

**Helping Those Who Help Themselves: Mid-Michigan Autoworkers and Discourses of
Responsibility for Health Insurance**

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Introduction

In late 2008 and early 2009, the effects of the global economic crisis became increasingly visible and widespread in the mid-Michigan city of Lansing. Several area businesses, both locally and nationally-owned, seemed suddenly to shut their doors, leaving vacant storefronts in malls and on the main street. Conversations overheard on the bus and over dinner touched on who had recently lost his or her job, upside down mortgages, neighborhood foreclosures, and the fear of impending layoffs at the State and at General Motors, two of the area's largest employers. The local unemployment rate had risen from 9.6% to 12.4% between April and June 2009 (United States Department of Labor 2010), and Lansing, already familiar with decades of deindustrialization, job loss, and economic depression, was exhibiting the effects of the global economic crisis.

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Then, on June 1st, 2009, the President of the United States announced that General Motors was filing for bankruptcy, further immersing members of the local community in the effects of the global recession. As part of the government's agreement to extend financial support to General Motors and to assist with its restructuring, the United States Treasury stipulated that GM would be required to make a variety of changes to its operating structure and its collective bargaining agreement with unionized employees (General Motors 2009). Included in these requirements was the condition that GM make significant modifications to its hourly employee health benefits. At the same time, public and legislative debate regarding national health reform began to increase.

Amid these circumstances, I began my dissertation research with employees at two Lansing area General Motors plants. My research examines the cultural assumptions that inform, reinforce,

and reproduce, the primarily private, employer-based health care system in the United States. Specifically, my research explores the ways in which employees at two GM plants in Lansing, Michigan, are constructing ideas of merit and responsibility for health insurance at a time of national economic crisis. It asks how they understand legitimate access to health insurance, and how they attribute responsibility for its provision, during a period in which the company they work for is facing government-enforced restructuring, recurring layoffs, and ongoing modifications to employee health benefits. How do they define morally legitimate access to health insurance; that is to say, who is entitled to, or “deserves” health insurance? Who bears responsibility for its provision or procurement? Is it the state, the employer, the individual, or a combination of the three? With the economic crisis and the government’s unprecedented action in the regulation of private industry – and its involvement in GM itself – along with increasingly vocal debates in favor of, and against, greater government involvement in the provision of health insurance, I was eager to explore workers’ ideas about the relative roles of the state, the private sector, and the individual in ensuring access to health insurance.

In this article, I examine the moral discourses of health insurance that circulated among GM workers at two Lansing area auto plants during 2009 and 2010. I will discuss a preliminary discourse analysis of statements and narratives regarding some of the moral dimensions of access to, and the provision of, health insurance. I will show that for the people with whom I spoke, work was a precondition for morally legitimate access to health insurance. I will also illustrate that the recession did not, in their opinions, alter this precondition. I will argue that their narratives about work and health insurance offer insight into notions of self-hood that, ultimately, help to naturalize the private, primarily employer-based health insurance model in

place in the United States. I will also illustrate that moral discourses for health insurance were frequently framed in biblical terms, reflecting a “deep cultural code” (Bellah 2006) of Protestantism within the population studied.

Anthropology, Market Based Medicine, Merit and Morality

This research provides a response to increasing calls (Horton and Lamphere 2006; Rylko-Bauer and Farmer 2002; Sargent 2009) for anthropologists to make market-based health care and health policy a topic of ethnographic enquiry. The negative impact of a market-based health care system on access to medical treatment and health services in the United States is well documented by anthropologists (Abraham 1993; Becker 2004; Becker 2007; Carillo et al. 2001; Horton et al. 2001; Rylko-Bauer and Farmer 2002, Farmer 1999, Sered and Fernandopulle 2005; Willging, Waitzkin and Wagner 2004). However, the *cultural assumptions* that inform and reinforce the private, employer-based health care system in the United States are not well examined. The research discussed here provides an ethnographic investigation into attitudes towards market based health care, with a focus on the ways in which ideas of deservedness and responsibility for health insurance are constructed.

This study is 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 1989). Such ideas

are especially salient in understanding constructions of merit and deservedness for 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), but it 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 (2002) 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; Ehrenreich 1990; McNamee and Miller 2004; Newman 1999), anthropologists have only begun to examine the way in which ideas about merit, individualism, work, and morality bear upon opinions about health insurance and health care (Becker 2004). The preliminary findings discussed in this article contribute to this growing focus within anthropology.

