield Traditional" insurance (also known as "Traditional Care Network"), or between the "Blue Care Network" HMO or "Health Alliance Plan" HMO. Traditional employees are automatically enrolled in the Traditional Care Network, and at the time of my fieldwork, they had the option of enrolling in either of the HMOs. However, HMOs have service areas, usually defined by the HMO and based on the availability of physicians in their networks. As HMOs are geographically based, and offer services limited to those providers that form part of the HMO network, initially, the HMO plans could not be offered to all GM employees. An employee could only enroll with the Blue Care Network or Health Alliance Plan HMOs if he or she resided in the geographical area served by the HMOs. As such, some of the participants were covered by the HMOs, while others were covered by the Traditional Care Network insurance plan.

In 2009, however, eligibility for enrollment in the HMOs was expanded to include one's area of employment, so that a GM employee could enroll in an HMO if he or she either worked or lived within the geographical area covered, effectively making all

traditional hourly employees eligible for such insurance. Lansing's Blue Care Network became open to new enrollment in November 2009. However, because the plan's rates had been higher than those of the Traditional Care Network, the UAW and GM agreed to an independent review of the rates, stating that the plan could be cancelled if its costs could not be reduced (UAW General Motors May 2009). At the time of my fieldwork, this review had not yet been completed, so enrollment in the HMO was still open to hourly workers.

Whether an employee was enrolled in the Blue Cross Traditional Network plan or an HMO plan, and whether or not they had ever been restricted from enrolling in the HMO is relevant when one considers the costs to the employee that are associated with membership in each plan. As indicated earlier, the cost of health benefits, paid on behalf of the employee, is covered by General Motors (UAW-GM Center for Human Resources 2010). There are no paycheck deductions for health insurance for active hourly employees. However, depending on an employee's plan membership, he or she may pay different amounts for deductibles, co-insurance, co-pays, and out of pocket maximums.

A short summary of terms relating to the financing of health insurance and health care costs is useful for understanding these different payment related concepts. The deductible refers to the aggregate amount an enrollee must pay in a calendar year for covered services prior to the health plan or program making a payment; there may be different deductibles for single individuals, and those whose families are covered by the plan (UAW-GM Center for Human Resources 2010). Once the deductible is met, a co-insurance may apply. A co-insurance is the amount an enrollee must pay to a provider for covered services, once the deductible has been met. The co-insurance is a percentage of

the amount charged by the provider, and may vary depending on whether or not the services are obtained from within or outside of the plan's network (Ibid). A co-pay refers to a flat rate that an enrollee pays to a provider for a service at the time that the service is provided, and is required regardless of whether they have reached their out-of-pocket maximum. An out-of-pocket maximum refers to an aggregate dollar amount that an enrollee pays during a calendar year for the deductibles and co-insurance amounts charged for services. There may be separate "in-network" and "out-of-network" out-of-pocket maximum amounts, depending on whether a service is performed by a provider within or outside of the plan's network (Ibid).

For GM employees, the above health insurance costs could vary, depending on an employee's plan membership. Amongst traditional employees, there was no deductible for members of the Blue Care Network (HMO), Health Alliance Plan (HMO), or Blue Cross Traditional Care Network plan. However, there were costly variations in co-pays, depending on the plan in which an employee was enrolled. For example, members of the Traditional Care Network plan paid a co-pay of $25 per office visit for up to five visits, after which they paid 100% of the cost of the office visit, with no out-of-pocket maximum. This co-pay structure applied to both single members and the members whose families were covered. By contrast, members of the Blue Care Network HMO paid $25 per office visit, with no limit on the number of office visits per single person or family. For members of the Traditional Care Network plan, the annual cost of visiting the doctor could quickly skyrocket, especially if the plan also covered family members. A family of four could quickly use up its first five visits covered by the $25 co-pay, and be required to pay for all remaining office visits, and any specialist office visits required thereafter.

By contrast, members of the Blue Care Network HMO plan could make unlimited numbers of routine and specialist office visits for a co-pay of $25. Not surprisingly, many employees I interviewed had wanted to change their membership from the Blue Cross Traditional Network to the Blue Care Network HMO, but had been prevented from doing so because of a freeze in enrollment or because they did not reside in the geographical region covered by the HMO at the time at which this was a prerequisite for enrollment. Needless to say, employees had widely varying experiences of using health insurance, even if they were "traditional" employees, whose benefits were amongst the most comprehensive compared to other types of employees.

The 2007 National Agreement established a new wage and benefit structure for employees hired on or after October 15, 2007. In its explanation of this change to existing members, the UAW described the purpose of the two-tier wage and benefit system as a way to "keep work in UAW GM plants, and to create a realistic possibility of adding work for future growth" (UAW GM 2007). The new wage and benefit structure provided significant cost savings to the Corporation (GM 2007), but the dramatic reduction in wages and benefits also left newly hired employees disillusioned and angry. According to the new structure, Entry Level workers receive a starting base wage of $14.00/hour, approximately 50% of the $28.12 base rate of traditional employees. Health benefits for Entry Level workers are also dramatically different to those of existing employees. There is a $300 to $600 deductible (depending on whether coverage is for a single person or a family) for Entry Level employees, compared to no deductible for traditional employees. The Entry Level employee health plan requires a coinsurance payment of 10-35% by employees (depending on whether services are provided by in-network or out-of-network

providers), whereas traditional employees pay no co-insurance to in-network providers and 10% for out-of-network providers. Like traditional employees covered by the Blue Cross Traditional Care Network, Entry Level employees make a $25 co-pay for the first five office visits per family, and pay 100% of the cost thereafter (UAW-GM Centre for Human Resources 2010). New employees are eligible for dental coverage and a vision exam only after 3 years, and full vision coverage after 5 years, whereas these benefits are available after seven months to traditional employees. To help defray the costs of health care, GM reimburses new workers up to $300 for singles, and $600 for a family, annually from a health care spending account. A Union Benefits Representative explained to me that this spending account is linked to a debit card from Bank of America, which employees can use to pay for goods and services related to their health, such as prescriptions and office visits. There was widespread scoffing – by Union Benefits Representatives, traditional employees, and Entry Level employees – at the inadequacy of a debit card as the major health benefit offered to Entry Level employees. During GM's 2009 restructuring, the 2007 contract was opened up and modified, extending the Entry Level wage and benefits structure to all new hires until the expiration of the 2011 contract, in 2015. The contract was also modified so that the company can continue to hire 20-25% of new employees under the Entry Level wages and benefit structure. This effectively solidifies the two-tier wage and benefit system as the default wage and benefit package offered to new employees.

The 2009 re-opening of the 2007 UAW-GM contract also introduced changes to the hourly retiree health benefits package. Hourly retirees represent yet another category of GM worker that has its own benefits package. Like their actively employed

counterparts, retired GM Lansing employees may enroll in the Blue Cross Blue Shield Traditional Care Network or one of the HMOs. However, unlike their Active counterparts, retirees pay a monthly premium for their health insurance of $11 per single person, or $22 per family, automatically deducted from their pensions checks (UAW-GM Center for Human Resources 2010). Retired hourly employees pay a yearly deductible of $159 for a single person, or $318 for a family, a 10%-30% co-insurance (depending on whether services are provided in-network or out-of-network), along with an out-of-pocket maximum that ranges from $265 for a single person seeking services from an in-network provider to $1061 for a family when services are sought out-of-network (Ibid). In a letter to UAW GM retirees, the UAW explained that as a condition of its continued financial support of GM throughout its restructuring, the Treasury Department "insisted that the benefits be immediately reduced to reflect GM's difficult financial situation" (UAW 2009). The UAW explained that in order to maintain the support of the Government, it was required to agree to a range of changes in retiree health benefits, including the cancellation of select classes of prescription drugs, the vision program, and dental coverage (Ibid). The union newsletters and press releases to active employees and retirees framed these changes in terms of shared sacrifices, explaining that union negotiators "worked hard and pushed for all stakeholders to share fairly in the necessary sacrifices to save GM" (UAW General Motors 2009). Although other health benefits remained unaffected, the fact that UAW members supported these changes (ratifying them in May 2009) led some Active workers to express a sense of guilt about the change, stating that they felt they had let down the retirees. The retirees I spoke with were stoic about the changes, accepting them as a necessary step in the maintenance of the Corporation.

It should also be noted that active production employees sometimes face lay offs. When hourly employees are laid off, their health benefits remain in place for a fixed amount of time, depending on seniority; continuing health benefits are indexed to the amount of time they have spent working for GM. For example, employees who have worked for less than a year at the time of permanent layoff are not entitled to the continuation of their health benefits; those who have worked for 1-2 years are entitled to 3 months of continued coverage; employees who have worked for 2-3 years are afforded 5 months of continued health benefits; those who have been in the workforce for 3-4 years are entitled to 7 months of coverage; employees who have worked for 4-5 years may receive up to 9 months of health benefits; those who have spent 5 to 10 years with GM are entitled to 12 months of heath coverage; and employees who have worked for GM for 10 or more years are entitled to 24 months of health coverage. Thus, production employees receive different levels of continued health coverage if they are laid off, depending on seniority.

Production employees, whether active or retired, traditional or Entry Level, receive a varied range of health benefits. GM salaried employees, whether active or retired, represent yet another group of employees with varying levels of health benefits. Salaried employees are not union-represented, and their levels of coverage are vastly different from those of workers on the production floor. Systematic information on active salaried employee health benefits was less readily available than that for hourly employees. However, interviews with active salaried employees, as well as information from the National Institute for Health Care Reform (a research and educational institute created by the UAW and GM) provides a basic overview of active salaried employees'

health benefits. In contrast to hourly workers, who pay approximately 7% of their health care costs, active salaried workers pay 32-36% of their health costs in the form of deductibles, co-insurance, and co-pays (personal communication, Marc Robinson, National Institute for Health Care Reform 2010). HMOs are no longer offered to salaried employees, who must now choose from two general types of health plans, a low premium/high deductible plan, or a high premium/low deductible plan (Ibid). For employees enrolled in the Blue Cross Blue Shield Basic plan, for example, annual deductibles range from $1300 for one person, to $2600 for two people, to $3100 for three or more people. Co-insurance rates range from 10% to 30% (for in-network and out-of network providers, respectively), and annual out-of-pocket maximums range from $2200 for one person, to $4400 for two people, to $5000 for three or more people. General Motors has been promoting Health Savings Accounts (HSAs) to its salaried employees, contributing $1300/year to those who open an account, the funds of which may be used to pay for health care costs. Regardless, the salaried employees interviewed expressed frustration at the high cost of health insurance, especially relative to their hourly counterparts.

Like their hourly counterparts, retired salaried employees' health benefits were cut back in the period surrounding GM's bankruptcy. As of January 1, 2010, health care coverage was *cancelled* for salaried retirees age 65 and older if they were also eligible for Medicare (General Motors Global Human Resources 2009). As with the reduction in benefits to the retired hourly workers, GM's official communication to salaried retirees framed the changes within the context of the company's financial struggles. In a letter to retirees, GM's then Vice President of Global Human Resources, Kathleen S. Barclay

explained that "As a result of the continued decline in the U.S. motor vehicle market and economic conditions, GM has concluded that it is necessary to make additional changes to the *General Motors Salaried Health Care Program* in order to better align our cost structure for long term viability" (Ibid). At age 65, medical, dental, vision, hearing aid, prescription drug, and extended care coverages provided under the *Salaried Health Care Program* automatically end for those eligible for Medicaid, and are replaced by a monthly pension increase of $300 (General Motors n.d. b, General Motors n.d. c). However, until age 65, retirees remain covered by GM's salaried retiree health care program. Those enrolled in the program may choose from three types of plans: a health savings account PPO through Blue Cross Blue Shield or COGNA/Health Alliance Plan; an enhanced PPO, or an HMO. Depending on the plan to which they subscribe, retirees pay monthly contributions of up to $235, an annual deductible of up to $1200 for an individual, or $2400 for a family, and an out-of-pocket maximum of up to $5800. Co-insurances for the PPO plans range from 10% to 30%, depending on whether services are provided in-network or out-of-network, and HMO co-pays range from $35 for an office visit to $250 for inpatient hospitalization (GM n.d. c). Arguably, salaried retirees saw the most significant cuts to their health benefits compared with other categories of GM employees, given that their coverage ceases altogether when they reach age 65.

Research Methods, Participants, and Data

Over a 23-month period (June 2009 to May 2011), I conducted participant observation and interviews at Lansing's two GM plants, Lansing Grand River Assembly, and Lansing Delta Township Assembly. This project also draws on documentary material

covering GM employee health benefits, and the ACA of 2010. This research was conducted with the approval of MSU's institutional review board (IRB) under approval # 07-419, first approved May 1, 2007 and renewed annually until 2013. All participants were offered anonymity and the names that appear throughout are pseudonyms.

Participant Observation

The majority of the participant observation for this project was conducted at GM's Lansing Delta Township Assembly plant. I had gained access to the plant through contacts made during my time as a research assistant for Dean Marietta Baba, who had studied plant culture at Lansing's GM facilities. My participant observation did not consist of working the production line, as do so many other anthropological projects addressing auto plants and industrial culture. In a city with an unemployment rate of 12% at the time of my fieldwork, spaces on the factory floor were keenly sought after. Regular tours of the factory floor with Union Representatives were the closest I came to observing "life on the line", but they did convey the physically and mentally demanding nature of production work, even in a facility as modern and ergonomically designed as LDTA.

The majority of my time at the plant was spent talking to production workers in LDTA's Skills Center, located down the hall from the doors to General Assembly. Between March and December 2010, I spent an average of 20 hours per week at the Skills Centre, meeting with workers who dropped in on either side of their shifts to socialize with other employees, pick up information from the union, use one of the computers in the Center, or ask the supervising union employee questions about job education and training. We discussed health insurance, but also talked about everyday

topics like family, plans for the weekend, upcoming vacations, and work. I kept daily field notes, recording my interactions with employees, and the goings on in the Center. I documented discussions of health insurance, as well the more every day aspects of employees' lives. I also took copious notes in my attempt to understand both plant culture and life as a GM employee (employees repeatedly referred to specific work practices, union contract clauses, and informal work behavior, as well as local plants and plant history, using a variety of acronyms and slang). I also recorded my observations of the overall rhythm of the plant and – when offered the opportunity for a tour or a walk-through – the production line: its pace, the technology present, and how employees behaved and moved through the space.

Interviews

I conducted semi-structured and unstructured interviews with 40 participants in this research. Often, the Skills Center was where I first made contact with individuals who I would then also formally interview. The union employee who supervised the Skills Center also served as an invaluable resource in my attempt to contact employees across a range of sampling criteria. He put me in touch with several production and salaried workers who were willing to participate in this study.

To be included as a participant, the individual had to be an existing, or a former employee of General Motors. Although not counted as participants, in two cases, spouses were also present at the interviews. The interviews lasted between 45 minutes and three hours each. Interviews were conducted at a location of the participant's choosing, typically his or her home, a coffee shop, or in an office at one of the plants. The

individuals I interviewed were drawn from a purposive sample which, combined with snowball sampling, allowed me to include participants representing a variety of characteristics which might affect their experiences with, and ideas about, health insurance.

I initially selected participants based on a variety of workplace related criteria, including the position they held with GM (i.e. whether an hourly or a salaried worker; whether a Traditional hourly or Entry level employee), and whether they were actively working at GM, laid off, or retired. As noted, these factors affect the type of insurance to which an employee has access. However, bearing in mind the differential experience of health care and access to health insurance between men and women (KFF 2014b), and between white Americans and racial and ethnic minorities (Carillo et al. 2001), I also purposefully sampled women, and racial and ethnic minority workers and retirees. This was a snowball sample in that I relied on participants to recommend individuals whom they thought might be interested in participating in the study.

Although I was eager to speak with Entry Level employees, it was particularly challenging to include them in my project. Despite multiple requests of existing contacts for the names of Entry Level employees who might be interested in participating in my study, only a few names were suggested. This may have been because Entry Level workers were less integrated into the existing network of GM employees than were traditional employees, and thus less well known to those I interviewed. It might also have been due to the politics surrounding the creation of the Entry Level wage and benefit system. This two-tier wage and benefit arrangement was ratified by UAW members, and created a situation in which traditional and Entry Level employees worked alongside one

another, doing the same job, for vastly different wages and benefits. It was common for traditional employees to comment that this made them feel uncomfortable, and I had heard that Entry Level workers were angry and frustrated about the wage and benefit differential. After repeatedly showing interest in speaking with Entry Level workers, and receiving surprisingly few recommendations of such names, it occurred to me that the lack of forthcoming references might also be a byproduct of the workplace dynamic created by the two-tier wage and benefit system. It is entirely possible that traditional and Union employees simply did not want me to speak with Entry Level employees because it might draw attention to the imbalance in wages and benefits to which traditional and Union employees had agreed, exacerbating an already awkward situation between co-workers and, in some cases, members of the same community.

Admittedly, lack of integration into the existing network of employees, and workplace politics, were not the only factors that made it challenging to include Entry Level employees in the project. As new employees, Entry Level workers have low seniority, and usually find themselves working the least desirable of the plant's three shifts: third shift (also known as the night shift). In fact, it was quite challenging to schedule interviews with those working third shift, as these employees typically spent the windows of time directly before and after work coordinating daily necessities like child care, meals, and errands, with spouses and partners, and the block of time between those two windows – the daytime hours – was reserved for sleeping. In the end, three Entry Level employees were recommended to me as potential participants, and I was able to speak with one of those employees. The following table shows the number of participants interviewed according to gender, race, ethnicity, and employee type. According to

information on record with the plants, this captures the demographics of the workforce, according to gender. Information about race and ethnicity was not available, however, based on participant observation, the sample approximates plant breakdown at LDTA by race and ethnicity. The sample is also representative of employee type, except for active salaried employees, who, in fact, made up a much smaller percentage of plant employees (7.5% of the plant employee population), than those interviewed (30%).

Table 1: Details of Research Participants

	GM employees interviewed for this project	**Percentage of participants**
GENDER		
Male	30	75%
Female	10	25%
RACE AND ETHNICITY		
White	30	75%
African American	7	18%
Hispanic or Latino	3	7%
EMPLOYEE TYPE		
Hourly/Production Active Traditional	9	23%
Hourly/Production Active Entry-Level	1	2%
Hourly/Production Laid off	3	8%
Hourly/Production Quit	1	2%
Hourly/Production Retired	2	5%
Union Active	5	12%
Union Retired	4	10%
Salaried Active	12	30%
Salaried Retired	3	8%

All participants took part in a semi-structured interview that followed an interview guide. The topics covered in the guide included the participant's work history at GM, his or her ideas about the company's bankruptcy, his or her personal experience – both past and present – with health insurance, knowledge about health reform, and ideas about merit and deservedness for health insurance. Some individuals participated in

additional informal interviews, which focused primarily on ideas about health reform and merit and deservedness for health insurance. In an attempt to preempt any potential bias due to my nationality (and any potential pre-conceived notions about whether or not I supported, or was critical of, nationalized health care, the health insurance model in place in Canada), I did not, in the lead up to interviews, disclose to participants that I was Canadian. At the end of each interview, if the topic arose, I did share this information. I also shared this information with those participants with whom I had a more ongoing and sustained relationship, as it inevitably surfaced as we got to know one another. I recorded the interviews, and took extensive notes during each interview, in an attempt to document themes and topics about which participants were particularly emphatic, and any insights that occurred to me, in context, as the interview was being conducted.

Documentary Sources

This dissertation also draws on documentary materials of two types: those that are relevant to understanding the content of the health insurance coverage experienced by participants, and those that shed light on the dominant discourses about merit and deservedness from a policy perspective, namely, the Affordable Care Act. Thus, for example, the documents analyzed include UAW and GM information packets and literature about health coverage distributed to GM employees and retirees that explain their health benefits, as well as the ACA legislation.