It is also important to note that ideas of merit, responsibility, and morality are especially salient at this moment in American history, as Americans attempt to make sense of the current economic

downturn. As the economic crisis unfolds, Americans are reexamining ideas of personal, business, and state responsibility and merit. Notions of deservedness and morality, whether implicit or explicit, pervade popular and political discourse about the current economic crisis. Unregulated private enterprise, most visibly represented by large financial institutions, is represented in the popular press as both irresponsible and undeserving of the financial relief it has received from the state. Newspapers, radio call in shows, and blogs convey innumerable condemnations by confused and angry members of the public about “irresponsible” homeowners who attempted to purchase houses they could not afford, and testimonials that “responsible” Americans, who did not financially overextend themselves, are more “deserving” of “bailouts” from the government than are the financial institutions that played such a key role in the economic crisis. Ideas about personal responsibility and merit prove to be especially salient when public dialogue turns to health insurance. Millions of “responsible” and “deserving” Americans have lost 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).

Methods

This article draws on a total of 11 months of fieldwork among GM workers between June 2009 and December 2010. It covers a period of time in which GM employees were confronted with a national economic crisis, a company bankruptcy, and the debates both leading up to, and following, the passage of the Patient Protection and Affordable Care Act. It is based on a preliminary analysis of fieldnotes and interviews with 42 General Motors employees based at two Lansing area car plants, the Lansing Delta Township (LDT) plant, and the Lansing Grand

River Assembly (LGRA) plant. Those interviewed included actively employed hourly workers, laid-off production line employees, union representatives, salaried employees, and retirees at both the hourly and salaried levels. Of those interviewed, the majority (32) self-identified as caucasian, seven participants self-identified as African American, and three participants described themselves as Latino. Thirty men were interviewed and twelve women participated in the interviews. Fieldwork consisted of one to two hour long semi-structured interviews with open-ended questions that focused on participants' work history with GM, ideas about the company's bankruptcy and restructuring, the role of the government in GM's recovery, individuals' health insurance coverage over time, general knowledge and opinions about impending or recently passed health reform legislation, and ideas about the relative roles of the state, the employer, and the individual in the provision and procurement of health insurance. Interviews were conducted at a location of the participants' choice, usually at home, in a public place, or in the plant, following the end of a shift. Fieldwork also consisted of participant-observation in LDT's "Skills Center", a series of rooms offering job training and various computer and print resources for the plant's hourly employees. Employees often spent time in the Skills Center just before or after a shift to use the computer or to socialize, and as such, it served as a sort of drop-in center for workers at the plant.

Methodologically, this research places emphasis on discourse and narrative as means through which to examine ideas about morally legitimate access to health insurance. As Becker (2000) notes, discourse embodies the ways in which societies construct reality, and as moral discourses, they reflect cultural ideologies. Narratives, or the stories that people tell about themselves, represent and lend coherence to lived experience in a meaningful way (Good 1994), and

incorporate and reflect particular discourses. Discourse is also replete with metaphors that reflect and reinforce concepts of morality (Lakoff and Johnson 1980). For this project, the content of interviews was analyzed using discourse and narrative analysis techniques to examine the ideological meanings contained and conveyed in the language used in participants' responses and narratives. Attention was paid to 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. It is these recurring themes, and their underlying cultural ideologies, that form the focus of this article. My research also takes as its subject the media discourse that accompanied the passage of the Patient Protection and Affordable Care Act, but as data analysis is ongoing, this paper is focused solely on the results of the interview analysis.

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Lansing and General Motors: Productivity and Investment in the Rust Belt

Lansing is a mid-Michigan city with a metro area population of almost 500 000 residents. It boasts a long and relatively successful history with the auto industry; in the early 20th century, R. E. Olds established the city's first Oldsmobile plant (Fine 2004), and despite plant closings over the past decade, GM has invested in, and maintains, two active plants in the Lansing area. Auto manufacturing plays a key role in the city's past and present (Chinoy 1992). Many of the GM employees with whom I spoke form part of the more than 100-year-old auto manufacturing heritage in Lansing, with several generations of family members having worked for Oldsmobile and General Motors. It is important to know that the two plants to which study participants belong are relatively productive and successful. They were not among the plants slated for

closure as part of the company's massive restructuring operation. LDT is considered the most modern domestic plant in GM's portfolio (General Motors n.d.) 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.). 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 I spoke with several workers who 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). Despite the relative productivity and success of the plants, however, workers were still keenly aware of the effects of the recession, and the company's restructuring.