Data Analysis

I took extensive field notes throughout the study, documenting my discussions and interactions with participants, as well as my observations of what happened at the Skills Center, and on the plant's production floor. I also took extensive notes during interviews. I transcribed the interviews and field notes. I cross-referenced the interview transcriptions with my interview notes, in order to verify that I had an accurate record, in the electronic transcription, of the tenor and points of emphasis in the interview.

After transcribing the field notes and interviews, I reviewed the data using content analysis. Using the interview schedule as a guide, I recorded broad, recurring themes that occurred in the interviews, and generated corresponding codes. I refined these themes and codes on an ongoing basis, as I read through the transcripts. I recorded the recurring thematic patterns and responses in a spreadsheet database, which also allowed me to examine links between ideas expressed and the details of participants, such as gender, race and ethnicity, and employee type. I also reviewed and created a summary of each interview, which allowed me to situate key, recurring themes, as expressed by a given participant, within the larger context of the interview, and their particular life experiences.

I used discourse and narrative analysis techniques to examine the recurring patterns, and dominant themes, in participants' responses. I paid particular attention to the ideological meanings contained and conveyed in the language used in participants' responses and stories about themselves. I noted the way in which concepts were framed, and the metaphors that were used to convey ideas about deservedness for health insurance. Different responses and narratives were grouped into categories reflecting

specific, recurring patterns, with special emphasis on the repetition of specific words, phrases, or general thought patterns. The same approach was used to analyze the print documents that make up the documentary sources of this dissertation. It is these recurring themes, and their underlying cultural ideologies, that form the focus of the remaining chapters of the dissertation.

CHAPTER 4: DEFINING MORALLY LEGITIMATE ACCESS TO HEALTH INSURANCE

Work: A Precondition for Morally Legitimate Claims to Health Insurance

In her explanation of the cultural analysis of interviews and life stories, Claudia Strauss (2005) discusses the importance of recognizing cultural keywords as a way to uncover and analyze the shared cultural assumptions held about a particular topic, within a particular group of participants or population. These cultural keywords offer insight into taken-for-granted assumptions about the subject, and reflect deeply held values that are ordinarily left unsaid. In my research into definitions of morally legitimate claims to health insurance, *work*, and several close associations – including responsibility, work ethic, and sacrifice – proved to be dominant keywords in participants' reflections upon who should have access to health insurance, and under what circumstances. When discussing responsibility for health insurance, participants repeatedly emphasized the importance of *work* in determining morally legitimate claims to health care.

That *work* consistently appears as a key theme in participants' reflections on merit and deservedness for health insurance is in keeping with the cultural and political importance placed upon work in the United States. The pervasiveness and the degree to which Americans organize their lives around work is documented by studies into overwork (Schor 1991), the way in which time shortages cause home and work lives to overlap (Hochschild 1997), the "time famine" for leisure activities that Americans experience because of the dominance of work in their lives (Robinson and Godbey 1997),

and the challenge, posed by work demands, of "keeping pace in a harried culture" (Daly 1996). Historically, the ideology of meritocratic individualism, which suggests that economic success is the result of talent, intelligence, and hard work, has promoted the high moral value placed on work in the United States (McNamee and Miller 2004). Meritocracy finds its roots in the Protestant ethic (Weber 2002), an approach to work and life promoted by early American Puritan sects that emphasizes the moral value of discipline, hard work, and the accumulation of wealth, and which – although now largely stripped of religious connotations – continues to inform secular attitudes towards work in the United States, whereby work is a morally praiseworthy activity (Feagin 1972, Furnham 1982, Karjanen 2010). Politically, work has been presented as a moral requirement for the receipt of cash benefits for the poor, as with the Personal Responsibility and Work Opportunity Act of 1996, which attached strict work requirements to the receipt of welfare in the United States. Layers of historical, cultural, and political emphasis on work have contributed to a pervasiveness (and self evident logic) of *work* as a concept around which life is organized in the United States. It is perhaps not surprising, then, that work featured as a keyword for so many of the participants in this study, when asked about morally legitimate claims to health insurance.

Amongst participants, there was an overwhelming insistence (68%) that merit for health insurance is predicated on one's ability, or willingness, to work. For some (32%), however, merit for health insurance was not predicated on work. Participants' ideas about the relationship between work and health insurance can be grouped into five overarching themes: 1) the assertion that access to health insurance should not be dependent on work, and that it is, instead, a human right; 2) the blanket assertion that one must work for

health insurance; 3) the insistence that the working uninsured – who might also be labeled the "deserving employed" – should be covered *because* they are working; 4) the distinction between the deserving unemployed and the undeserving unemployed – and corresponding moral claims that certain categories of the unemployed are undeserving of health insurance – as well as a fixation on distinguishing between the deserving and undeserving unemployed in order to assign merit for health insurance; and 5) the suggestion that those unable to find employment can still make moral claims to health insurance through volunteer work, indexing their level of health coverage to the amount of time spent in the workforce, or grading their coverage according to work history. Throughout, the majority of participants' comments reflect neoliberal ideas about the self and the state, they mirror neoliberal attitudes towards existing redistributive policies such as welfare, and they reflect metaphors of morality based on accounting schemes and competition, which also carry neoliberal values.

This chapter explores the central role of *work*, and its related concepts, in defining legitimate access to health insurance for the GM employees who participated in this study. It begins with an examination of the ideas of a minority (32%) of participants that access to health insurance should not be dependent on work, and that it is, in fact a human right. It presents these participants' desire for universal access to health insurance, and the ways in which they situate their reasoning within the larger context of historical, and contemporary, political and economic events. It then turns to the idea, held by the majority (68%) of participants, that work is central in determining deservedness for health insurance. It unpacks the various taken-for-granted assumptions and meanings associated with work, including the centuries-old notion of the "deserving poor" and

"undeserving poor", as well as the importance of metaphors of accounting and competition in participants' judgments about responsibility for health insurance. In so doing, this chapter suggests that participants' ideas about merit and deservedness for health insurance reflect neoliberal economic and political rationalities that normalize the link between employment and health insurance in the United States. This chapter shows that the continuing association of work with merit for health insurance reflects and reproduces neoliberal notions of self-hood, cultural citizenship, and responsibility for health, which emphasize the moral value of economic productivity, independence, and enterprise, and in so doing, normalize the ideal of the individual as responsible for his or her health, while simultaneously divesting the state of responsibility for the health insurance of its citizenry.

Health Insurance as a Human Right

For a minority (13/40, or 32%) of participants, merit and deservedness for health insurance were unrelated to work. Specifically, these individuals described access to health insurance as a "human right". Although these individuals represent a minority of participants, their insights contribute to a more complete understanding of the views of the people interviewed. They attest to the deep concern, held by some participants, for the health and well being of fellow Americans. Furthermore, the idea that health care is a human right represents an understanding of health insurance that is dramatically different to the idea, held by most (68%), that health insurance should be earned. What follows is an examination of the idea, held by some, that access to health insurance is a right.

From a theoretical perspective, the idea of a right to health raises complex philosophical questions. As Daniels (1995) explains, a right to health care can only be

claimed if it is informed by a general theory of distributive justice, or a theory of justice for health care. There are multiple theories of justice that could inform the idea of a right to health care, including one that requires fair distribution of resources (Rawls 1971), or equality of opportunity (Daniels 1995). The discussion of such theories is perhaps best explored elsewhere; what is of significance here is that for almost one third of participants, the idea that "health care is a human right" informed their understandings of merit and deservedness for health insurance. Furthermore, setting aside philosophical issues attendant to justifying rights to health or health care, from a policy perspective, numerous international organizations promote a rights-based understanding of health care. These include the United Nations Universal Declaration of Human Rights (United Nations 1948), the Pan-American Union, the World Health Organization, and the European Union (Reid 2009). Thus, from a practical perspective, the idea that health care is a human right is well established on an international scale. As will be discussed below, participants also referred to this global context in discussing the idea that access to health care is a human right. The following comments illustrate the idea that access to health insurance is a human right:

> Actually, I think it should be a right for people. I think when people get sick, it should be available like other things are available to people… If they (when I talk, "they", I mean the government), if they can use tax money to fix a road and people are paying taxes for that but they don't drive, then why – everybody, somewhere down the line, needs some kind of medical coverage.
>
> [Elaine, 46 year-old production employee]

> I believe that health care is a human right, and I think that trumps individual rights. I don't think that health insurance should be tied to whether you work or not. I do believe we are our brother's keeper, our sister's keeper. I believe that a civil society considers everybody. A good life is not something that should be earned.
>
> [Annette, 67 year-old retired salaried employee]

> But let's just talk about health care as a human right. You know, we look at the world view – there's a world view to this. And there is such a thing as human rights. And other countries adhere to that. I don't know what's going on in the United States of America. But other countries adhere to a human right, to even to work. It's a human right to work, to get paid a fair wage. There are human rights all over the place. And I agree with the fact there is a human right to affordable health care.
>
> [Sam, 57 year-old active union employee]

These comments reflect the view that access to health care is a human right. Elaine's suggestion that the government should use taxes to pay for health care, so that it should be available to everybody, suggests that the right to health care be supported by a redistribution of wealth, through taxes (and, in fact, suggests a theory of justice informed by the equal distribution of goods (Ruger 2010)). Annette states plainly that she does not think access to health insurance should be dependent on work, and frames this within the context of societal responsibility. Others, like Sam, clearly situate the concept of health care as a human right within an international context, suggesting that the United States is out of step with international trends towards declaring health care a human right. When discussing their belief that health care was a human right, these participants were emphatic that all Americans have equal access to health care. Their voices were filled with incredulity that the United States could not guarantee everyone health insurance, and were passionate about their concern for those who were uninsured. The same participants who framed access to health insurance as a human right also supported the idea of universal health coverage.

Discussion of support for universal health coverage requires a clarification of terms. Universal insurance coverage, in broad terms, refers to the provision of health insurance to all members of a society. Universal coverage may take many forms, involving differing degrees of public and private insurance financing, delivery of

services, and administration. Reid (2009) describes three general types of universal coverage, each featuring a different combination of private and public provision and administration of health care. For example, the Bismarck model (on which the French and German health care systems are based, for example), provides universal coverage through multiple non-profit private insurance plans, financed through payroll deductions, and with cost containment regulated by the government (Reid 2009). According to the Beveridge model (on which Britain's National Health Service is based), health care is provided and financed by the government, through taxes (Ibid). In this case, the majority of hospitals are owned by the government, and some physicians are government employees, while others are private doctors who bill the government for their services (Ibid). The National Health Insurance model (on which Canadian and Australian Medicare systems are based) relies on private providers, and a government run "single payer" health insurance program, funded by taxes. Therefore, universal coverage can be attained through a combination of public and private financing and delivery mechanisms. However, the overall goal of such coverage is the same: to provide all members of society access to health care. As noted, the participants who defined health care as a human right also supported some form of universal health coverage. The following comments illustrate how some participants explained their support for universal coverage:

> It works in other industrialized countries. Why can't it work here? I mean, it's as simple as that. And when you look at countries like Germany, and France, and all the other ones like that, and it seems to work, you know, it's kind of hard to argue and say we can't do it here.
>
> [Ryan, 43 year-old active production employee]

> I'm interested in national health care. You know, opening up Medicaid and Medicare to everyone – there are already government guidelines for it. But, just to make it one big, massive thing, I know it would be a lot, but it's already there, so I think it could work… I'd like something like they have in Canada or France, where everybody's covered. Everybody had it. And everybody's was the same. Everyone who has an illness, or needs to visit a doctor, can visit the doctor. The bills are taken care of, and the government would have a program that wasn't full of red tape, and bureaucracy.
>
> [Dawn, 38 year-old active production employee]

> National health care is the ideal situation. Where there is no private industry involved. Private industry is going to profit at the expense of people. And when the health care industry – when we're dealing with people's lives, that's not acceptable. It's a moral failure.
>
> [Andrew, 39 year-old union employee]

These comments illustrate some of the reasoning behind participants' support of universal health coverage. Some (38%) supporting universal coverage, like Ryan, cited other industrialized countries as examples of places that have implemented a national system. Others (23%), like Dawn, specifically stated support for national health insurance, and thought that existing government programs, like Medicaid and Medicare, could be expanded to create a national program. And some (38%), like Andrew, argued for national health insurance as an alternative to a private system based on profit. As Andrew explained, it was a question of morality to provide national health insurance. For these participants, access to health insurance was not dependent on work; there was no prerequisite for moral claims to health insurance. Rather, access to health care was seen as a human right, and universal health coverage an appropriate vehicle for fulfilling that right to health care.

Those who supported the idea that access to health care is a human right, as well as universal health coverage, also showed a keen awareness of the larger unfolding economic context. These participants situated merit and deservedness for health

insurance within the effects the ongoing recession, and larger economic forces, including deindustrialization. Of the 13 participants who thought that health care was a human right, and that this right should be met through universal health insurance, 10 framed their support for these ideas in terms of political economic forces. The following comments illustrate this concern for the recession, and how it might affect access to health insurance:

> Health care is a human right. Absolutely. And it's a moral issue. We're always going to have someone who can't get a job. We have an economic decline. Was this – the auto companies took a hit – was this the workers' fault that they're all getting laid off and unemployment's shot overnight to over 10%, or 15%? It's probably 18% in Michigan, or higher. Was it the workers' fault that this happened? We should not let anybody in this country fall through the cracks.
>
> [Frank, 55 year-old active union employee]

> Everyone should have health insurance. Because, like I said, why aren't they employed? If they government moved their job to Mexico, the government should be providing for those people. I'm sorry. If you take away the people's means to make a living, you've got to take care of them.
>
> [Dawn, 38 year-old active production employee]

> How much money would this company have saved through the years, if we would have had a nationalized health plan? And the company wouldn't have had that cost on their books. For both active and retired, management and hourly. Ridiculous. It's just absurd. And the company would've been stronger.
>
> [Andrew, 39 year-old union employee]

These comments reflect the insistence, among some participants, that access to health insurance be situated within local, national, and even international economic contexts. Comments like Frank's show a belief not only that access to health care is a human right, and a moral issue, but that it must situated within a larger economic context, namely, the local and national results of GM's restructuring: unemployment. The comment, like Andrew's, that nationalized health care would have saved GM money also shows how some participants situated the justification for a universal health plan within the very

immediate economic context of GM's financial viability (although, it should be noted that Andrew, whom we met earlier, also argues for the moral imperative behind national health insurance). Dawn's comment calls into question larger political economic forces – federal industrial policies and the history of deindustrialization in both Michigan and the United States – and suggests that when Americans can no longer find jobs, the government must step in to "take care of them". For these, and other participants (10/40, or 25%), their support of unconditional access to health insurance was based, in part, on a recognition of the effects of the ongoing recession, and larger political economic forces, on Americans' ability to obtain health insurance. They did not see work as a prerequisite for access to health insurance, and, in fact, saw the inability to guarantee work as justification for universal access to health care.

The Importance of Work: Meritocratic Individualism, The Protestant Ethic, and Neoliberal Rationalities

For almost one third of the participants, health insurance was a human right, regardless of employment status. However, the basic assumption amongst over two-thirds (68%) of the participants in this study was that work should be a prerequisite for morally legitimate claims to health insurance. For the majority of those interviewed, the following comments are indicative of how participants presented their understandings of merit and deservedness for health insurance:

> I don't see health care as being a right, and I guess that's the easiest way to put it. I don't see it as being a right; I think it's something that – it's something that you work towards and for.
>
> [Brian, 54 year-old active salaried employee]

> The long and the short of it is you've got to make people responsible for their actions. If you're going to get something, you should pay for it. I earned my health benefits. Seniors have earned their Medicare.
>
> [Trevor, 38 year-old laid off production employee]

> I think it is a moral obligation that we provide health care to everybody. But I don't think that we'd need it totally free. It can't be just given out. There needs to be – you gotta work for it, somehow. If you give it to everybody, then nobody's going to want to work towards other goals, either. Whether it be saving for retirement, or a house, or whatever.
>
> [Robert, 62 year-old retired union employee]

> I think everybody should have health care. Okay. I do think it's, I'll say, a necessity, for how we are. I just think that if you're not doing anything to help earn it, that's where my little spot, in my mind, thinks, you know, gee whiz, why should they get it if they're not doing anything for it?
>
> [Wade, 42 year-old active production employee]

These comments reflect the emphasis participants placed on work as a prerequisite for morally legitimate claims to health insurance, and illustrate one end of the work-health insurance continuum: the unequivocal association between work and deservedness for health insurance, and the denial of health insurance as a human right. They explicitly link health insurance to work, as something to be earned. Brian notes that health insurance is something that one "work[s] towards and for", while Trevor sees health insurance as something "you should pay for", and as something to "make people responsible for". Robert doesn't think health insurance can be "just given out", and that you "gotta work for it". He also sees it within the framework of moral hazard: he fears that if one is not forced to work for goals such as saving for retirement, the purchase of a house, or health insurance, then there is no incentive to work. Ultimately, however, these comments reflect something deeper than a mere concern for work as a moral prerequisite for claims to health insurance. At a basic level, these comments suggest that the ideology of meritocracy and a secular manifestation of the Protestant ethic guide these participants'

ideas about merit and deservedness for health insurance. This is a theme to which this chapter turns shortly, as meritocratic values featured throughout participants' discussions of merit and deservedness for health insurance. First, however, it is important to understand participants' focus on work within the context of the role of work in their daily lives.

For most study participants, work was a key concept around which life was organized. A brief overview of the daily work lives of participants offers insight into why this was so. At a basic level, the omnipresence of work was evident in the amount of time it consumed. On a regular basis throughout my fieldwork, employees at the Lansing Delta Township Assembly (LDTA) plant were required to work extra hours. Even during GM's restructuring, the plant ran 24 hours a day, supporting three shifts of employees, with mandatory overtime on weekends. When this happened, the production line ran continuously, with employees doing a "hot handoff" from one shift to the next, passing tools and equipment to employees on the next shift so that the line never stopped. Thus, for participants working six days a week, work dominated their weekly schedules. Although most participants were thankful for the additional wages provided by the overtime, many added that the extra hours made home life hectic, and forced them to give up valuable time with their families. Thus, on a very basic and tangible level, work pervaded the lives of those interviewed.

The overarching influence of work on participants was also evident in the nature of their daily routines. In particular, the pace and type of work carried out in the plants fueled work's overdetermining influence on employees' lives. While walking the shop floor, I was struck by the focus and activity of the production employees. The Lansing

Grand River Assembly (LGRA) and Lansing Delta Township Assembly (LDTA) plants are lean manufacturing facilities, which, unlike traditional plants, do not rely on "floaters", or personnel who fill in for absent employees (Brondo and Baba 2010). Instead, these plants rely on teams of workers with a leader who puts his or her duties on hold to take the position of any employee who is temporarily offline for whatever reason – for a bathroom break, to make a repair on the line, or because of unplanned absenteeism (Ibid). Thus, there is little flexibility in production workers' time while on the job; even a trip to the bathroom requires a slight shift in personnel so that the production line can keep moving. Furthermore, the pace of work at the plants is quick and efficient, and operates on a rapid "just in time" philosophy, from the delivery of parts by suppliers to the assembly of the vehicles on the line. As Brondo and Baba note (2010), when a lean facility is operating at maximum capacity, there is very little room for error, and the result is "physical fatigue and mental stress among workers" (p. 271). Although salaried employees generally had a little more flexibility in their workday than did their production line counterparts, they, too, were often pushed to their limit; one salaried employee told me "I very seldom take lunch. I just eat on the fly", while another generously agreed to an interview as long as I didn't mind that he ate his lunch while we talked. Thus, the relatively rushed, intensive nature of their jobs, with little flexibility or down time, compounded the impact of work on participants' daily lives.

For some workers, the nature and pace of work at the plants also lead to physical injury. Although production employees' work stations and equipment are ergonomically designed, I learned that injuries on the line, including repetitive stress injuries, were still not uncommon amongst workers. One production employee told me that he could no

longer ride his motorcycle or mountain bike because his grip was too weak, a problem he attributed to the tools he handled on the production line. I met three employees who were "on restriction"; they had been deemed unable to work because of a repetitive stress injury sustained on the line, and could only return to work if they could be placed in a role that did not prevent recovery from that injury. Thus, work was the source of injury for some workers, providing a constant reminder of the way in which work was influencing and impacting their lives.

The impact of work on employees' lives was further over determined by the effect of shift work. Thirty percent of LDTA's production employees worked third shift, from 10:30pm to 6:42am. Working this shift required strategic scheduling with a partner or a spouse in order to coordinate running a household. I found that employees on third shift were so focused on achieving this balance that it was often difficult for them to make time to meet with me. It was simply too tricky to manage household obligations while on third shift *and* make time for an interview that might fall at a crucial time in their day. In a very real sense, then, work dominated the lives of the plant employees I interviewed, and it did so at several levels: they were regularly engaged in mandatory overtime, working six days a week; while on the line or in the office they operated at a rapid pace; some experienced job related injuries, and some were forced to reorganize their lives to accommodate a work day beginning at night. Work dominated the lives of those I interviewed, and its omnipresence offers a basic backdrop against which their focus on work may be understood.

It is also important to understand participants' comments about merit and deservedness for health insurance in light of the way in which General Motors employees

have, historically, obtained health insurance. Production employees began obtaining health insurance through their employer in 1950. United Auto Workers communications to members about health insurance frame insurance as a benefit which employees have *earned*, and which they have, under some contracts, retained in lieu of hourly wage increases. From this perspective, health insurance is, like wages, something that hourly employees do actually *work for*. For most GM employees, then, personal experience suggests that health insurance is a commodity to be earned, as it has been since the union secured health benefits for its membership in the 1950s. In this respect, when participants insist that people should work for their health insurance, they are stating the obvious, in terms of the structure by which they obtain their health insurance. However, participants' comments that individuals should earn their health insurance also reveal a more complex rationality and view of the world.

Implicitly, participants' emphasis on work as a prerequisite for morally legitimate claims to health insurance reflects the values of meritocratic individualism, and suggests a secular interpretation of the Protestant ethic. Meritocratic individualism refers to the ideology that economic success or misfortune is the individual's responsibility, and his or hers alone (Bellah et al. 1996; McNamee and Miller 2004). According to this perspective, personal success, failure, prestige, status, and income are attributable to an individuals' merit and achievement in the realm of employment (Durrenberger and Eram 2005). Economic success comes to those who work hard, and, according to this doctrine, it is uninfluenced by factors beyond an individual's control, including socioeconomic background, discrimination, and market forces (McNamee and Miller 2004). Futhermore, economic failure is the result of moral failure and personal sloth (Handler and Hasenfeld

1991; Olsen 2002). Meritocratic individualism has its roots in the Protestant ethic of early American Puritan sects, which viewed economic and vocational success as a sign of moral worthiness and of God's blessing (Newman 1999; Weber 2002). According to this ethic, individuals were to take an ascetic, disciplined and organized approach to work and to all aspects of life, and found themselves religiously obligated to pursue profit and accumulate wealth (McClosky and Zaller 1984).

The ideology of meritocracy, and the logic of the Protestant ethic – even in secular form – remain central to understandings of the importance of work in the Midwest, especially in rural settings. Although Lansing is a mid-sized city, the local auto plants have a history of drawing workers from their rural surroundings (Brondo and Baba 2010, Chinoy 1992, Fine 2004), and workers at both plants claim farming heritage, or still help to maintain farms. As Scheper-Hughes and Lock (1987) note, among rural Midwesterners, "laziness is a most serious moral failing", and the inability to stand up on one's feet, to be productive is "reviled as godlessness" (p. 18). Strauss (1966) explains that for Americans, to be "upright" means not only to being physically, but also morally, upstanding. For the majority (68%) of study participants, it was a self-evident fact that one should work for health insurance. To be deserving of health insurance, one has to be upright, both physically and morally, and this requires working. When participants say that health insurance is not a human right, but rather "something that you work towards and for", or when someone suggests that he, and seniors, have *earned* their health benefits, they are stressing the importance of "work" in securing health insurance. Comments that health insurance shouldn't be "totally free", and questioning the extension of health insurance to those who are "not doing anything to help earn it", suggests that

work provides the moral linchpin for securing health insurance. In keeping with the values of meritocracy and the Protestant ethic, to work is to be engaged in a morally praiseworthy activity, and it proves one's moral character, and thus deservedness for reward – in this case, health insurance.

Throughout my interviews, many participants also referred to the importance of having a strong work ethic. One salaried worker, 46 year-old Lana, told me about how she had worked through the first two rounds – and most of the third – of her cancer treatment. She simply could not "sit at home and do nothing", while her colleagues worked. When I asked another salaried employee, Carl, 57, why he thought health insurance should be earned through work, he explained:

> I think that's the way my dad, you know, my dad and mom believed that, you know. I grew up in the '50s, '50s and '60s, and life was good, but everybody worked for a living, and the ones that didn't work were bums, you know? If you wanted something, you went out and earned it. That's how I was raised. "You want that new baseball glove? Guess what? Go mow lawns for the summer".

Growing up, Carl learned that not working was a moral failing. To not work earned someone the shameful title of "bum". Work was the legitimate means by which material rewards were obtained. Active production employee, Doug, 48, explained that work was key in defining merit for health insurance: "It's what you do, you work. If you want something, you've got to work for it. No handouts". Robert, 62, who had recently retired from his job with the union, explained his ideas about the importance of work in securing health insurance as such:

> When I was working and raising my family, a family of three boys, and then eventually had five… I gave up – I guess I gave up a lot of the things that other people had. I didn't have all the toys. I didn't have the snowmobiles, or the four-wheelers, or I didn't have a new car every year. And I saved because I knew that – because I was brought up that way. You need to save to pay for your own way. So, now, I'm retired, and I can afford the toys that I want. And I'm not afraid of

> having the health insurance that I have to pay $140 for an office visit. That's my choice, and that – because I can afford it, that's the choice I go with. For some people to slide along in life and then want everything, I don't agree entirely with it.

Robert conscientiously saved his money and went without "all the toys" so that he could afford his health care costs. In the many years leading up to his retirement, he exercised self-discipline by saving, taking care of his family, and foregoing material distractions like a new car. Because he worked hard and saved his money, he could now afford his health costs, which, at the time of our interview, had just increased for UAW retirees. Throughout, participants' comments illustrate the moral value placed on work, the importance of self-discipline and earning one's keep, and the perception that failure to work is also sign of moral failure. As such, on a basic level, the emphasis on work as a prerequisite to morally legitimate claims to health insurance reflects the values of meritocratic individualism and a secular manifestation of the Protestant ethic, and reinforces the logic linking health insurance to paid employment.

Neoliberal Rationalities of the Self, Part I

Participants' emphasis on work as a prerequisite for morally legitimate claims to health insurance is also reflective of a larger neoliberal political and economic rationality that informs ideas about responsibility for health within the United States. The comment that health insurance is not a right, but rather something that one earns, and the emphasis on personal responsibility for one's actions and on paying one's own way, do not just reflect the cultural vestiges of the Protestant ethic and meritocratic individualism. These comments also invoke key neoliberal tropes about personal responsibility and the role of the state. Neoliberal values stand upon the shoulders of the Protestant ethic and

meritocratic individualism in the United States. They build upon, amplify, and lend legitimacy to the cultural salience of these ideologies. However, participants' emphasis on the importance of the individual, as opposed to the state, in procuring and providing health insurance, as well as the importance placed on work in earning what would, in all other industrialized nations, be considered a social benefit, is indicative of the influence of neoliberal values in ideas about merit and deservedness for health insurance. Because these themes were so pervasive in participants' ideas about merit for health insurance, it is worth investigating the larger ideology of which this emphasis on work, individualism, and freedom from the state, is a part, and the ways in which it reinforces the normative link between employment and health insurance.

Neoliberalism refers to an economic and political doctrine that gives supremacy to free markets as methods of handling not only the economic affairs of a nation, but also as a political ideology (Hartman 2005). Neoliberalism as an economic and political ideology is widely understood to have had its genesis in the 1970s and 1980s, when Margaret Thatcher and Ronald Reagan came to power in the United Kingdom and the United States, instituting policies based on the economic ideas of Friedrich von Hayek and Milton Friedman (Ong 2006). In the writings of Hayek and Friedman, the wellbeing of both political and social life are to be ensured not by the centralized planning and bureaucracy of the state, but through the free market and individual actions that aim to maximize self-interest (Hayek 1960; Friedman 1982). According to neoliberal philosophy,

> As many costs as possible should be shifted from the state and back on to individuals, and markets, particularly labour markets, should be made as flexible as possible…The presumption is always in favour of recreating the widest possible conditions for markets to flourish, which means

> removing as many restrictions on competition as possible, and empowering market agents by reducing the burdens of taxation (Gamble 2001: 131-132)

Neoliberalism's relevance to understanding attitudes towards merit for health insurance becomes clear when one considers that it represents not only an economic philosophy, but also a political rationality that can be applied to a range of governance issues, including health. Here, rationality refers to any body of systemic thought about the nature of things (Dean 1999: 11). Government, or governmentality, in this context, refers to a way of acting on individuals to shape, guide, correct, or modify the ways in which they conduct themselves (Foucault 1991). The concept of governmentality avoids the notion of the state as an overarching, repressive authority that guides individual action, and instead recognizes that government is achieved through the self-governing activities of individuals, which are brought into alignment with political objectives (Rose 1992). The state might be conceived of as "governing from a distance" (Hartman 2005; Rose 1992), a process whereby individual subjects are encouraged to embrace the freedom of self-management through the values of neoliberalism, and with the guidance of experts (Hartman 2005; Rose 1992). Neoliberalism, as a form of political rationality, bears upon attitudes towards merit for health insurance in the United States because it encourages individuals to develop a particular understanding of the self and the state that normalizes the link between employment and health insurance, and denaturalizes the idea that the state should be responsible for health insurance. To gain a better understanding of the way in which this is achieved, it is helpful to examine the way in which the self and the state are conceived of under neoliberalism.

Neoliberalism promotes a concept of the self that reflects what Heelas and Morris (1992) describe as "enterprise culture". Specifically, it constructs a mode of self-hood defined in terms of the virtues of enterprise; independence, responsibility, discipline, and autonomy. Those who have adopted the values of enterprise are to live their lives as though they were small businesses, dedicating their skills and efforts to maximizing their personal wealth (Heelas and Morris 1992). They are to be independent, rugged, autonomous, prepared to take on responsibilities, and innovative, always alert for opportunities to increase their income by responding to new consumer requirements, or by shrewdly investing their income (Ibid). Under neoliberalism, and the enterprise culture that it fosters, the state is neither desired nor considered capable of managing the affairs of individuals. As Rose explains, according to enterprise culture, and the neoliberal rationality that lies behind it, "the problem, and its solution, is a matter entirely for oneself" (1992: 141). The state exists to ensure that the ambitions of the individual can flourish unimpeded by excessive regulatory policy (Rose 1992), and anti-state rhetoric ensures that expectations of the state in the realm of welfare policy and other redistributive roles are dampened (Hartman 2005).

Neoliberal ideas about the self and the state are reflected in, and help naturalize, ideas about health. Specifically, they reinforce the notion that the individual, rather than the state, should be responsible for individual health, and they normalize the link between work and health insurance, as well as the idea that health insurance should be purchased. The notion that the individual should assume responsibility for his or her health dates to Classical times (Reiser 1985), but emerged as a technology of governance during the eighteenth century (Foucault 1980), and has gained increasing prominence in the past

three decades with the emergence of neoliberalism (Conrad 1994; Minkler 1999). According to neoliberal rationality, the individual, as opposed to the state, is expected to respond to and manage his or her health. Self-responsibility for health allows the individual to fulfill the neoliberal ideals of independence, autonomy, and freedom from government intervention. The realization of this ideal is achieved through conscious attention to public health programs and the advice of medical experts, who provide guidance on appropriate dietary, drug, and exercise regimes (Donahue and Maguire 1995, Lupton 1995). This divests the state of direct responsibility for health, yet ensures that individuals work upon and monitor themselves in such a way that their practices are brought into alignment with the objectives of the state, namely, to create healthy, self-responsible individuals.

Participants' assertions that health insurance should be earned, that work is a prerequisite for health insurance, and that the individual is responsible for health insurance encapsulate key tenets of neoliberalism, manifested in ideas about responsibility and merit for health insurance. Participants' comments that health insurance is not a *right* reflect the idea that the state should not be responsible for health insurance. Those holding this view would argue instead, as Brian put it, that health insurance is "something you work towards and for", and as such, represents not only an economic endeavor, but also an individual one. Comments asserting that you have to "make people responsible for their actions", and that "if you're going to get something, you should pay for it", reflect the neoliberal emphasis on personal responsibility and economic productivity. The insistence that health insurance can't "just be given out", and that it should be worked for, as one works for retirement, also reflects an insistence on the

individual, and economic productivity, in defining morally legitimate claims to health insurance. That health insurance should be tied to individual efforts in the form of work reflects a neoliberal approach to the self, the state, and to health which, ultimately, reproduces and reinforces the logic of the private, employer-based health insurance model upon which these employees' own insurance is based.

Ways of Ensuring the Work-Health Insurance Connection: Community Service, Indexing, and the Gradation of Benefits

Before I began my fieldwork, I wondered whether the recession might be a catalyst for a rethinking of the cultural logic equating deservedness for health insurance with economic productivity, and the larger neoliberal rationality of which it is a part. When I asked General Motors workers if they thought their ideas about health insurance might have changed since the onslaught of the recession, some replied that they thought that they had. Many more millions of people were, as Troy, a 37 year-old male supervisor explained it, "in a world of hurt", through no fault of their own. For others, the ranks of the uninsured had swelled to include not only the working poor, but also the middle class. As we saw at the beginning of this chapter, some participants specifically cited the recession, and the larger economic context, as justification for their support of a universal health insurance program. Yet, for the majority of participants, work remained a precondition for health coverage. For some individuals, there were ways to ensure health coverage during a layoff, and to ensure that hard work was rewarded. These ideas represent another theme which emerged in participants' discussions about merit for health insurance: the idea that morally legitimate claims to health insurance can be upheld even in times of unemployment through alternative forms of work, such as

community service, or through indexing health coverage to the amount of time spent in the workforce. Like working, these were considered morally legitimate ways to claim access to health insurance, even if one was out of work. Again, the local context for GM workers provides some insight into these responses.

Most of the workers I interviewed were well acquainted with the cycle of layoffs and unemployment attached to the auto industry; many had experienced layoffs, and even those that had not had either felt job insecurity, or were witness to the effect of layoffs within their community. For years, GM guaranteed pay and benefits to laid off production workers if they attended the company Jobs Bank, a program set up by mutual agreement between the U.S. automakers and the UAW to protect workers from unemployment. The Jobs Bank provided a space where laid off workers could seek other work, retrain, or take college or university courses. However, it was also controversial, because not all those participating in the program undertook such activities; it developed a reputation as a place for people to "sit around, watch movies, or do crossword puzzles" (Langfitt 2006). Amongst those I interviewed, however, there was a strong sense that sitting around "doing nothing" was not an option. One employee, Andrew, 39, explained that after a day in the Jobs Bank, he and four friends said to the coordinator, "You've got to get us out of here. We can't take this anymore! We'll do anything, whatever, I don't care, just get us out of here". The coordinator made some phone calls and the four friends started to volunteer with a local community services agency, shoveling sidewalks and delivering food to the elderly, and eventually, helping in the kitchen and organizing fundraising efforts. Another UAW employee, Dennis, 63, worked with GM management to enable those in the Jobs Bank to do volunteer work in local schools. For several

participants, volunteering in the community was one way of doing something productive with their time while laid off. Their comments – and actions – illustrate that they were dissatisfied with being "idle" in the Jobs Bank, and that they saw volunteer work as a legitimate way to be productive and to contribute to their community. This emphasis on productivity and contribution to the community even at times of "idleness" permeated participants' ideas about morally legitimate claims to health insurance.

In particular, many participants saw community service and volunteer activities as alternate forms of work that could justify the receipt of health insurance. Recognizing the difficult local job market, lack of job security at GM (the Jobs Bank was eliminated in 2009), and high local unemployment rate, participants suggested that government subsidized health insurance be extended to the uninsured in exchange for volunteer work. Ralph, a 65-year-old production line retiree, thought that community volunteer work allowed one to make moral claims to health insurance. He explained that he was reluctant to support the idea of subsidized health insurance, but "If you get it, you should have to earn it through community service", adding, "You're a better person if you work for what you get." Other participants suggested the unemployed and uninsured clean up parks, build playgrounds, or engage in some other form of community volunteer work in order to "earn" health insurance. In this respect, lack of formal employment need not hinder one's ability to make morally legitimate claims to health insurance; unpaid work represents another way to justify deservedness for health insurance.

For some participants, indexing health benefits to the amount of time spent in the workforce was another way that morally legitimate claims to health insurance could be upheld in times of unemployment. Some suggested that health insurance might be

provided to the recently unemployed along a sliding scale, depending on whether or not one was actively looking for work, and according to how long one had been in the workforce:

> If you're unemployed but you're looking for work, you should be subsidized. I'm a firm believer that if you work hard, good things will come.
> [Donald, 51 year-old laid off skilled tradesperson]

> The unemployed should get government help for health care for a certain amount of time. But it should be finite, not indefinite. It should depend on how long you've been working. For example, if you've been working for ten years, you would get ten months of coverage.
> [Peter, 43 year-old active production worker]

Joe, a 65-year-old retired tradesperson suggested that the temporarily unemployed should be covered by the government as they searched for work, but for a limited time: 90 days, and at less coverage than they might otherwise receive through employment. There had to be, as he put it, "some incentive to find work…You've gotta give them some responsibility". For these workers, health insurance remained a benefit to be earned through work, and like any such benefit, it could be dispensed in varying degrees of quality, and for varying lengths of time. Importantly, it could be indexed to the amount of time one had spent in the workforce, and it could be provided as an incentive and a reward for actively seeking employment. Such ideas are not necessarily surprising, given the familiarity of GM employees with contributory programs such as unemployment insurance, which are tied to active participation in the labor force and payroll deductions (Hasenfeld and Rafferty1989). However, what is of note is the repeated association of access to health insurance with *work*.

For the majority of those interviewed, even in uncertain economic times, morally legitimate access to health insurance was tied to paid employment, volunteer work, the

amount of time spent in the workforce, or the pursuit of future employment. At a time in which the ability to be economically productive was necessarily limited by larger political economic factors, and GM employees – both salaried and UAW-represented – were seeing a reduction in health benefits, these responses seemed out of step with the material realities of the recession. The people I was interviewing might, at any time, be laid off, or they might not get called back to the line. They might soon lose their jobs, and their health coverage, for good, or at least see a significant reduction in benefits. Furthermore, these individuals represented a group of workers whom many would consider to be amongst the most exposed to discourse about health care reform and advocacy for nationalized health care. The United States labor movement has been active in the promotion of universal health care since the early twentieth century (Derickson 1994), and the UAW has publicly supported the implementation of national health insurance since the 1960s (Halpern 2003, Jacobs 1987). During my time at the car plants, union employees who were in positions of leadership or authority, from benefits representatives to those in charge of training, cited universal health care as a desirable goal. Yet both salaried and hourly production workers repeatedly expressed suspicion towards the idea of universal health insurance, supporting instead a model in which the employer and the individual assumed primary responsibility for the provision and procurement of health coverage.