Rights and Responsibilities: Health Care and the Role of State

Debate surrounding the form and content of national health reform at the time of my fieldwork provided an entrée for discussions regarding workers' ideas about the ideal role of the state in the provision of health insurance to Americans. I was particularly intrigued by this topic given the government's recent financial involvement in GM's restructuring and the management of its bankruptcy, and the way in which these events might provoke reflection on the role of government in private enterprise. Would workers' ideas about government involvement in health care parallel or diverge from their opinions about the role of the government's role in their

employer's financial recovery? I was especially interested in workers' ideas about the "public option", a government-sponsored insurance plan offered through insurance exchanges that would be less expensive than the plans offered by private insurance companies, and a single-payer plan, ideas both of which enjoyed decreasing levels of public and political attention as the health reform debate progressed.

The workers with whom I spoke expressed reluctance regarding the role of the state in GM's financial affairs. For the majority of those interviewed, the government's involvement in GM's restructuring was seen as a necessary evil, an act that contradicted their beliefs about the role of government in private enterprise, but which was, nonetheless, required in order to maintain the financial stability of the company. Some participants likened the financial health of General Motors to the financial health of the country, saying that the collapse of GM would have led to the financial collapse of communities across the United States, including their own. As such, the government's support of their employer was justified. As we shall see, however, ideas about the role of government in the provision of health insurance were much more nuanced and varied than those about the role of the state in GM's financial stability; no easy parallels or divergences appear.

Conversations about the role of the state in the provision of health insurance typically began with a discussion about impending or recently passed health reform. My fieldwork spanned the lead up to, and the months following, the passage of the Patient Protection and Affordable Care Act, and as such, the bill was in various stages of debate as I spoke with workers. There was very little familiarity with the idea of the "public option" among those I interviewed, perhaps due in

part to the fact that, despite shrinking coverage, the GM employees with whom I spoke were insured and were not actively seeking alternative means of health insurance coverage. However, of those who expressed knowledge of the concept, the majority were supportive of the idea of creating a health insurance plan that was less costly than existing private options. Perhaps due to long-standing political and popular debates about nationalized health insurance, and exposure to media reports that both support and denounce the system, there was much more familiarity with the idea of single-payer health care. However, there was little consensus as to whether or not a single-payer health care system was desirable. Respondents agreed that greater government involvement was warranted in the health care system, but they lacked consensus regarding the appropriate form of that intervention. As we shall see below, for some, the role of the government was clear, and for others, it was less well defined.

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Approximately one-third of the employees with whom I spoke supported the idea of a single-payer health care system. They thought that the government had a clear responsibility to provide for the safety and security of its citizens, which they defined to include health care. For such workers, health care was a human right, to be protected and promoted by the state. Such participants stated clearly that they thought that a national health care system “like Canada’s or the UK’s” should be enacted in the United States. Arguments were framed in both moralizing and utilitarian terms; they viewed health insurance as a collective responsibility, towards which all Americans should contribute, and as a practical way to reassign crushing health care costs from employers, such as their own, to the state. For such workers, there were no preconditions for acquiring health insurance; health care was an inalienable human right, not a privilege or a commodity to be earned through employment. The majority of employees who subscribed to this

perspective were either United Auto Workers (UAW) representatives, or hourly workers. Those salaried employees who expressed similar viewpoints were in the minority amongst their colleagues.

For a minority of workers, the role of the government was clear, but it was not to provide health insurance. For these individuals, the role of the state was to serve as a regulator of the health care system. These individuals were not in favor of direct government involvement in the provision of health insurance, and supported neither a single-payer health care system, nor a public option, the latter representing what they thought would be a slow erosion of the private insurance market. Instead, they viewed the government's role as a regulator whose job was to ensure that employers could afford to offer health insurance to employees, and to control medical and health insurance costs so that health care could be affordable to both employers and to those forced to buy health insurance on the open market. For these individuals, health care was not an inalienable right, but rather a commodity to be earned. The government's main role was to provide the regulation necessary to ensure that this commodity was affordable. For such individuals, the employer and the individual were responsible for the provision and procurement of health insurance. Both hourly and salaried employees expressed such views, as did both active workers and retirees.