Neoliberal Rationalities of the Self, Part II

Further discussion with these workers, however, revealed a view of the world and of themselves that accounted for their ideas about health insurance, and their own precarious placement in the current political economic context. Walter, a retired

tradesperson, was soon going to be facing reduced dental and vision benefits. As a result of GM's restructuring, the UAW had recently voted to cut dental and vision benefits to hourly retirees (United Auto Workers 2009). Walter, however, was not that worried. He and his wife had saved their money, and could afford to take on the extra costs. Another participant, Lana, 46, had recently returned to work after receiving breast cancer treatment. As a salaried employee, she had seen the cost of her health insurance rise repeatedly, and while undergoing cancer treatment, she had spent tens of thousands of dollars on medical bills. Lana was adept at navigating the health insurance bureaucracy, and had learned some tricks of the trade in order to reduce her bills, but still admitted that she was regularly frustrated by the unpredictability of costs and the glacial speed at which bureaucratic problems were reconciled. In the end, she and her husband had taken out a personal loan in order to cover the additional costs of her care. Another worker with whom I spoke, Trevor, 38, had been laid off for 6 months. Although drawing 80% of his pay, and receiving full health benefits, he would lose both if he could not find a job within the next year. He had applied for over 50 jobs, and had not received any offers for an interview. The one employer to make contact with him, a manager at a State of Michigan agency, advised him not to expect an interview; the state was receiving an average of 400 job applications for each opening, and he had not qualified for the position in question. Trevor was taking advantage of his time at home; he was taking care of his young children, and tending to a large vegetable garden, both of which, he was keen to point out, allowed him and his wife to save on daycare and grocery bills. Like Walter, Trevor thought he would be able to weather the storm. He had once made $50 000 in one year cutting lawns, and felt terrible that in order to draw four fifths of his

paycheck (his unemployment benefit pay at the time) while laid off, he couldn't work outside the home; "I don't like to get paid money for free", he told me. "You work hard, you make a living. I don't like getting paid to do nothing." Trevor did not think that others should have to subsidize the cost of his health insurance, either. As he put it, "What did Bill Gates do to have to pay for my health care?"

These comments offer some insight into the ways in which these participants view the world, and how they understand themselves. Their systematic understandings of the world and of the self – what we have termed rationalities (Dean 1999: 11) - reflect the values of "enterprise culture" (Heelas and Morris 1992) which emphasize the importance of responsibility, competition, self-discipline, and self-reliance. Under enterprise culture, and the larger neoliberal rationality to which it belongs, the market reinforces virtues such ambition, self-reliance, and thrift. These values are inherently moral, to be striven for. According to this perspective, those who are unemployed should actively seek work, rather than taking refuge from the "dependency culture" provided by the state (Heelas and Morris 1992). Walter's and Trevor's understandings of the self, and their opinions about merit and responsibility for health insurance, reflect this form of rationality. Walter had done the right thing; he had saved his money, so he and his wife could afford to pay for their dental and health benefits. According to Walter, those who had not saved their money should not have health insurance paid for by others. As he put it, "If you don't save your money, too bad for you". He thought that health insurance should be earned; even those who might receive government subsidies for health care should be required to do some kind of volunteer work in return. Like Walter, Trevor was confident in his abilities to look out for himself and his family. He believed that his entrepreneurial

talents, his resourcefulness, and his ability to work hard would ensure his financial safety. According to Trevor, no one - not even Bill Gates - should be responsible for paying for his health insurance.

These findings are consistent with the observations made by Schneider (2000) in her study of working and middle class Americans' perceptions of welfare reform in the mid-1990s. She argues that perceptions of who is deserving of government aid are influenced by subjects' own experiences, and the way in which they view their own socioeconomic positions. She suggests that working and middle-class Americans who consider themselves to have undergone personal hardship in order to attain financial security resent those who have not done the same. Because these classes see themselves as having attained relative stability without government aid, they see the receipt of government aid amongst welfare recipients as unfair.

Schneider's findings offer insight into the comments made by Trevor and Walter about legitimate access to health insurance. In personal narratives, both had described how they had made extraordinary personal sacrifices to attain what they now had. Walter had foregone university in order to support his mother and his four younger siblings. Over the course of 50 years, he had earned two journeyman's cards, or apprentice-ship based certifications in the industrial trades, and had saved his money in order to be able to take care of his wife and her four children from a previous marriage. Trevor had started his own lawn care business, which he had pursued aggressively, and which had required early mornings and late nights. In order to save money, he had enrolled at a community college instead of attending the local state university. At the time when I interviewed him, he was proud of the fact that he and his wife had no credit card debt,

their home was nearly paid off, and they were saving money by growing their own vegetables. They, too, were making significant sacrifices and self-consciously living a lifestyle of thrift and savings. Lana had worked through most of her cancer treatment, cutting back to part time only in the final stages of her chemotherapy. For both Walter and Trevor, the receipt of health insurance should be contingent upon hard work, whether paid or volunteer. Despite personal hardships and the ongoing recession, a strong sense of personal sacrifice, independence, ambition, and thrift informed their understandings of merit and deservedness for health insurance, reflecting neoliberal understandings of the self, and a moral order in which hard work represents and reflects these values.

The Deserving Employed

Another key theme illustrating participants' view of work as a moral prerequisite for health insurance was their acknowledgment that those already in the workforce, but who remain uninsured, are deserving of health coverage. Participants repeatedly explained that anyone who was employed could make a morally legitimate claim to health insurance. They discussed what might be called the deserving employed (Howe 1990, Katz 1990), those who did not have health insurance – but deserve to have it– because they were working. In discussing this group of people, participants often referenced the working poor whose jobs did not offer health insurance, or whose incomes were too low to allow them to purchase health insurance themselves. The following comments illustrate the assertion that anyone who is employed should be covered because they are actively working:

> If they're working, and they're working hard, but they're still not bringing in enough income to pay for health care, I don't think that's fair. I think, if you're working and working hard, you should be offered health care.

[Claire, 38 year-old production employee]

> I'm the only sibling who's got health care. I've got two sisters and two brothers, and I'm the only one who has it. For them, it's huge. But they should be covered. They work just as hard as the next person.
>
> [Larry, 43 year-old union employee]

> If you're ambitious enough to have a job, you should have health care, because a lot of jobs don't provide health insurance, or enough money to buy it.
>
> [Janine, 51 year-old production employee]

For these participants, work represented the moral checkmark for securing access to care. If one was working, yet unable to afford the cost of health insurance, or if one's employer did not offer health coverage, one could make a morally legitimate claim to health insurance. Here, the key defining characteristic was one's active engagement in employment, and a willingness to make a sacrifice, in the form of hard work, to earn one's health insurance. Echoing the values of the Protestant ethic, for these participants, work represented an activity that was inherently valuable and worthy of reward, in this case, in the form of health insurance. Their comments also reflect the values of meritocratic individualism. Participants' responses implied that the uninsured were working hard, and that they needed to be rewarded accordingly. Lawrence's comment that his brothers and sisters were just as hard working as the next person reflects the idea that hard work should result in material rewards, in this case, in the form of health insurance. Claire's comment that if one is "working, and working hard" one should be insured also reflects this ideology; for her, it was simply not *fair* for one to work that hard without recompense. Both comments suggest not only that hard work should be compensated with material reward—as a rational economic transaction (labor exchanged for health insurance) – but also that the recipient is worthy of such gains because hard work proves strength of moral character, and thus worthiness for reward. Their comments

are imbued with the taken for granted assumption inherent in meritocratic individualism that individual hard work results in material gain, in this case, in the form of health insurance. Importantly, however, these participants' observations also suggest flaws in this ideology. They noted that the unemployed uninsured were engaged in their part of the contract of meritocracy – working hard – but that these efforts were going unrewarded. They were missing out on compensation for their efforts, despite an ideology that suggests that hard work should be rewarded materially. Despite implying its flaws, however, participants hung their justifications for deservedness for health insurance on the ideology of meritocratic individualism, with work representing the key defining characteristic for morally legitimate claims to health insurance. Work was seen as the qualifying characteristic for material rewards, met or unmet, in the form of health insurance.

The Deserving and Undeserving Unemployed

Participants' ideas linking health insurance to work were illustrated in another key work-related theme: the distinction between the deserving and the undeserving unemployed. According to participants, morally legitimate claims to health insurance were more precarious and conditional for those *not* actively engaged in work. For example, when asked about the appropriateness of subsidizing the cost of health insurance for those who were unemployed and could not afford health insurance, 20% (8/40) thought that the unemployed should be granted unconditional, state-supported access to health insurance. Twelve percent (5/40) of participants did not think that the government or taxpayers should subsidize health insurance for the unemployed, while the remaining 68% (27/40) of participants thought that the unemployed should receive help

only if they were recently laid off or actively seeking work. Participants in the latter group made a distinction between what some authors have described as the "deserving" poor or unemployed, and the "undeserving" poor or unemployed (Howe 1990, Katz 1990). And in discussing this concept, some participants were preoccupied with determining who belonged to which of these two groups.

The concepts of the "deserving" and "undeserving" poor have existed for over five hundred years in Anglo western society. They date to fourteenth century England, when changes in economic organization and demographics led to declining fortunes for landlords and employers, who began to attribute their decreasing wealth to the purportedly poor work habits of their laborers (Howe 1990). The landed groups extended their condemnation of the working poor to the unemployed, whom they presented as criminals who "preferred to beg, steal, and lie rather than to work" (Ibid: 4). These assumptions about the poor and the unemployed continued in Elizabethan and Victorian England, where they were reiterated through various poor laws (Howe 1990). More recently, they have been reinforced in the United States through welfare policy (Schneider and Ingram 2005).

As Howe (1990) notes, the concepts of "deserving" and "undeserving" poor now persist as "stock cultural knowledge" (p. 2). As cultural tropes, they confer eligibility for state support, and are based on a set of moral and evaluative criteria that distinguish between the relative virtue of two types of groups of the unemployed. The morally virtuous, or "deserving" unemployed include children, the disabled, and the elderly (Gans 1995, Handler and Hasenfeld 1991; Handler 2004; Katz 1990). It also includes those who are out of work through no fault of their own, are eager to return to work, and are "on the

whole willing to accept any reasonable job offer" (Howe 1990: 2). As such, they represent that class of unemployed who are legitimately eligible for state support. Furthermore, they are judged as morally similar to the employed because, like this group, they value the importance placed on work, independence, individual responsibility, and the family. In this sense, they are admitted into the same "moral community" as the employed (Ibid). The "undeserving" unemployed are defined by an opposite set of values, including laziness, dependence, and an unwillingness to take on work. Because they are assumed to have made a choice to not work, they are perceived as being outside the moral community of the employed (Howe 1990).

For many of the participants I spoke with, the concepts of the "deserving" and "undeserving" unemployed were salient, and helped to define legitimate access to health insurance. According to them, the *deserving* unemployed were the disabled, children, the elderly, and in some cases, the recently unemployed who simply could not find work due to the ongoing recession. The *undeserving* unemployed were those who were not willing to look for work, or who thought that it was acceptable for others to pay for their health insurance. The following statements reflect this general consensus that there was a line between the deserving and undeserving, and that it depended on willingness to be employed:

> Depends on their motive for being unemployed, okay? Like I said, if it's because they can't find a job, and things are tough right now, I understand… I mean, we'll support you medically, but you've got to be out there looking for work. At least make an effort. Don't just sit back and do nothing. I don't support that at all.
>
> [Carl, 57 year-old salaried employee]

> If a person is unemployed, but they're seeking employment, then, yes, they should have health insurance subsidized by the government and fellow taxpayers. But it's different than if someone is seeking a free ride. If I am not trying to apply myself because I know I can get welfare, and somebody else is going to provide my

> health insurance, then I have a moral obligation to apply myself and to seek ways to support myself. I can't just sit there and think that someone else is going to do that for me. In the job market now, it's very difficult, but you see people that, no matter what degree they have, they're willing to do whatever it takes to provide for themselves. So that type of initiative -- if they're seeking-- then I think that's a bit different. But if I'm going on welfare, and not applying myself, no one else is going to do that for me. I grew up in the inner city, and I saw people abusing welfare, people who would just be getting up as I was leaving the house for school.
>
> [Lana, 46 year-old salaried employee]

> I want everybody to be working. And I don't know how to get rid of the welfare bums. In that, there are some people that have legitimate issues, but there are people out there that have just lived off welfare all their life and I don't like paying their welfare checks and I don't want to pay their health insurance. So I guess in my perfect world, everybody's working, and then the employers would provide their healthcare, they would take care of their people.
>
> [Tammy, 42 year-old salaried employee]

> I think there are a lot of able bodies out there that can work that just choose not to. And I don't really want to support them by paying more in taxes. I wouldn't mind paying more for people that needed it and weren't able to work, like older people, and disabled people. I think we have an obligation to them, but I don't feel like I have an obligation to pay more in taxes for lazy people.
>
> [Brett, 28 year-old production employee]

> I think that you should pay for your own insurance. And like I said, get a job. You pay so much for your insurance, to have good insurance. I don't see anything wrong with that. I think that hits the nail on the head. Because you've got a lot of people who just have babies to get on welfare, and they sell their food stamps to people for real cash. I mean, I just know that that goes on. I've even been offered that, when I was in Tennessee. You know, these people have $400 extra to sell in food stamps…And that's been like that forever.
>
> [Anne, 51 year-old production employee]

For these individuals, morally legitimate claims to subsidized health insurance depended on one's apparent willingness to engage in paid work. They acknowledged that lack of jobs might prevent someone from finding work, but stressed the importance of seeking work, even in tough times. Furthermore, participants were uncomfortable with the idea of contributing towards the health coverage of those who appeared unwilling to work, or

seek work. Here, participants referred to "able bodies" who "choose" not to work, "lazy people", "those who sit idly by and expect everything to be handed to them", and "welfare bums". As Tammy explained, she did not "like paying their welfare checks, and I don't like to pay their health insurance". For these individuals, deservedness for health insurance hinged on willingness to work, and suspicion of the "motives" for being unemployed mitigated their willingness to envision extending subsidized insurance to the unemployed, in the same way that it influenced their willingness to support those on welfare. Thus, in imagining hypothetical instances in which subsidized health insurance might be extended to the uninsured, participants viewed health insurance as a redistributive policy akin to welfare, and they were reluctant to support individuals whom they perceived as deliberately taking advantage of the system. Some cited personal experience as a reason for their beliefs: Lana tells us that she grew up seeing the abuse of welfare in her neighborhood, while Anne says that someone had once tried to sell her food stamps. For others, however, the "welfare bums" and "lazy people" were more anonymous.

The anonymity of the category of the "undeserving" is crucial in understanding how this classification functions as a cultural trope. As Howe (1990) notes, when assigning the label of "undeserving", it is generally "anonymous others" who are being grouped together (p. 2). Since the 1960s, when welfare policy began to present the recipients of state support as primarily single African-American women (Bensonsmith 2005), the mass media has denigrated welfare as a program for "other" people who are different from, and do not adhere to, white middle-class work and family values. At no time did participants in this study explicitly reference specific racial groups in defining

the "undeserving" unemployed who might be taking advantage of the system. However, their repeated reference to an unidentified individual who is "lazy", a "welfare bum", and who just has "babies to get on welfare" reflects an abstract othering of an amorphous group of individuals that mirrors the popular media's negative treatment of welfare recipients (Gilens 1999). As Tammy notes, "there are some people that have legitimate issues", but in fact, it is difficult to know who has "legitimate issues" and who "sit idly by and expect everything to be handed to them" (Rick, 50 year-old retired union employee). Not surprisingly then, accompanying this delineation between the deserving and undeserving unemployed, there was also a preoccupation with determining who belonged to each category. The following exchange with Lana, whom we met earlier, is indicative of this concern:

> Lana: Right, so I got one person who's mentally handicapped, right, and they're trying to do all they can do, and they're working in a minimum wage job, and they're doing the best they can, right? But they can't afford healthcare. And you would want somebody taken care of – and then you got, I don't know, somebody like an electrician or something, that's taking money under the table, up to a drug dealer, or whatever you want to, you know. So, they're making, they're making probably 40, 50 000 dollars a year, it's looking like they're making maybe 10 000 dollars a year, and so, as a government, right, I got to give healthcare to both those people, they're both making 10 000 dollars that I know about. So, you can't really tell who needs, who really needs help and who doesn't. And I just don't know a way – if you could really tell who needed help, I would be all for, I think everybody in America would be all for, giving money, you know, out of our taxes, right, to help the people who really can't help themselves. But I don't – it's not the numbers they say, right? Because we wouldn't be selling that many cigarettes, and liquor, and casinos wouldn't be doing that well, and, you know?
>
> Christine: So, you'd be for extending health insurance that's maybe subsidized through taxpayers? Or?
>
> Lana: Only if you could tell who really needed it, and I don't think you can. So, I guess I have to say no, I'm not for that. I'm more for, let's make it more affordable. And I wonder what would happen if you did offer affordable healthcare, only for people who worked? You know? I think that'd be kind of interesting.

In this exchange, Lana's ideas mirror those of other participants: she recognizes that some people are clearly "deserving" of subsidized health insurance. These individuals are, for example, the mentally handicapped, who are working low-wage jobs. They are those who are, through no fault of their own, disadvantaged, and who are, despite their challenges, working hard. By contrast, there is a second group of people, the "undeserving", who are cheating the system, and therefore, not worthy of receiving state subsidized health insurance. This group of individuals includes, for example, an electrician who does not claim all of his income, and a drug dealer. However, Lana recognizes that there are difficulties inherent in differentiating between the hard workers and the people cheating the system. Because she does not think the truly deserving can ever be identified, she dismisses the idea of subsidizing health insurance. Instead, she reiterates the preference, expressed by other participants, to tie health insurance to employment.

As Howe (1990) explains, there are several problems inherent in trying to differentiate between the deserving and undeserving employed. To begin with, there is "no consensus about whether this distinction has any real basis in fact", or whether there is a relatively large or small group of individuals who are taking – or trying to take – advantage of government redistributive policies (Howe 1990: 2). Furthermore, there is no consensus concerning the actual classification of the unemployed; as Howe notes, "who is deemed to belong to the one or the other of these classes varies considerably from person to person" (Ibid). Deciding who falls into each category, or how to define each group of people, is subjective. This ambiguity is illustrated when Lana, who, after

dissecting the problems inherent in determining who can be classified as legitimately "deserving" of subsidized health insurance, and who is "undeserving" by virtue of an attempt to take advantage of the system, abandons the idea, and turns instead to the idea of linking health insurance to employment. She reinforces this association, suggesting those who work might be offered more affordable health care, simply by virtue of working. Again, work is promoted as a morally praiseworthy activity to be rewarded. Regardless, her dissection of the difficulties inherent in differentiating the deserving from the undeserving unemployed illustrates the cognitive, and practical, challenges posed by these categories. It is also representative of the preoccupation with these classifications expressed by participants.

It is worth noting the gendered dimensions of notions of deservedness. The ways in which participants framed work conforms to gendered concepts of the idea: throughout, participants consistently referred to "work" in terms of paid or volunteer labor outside the home. Conditions of deservedness were decidedly focused on work conducted outside the home, as opposed to labor traditionally done by women, such as childrearing and managing the household. In this respect, participants' framing of deservedness reinforces gendered imagery of deservedness, emphasizing paid work over unpaid labor, and tended to conform to gendered concepts of deservedness, merit, and labor.

Metaphors of Morality

The above discussion illustrates the ways in which participants framed morally legitimate claims to health insurance in terms of work, and the deserving and undeserving

unemployed. However, another pattern emerges if one looks closely at the language used in these instances to describe deservedness for health insurance. In their discussions of access to health care, participants repeatedly draw on specific metaphors to convey ideas about merit for health insurance. Throughout our conversations, participants typically framed morally legitimate access to health insurance using metaphors of accounting, physical orientation, and competition. As Lakoff (2002) notes, these are dominant metaphors for the ways in which Americans conceptualize morality, and form part of a larger moral order based on the metaphor of morality as strength. What follows is an examination of the ways in which participants used metaphor to convey their ideas of merit for deservedness, as well as the suggestion that these metaphors carry neoliberal values of social worth and morality. First, however, it is useful to examine the importance of metaphor in conceptualizing abstract ideas such as deservedness and morality.

Lakoff and Johnson (1980) argue that metaphor is a central organizing structure for the way that we interpret the world, and that it is, in fact, very common in language, thought, and action. They suggest that metaphor pervades our conceptual system because it serves a useful purpose: it helps us understand and convey abstract concepts that would otherwise be difficult to describe. Specifically, metaphor helps us process aspects of experience that cannot be adequately comprehended in their own terms, such as mental activity, time, work, human institutions, and social practices (Lakoff and Johnson 1980: 177). As a cognitive tool, it allows us to "structure the less concrete and inherently vaguer concepts (like those of emotions) in terms of more concrete concepts, which are more clearly delineated in our experience" (Ibid: 115). Metaphor is so "good to think with" (Scheper-Hughes and Lock 1987: 18), in fact, that much of our social reality is

understood in metaphorical terms, and much of moral reasoning is, in fact, based in metaphor (Ibid: 5). Participants' comments about merit and deservedness for health insurance proved fertile ground for the use of metaphor as a way to conceptualize and convey ideas about morally legitimate claims to health insurance.

Accounting

If we review the comments made by participants about the importance of work in defining deservedness for health insurance, their explanations enlist metaphors based on accounting and reciprocity to convey the idea of merit and fairness. Participants' ideas about deservedness centered on the concern that someone might obtain health insurance *for free*, or that it might be erroneously *given out*. Randy, a 46 year-old production employee, explained that "We're all entitled to medical help… But not at the *expense* of others". Wade, a 42 year-old production employee, drew on accounting and reciprocity metaphors when he explained to me, "You pay so much for health insurance. I'd hate to pay for somebody to get better health insurance than I have, when *I work my butt off for it*." Trevor earnestly asked, "What did Bill Gates did do to have to pay for my health care?" According to Trevor's understanding of reciprocity and accounting, Bill Gates does not *owe* him anything. In all of these examples, metaphors of accounting and reciprocity express ideas about merit for health insurance. According to participants, it is immoral for health insurance to be provided *for free*, or *at the expense of others*, or for someone to *work his butt off for it*, when someone else need not make the same sacrifice.

The reason for participants' emphasis on accounting, financial transactions and reciprocity become clearer if one considers the way in which various components of a

larger metaphorical system encompassing time, money, labor, and health insurance interact. As Lakoff and Johnson (1980) note, two structural metaphors that are important in Western industrial societies include "time is a resource", and "labor is a resource" (p. 66). Because they are limited resources in Western society, they are also valuable commodities (Ibid: 9). Labor is a resource because it can be precisely quantified in terms of time (as with hourly wages or yearly salaries), it can be assigned a value per unit, it serves a purposeful end, and it is used up progressively as it serves its purpose (Ibid: 66). Since labor is typically quantified in terms of time in industrial societies, it follows that time is resource, as well. Health insurance forms part of this time-labor-commodity metaphorical system because, like time and money, it is a commodity. As a benefit of employment, which is sometimes provided in lieu of hourly wages, it is earned through time and labor (on the production line or in the office). Put simply, GM employees give up time, and expend labor, for wages and health insurance.

Furthermore, the actual work environment – on the production floor, especially – encourages the quantification of time and labor, thus reinforcing the time/labor as resource metaphors. For example, production employees are assigned work on one of three fixed shifts; they earn an hourly wage; labor contracts ensure the strict and constant monitoring of contractual and non-contractual absences, and they encode vacation days, as well as the appropriate compensation for mandatory overtime. All of this quantification of time and labor reinforces the metaphors that time and labor are resources. Furthermore, material resources and labor are quantified on the production line through the process of the work itself: employees assemble vehicles with measurable material parts which – in a lean plant such as LDTA or LGRA – are kept in relatively low

quantities so as to avoid "waste". However, the quantities of these parts must also be carefully maintained so as to ensure that the production line keeps moving, resulting in a delicate balancing act of just enough, but not too many, assembly parts. Time and labor are further quantified on the shop floor with visual reminders designed to help employees gauge their rate of production: a large digital "scoreboard" above the shop floor documents how many vehicles need to be made each shift, and where the workers are in achieving that goal, encouraging workers to adjust their production pace accordingly. Combined, and within the context of the production of vehicles, all of these factors reinforce the logic of the metaphor that time and labor are resources. Through repetitive, often strenuous work on the line, these metaphors are reinforced through, and grounded in, experience. GM employees give up valuable resources in the form of time and labor, and one of the ways in which they are compensated is through health insurance benefits. It is logical, within this schema, that health insurance is seen within the time-labor-commodity metaphor, and that it is conceived of in terms of accounting.

Physical orientation

In addition to metaphors of accounting and reciprocity, participants also employed metaphors of physical orientation to convey ideas of merit and deservedness for health insurance. Specifically, participants emphasized the importance of being "upright" in defining merit for health insurance. There was a concomitant admonition against "being idle" or "sitting back", and having health insurance "handed" to someone. Comments like those of Rick, a 50 year-old retired union employee, were typical of participants, and illustrate this emphasis on being upright in defining legitimate access to health insurance: "I'm a firm believer that you still have to work to get something. I'm

often irked by those who sit idly by and expect everything to be handed to them." Carl, a 57 year-old salaried employee, said, "I mean, we'll support you medically, but you've got to be out there looking for work. At least make the effort. Don't just sit back and do nothing". These admonitions against sitting *idly*, or *sitting back* and *doing nothing*, and the concomitant suggestion that the uninsured should be working or looking for work, reflect a very specific understanding of morality in which physical orientation reflects not only the physical state of standing or locomotion, but also a symbolic meaning. As Strauss notes, being upright has two connotations to Americans: the first, to stand up, to be on one's feet; and the second, a moral implication "not to stoop to anything, to be just… to stand by one's convictions" (1966: 137). Thus, being upright is good, and being low (literally, as in the case of sitting back or laying down) is bad (Lakoff 2002). As Scheper-Hughes and Lock (1987) note, the symbolic importance of "being upright" is especially salient in the United States Midwest. According to this understanding of morality, to be upright is to work, and to not work is low, or immoral. This conceptualization of morality dovetails with, and reinforces, the metaphors of "time is money", and "labor is money"; to be upright is to be industrious, productive, laboring, and earning money, whereas to be "low" is to be inactive, unproductive, not working, nor earning money. Thus, to be sitting around, sliding by, doing nothing, or having things handed to one, is low, both physically and morally. According to this understanding of morality, those who deserve health insurance are those who are physically and morally upright, while those who are physically and morally "low" are not deserving of health insurance.

Competition

In addition to framing deservedness for health insurance in terms of metaphors of accounting and physical orientation, participants also employed metaphors of competition to express ideas about merit for health insurance. In these cases, health insurance was framed as a reward in a competition, specifically, the competition of life. As Lakoff (2002) notes, this view of the world reflects the assumption that life is a struggle for survival, and implies a moral order based on reward and punishment. According to this model of morality, "survival in the world is a matter of competing successfully" (Ibid: 67), and to survive, one must learn self-discipline. Success, therefore, is a sign of self-discipline, and a "just reward for acting within this moral system" (Ibid: 68). Competition is a "crucial ingredient" in such a moral system, as competition reveals who is self-disciplined, and thus deserving of success, and "who is fit enough to survive" in the world (Ibid). Invoking this metaphor of competition, Carl, a 57 year-old salaried employee, explained to me, "If you're just sitting back, then guess what? You don't have any [health insurance] available to you, you know? That sounds very cold, but by the same token, everybody else is trying to *survive*" (emphasis added). Wade's earlier comment that he would hate to pay for somebody to get better health insurance than he has, when he *works his butt off for it* also reflects this same metaphor of competition. For Wade, paying for someone else to be better rewarded than he is clearly unjust. Brett, a 28 year-old production employee told me,

> I guess I, I don't know, I look at myself and I've always worked, and I was always told to work so that I could have benefits and stuff like that. I guess I'm worried that people are getting something for nothing, and I don't want them to rely on my work habits to be covered for health benefits.

Brett's fear that someone else is getting *something for nothing*, and that it could be as a result of his work habits also frames deservedness for health insurance in terms of metaphors of competition. Here, his fear is that someone else will "get ahead" because of his strong work ethic, when he deserves the rewards of working hard. As a model of morality based on competition, reward and punishment are integral to its logic. In all of these examples, health insurance is framed as a reward for self-discipline and hard work. In this model of morality, reward – in this case, health insurance – given to those who have not earned it through competition is immoral. As Lakoff notes, unjust rewards "violate the entire system", and remove the incentive to become self-disciplined (2002: 68). Indeed, participants' comments regarding the need to be working, or looking for work, the need to be upright and not "sitting back", the accounting of time and labor spent in earning health insurance, and the framing of health insurance as a reward all reflect the importance of self-discipline in defining deservedness for health insurance.

This emphasis on self-discipline reflects not only a secular interpretation of the Protestant Ethic and the influence of meritocratic individualism, but also the values of neoliberalism. As we have seen, neoliberalism emphasizes the importance of self-discipline, self-reliance, and competition. As Heelas and Morris (1992) explain, enterprise culture and neoliberal rationality require both winners and losers in order to ensure competition. In this context, the uninsured are clearly the "losers", individuals who have not demonstrated the self-discipline required to earn the reward of health insurance, while health insurance is the reward for the hard work and self-reliance of the "winners". Ethnographic evidence supports this suggestion. Sered and Fernandopulle (2005) explain that the downwardly mobile and uninsured in the United States report

being treated like "losers". Becker's (2007) study of the health care safety net shows that the uninsured observe a hierarchy of treatment in public hospitals: the insured are treated first, followed by those with Medicaid, followed by the uninsured. My research with General Motors workers reinforces this suggestion; many participants framed health insurance as a reward in a competition, as something that they had "won", and objected to the thought of others receiving the same reward without having earned it. As such, the metaphors of competition and reward encapsulate key neoliberal values. Metaphors of accounting and physical orientation also reflect the neoliberal emphasis on self-reliance, industriousness, ambition, and independence.

This chapter explored the central role of work in participants' definitions of morally legitimate claims to health insurance. A minority of participants disregarded work as a prerequisite for morally legitimate claims to health insurance, stating instead that access to health care is a human right, and that such access should be ensured through a universally accessible health insurance. They also situated their arguments within the framework of the recession, and larger economic forces. However, for a majority of participants, work symbolized the lynchpin for morally legitimate claims to health insurance. Their ideas about the importance of work in defining merit and deservedness for health insurance centered on four key themes: that work is a prerequisite for access to health insurance; that the working uninsured deserve to be insured by virtue of the fact that they are working; that the unemployed uninsured can be classified as either deserving or undeserving of health insurance, depending on their willingness to seek work; and the suggestion that those who are unable to find work can still make moral claims to health insurance through community service or volunteer work, and by

indexing their level of insurance coverage to the amount of time spent in the workforce. Furthermore, participants employed various metaphors to convey these ideas, namely those of accounting, physical orientation, and competition. Throughout, ideas linking health insurance to work, and the metaphors of morality used to convey these ideas, reflect not only the vestiges of the Protestant Ethic, and the ideology of meritocratic individualism, but also neoliberal notions of self-hood and responsibility for health, which emphasize the moral value of economic productivity, independence, and enterprise. Combined, these understandings of the self and the moral order reinforce the ideal of the individual as responsible for his or her health, and further normalize the link between health insurance and employment.

CHAPTER 5: RIGHTS AND RESPONSIBILITIES: HEALTH INSURANCE AND THE STATE, THE EMPLOYER, AND THE INDIVIDUAL

The previous chapter explored the ways in which some General Motors employees define merit and deservedness for health insurance, showing that for a majority of participants, "work", in its various manifestations, represented the key to morally legitimate claims to health insurance. Seen within the context of rights and responsibilities, health insurance was presented as the responsibility of the individual, as opposed to a right conferred by the state, reflecting not only strains of the Protestant ethic and meritocratic individualism, but also neoliberal understandings of the self and the state. One goal of this research is to better elucidate the ways in which participants view the relative roles of the individual, the employer, and the state in the provision of health insurance. It necessarily calls into question models of rights and responsibilities for health insurance.

Article 25 of the United Nations *Declaration of Human Rights* lists adequate medical care and security in the event of sickness as a universal human right (United Nations 1948). Responsibility for health insurance is a feature of the "moral order of healthcare", that is, the system of "rights, obligations and duties" that mediate relationships among actors in the health care arena (Langenhoven and Harré 1994). As Garrety et al. (2014) note, moral orders are multi-layered and often contested. They can be found "at different levels of generality – from the policies and regulations that allocate rights and responsibilities to institutions, to the implicit "rules" that shape interactions in single healthcare encounters" (Garrety et al. 2014: 71). Access to health insurance – and

the rights to this access, as well as the responsibility to provide insurance – are part of this moral order. In most developed nations "people position themselves as having 'rights' to healthcare based on their vulnerability to sickness or disability, and see its provision as a state 'responsibility'" (Garrety et al. 2014: 71). This configuration of rights and responsibilities manifests itself in several models of health insurance coverage throughout the industrial world (Reid 2010). Although these models rely on different arrangements, and varying degrees of involvement, between the government, the private insurance industry, the employer, and the individual, they all share the common feature of ensuring relatively universal, comprehensive coverage to citizens (Ibid).

By contrast, in the United States, the moral order of health care does not assign citizens the right to health insurance, nor does it confer a responsibility to the state to provide health insurance to all citizens. As is well documented, the United States is the only major industrialized nation in the world whose government does not provide (or in some way facilitate) universal and comprehensive health insurance coverage for its citizens, and where health care for the majority of the population is financed by for-profit insurance companies (Becker 2007; Laham 1993; Navarro 1992; Rushefsky and Patel 1998; Starfield 2000). Instead, rights and responsibilities for health insurance in the United States are framed in terms of consumer choice. Neoliberal rationality stresses freedom from state control, and the maximization of individual choice and self-fulfillment (Rose 1992). This translates into the "right" to choose one's health insurance, and freedom from government "intervention". Indeed, fear of a loss of consumer choice is a popular theme in the dismissal of national health insurance proposals in the United States (Skocpol 1996); critics claim that national health insurance would allow the

government, not the individual, to choose one's health insurance or one's doctor. Private health insurance, by contrast, maintains the cultural logic that the freedom to purchase health insurance is a manifestation of autonomy and the ability to exercise control over health. In the United States, responsibility for health is also defined in terms of individual behavior and choice. As Donahue and Maguire note,

> the "responsible" person…is one who buys sufficient health insurance, consumes the right diet and avoids consuming the wrong products, purchases health professional care wisely, takes prescribed medications and complies with other "doctors' orders", takes stress-reducing vacations, and invests in a good health spa (1995: 48)

Here, self-responsibility for health is defined by the purchase of the right products (including health insurance), self-monitoring of one's health, and adherence to a "healthy" lifestyle.

Health policy in the United States reinforces this particular interpretation of rights and responsibilities. As Starr (2011) notes, Federal law "recognizes only one right of all persons to essential health care – a right to receive emergency medical services" (p. 242). From a policy perspective, Medicare and Medicaid represent a shared responsibility for health insurance, with insurance costs financed through taxes paid by the healthy and sick alike (Ibid). Although discussed in greater detail later in this chapter, it is worth noting here that the Affordable Care Act (ACA) does not establish a general right to health care nor to health insurance. It does create a right to federally subsidized coverage for individuals who would, otherwise, be unable to afford insurance. However, as Starr (2011) notes, on the whole, rather than enshrining a right to health care or insurance, the ACA creates a "series of individual rights in relation to private insurance", including, for example, a right against being denied coverage due to a preexisting condition, and a right

against lifetime limits on coverage (p. 248). Again, rights are framed in terms of consumer rights, in this case the right, as a consumer of insurance plans, against being denied coverage. In terms of responsibility, the ACA puts forward a notion of "shared responsibility" for health insurance, emphasizing the role of employers and individuals – but not the state – in the purchase of health insurance (ACA 2010: 317, 342).

This chapter examines participants' understandings of rights and responsibilities for health insurance. Chapter Four showed that individual sacrifice and "work" emerged as key concepts around which morally legitimate claims to health insurance were organized by participants. However, my analysis of the data also revealed that there was strong support among participants for some sort of universal access to health insurance, implying a role for the state in ensuring citizens' access to health care. Although, as indicated in Chapter Four, the majority of participants did *not* view health insurance as a human right, but rather a commodity to be earned, they *did* value the idea of universal health coverage. I use the term "universal health insurance" or "universal coverage" to refer to any form of health insurance program designed to cover all members of a society (Reid 2010, Starr 2011). Although, as indicated in Chapter Four, this universal coverage may be achieved through a variety of public and private mechanisms, in each case, it relies on some degree of government financing, administration or regulation. As such, it necessarily implies the involvement of the state, the apparatus through which health insurance is managed. This chapter unpacks the apparent paradox inherent in the simultaneous desire for universal health coverage, and the denial of health insurance as a right. It also illustrates that for those who were ambivalent towards universal coverage, commitment to this type of health insurance was tempered by concerns about financial

sacrifices, in the form of taxes, and a lack of faith in government's ability to execute policy. I apply Ruger's (2007) adaptation of "incompletely theorized agreements" (originally developed to facilitate deliberation in law, but used by her to analyze norms and values about health care) to understand the ambivalence expressed by participants. In so doing, this chapter also reveals the ways in which participants viewed the ideal role of the individual, the employer, and the government, in ensuring access to health insurance. I draw on interviews with specific individuals to illustrate the ambivalence and conflicting ideas expressed by so many participants about responsibility for health insurance.

Because ideas about the roles of the individual, the employer, and the state in the provision of health insurance necessarily have policy implications, this chapter also situates these ideas within a policy context. As Shore and Wright (1997) note, policy both reflects and shapes a specific understanding of the social order. This chapter examines how the ACA – signed into law immediately prior to this fieldwork – assigns responsibility for health insurance. It also suggests that this legislation not only reinforces the employer based model for health insurance and market-based medicine, as well as an interpretation of rights and responsibilities based on consumer choice, but that it in fact reflects and reinforces the values and norms discussed by study participants regarding merit and responsibility for health insurance.

Health Care For All: Ambivalence, Compartmentalization, and Incompletely Theorized Agreements

Debate about national health reform at the time of my fieldwork provided an entrée for discussions with participants about the ideal roles of the individual, the employer, and the government in the provision of health insurance to Americans. In an effort to gain a better understanding of their ideas about responsibility for health insurance, I asked participants a suite of questions which included (but were not limited to) their likes and dislikes about the recently passed reforms; how they viewed the relative roles of the individual, the employer, and the government, in the provision of health insurance; what they thought about national health insurance and a public option (two policy proposals which, although initially somewhat popular, had faded as the reform debate had progressed); and how – in a perfect world – they thought health insurance should be provided. Their responses showed that 30% (12/40) did not support universal coverage, 32% (13/40) supported the idea of universal coverage unconditionally, and 38% (15/40) supported it with reservations. The importance of the distinction between the latter two categories will be discussed below. Closer examination of the responses of the last group showed that those who were unsure about the idea of universal coverage were, in fact, supportive of the idea in principle, but this support waned when they reflected on the specifics required to achieve the goal of universal coverage. However, if one considers that 32% of participants supported the idea of universal coverage, and 38% supported this idea in principle, 70% of participants were, on some level, supportive of universal health insurance. Thus, it is worth exploring the reasons for participants' ambivalence towards universal coverage, and the apparent

paradox between a majority (68%, as indicated in Chapter Four) who believe that health insurance is not a right, and a majority, in principle at least, who believe that the government should ensure that all Americans have access to health insurance.

Randy's Story

Randy's perspective on merit and responsibility for health insurance epitomizes the responses of participants in this study, and in several ways, his personal story was similar to those of many of the people I interviewed. His take on responsibility for health insurance also encapsulates the ambivalence expressed by many participants when asked to reflect upon the way in which health insurance should be provided to Americans. I use Randy's example to illustrate the apparent paradox in participants' simultaneous desire for universal health care and denial of health insurance as a human right, as well as the tendency for participants' support for universal care to be tempered by their perceptions about the practical requirements of implementing such a goal. I follow Randy's story with examples from other participants about their ambivalence towards universal coverage.