For a majority of workers, however, the precise roles of the state, the employer, and the individual in the provision and procurement of health insurance were not well defined. Amongst these workers, there was support of greater government provision of health insurance, including the idea of a single-payer system, a public option, or an expanded "safety net"¹ but respondents'

own role in achieving that goal complicated support for that ideal. These individuals supported the idea of greater government provision of health insurance, yet disagreed with the prospect of having to pay higher taxes, or contribute financially in some way, in order to subsidize the health care of individuals whom they perceived as not meriting health insurance sponsored by others. For these workers, health insurance should be earned, and there was much consternation and concern about ensuring that distinctions be made between those they perceived as “deserving” of state sponsored health insurance, and those deemed “undeserving” of such care, key concepts to which I will turn in the next section of this paper.

Work: A Precondition for Morally Legitimate Access to Health

For the majority of the GM workers with whom I spoke, health insurance was not a human right but rather a privilege to be earned through hard work² and sacrifice. Those who had worked to earn health insurance could make a morally legitimate claim to health insurance. Those who worked hard but did not have health insurance also merited such coverage. In these instances, 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 on the open market. As Lawrence³, a 43-year-old white union representative stated, he had a hard working brother and sister who went without insurance, and they both deserved to be covered, because, as he put it, “They both work as hard as the next person”. Robert, a 55-year-old African American active production line worker nearing retirement stated that “There are a lot of people out there who are working hard, and they need help. If you’re working and you’re working hard, you should get some help from the government”. Janine, a 51-year-old African American retired hourly worker explained that “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." 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. The importance of work in the procurement of health insurance extended to one employee's analysis of the government's provision of Medicare: "Seniors have *earned* their Medicare" (Jim, 38 year-old white laid off production worker), he explained, and the government's role in assisting seniors was, therefore, justified.

For those not actively engaged in work, morally legitimate claims to health insurance were more precarious. Here, the distinction was often made between what some authors have described as the "deserving poor" (Gans 1995; Handler and Hasenfeld 1991; Handler 2004; Katz 1990), that is, those who are unable to work, through no fault of their own, and the "undeserving poor", those who are able to work but who, in the eyes of others, choose not to. For those participants who saw health insurance not as a right, but rather as a privilege or a commodity to be earned, there were certain groups of people who, like the "deserving poor", merited health insurance even if they could not pay for it. Children, the elderly, and the disabled merited health insurance, even if they could not actively earn it through employment. By contrast, those who did not work, but were capable of doing so, the "undeserving poor", did not have a morally legitimate claim to health insurance subsidized by taxpayers or the state. Statements such as these were common amongst those trying to delineate between individuals who merited subsidized health insurance, and those who did not:

I wouldn't mind paying more for people who need health insurance and can't work, like elderly people and the disabled. We have an obligation to those people. But not to lazy people. There are

a lot of able bodies out there that could work but choose not to. I'd be worried that people are getting something for free. I don't want someone else to rely on my work habits to be covered. (Daryl, 27-year-old white active production worker)

If you're not doing anything to earn it, why should you get it? You pay so much for insurance. I'd hate to pay for someone to have better health insurance than mine when I work my butt off for it. (Anne, 51-year-old African American active production worker)

For those with whom I spoke, morally legitimate claims to subsidized health insurance depended on one's willingness, as perceived by others, to engage in paid work. Participants were uncomfortable with the idea of contributing towards the health coverage of those who appeared unwilling to do so. Here, morally legitimate access to health insurance was framed in terms of accounting schemes, employment, and wealth (Lakoff 1996). Participants' ideas about fairness centered on the concern that someone might obtain health insurance *for free*, or that someone who had *worked his butt off* would *pay* for someone who hadn't *earned* his or her health insurance. The metaphors used to conceptualize morally legitimate access to health insurance focused on ideas of financial transactions, work, reciprocity, and debt. As Lakoff (1996) notes, these are dominant metaphors for the ways in which Americans conceptualize morality. Although the data analysis discussed here is preliminary, it should be noted that ideas privileging work as a precondition for morally legitimate access to health insurance spanned racial, ethnic, and gender categories in the sample group.⁴