I met Randy, 46, on a rainy spring afternoon at one of the local cafés in Lansing. He was referred to me by another member on his team at LGRA, where he had begun working third shift in General Assembly in 2000. Like many of those I interviewed, Randy was from a GM family. His father and uncles had all worked for GM, and he described himself as a typical "GM kid". His experience of GM as a child left him with a sense that "nothing is secure"; with family members working at the plant, he "understood the ramifications of how the economy works, the long layoffs, and the strikes". He told me he took on the night time production work as "something extra" – he already had a

full time day job in manufacturing at another Lansing business – because he was, at the time, worried about his finances. He juggled the two full time jobs for three years, following a tight schedule and sleeping only four hours a night. Eventually, the constant work led him to loose track of the days of the week, and ultimately, led to ill health. He quit the original manufacturing job, staying on with GM, and eventually transferred to the day shift. He invested the money he saved, and at the time of our interview, explained that he now felt financially comfortable. His commitment to work – although in this case somewhat extreme – was, in fact, not uncommon among those I interviewed. Throughout my fieldwork, I met retired workers who had gone into business for themselves in the construction industry, worked in administrative positions for insurance companies, and as consultants in the auto industry. I met production employees who were studying part time, and a cancer survivor who had worked through almost all of her cancer treatment. I met production workers who recalled organizing volunteer work so that they could do "something productive" while laid off. Randy's keen work ethic, although certainly dramatic in this instance, was part of a larger trend among participants towards a deliberate commitment to work, and his personal experience influenced his ideas about merit and responsibility for health insurance.

Randy's ideas about responsibility for health insurance are indicative of the larger group of participants in that he was ambivalent about how health insurance should be provided, and by whom. He expressed a reluctance to define health insurance as a right, but he expressed a desire for some sort of universal health coverage. At the same time, he held reservations about the viability of such a program. When I asked whether he thought of health insurance as a human right – as something all humans are entitled to – he

replied, “No. You should be able to obtain health insurance, but that’s really on you. We’re all entitled to obtain medical help, okay? But not at the expense of somebody else.” When I asked him how, ideally, he saw the provision of health insurance, our conversation unfolded as follows:

> Randy: Well, all citizens would get medical.
>
> Christine: Okay. And how would that be provided –
>
> R: Paid for? Yeah, back to the national tax, you see.
>
> C: So you’d want a national tax?
>
> R: Yes. But see, the problem with a national tax is: how do you make it fair, so that everybody pays for it? See, this new reform is if you make over $200 000, you’re going to pay more money. I’m in that category. People who have dividends on investments, but here, me, again, will pay a tax on that. Why should I pay more taxes on money that I worked hard to earn because I made the right decisions when I was growing up? I made the right decisions ten years ago. Twenty years ago. And people continue to make the wrong decisions every day. And the government says, That’s okay, we’re going to take care of you, because John Doe over there made the right decisions, stayed out of trouble, made something of himself, and he has extra money. And, well, this is the new America, and we’re going to force him to pay for my program so that every American can get insurance.

In Randy’s opinion, health insurance was not a right. He clearly thought that one should be able to obtain health insurance, but that it was an individual responsibility, and an individual expense. He also explained that, in an ideal world, all citizens would have access to health insurance through a program nationally funded through taxes. Yet when probed about how that goal would be achieved, he expressed reluctance at having to make personal financial sacrifices in order to ensure that other Americans would have access to health insurance. This reluctance was framed in terms of fairness; he did not think it was fair for someone who had worked hard and made the “right decisions”, to pay higher taxes to cover the insurance of those who had made poor life choices. Randy

contrasted himself as a responsible, hard worker who made smart decisions against an anonymous group of people whom he thought of as irresponsible and having had made poor life choices, suggesting that the potential recipients of tax payer funded health insurance were not deserving of the financial sacrifices he would have to make in order to help them obtain medical coverage. Ultimately, his support of some sort of national system that would allow "all citizens [to] get medical" was tempered by his belief that the material sacrifices required of someone like himself were unfair. In this sense, his desire for universal coverage was mitigated by his ideas about work, fairness, and personal sacrifice.

Other participants were similarly ambivalent when discussing their desire to extend health insurance to all Americans. While Randy was among the many "ambivalent" participants reluctant to take on the financial commitments required to make universal coverage a reality, many others who supported the idea of a national system of health insurance were hesitant because of their doubts about the government's ability to execute policy. Simply put, they did not see the government as capable of managing a program such as universal health care. The following comments show how some participants' support for a national system waned when they considered the government's role in achieving it:

> I would think a national health insurance would be more equitable for US citizens, as a whole. Whereas right now, it seems to be the only ones that enjoy better medical benefits are the ones that happen to have better jobs. Alright, higher paying, or whatever might be the case. Why should someone who can only be earning minimum wage at Macdonald's be denied, be not receiving health care, when they're putting in 40 hours a week, versus someone who works at a manufacturing facility down the road, are putting in 40 hours a week? I see nothing wrong with something universal, but it goes right back to the government's history of economics and, you know, can they capably run it without bloating the entire debt of the country? So that's my hesitation, there.

[Rick, 50 year-old retired union employee]

> Well, I think universal health care is a good thing in that people are getting coverage that don't have coverage. But, you know, seeing how systems have operated in the past, one would tend to feel, is the money getting to where it should get? And as proper representation on that, as opposed to inflating; that we need more and more and more taxes, when in reality, one really doesn't, to accomplish what they need to accomplish. So, there's always that concern for me, that it wouldn't be managed well. That the money wouldn't get to where it should, that it wouldn't be distributed properly.
>
> [Mike, 57 year-old union employee]

> Yeah, I think national health care is a great idea. But I don't know as… how can I say that? Hmm. I would rather – I would prefer that the government stay out of it, but still have insurance available to somebody, somehow. And I don't know how that would've happened without the government getting involved. I don't. 'Cause again, I guess the old adage is, if the government gets involved, it's going to cost more, and be more… oversized, basically.
>
> [Robert, 62 year-old retired union employee]

These comments reflect the ambivalence many participants felt when they tried to reconcile their desire to see some sort of national health insurance plan extended to the uninsured with their ideas about government's ability to manage such a program. Observations, like Mike's, that it is unfair for those working low wage jobs to be uninsured, and Rick's and Robert's wish to see a more equitable distribution of health insurance, and to have it "available to somebody, somehow" show a genuine concern for the uninsured and a desire to see justice in the distribution of health insurance. But they could not reconcile this concern with their perceptions of government's ability to manage finances, citing reservations that the money "wouldn't get where it should", that government involvement would make a national health plan "cost more", and that it would bloat "the entire debt of the country". Their commitment to a universal health insurance program was tempered by concerns about government effectiveness.

The denial of health insurance as a human right and the simultaneous desire for some sort of universal coverage, as well as the ambivalence expressed towards the ultimate goal of universal coverage, reveal some of the uncertainty that characterized participants' ideas about health insurance. In fact, this wavering may be in keeping with Americans' tendency towards ambivalence on social and political issues. Lipset (1963) explains that American political culture is full of unresolved conflicts, especially between freedom and equality, and particularly when applied to social policy. Feldman (1988) notes that individuals' inconsistencies about various principles prevent them from fully subscribing to exclusively "liberal" or "conservative" ideologies, and from forming coherent, integrated positions on social issues. For GM workers in this study, health insurance was one such issue. Indeed, participants' responses rarely fell neatly into predictable or stereotypical categories such as "liberal" or "conservative", but instead showed a combination of values from across the political spectrum. As Strauss (2005) explains, ambivalence and even the compartmentalization of different cognitive schemas is not uncommon in discourse about public ideas (such as a country's national health insurance system), and is especially likely to emerge in lengthy interviews, or over the course of several interviews. It is also more likely to emerge as a result of "the interviewer asking different kinds of questions and eliciting different kinds of discourse (e.g. personal narratives as well as general statements of opinion)" (Ibid: 239), as was the case with this project. Furthermore, from a practical perspective, lengthy interviews allow participants to "think about the topic more and come up with another point of view that they also hold", and to "conduct a more thorough mental inventory, unshelving schemas that are not usually displayed at the same time" (Ibid: 224). Seen within this context, it is

not entirely surprising that some participants offered ideas that were at odds or not fully reconciled. When participants explain their hesitations about a national health program with verbal fumblings like Robert's "But I don't know as… how can I say that? Hmm.", or phrases that hedge, such as "So that's my hesitation there", "So there's always that concern for me", or "Yes, but, the problem with a national tax is…", they are displaying their ambivalence – and "psychic conflict" (Ibid: 223) – about the topic. These self-conscious hesitations also suggest that speakers recognize that they hold inconsistent ideas.

According to Ruger (2007), it is these inconsistent ideas that hold the key to understanding conflicting ideas about rights and responsibilities for health insurance. Her analysis of health care policy formation and public attitudes towards health reform in the United States offers insight into the logic behind participants' ambivalence about health insurance. In her dissection of the trajectory of the Clinton administration's Health Security Act, Ruger applies an "incompletely theorized agreement" (ITA) framework regarding consensus building to explain the 1993-94 failure of health reform. ITA is rooted in contemporary legal (Sunstein 1995) and political (Rawls 1993) theory, and is typically used "to understand how stability and social agreement is established among elites in the judiciary and politics when there is disagreement on fundamental matters" (Ruger 2007: 53). Although originally intended to facilitate elite deliberation in law and politics, Ruger argues that an ITA framework can also be used to understand how values about health care are internalized and processed by the public and politicians. According to ITA theory, values and norms operate at multiple levels of generality and degrees of internalization. These values may be "high-level", "mid-level", or "low level". An

"incompletely theorized agreement" is one that is not uniformly theorized at all levels and across all dimensions of specificity (Ibid: 53). Policy must be uniformly theorized on high-level, mid-level, and low-level principles and values in order to be accepted by the public, agreed upon by politicians, and enacted as legislation. Using the Clinton Health Security Act as an example, Ruger argues that its failure was due to a lack of reconciliation (amongst the public as well as political elite) between high-level values justifying health care for all, the mid-level value that universal health coverage should exist, and the low-level principles informing the way in which this universal coverage should be funded. She suggests that while the public and political elite had agreed on the mid-level principle of universal health care, there was a lack of consensus on the high-level values that justified this principle, as well as a lack of agreement on the low-level public moral norm of willingness to pay for universal health insurance. Ruger's use of ITA to analyze the failure of the Clinton reform provides insight into the ambivalence and contradictory responses of participants about health insurance.

Her analysis is particularly useful in examining the paradoxical result that 68% of participants did not support the idea of health care is a human right, while 70% showed support (either full support, or support in principle) for universal health coverage. Ruger explains that the "right to health care" is a high-level principle. However, it is but one such principle that can be used to justify the mid-level principle of universal coverage. Other high-level principles behind the ideal of "health insurance for all" include: communitarian theories of justice that require collective responsibility; utilitarian or welfare economic theories that promote the greatest good for the greatest number of people; liberal egalitarian theories of justice that require equality of opportunity; a theory

of justice that requires the fair distribution of resources; ethical theories that emphasize compassion, charity, and altruism as moral concern for others; human workforce concerns about workforce productivity and global competitiveness, and a concern for the financial risks associated with lack of insurance or underinsurance (Ruger 2007: 69). In Chapter Four, we saw that 32% of participants thought that access to health care was a human right, and that these same participants supported universal health coverage. The two variables were correlated. However, although 32% of participants thought that health insurance was a human right – and this corresponded to support for universal health care – the "right to health care" is not the only high-level principle supporting universal coverage, and the absence of support of this principle does not mean that participants did not hold other high level principles justifying their desire for universal coverage. That the majority of participants did not see health insurance as a human right, and that a similar number did want to see universal coverage does not necessarily suggest a paradox, or contradictory information. Instead, it suggests that these participants may have held other, unarticulated high-level values that informed their desire for universal coverage and "medical for all". The limitations presented by this distinction will be discussed in the conclusion.

Secondly, an ITA framework helps us understand the ambivalence exhibited by participants when they discussed their desire for a national health plan. As Blendon, Brodie, and Benson (1995) note, Americans tend to have competing core values, to express ambivalence about health and health care, and to exhibit conflict among core beliefs in relation to health care (in Ruger 2007). These conflicting core beliefs include: a moral commitment to the uninsured; a limited willingness to sacrifice; a reasoned self-

interest in what changes would be enacted; and a distrust of government (Ibid). Participants expressed this full range of conflicting core beliefs. There was a commitment to the uninsured, with participants pointing out the inequity of a system that allows a worker in a low-wage job to go uninsured while a worker in another job receives coverage, and the sense that universal coverage would be "more equitable" for all Americans. Participants also expressed a suspicion of government, and its ability to manage taxes and large programs, as well as a reluctance to pay higher taxes in order to fund a universal health plan. Among participants, this resulted in a strong tug between the desire to help the uninsured, and cynicism towards the government's ability to carry out a national health insurance plan, as well as a reluctance to make personal sacrifices to fund health insurance for others. As Ruger (2007) notes, universal health coverage represents a mid-level value, while the means required to achieve this goal – including the willingness to pay higher taxes, and the involvement of government apparatuses – are, in conceptual terms, of another (in terms of the framework she uses, a lower) level. According to ITA theory, it is this lack of congruence across levels that results in ambivalence. Although participants were supportive of the mid-level goal of universal insurance, their ideas about how to – in practical terms – achieve this goal, were unresolved. They were reluctant to pay higher taxes in order to fund the redistribution of resources required for a universal system, and they were suspicious of entrusting the government with this task. Ultimately, it was this concern about lower level principles that mitigated their desire for a universal health plan. Ruger suggests that "when individuals experience ambivalence about abstract values and principles, they must draw on lower-level principles and concrete considerations that appeal to them to justify policy choices" (2007: 57). This

offers insight into why a reluctance to pay higher taxes, and a mistrust of government efficacy, might have overruled some participants' support for universal health coverage. Ruger's adaptation of ITA is useful because it helps to account for, and put into perspective, the ambivalent and contradictory responses about responsibility for health insurance that characterized participants' thoughts about health insurance.

The Relative Roles of the Individual, the Employer, and the State

Despite the ambiguity of participants' responses about universal health insurance, is it possible to distill how they viewed the ideal roles of the individual, the employer, and the state, in the provision of health insurance? As we have seen in Chapter Four, there was a strong emphasis on personal responsibility, as represented by individual work habits and personal sacrifice, in participants' ideas about merit and deservedness for health insurance. When asked directly how they envisioned the relative roles of the individual, the employer, and the government in the provision of health insurance, the responses reaffirmed this emphasis on the individual. They reaffirmed the centrality of the individual, as opposed to the state, in the provision of health insurance. Many added an additional caveat that contributions should be commensurate with individual income. Participants also suggested that the government act as a regulator, containing costs, enforcing insurance industry standards, and subsidizing the insurance costs of small businesses. They could see the government as a provider in limited circumstances, primarily, when individuals could not afford health insurance themselves. They saw the employer as an ideal vehicle through which to provide health insurance, with the qualification that employers be expected to provide insurance to employees only if the

company could afford to do so. In his reflection on where the burden of responsibility for health insurance should fall, Brian said,

> I think the individual has to take a fairly high degree of responsibility for his or her own health, and also accept the consequences when they don't take that responsibility. I think they have the primary responsibility for providing insurance or healthcare for themselves. And I think the employer has an obligation, to the extent that they are capable, of assisting in that. They have a responsibility to their workforce to provide at least a minimal amount of care and to offer the ability to purchase additional care through the employer. I think the government's primary role with healthcare is to make sure that it has adequate regulation but not over-regulation, and to facilitate employers in being able to provide that insurance.
>
> [Brian, 54 year-old salaried employee]

Lana, whom we met in Chapter Four, explained her ideas about responsibility for health insurance as such:

> I think the government should work on lowering the cost of health insurance. I think the employers should provide health insurance for their employees. And I think the individual should work. They should get up every morning, and work. Or choose not to work, and don't expect anything.
>
> [Lana, 46 year-old salaried employee]

Brian's and Lana's comments reflect a general tendency among participants to delineate a specific constellation of roles and responsibilities for health insurance, by actor or sector. According to this range of responsibilities, the individual should be at the forefront of the provision of health insurance, the employer would play a role – when affordable – in providing options for coverage, and the government should serve as a regulator. Some participants, drawing attention to the high cost of health insurance, thought that individual responsibility for health insurance should correspond to one's income. Greg, an active salaried employee told me,

> I think the individual has a responsibility to provide something for themselves, provided they can afford it - or based on your wages, maybe that's an idea; you throw it into their tax return: "Based upon your adjusted gross income, your own portion for your own healthcare is X amount of dollars."
>
> [Greg, 50 year-old active employee]

Others added that the government should subsidize the cost of health insurance for those who could not afford it:

> Maybe that's where the government's option of their own health insurance could be good, if – if handled properly, not we're just going to give it to everybody who doesn't have it, but if you make X number of dollars, you pay a certain deductible, or co-pay, the same kind of thing, as you make more you pay more, I guess, from an individual's perspective, and if you're unemployed, and maybe you're unemployable, then maybe we cover you for all your life, I don't know.
>
> [Lonnie, 54 year-old salaried employee]

These comments still place the individual at the forefront in securing health insurance. However, out of concern for those who cannot afford health insurance, or who cannot find employment, participants suggest that the government be responsible for alleviating the financial burden of health insurance through tax measures and by indexing health insurance costs to income. Thus, the state is also assigned responsibility for ensuring access to health insurance.

Participants also thought that the government's responsibility was to subsidize the cost of health insurance for small businesses, so that they could provide it to employees. There was a keen awareness, perhaps because of the cost of health insurance to General Motors, that health insurance is costly to businesses; a figure commonly mentioned in the media at the time of fieldwork was that $1500 of the cost of a U.S.-made GM vehicle went to employee health care costs (Will 2005). During interviews, participants referred to the high cost of health insurance to GM; union members had agreed to cuts to retiree health care spending as part of the 2009 restructuring, and salaried employees described a

constant erosion of health plans and coverage. Participants were very much aware of the effect of health insurance costs on businesses. Furthermore, they were particularly sensitive to the cost of health insurance for small businesses. In this case, they thought it was government's role to make insurance more affordable to small business. Wendy, a retired UAW employee who now worked for an insurance company herself, explained to me,

> I always thought of it as, I want to say, a gift. A gift from a company, to give you health insurance. I don't think that they're obligated, ever. You know. They're a company. Their whole purpose is to make money. If they can afford to do it, if they have a profit margin that's – and their stockholders have a good income coming in from it, absolutely, then I think it's something that if they – it's not going to hurt the company, then they should provide it for their employees. If small businesses, they have ups and downs, and all over the place. If that happens, then I think the government can subsidize small businesses.
>
> [Wendy, 55 year-old retired union employee]

As Wendy's comment illustrates, participants viewed the government's role as one of facilitating the purchase of health insurance for those businesses that could not afford to buy coverage for employees. Wendy was the only participant who categorized health insurance as a *gift* from the employer, however, this comment is in keeping with the sentiment, common among many participants, that a company offer health insurance at its discretion, provided it can afford to do so. Here, the company is not seen as obligated to provide health insurance to employees, and its bottom line is given priority over the health insurance needs of employees.

In summary, when asked about the relative responsibility of the individual, the employer, and the government in providing health insurance, participants presented a breakdown of duties and obligations by actor or sector. According to this model, the government was seen as a regulator, responsible for cost containment and subsidizing

employers so that they could provide insurance to employees; next, the employer was seen as the vehicle through which individuals should be insured, with the caveat that the employer be able to afford to do so; and finally, the individual was seen as being responsible for obtaining health insurance, ideally through work. In the event that someone could not afford to buy insurance, participants saw the government as being responsible for subsidizing that cost, and making it more affordable to the individual by indexing payments to personal income. Although responsibility for health insurance was distributed between the government, the employer, and the individual, ultimately, the focus was on the responsibility of the individual in providing health insurance, with the government acting as a facilitator of this model, making it more accessible through the employer, or directly to the individual citizen.