Before I began my fieldwork, I wondered whether or not the current recession might be a catalyst for a rethinking of the cultural logic equating deservedness for health insurance with economic productivity. When I asked the 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 it had. Many more millions of people were, as one man 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. Yet for the majority of the people with whom I spoke, work remained a precondition for health coverage. For these individuals, there were ways to ensure health coverage during a layoff, and to ensure that hard work was rewarded. For some, volunteering was a morally legitimate means of claiming access to health insurance if one was out of work. As Ralph, a 65-year-old white production line retiree explained, 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. You’re a better person if you work for what you get.” 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. As Donald, a 51-year-old white laid off skilled tradesperson stated, “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.” Peter, a 43-year-old African American active production worker explained, “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”. Joe, a 65-year-old white 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 may not seem surprising, given the familiarity of GM employees with contributory programs such as unemployment benefits, which are tied to active participation in the labor force and payroll deductions (Hasenfeld and Rafferty 1989). However, what is of note is the repeated association of access to health insurance with work, whether recently lost employment, volunteer work, or future employment. For the majority of those with whom I spoke, even in uncertain economic times, morally legitimate access to health insurance ought to be tied to paid employment. At a time in which the ability to be economically productive was necessarily limited by larger political economic factors, and General Motors was cutting health coverage to employees and retirees, these responses seemed out of step with the material realities of the recession. The people with whom I was speaking 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.

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. One retiree with whom I spoke, Walter, 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 worker with whom I spoke, Jim, 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. Jim 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, Jim 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 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." Jim 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?"

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The comments of the GM workers whom I interviewed offer some preliminary insight into the ways in which they view the world, and how they understand themselves. Their systematic understandings of the world and of the self – what we might term rationalities (Dean 1999: 11) - reflect the values of what Heelas and Morris (1992) describe as "enterprise culture". According to Heelas and Morris, enterprise culture constructs a view of the world and a mode of self-hood defined in terms of the virtues of enterprise: responsibility, competition, discipline, hard work. Those who have adopted the values of enterprise try to live their lives as though they were small businesses, dedicating their skills and their effort to maximizing personal wealth. This wealth is used to "take responsibility" for, and so exercise accountability over, one's education, housing, and health requirements, rather than relying on offices and organs of the state (Heelas and Morris

1992: 1). Under enterprise culture, and the larger neoliberal rationality to which it belongs, the market reinforces virtues such as 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 (Ibid). Walter’s and Jim’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 once they were to lose them. 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, Jim 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 Jim, no one - not even Bill Gates - should be responsible for paying for his health care.

These findings are consistent with the observations made by Jo Anne Schneider (2000) in her study of working- and middle-class Americans’ perceptions of welfare reform in the mid-1990s. Schneider (2000) 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 Jim 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. Jim had started his own lawn care business, which he had pursued aggressively, and which had required getting up early and going to bed late. 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. For both Walter and Jim, the receipt of health insurance ought to be contingent upon hard work, whether paid or volunteer.

This sentiment was echoed by other interviewees, who explained that personal experiences had made them skeptical of the idea of extending subsidized health insurance to all Americans. To extend health insurance coverage to those who had not actively "earned" it was akin to redistributive programs such as welfare, of which many interviewees were suspicious.

Discussing personal experiences that influenced their thinking about such programs, interviewees made statements such as these:

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, 42-year-old white salaried employee)

The way I was raised, everybody worked for a living. If you wanted something, you went out and earned it. If you just sit back, it shouldn't be available to you. It sounds cold, but everybody else is trying to survive. Life experience has made me more cynical. A lot of people have kids just so that they can get government money. (Paul, 39-year-old white 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 African American active production worker)

Other employees who were interviewed cited abuse of the disability system at the plant as a reason for being reluctant to support extending health insurance to the able bodied. As Ron, a 51-year-old African American salaried employee explained, he was suspicious of the fairness of extending health insurance to the able bodied because of the abuses he saw, "Like healthy individuals who don't work, who go on disability because they can get away with it". In recounting personal experiences that influenced their ideas about responsibility for health insurance, participants repeatedly referred to metaphors of morality that centered on work, debt, and reciprocity: health insurance should be *earned*, and they did not approve of a *free ride*.