The Moral Order of the Patient Protection and Affordable Care Act

Importantly, health policy has the ability to formalize the types of obligations and responsibilities for health insurance outlined by participants. The Affordable Care Act, passed at the time of fieldwork, actively encodes specific rights and obligations for health insurance. As Shore and Wright (1997) note, policy and governance are inherently moral undertakings. Although cloaked as neutral, objective, rational artifacts, they are the product of "subjective, ideological, and arguably highly 'irrational' goals", human agency, and political interests (Ibid: 11). Although the Affordable Care Act is, at a basic level, a "legal-rational" artifact, it is also a moral document, and it reflects the political interests of those actors and institutions at the nexus of health policy. Furthermore, it projects a specific moral order by virtue of its assignment of responsibility to the

individual, the employer, and the state in the provision and procurement of health insurance. This section examines the way in which the ACA constructs a particular moral order, or system of rights and responsibilities, for health insurance. I argue that the ACA reinforces the existing moral order of health care in the United States by allocating primary responsibility to the individual and employer to ensure health insurance coverage, and in so doing, reinforces a neoliberal model of health care based on market based medicine and consumer rights. I also show that the distribution of rights and responsibilities encoded in the law mirrors the ideas expressed by participants. This necessarily raises the issue of governance, and I explore the role of the ACA in shaping Americans' construction of themselves, norms of conduct, and the social order.

The Affordable Care Act sets out a particular moral order that assigns specific responsibilities to the individual, the employer, and the state for the provision and procurement of health insurance for Americans. What follows is a general overview of the ways in which responsibilities, and in some cases, rights, are assigned by the ACA to these three actors. The ACA expands state responsibility for the provision of health insurance, most visibly through Title II, *Role of Public Programs*, Subtitle A, *Improved Access to Medicaid* (Patient Protection and Affordable Care Act (PPACA) p. 392). This part of the law effectively increases government responsibility for providing health insurance to Americans and legal residents. It does so by expanding eligibility for Medicaid for low-income individuals from a median eligibility of 46% of the federal poverty level (approximately $11 200 for a parent of a family of four) to 133% of the federal poverty level (approximately $31 720 for a family of four) (KFF 2014b, Medicaid 2014). However, an important feature of Medicaid is its funding structure; although

partially funded by the federal government, it is administered by the states. The ACA restricts federal Medicaid payments to those states that participate in the expansion of Medicaid. In June 2012, the Supreme Court ruled that this condition was unconstitutional. As a result of this ruling, participation in the ACA's Medicaid expansion program became optional for states (KFF 2014d). Thus, although the ACA increases the government's responsibility to individuals, the implementation of this expanded obligation – at least in the expansion of Medicaid – occurs at the discretion of the state.

So far, adoption of Medicaid expansion has been inconsistent among the states (KFF 2014d). As a result, state responsibility for health insurance to those meeting the new eligibility criteria has been inconsistent. Currently, 29 states, including the District of Columbia are implementing Medicaid expansion, while 22 states are not (KFF 2014d). For low-income individuals in "opt-out" states, they remain eligible for Medicaid under pre-ACA eligibility rules; they qualify for Medicaid only if they have an income of below (a state median of) 46% of the federal poverty level (Ibid). As will be discussed, federal assistance for premium tax credits and subsidies for the purchase of health insurance is available for those making between 100% and 400% of the federal poverty level. Thus, those individuals who make between 46% and 100% of the federal poverty level (for a family of four, between $11 000 and $23 900) will fall into a "coverage gap"; their incomes are too low to allow them to purchase health insurance through exchanges or on the open market, but their incomes are above the (pre-ACA) state cutoff level for qualification for Medicaid (KFF 2014d). Importantly, this will leave low-income individuals in "opt-out" states without health insurance. The Kaiser Family Foundation

(2014d) estimates that nationally, 4.8 million adults (10% of the nonelderly uninsured) will be affected by lack of Medicaid expansion and that these people "are most likely to remain uninsured". In "opt-out" states, the percentage of the population that will fall into this coverage gap is as high as 29% (as is the case in Alabama) (KFF 2014d), and it will disproportionately affect African Americans (Tabernise and Gebeloff 2013). In fact, according to a New York Times article, 68% of poor, uninsured African Americans and single mothers live in states that have opted not to expand Medicaid eligibility (Ibid). Thus, although the ACA expands state responsibility for health coverage, this obligation is not binding among the states, and is occurring in a piecemeal fashion. The 2012 Supreme Court ruling dilutes the ACA's allocation of responsibility to the government for ensuring health coverage for low-income Americans, effectively making this obligation optional, and discretionary, by state. In so doing, it obviates state responsibility for millions of low-income Americans, many of whom are racial minorities and women. As such, in "opt-out" states, the ACA fails to ensure "Quality, Affordable Health Care For All Americans" (PPACA 2010: 18). Thus, it contributes to racial and ethnic health disparities, a well-documented feature of the American health care system which the federal government seeks to reduce through policy (DHHS 2011).

In addition to the (handicapped) expansion of Medicaid programs, the ACA assigns state responsibility for health insurance in the form of subsidies to individuals for the purchase of health insurance, and the establishment of health insurance exchanges, or "marketplaces". For those with incomes between 100% and 400% of the poverty level, the law stipulates that the government provides subsidies to help pay the cost of private insurance premiums; these subsidies come in the form of tax credits, graduated by

income (KFF 2014d, Starr 2011). In addition, the law stipulates that the government assists some individuals (those with incomes below 250% of the poverty level) with the cost of deductibles and copayments. The state is also responsible for setting up state-based health insurance exchanges to act as a market place for individuals and small businesses purchasing health insurance (KFF 2013). The ACA does not create an obligation for the state to subsidize the cost of insurance for those with incomes above 400% of the federal poverty level, who represent 21% of the uninsured, or undocumented immigrants, who make up 13% of the uninsured population. While the former group may purchase health insurance through the state marketplaces, the latter is barred from doing so (KFF 2014d). While the former group is likely able to afford to purchase private health insurance, the latter is not, and "is likely to remain uninsured" (Ibid). Thus, state responsibility for health insurance provision expanded under the law to include financial assistance for individuals with the cost of purchasing health insurance, and costs associated with paying for health care, as well as the provision of a structure for the purchase of health insurance. However, it explicitly prohibits the state from assisting undocumented immigrants with the purchase of more affordable health insurance plans in the state marketplace, or from assisting them with premium subsidies.

The ACA also encodes specific individual responsibilities for the provision and procurement of health insurance. These obligations fall under *Subsection F, Shared Responsibility for Health Insurance* (PPACA 2010: 317). Part 1, *Individual Responsibility for Health Care*, also known as the "individual mandate", formalizes individual obligations in relation to health insurance by requiring individuals to obtain health insurance, and maintain a minimum level of coverage over the course of a year

(PPACA 2010: 317, Starr 2011). Compliance is enforced through a series of taxes that gradually increase with time (IRS 2014). Individuals may obtain coverage through their employer, through the state health insurance exchanges, or directly from an insurance company (IRS 2014). As indicated earlier, the ACA also encodes specific rights for individuals. It does not establish a general right to health care nor to health insurance. It does create a right to federally subsidized coverage for individuals who would, otherwise, be unable to afford insurance. However, as Starr (2011) notes, on the whole, rather than enshrining a right to health care or insurance, the ACA instead creates a "series of individual rights in relation to private insurance", including, for example, a right against being denied coverage due to a preexisting condition, and a right against lifetime limits on coverage (p. 248). As noted earlier, rights are framed in terms of consumer rights, in this case the right, as a consumer of insurance plans, against being denied coverage.

The ACA also assigns responsibility for health insurance provision to employers. *Part II* of the law's *Shared Responsibility for Health Insurance* applies to employers, and formalizes their obligations to offer employee coverage (PPACA 2010: 317, 342). For example, it requires employers with more than 200 employees to automatically enroll employees into health insurance plans offered by the employer (KFF 2013). Employers with 50 or more employees are required to provide health insurance if their employees would, otherwise, qualify for government subsidies (Ibid). In terms of rights, small businesses with 25 or fewer employees are provided tax credits to help fund the provision of employee health insurance (Ibid). As such, the ACA encodes specific employer responsibilities and rights regarding the provision of health insurance to Americans.

Thus, the ACA lays out a specific constellation of rights and responsibilities for health insurance. Although the law expands the state's role in the provision of health insurance, overall, it assigns the bulk of responsibility to the individual and the employer for furnishing health insurance. Notwithstanding the (inconsistent) expansion of Medicaid across the states, insurance subsidies, and marketplaces set up by the state, it is primarily the employer and the individual that "share" the responsibility of providing, or procuring health insurance. As such, as Horton et al. (2014) note, the ACA "merely expands rather than reforms the existing fragmented and costly employer-based health care system" (p. 1). However, the ACA goes further than merely expanding the existing model for health insurance. In particular, the law reinforces the existing paradigm for merit and responsibility for health insurance in the United States by further strengthening the cultural logic that health insurance is obtained through work. The *Shared Responsibility* provision formalizes the employer as a primary vehicle for the procurement of health insurance; the ACA's employer mandates and tax credits reinforce, and formally legitimize, employer responsibility for health insurance. In so doing, they further naturalize the cultural assumption that health insurance is tied to employment. The ACA confirms, reinforces, and promotes the self-evident logic, discussed by participants, that employment is the vehicle through which health insurance should be obtained. It also reinforces the dominant cultural logic that health insurance is an individual responsibility. The law's *Shared Responsibility* provision makes Americans legally responsible for maintaining a minimum level of coverage (PPACA 2010: 317). The law frames this responsibility in terms of consumer choice (PPACA 2010: 154) and rights which revolve around private insurance, including a "right against arbitrary

rescissions and unreasonable limits of coverage" (Starr 2011: 248). With this emphasis on employer and individual responsibility for insurance, the ACA reinforces the cultural legitimacy of the primarily private, employer-based model for health insurance.

Shore and Wright (1997) remind us that policy is a tool of governance (Foucault 1991). As a political technology, it has the power to shape the way individuals construct themselves as subjects, to prescribe behavior, and to define social relations in a way that contributes to a government's model of social order (Shore and Wright 1997: 5). This model of the social order is constituted by specific norms, which, once internalized, inform the ways in which individuals understand themselves and the world, and behave. The Affordable Care Act is a tool of governance, promoting very specific notions of state, employer, and individual responsibility for health insurance. The ACA promotes a neoliberal rationality, which rests on the idea that the individual, as opposed to the state, should be responsible for his or her health, and that health insurance should be tied to employment. According to neoliberal values, the state is neither desired nor capable of managing the affairs of its citizens. Rather, neoliberalism emphasizes the role of the individual in managing these affairs by promoting a construction of the self that emphasizes the importance of independence, self-reliance, and economic productivity (Heelas and Morris 1992). Self-responsibility for health allows the individual to fulfill the neoliberal ideals of independence, autonomy, and freedom from government intervention. The ACA's individual and employer mandates promote this type of rationality by formalizing individual responsibility for the purchase of health insurance, and by making employment the vehicle required to obtain health insurance, whether through an employer-provided plan, or purchased with wealth earned through employment. Notably,

the *Shared Responsibility* provision applies to individuals and employers, not the state (PPACA 2010: 317, 314). As such, it encodes neoliberal values that divest the state from primary responsibility for the provision of health insurance to citizens, and emphasizes individual responsibility for health insurance, via employment.

The ACA further promotes individual responsibility for health insurance through its emphasis on "consumer choice" in health care. Neoliberalism defines self-responsibility for health in terms of consumer behavior and the purchase of health-related products, including insurance (Donahue and Maguire 1995). The ACA's emphasis on "Consumer Choices" (2010: 130) and rights, while serving the very necessary purpose of protecting consumers from ruinous and discriminatory practices carried out by insurance companies, nonetheless presents health-as-consumption as a foregone conclusion. It presents as taken-for-granted, and does not challenge the existing neoliberal assumption, that citizens' relationship to health is one as consumers of commodities. Accompanying neoliberalism's focus on consumption is its concomitant emphasis on competition. As Heelas and Morris (1992) note, neoliberalism, and the "enterprise culture" it promotes, foster a construction of the individual based on wealth creation. According to this rationality, economic productivity is a measure of moral worth (Handler and Hasenfeld 1991). Success is displayed by way of conspicuous consumption, and "the cultural emphasis on competition in the realm of production is readily transferred to competition in the realm of consumption" (Heelas and Morris 1992: 13). The ACA reinforces this construction of the self as a competitive wealth producer through, for example, the tiered nature of the health insurance plans available through state Exchanges. The ACA separates health insurance plans offered through state Exchanges into the following

categories: Bronze, Silver, Gold, and Platinum. These categories are defined by the plans' actuarial value, or the percentage of health care costs paid by each type of plan. The higher the actuarial value, the more the plan will pay for health care costs, and the lower the out-of-pocket costs will be to the consumer. Cost coverage occurs along a continuum, with Bronze plans covering the least, and Platinum plans covering the highest percentage of health care costs. However, the cost of plans to the consumer also occurs along a continuum, with Bronze plans having the lowest premiums, and Platinum plans having the highest premiums. The use of terminology (Bronze, Silver, Gold, Platinum), which is inherently value laden and culturally salient (in the United States, "platinum" cards were once considered a sign of elite status and wealth for credit card holders) necessarily suggests that levels of health coverage also correspond to financial wealth, and, by extension, ability to purchase particular consumer products. As such, the levels of coverage function as signifiers of status and relative "success" in the competitive project of wealth creation, and consumption. In this case the purchase of health insurance plans defined as either Bronze, Silver, Gold, or Platinum, signifies one's relative ability to create wealth, and consume accordingly. Thus, the ACA's emphasis on consumer choice and the framing of health insurance in terms of status markers reinforces a neoliberal construction of the individual as a wealth producer and consumer, and presents individual responsibility for health insurance as a foregone conclusion.

How do the neoliberal values of the ACA relate to the ideas of participants about the relative roles of the individual, the employer, and the state, in the provision and procurement of health insurance? Participants explained to me that they saw the government as an industry regulator, responsible for cost containment and subsidizing

employers so that they could provide insurance to employees. They saw the employer as the vehicle through which individuals should be insured, with the caveat that the employer be able to do so. They saw the individual as being responsible for obtaining health insurance, ideally through work. In the event that someone could not obtain it through their employer, nor afford to purchase it, participants saw the government as being responsible for subsidizing the cost, making it more affordable by indexing it to personal income. Ultimately, participants focused on the individual as being responsible for obtaining health insurance, with the government acting as facilitator of this model, making it more accessible through the employer, or directly to the individual citizen. These ideas are strikingly similar to the general distribution of responsibilities promoted in the ACA, with its emphasis on the government as a facilitator to both individuals and businesses in the purchase of health insurance, through tax credits and premium subsidies, indexed to income and business size.

How can we make sense of this confluence of values between participants and policy? Does it reflect the policy debates that participants may have been exposed to in the lead up to the passage of the bill? Almost three quarters (73%, 29/40) of participants told me that they were following health reform, or following it "a little bit". It is possible that they retained information about the law, discussed in the media or among friends, family, and colleagues, even if they were not consciously seeking information about it, and that they drew upon this information when reflecting on ideas about responsibility for health insurance. What is of significance is what this confluence of values suggests about the ability of policy to shape subjectivity and understandings of the social order. The ACA has the ability to guide and shape ideas – potentially even at a very early stage in

the policy process – about self-responsibility for health and the role of the state. It will also serve as a powerful reinforcement of existing dominant neoliberal understandings of the self and the state, which place the emphasis on the individual, as opposed to the government, for the provision and procurement of health insurance. Not only does it formalize and codify these neoliberal values, in so doing, it adds another layer of legitimacy to the existing cultural assumption that the individual is responsible for health insurance, that work is the primary vehicle through which it is to be obtained, and that market-based medicine is a valid model for the distribution of health care.

We have seen that the GM workers I interviewed held contradictory views about the relative roles of the individual, the employer, and the government in the provision of health insurance. According to the majority of participants, health insurance is not a human right. However, an equal number of participants expressed a desire for some sort of universal health insurance coverage. ITA theory helps us understand the seeming contradiction between the desire for universal coverage and a reluctance to define health care as a human right; the former is a "mid-level" value, which can be supported by various "high-level" values, the right to health being just one of many such values. For a little more than half of those who supported universal health insurance, their support dissipated out of a reluctance to pay higher taxes, and a lack of faith in the government's ability to manage social programs. ITA also contextualizes this ambivalence towards universal coverage; it illustrates how "low-level" values (such as relative willingness to pay for others' health insurance, and faith in government) can trump mid-level values like "health care for all". Ultimately, when asked to reflect on the obligations of the government, the employer, and the individual in the provision of health insurance,

participants reaffirmed their emphasis on the individual, and to a certain extent, the employer. With its emphasis on individual and employer "shared responsibilities", the ACA reinforces the central role of the individual in providing insurance, with work as the linchpin for securing coverage through either the employer, or on the open market. The law's emphasis on "consumer choices" and rights takes as a fait accompli private insurance and market based medicine as the vehicles through which Americans obtain their health coverage. As a moral undertaking, the ACA constructs a specific moral order, or constellation of rights and obligations. Its various provisions add layer upon layer of legitimacy to the existing cultural assumption that the individual is responsible for health insurance, that work is the primary vehicle through which it is to be obtained, and that market-based medicine is a valid model for the distribution of health insurance. As such, it reinforces and promotes existing neoliberal understandings of the self, the state, and the social order in the realm of health insurance, ideas that were also expressed by participants.

CHAPTER 6: CONCLUSION

This dissertation has examined the ways in which workers and managers at two General Motors plants in Lansing, Michigan, construct ideas of merit and deservedness for health insurance. It has explored how they perceive the appropriate roles of the individual, the employer, and the state, in the procurement and the provision of health insurance, at a time when these ideas were in flux, and being challenged by the material realities of economic instability. This project has also consisted of the discourse analysis of policy portrayals of responsibility and deservedness for health insurance. In so doing, it has attempted to elucidate the cultural assumptions that reinforce and reproduce the private, employer-based health insurance model, and questioned whether these assumptions were being challenged during a period of economic downturn, company restructuring, and health reform. Using examples from fieldwork and interviews, it has explored the way in which the groups studied understand notions of work and productivity, as they relate to ideas about responsibility for, and legitimate access to, health insurance. It has paid particular attention to the role of ideas about morality in defining the relationship between work and legitimate access to, and responsibility for, health insurance. In this chapter, I present an overview of the findings of this study. I also explain how this dissertation connects to existing scholarship in medical anthropology, identify areas for future research, and suggest ways in which research such as this can contribute to policy development.

Overview of Findings: Answering the Research Questions

The overarching research question informing this study has been: "How are Americans constructing notions of responsibility and merit for health insurance at a time of national economic crisis?" I sought to answer this question by looking at the ideas and beliefs of a group of autoworkers, and by examining the content of the Affordable Care Act. Specifically, I asked: 1) How do the auto workers interviewed define merit and deservedness for health insurance, and morally legitimate claims to health care; 2) Are these assumptions being challenged during a period of economic downturn, company restructuring, and health reform; 3) How do participants express and reconcile conflicting ideas of merit and responsibility for health insurance; and 4) What ideas of merit and responsibility for health insurance are conveyed and encoded in emerging health care policy?

Definitions of Deservedness and Responsibility for Health Insurance

As we saw in this dissertation, participants overwhelmingly saw "work" as the lynchpin for morally legitimate claims to health insurance. Specifically, they defined merit and deservedness for health insurance according to one's ability, or willingness, to work. Their ideas about the importance of work in defining merit and deservedness for health insurance centered on four key themes: that work is a prerequisite for access to health insurance; that the working uninsured deserve to be insured by virtue of the fact that they are working; that the unemployed uninsured can be classified as either deserving or undeserving of health insurance, depending on their willingness to seek work; and the suggestion that those who are unable to find work can still make moral

claims to health insurance through community service or volunteer work, and by indexing their level of insurance coverage to the amount of time spent in the workforce. Furthermore, participants employed various metaphors to convey these ideas, namely those of accounting, physical orientation, and competition.

Throughout, ideas linking health insurance to work, and the metaphors of morality used to convey these ideas, reflect not only the vestiges of the Protestant Ethic, and the ideology of meritocratic individualism, but also neoliberal notions of self-hood. For example, the metaphors of accounting, physical orientation, and competition used by some participants to explain merit and deservedness for health insurance reflect key neoliberal values of self-reliance, industriousness, independence, and competition. The idea that one should *earn* one's health insurance encapsulates the neoliberal value of economic productivity. The insistence that the "reward" of health insurance can be attained even in times of unemployment through volunteer work, or by indexing one's coverage to the time spent in the workforce, not only reflects the neoliberal emphasis on competition and productivity, but also echoes existing neoliberal social policies; some participants' ideas about deservedness for health insurance mirrored larger attitudes towards the poor and welfare policy in the United States. In fact, defining those who merit health insurance as those working, or willing to work, is in keeping with policy and discourse about poverty in the United States that focuses on concepts of productivity, cost, and eligibility as defining characteristics for welfare support.

This discourse reflects the cultural tendency, within the United States, to measure people by their ability to produce wealth, and is illustrated in current welfare policy (Katz 1990). For example, the Personal Responsibility and Work Reconciliation Act

(PRWORA) of 1996 stipulates that welfare benefits are not an entitlement, but must be earned through work requirements (Handler 2004). In this respect, some participants' emphasis on the role of work in defining merit for health insurance reflects larger discursive trends about the value of the individual, and the role of the state, in American society.

These understandings of the self and the state may also be situated within a larger policy context. While social citizenship – rights that attach by virtue of citizenship status - in most industrialized nations outside the United States corresponds to political citizenship or long-term residency (Handler 2004; Olsen 2002), in the United States, social citizenship is predicated upon economic productivity. Social rights and benefits conferred in other industrialized nations, such as welfare benefits or health insurance, must be earned in the United States. Even the Old-Age Security component of Social Security, the United States' most expansive and popular benefits program (Olsen 2002) is based on work record and contributions. Neoliberal rationality, which promotes market-oriented assumptions about social value, reinforces and amplifies the assumption that social worth and cultural citizenship are predicated on the ability to be economically productive. It reconfigures the notion of human value to reflect the characteristics of neoliberal enterprise culture: self-responsibility, ambition, independence, and the accumulation of wealth. The opinions of participants that emphasized the importance of work in defining morally legitimate claims to health insurance may be seen within the larger context of these neoliberal political and economic rationalities. They both reflect, and reproduce, these market-oriented values that inform American constructions of social citizenship.

As we saw in this dissertation, however, not all participants subscribed to neoliberal ideas about the individual and the state. A small, but vocal, minority challenged neoliberal notions of personal responsibility and the importance of small government, insisting that health insurance is not something to be earned, but rather, a human right. They argued for greater government involvement in the provision of health insurance, in the form of universal health coverage. In terms of the ways in which they understood deservedness and responsibility for health insurance, there was congruence between the different levels of principles informing their ideas about access to health care. Recall that Ruger (2007) identifies three levels of principles: high, medium, and low level values, which inform ideas about policy amongst the public, and policy makers. When these three levels of values are in agreement, there is consensus about a particular policy issue. For those participants supporting the high level idea that health care is a human right, they held concomitant support of the principle of universal health insurance, and supported the low level principle required to achieve this: government involvement in the provision of health insurance. As such, there was agreement between the different levels of principles. They held an integrated view of, and reasoning about, merit and deservedness for health insurance: health care is a human right, it should be protected through universal health insurance, and the government should help provide this insurance. They also drew attention to the larger political and economic environment facilitating job loss and deindustrialization in Michigan, and argued that such circumstances obligate the state to provide care for its citizens. In this respect, they challenged some of the central tenets of neoliberalism – the breaking down of trade barriers, small government, and individual responsibility for social welfare – and

illustrated an awareness of the effects of a larger political economic system on their lives, and the lives of others. This group of participants also expressed a deep concern for those facing the effects of the economic downturn: job loss and eventual loss of health insurance.

It would be inaccurate to assume, however, that the majority, who supported a more market-oriented approach to responsibility for health insurance, did not also care deeply about the unemployed and the uninsured. Rather, their viewpoints were simply more conflicted, and their opinions ambivalent or compartmentalized. These participants showed a moral commitment to the uninsured, pointing out the inequality of a system that does not cover all members of society, and suggested that universal coverage would be more equitable for all Americans. However, they could not reconcile these moral concerns with ideas about how to achieve the ultimate goal of health care for all. Rather, these participants held values of different levels that were not mutually reinforcing, and thus in conflict.

As we saw in Chapter 5, the idea "health care is a human right" is a high level value, universal coverage is a mid-level principle, and the means required to achieve this goal – government involvement, and higher taxes, for example – represent low level principles. The majority of participants supported the mid-level principle of universal coverage, but did not support the higher level principle informing it, "health care is a human right", nor the lower level principle supporting it: greater government involvement in the provision of health insurance, and personal sacrifices in the form of higher taxes. Ultimately, this concern about lower level principles mitigated their desire for a universal health plan. In the end, this lack of agreement between high, mid, and low

level principles led to comments about merit and responsibility that were either compartmentalized (e.g. speakers made contradictory comments that were un-reconciled, which they were unaware of), or ambivalent (e.g. participants held contradictory views, but they were aware of them, and expressed frustration at being unable to reconcile them).

It should be noted, however, that the "right to health care" is not the only high-level principle supporting universal coverage, and the absence of support of this principle does not mean that these participants did not hold other high level principles justifying their desire for universal coverage. That the majority of participants did not see health insurance as a human right, and that a similar number did support universal coverage suggests that these participants may have held other, unarticulated high-level values that informed their desire for universal coverage. Ruger (2010) has identified several of these high-level values, and further research could investigate which of these principles inform a desire for universal coverage amongst those who do not see it as a human right.

Economic Instability: A Challenge to Ideas of Merit and Deservedness?

Given the political and economic context in which I was conducting this research, another key research question informing this project was whether participants' ideas about merit and deservedness for health insurance were being challenged by the recession and GM's restructuring. Ultimately, the recession, and GM's financial difficulties, did not change most participants' ideas about merit and responsibility for health insurance. Although almost all participants conceded that these factors made access to health insurance more precarious – for both GM employees, and the population at large – most participants maintained that work was an appropriate vehicle for securing health

insurance. They suggested that even in tough economic times, the unemployed could secure health insurance through volunteer work and community service, or by indexing health coverage to the amount of time spent in the work force. These suggestions are in keeping with the very real experiences of the GM employees interviewed, some of whom, while laid off, had either done volunteer work themselves, or had experienced the indexing of their own health benefits to the length of time they had been working for GM.

Ultimately, however, the idea that work remains the intervening institution for access to health insurance suggests the influence of a larger neoliberal approach to rights of social citizenship. The insistence that individuals, rather than the state, are responsible for health coverage, even in tough economic times, reflects neoliberal values of personal self-sufficiency and small government. The suggestion that individuals conduct volunteer work for health coverage reflects "enterprise culture" (Heelas and Morris 1992), which lauds the importance of ambition and entrepreneurial values. The indexing of health coverage to time spent in the labor force, while currently a contractual benefit of UAW workers which is designed to protect their access to health insurance during lay offs, also reinforces a market-oriented approach to human worth, suggesting that employment is a legitimate prerequisite for access to health insurance, and that work is rewarded with health coverage only to the extent that one has participated in the labor force. In summary, then, in general, participants' ideas about merit and deservedness for health insurance were not altered by the recession, nor GM's restructuring. Instead, their ideas were adapted to take into account these events, and still privileged the importance of work in defining morally legitimate claims to health insurance.

Health Policy and Constructions of Deservedness and Responsibility

The other significant political development at the time of this research was the passage of the Affordable Care Act (ACA). Recognizing that policy has the ability to shape how people construct themselves, and define a range of acceptable conduct, what does this law convey about merit and responsibility for health insurance? The ACA explicitly emphasizes individual responsibility for health insurance through the "individual mandate" by legally obligating *individuals* obtain health insurance (as opposed to, say, significantly expanding the government's role in providing insurance). By virtue of the fact that it is law, it formalizes individual responsibility for health insurance. It frames this responsibility in terms of consumer choice, a key neoliberal trope that helps to divest the state of responsibility for social programs. It reinforces the employer-based health insurance model by making employment the vehicle required to purchase health insurance, whether through an employer-sponsored plan, or with funds earned through employment. The ACA provides a moderate, handicapped expansion of Medicaid, and thus, a relatively limited expansion of state involvement in the provision of health insurance.

Implicitly, policy has the ability to define a range of acceptable norms and practices, which, once internalized, inform the ways in which individuals understand themselves and the world. The ACA defines the social order in terms of neoliberal values that divest the state of primary responsibility for the provision of health insurance, and emphasize individual responsibility for health insurance, through employment. It not only reflects the dominant employer-sponsored model of health insurance delivery in the United States, and the values of the majority of participants in this study, but it also

actively reproduces these norms, further promoting work as the catalyst for access to health insurance.

As policy, the ACA strengthens the moral assertion that health insurance must be earned through personal sacrifice and work; it legally encodes, and formally legitimizes, the idea that access to health insurance is predicated on economic productivity. As such, is reinforces dominant neoliberal discourse that the individual, through employment, is responsible for providing health insurance, while simultaneously divesting the state of the bulk of this responsibility. In this respect, the ACA functions a tool of governance, promoting very specific notions of state, employer, and individual responsibility for health insurance.

As Marmor and Oberlander (2011) note, the ACA's reliance on the existing model of employer-sponsored health insurance is the result, in part, of the legislative and institutional constraints faced by those who promoted health care reform, and as such, it "stands as an extraordinary legislative accomplishment" (p. 127). However significant a legislative feat, the law's reliance on private industry and employment-based health insurance only reinforces the role of capitalism in the provision of health insurance in the United States. It strengthens the overall neoliberal project of privatization, divestiture of social programs from state responsibility, and the shifting of these responsibilities to the individual. The ACA leaves the dominant model of private employer-based health insurance intact, and in this respect, it "represents a boon for the very forces of capitalist accumulation" (Horton et al. 2014).

Politics and Private Insurance: a Cultural Critique

There have been repeated calls (Horton and Lamphere 2006; Rylko-Bauer and Farmer 2002; Sargent 2009; Horton et al. 2014) for medical anthropologists to make market-based medicine and neoliberal approaches to health care within the United States the topic of anthropological enquiry. This dissertation forms part of a growing body of anthropological literature (Connealy 2012 ; Horton et al. 2001; Willging, Waitzkin and Wagner 2004) that responds to these calls by examining the cultural assumptions behind, and political economic dimensions of, private health insurance in the United States. It has questioned the cultural assumptions behind the primarily private, employer-based model, and highlighted the ways in which it is reproduced and normalized.

My inquiry into ideas about health insurance forms part of a larger discussion in the fields of medical anthropology, and the anthropology of policy, which focuses on neoliberal dimensions of health, and the ways in which policy can prescribe, sanction, and shape behavior. Scholars across the social sciences (Conrad 1995; Donahue & McGuire 1995; Greco 1993; Lupton 1995; Minkler 1999; Nettleton 1997; Rockhill 2001; Rose 1992) have drawn attention to the ways in which neoliberal values inform American approaches the health and health care. This research builds upon existing analyses of the intersection of neoliberal values and the management of health, and expands the scope of this analysis. There has been substantial anthropological exploration of the nature and context of the concept of "personal responsibility for health", yet this has focused largely on self-monitoring and behavioral choices, such as those relating to diet and exercise. This study has broadened the interrogation of neoliberalism and health by looking at the ways in which ideas of responsibility manifest themselves in attitudes towards health

insurance, and in ideas about the relative roles of the individual, the employer, and the state in ensuring access to health care. As such, this dissertation has provided new information regarding the ways in which responsibility for health is conceived of and constructed in the United States. It has drawn attention to the ways in which legitimate access to health insurance is defined, and the way in which responsibility for health insurance is constructed.

As Willen (2012) notes, relatively little is known about how deservingness is reckoned in the health. Willen (Ibid) adds that this "is a complex matter of great significance, particularly in an era of neoliberal pressures including the increasing privatization and commoditization of health care" (p. 814). She asks, "What criteria influence deservingness assessments, and what role does ideology play? Who is responsible for providing health care, and how should costs be covered?" This dissertation has provided some preliminary answers to these questions, focusing on a specific group of autoworkers, and the ways in which they understand ideas of deservedness and responsibility for health insurance. It has also built upon, and expanded, existing scholarship (Becker 2004) on the intersection between merit, deservedness, work, and productivity, in defining morally legitimate access to health care. And in keeping with a critical medical anthropology approach, it has considered how individuals' opinions about, and experiences with, medical systems reflect larger political and economic forces.

This study has contributed to the anthropology of policy by examining how health policy defines the parameters by which Americans have access to health insurance, by situating the ACA within a larger ideological and political economic context, and by

highlighting the ways in which a group of autoworkers thinks about policy options like universal health insurance. It offers insight into some of the assumptions that privilege health care as either a right or a commodity, and helps to explain the rift between the "complex contradiction" (Sargent 2009) between support for universally accessible health insurance on an abstract level, and absence of this same support on a more practical level, the presence of which is required to achieve consensus about policy. It provides insight into the cultural resilience of the private, employer-based health insurance system, and thus offers an expanded perspective on reasons for the continued support of a health insurance model that poses economic and health–related problems for millions of Americans. Additionally, by focusing on the role of morality in defining the relationship between work and legitimate access to, and responsibility for, health insurance, it has highlighted how cultural assumptions about work bear upon receptivity to ideas, such as universal health insurance, that challenge the work-health insurance paradigm.

According to theories of governance, policies work not only to prescribe conduct in a top-down manner, but also promote the internalization of norms of conduct "so that they, themselves contribute, not necessarily consciously to a government's model of social order" (Shore and Wright 1997: 6). This dissertation has highlighted the ways in which ideas about responsibility for health insurance correspond to policy prescriptions in this domain. It has shown how the opinions and insights of a group of autoworkers both refute, yet may also reflect and reproduce, broader ideologies and political economic structures, including neoliberal approaches to the self, the state, and to health. Ultimately, by dissecting the assumptions inherent in ideas about who bears responsibility for the

provision of health insurance, this research contributes to a better understanding of the cultural logic of the American health care system. In this respect, this research makes a contribution to the ongoing dialog on health policy in the United States in general, and on health care reform in particular.

Areas of Future Research and Policy Considerations

As the implementation of the ACA continues, health policy, and ideas about merit and responsibility for health insurance remain highly relevant topics of inquiry within anthropology. Some participants commented that they were uneasy about government involvement in the provision of health insurance because they saw government as ineffective. It would be useful to examine how the media frames responsibility for health insurance, and especially government effectiveness; this could offer insight into what appears to be a reference to neoliberal discourse about government's role in social programs. On a very specific level, several questions arise regarding the intersection of the ACA and the existing work-health insurance paradigm in place at General Motors: How will the implementation of the ACA affect workers' access to, and experience of, health insurance at GM? Five years after the recession, have ideas about merit and deservedness changed or remained the same amongst participants? As more Entry level workers (with fewer health benefits than their Traditional counterparts) enter the GM labor force, does this affect ideas about work and responsibility for health insurance? As a large-scale provider of employer-sponsored health insurance, GM remains fertile ground for examining the effects of health care policy, and ideas about the link between work and access to health insurance.

On a more general level, market-based medicine, and neoliberal approaches to health, remain salient topics of anthropological inquiry. Has the implementation of the ACA affected ideas about the role of the state, the employer, and the individual in the provision of health insurance? Has it reinforced the norms that it apparently encodes? What has been the effect on ideas about universal health coverage with the passage, and unfolding implementation, of major health reform? What has been the political rhetoric surrounding, and what have been the media representations of, health reform? What messages about the appropriate role of the individual, the employer, and the state, are conveyed in the repeated legal challenges to the ACA? The national debate surrounding the nature and implementation of the ACA provides rich material for understanding the ideological dimensions of the United States health care system, and the policy that shapes, reinforces, and reproduces this system.

This dissertation has highlighted some of the assumptions that inform and help to reproduce the primarily private, employer-based health insurance model in place in the United States. There are reasons to think it captures bigger trends in the way that Americans think about responsibility for health insurance: some of the findings of this dissertation, namely, that reluctance to support universal health programs is informed by a lack of willingness to pay higher taxes, and a lack of faith in government to execute policy, is in keeping with Kaiser Family Foundation (2009b) research on ideas about national health insurance. Admittedly, the results of this dissertation are limited to the group of participants interviewed and may not be generalizable. However, knowing the specific insights and the details of the reasoning, as expressed by participants, about merit and deservedness for health insurance, the role of work in defining legitimate access to

health insurance, and the relative roles of the individual, the employer, and the state in its provision, can offer a more nuanced, detailed, and complex understanding of the way that some people think about access to health insurance. Ultimately, this can enable policy makers to better understand avenues for, and barriers to, policy change. Furthermore, the autoworkers involved, although perhaps largely privileged in their level of health insurance coverage, relative to millions of uninsured, or underinsured, Americans, nonetheless symbolize lay understandings of merit and deservedness. Lay understandings represent potentially influential "deservingness assessments" (Willen 2012), in the realm of policy-making and health reform.

Concluding Thoughts

In the preceding chapters, I have illustrated some of the ways in which a group of mid-Michigan General Motors employees have understood ideas of deservedness and responsibility for health insurance. Their opinions and insights reflect the degree to which personal experience, and ideas about morality, inform their opinions about legitimate access to health insurance. For some participants, morally legitimate claims to health insurance were based on the idea that health care is a human right, while for others, health insurance was seen as a commodity, to be earned through hard work. Participants' understandings of the ideal role of the government, the employer, and the individual, varied accordingly. While a minority of participants challenged a market-oriented approach to health insurance, the majority of the group expressed ideas about health insurance more in keeping with a neoliberal perspective on health: an approach that privileges the role of the individual in managing personal health, an emphasis on the

importance of hard work and economic self-sufficiency in defining both the moral, and material requirements in order to manage health, and the idea that the state is not well suited to managing the health affairs of its citizens. From a policy perspective, the ACA reinforces this neoliberal approach to health, by explicitly defining health insurance as the responsibility of the individual, with employment as the vehicle for meeting this responsibility. With a relatively limited expansion of state involvement in the provision of health insurance, and an increased emphasis on private, employer-based health insurance, the ACA reinforces existing market-based approaches to health insurance in the United States.

The neoliberal prescriptions of the ACA, and the neoliberal values about deservedness for health insurance expressed by some participants, represent a powerful combination of legal and lay positions on access to health insurance. The degree to which the values inherent in each position overlap highlights the convergence of policy and the internalization of norms of behavior, and the powerful effect the ACA may have to further legitimize neoliberal approaches to the self and the state in the realm health insurance. Combined, the macro-level political and economic rationalities encoded in the ACA, and the notions of self and state that they promote, along with individual emphases on the importance of self-responsibility for health and personal "enterprise culture" – as illustrated in the responses of some participants – help to further normalize the already dominant primarily private, employer based health insurance model in place in the United States, and naturalize the link between employment and health insurance. These mutually reinforcing macro and micro-level understandings of health, which link morality, work, and deservedness for health insurance, act as the ideological glue that makes the link

between health insurance and employment seem culturally sound and "functionally rational" (Sered and Fernandopulle 2005) in the United States. Given the seeming cultural logic within the United States of linking health insurance to employment, and recent health reform emphasizing employment and the individual in securing health insurance, it is likely that the primarily private, employer-based health insurance system will continue to be the dominant model for the financing of health insurance in the United States. Yet anthropology can highlight the degree to which this model for health insurance, even if powerfully entrenched at both the macro and micro-levels, carries inherent power imbalances worthy of investigation, analysis, and action.

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