Personal experiences witnessing the abuse of disability programs at work and government social programs such as welfare made them reluctant to support the idea of extending universal health benefits to all Americans.

What bears further interrogation in these examples is the meaning carried in discourse welfare recipients. Several scholars (Gans 1995; Gilens 1999; Handler and Hasenfeld 1991; Schram 1995) have highlighted the stereotypes about minorities, women, and the poor that are carried in language used to describe recipients of redistributive programs such as welfare. Furthermore, repeated reference was made by interviewees to those who “chose” not to work, those who were “lazy”, or individuals who were “unwilling” to seek employment. Further data analysis is required to deconstruct the ideological meanings contained in such words and phrases. However, labels such as “unwilling” and “lazy” may collapse multiple causes of unemployment into one category: that of the able bodied person who simply chooses not to engage in the workforce. Such labels do not account for structural causes of unemployment, such as shifts in the economy, or other factors that influence success in the job market that are beyond an individual’s control, including socioeconomic background (which affects the education, social, and cultural capital needed to achieve financial stability), and racial discrimination, which can negatively affect health, educational attainment, and success in the job market (McNamee and Miller 2004). Notably, larger structural factors influencing access to health insurance were discussed during interviews, albeit by a minority of respondents.⁵ However, the analysis of the discourse used by interviewees to describe recipients of redistributive programs bears further investigation. For the purposes of this article, I raise comments about witnessing abuse (whether real or perceived) of the welfare and disability systems as an illustration of the role of personal experience in constructing ideas about deservedness for health insurance, and as an illustration of the moral discourses that are used to make sense of these experiences.

Helping Those Who Help Themselves: Biblical Discourses of Health Insurance

Ideas about deservedness for health insurance were consistently framed in Biblical terms by the Lansing area autoworkers with whom I spoke. For those who supported the idea of extending health insurance as a human right, supported financially through taxpayers and the government, there were repeated references to Christian teachings as a framework in which to situate ideas about access to health care. As Ray, a 52 year-old African American salaried employee stated, “We’re a country founded on Christian values and we shouldn’t lose sight of those. Jesus Christ was a proponent of healing and making sure that people’s needs were met. The principles of Christianity are that we should care for one another”. Rick, a 59 year-old retired production line worker stated that his faith played an influential role in his views about health insurance. In explaining his belief in the necessity of a government sponsored health plan, he said, “People are good, overall. Some are luckier than others. We need to do whatever we can to make life good for everybody”. Diane, a 35 year-old African American active production line worker explained that she thought that nationalized health insurance should be pursued because:

You are your brother’s keeper. The Bible says so. The Bible says to love your neighbor, love your enemy. And Jesus Christ would support anything that treats everyone the same. He’d support anything fair.

For these workers, and others who made similar statements, ideas about morally legitimate access to health insurance were framed as a Christian imperative to ensure universal access to health care. According to this perspective, health insurance should be extended to all those in need of health care, regardless of circumstance.

Ideas about Christianity and the Bible were also drawn upon as a means of demarcating the limits and parameters of morally legitimate access to health insurance. For these workers, the

Bible provided clear guidelines for determining who merited health insurance, and who did not.

Comments such as the following are illustrative the ways in which the Bible was referenced as a means to define morally legitimate claims to health insurance:

We have a responsibility, biblically, to help our widows, and orphans, and the disabled. But also, we have a biblical obligation to apply ourselves and to be the best we can. Health care is not a *right*, it's something that we *work* for. We live in a world where we support ourselves. (Joy, 35-year-old white salaried employee)

Some people don't work. They don't deserve it...No one's entitled to anything for free. The Bible says, "A man who shall not work shall not eat". We all feel entitled. That's wrong. (Jim, 38-year-old white laid off production worker)

Look at Deuteronomy. One of the precepts of social responsibility is that if you're walking through a vineyard and you're hungry, you can eat your fill of grapes, but you can't put any in your pockets. If you're walking across a field of ripe grain, and you are hungry, you can eat your fill, but you can't put any in your pockets. So, it feels like you are entitled to some. You're entitled to have your immediate needs met, but you can't feed your family that way, you can't start a business that way. You can't even store up so much that it will relieve you of the anxiety of thinking, "Well, maybe I oughta get a job". So that was that biblical precept, and Jesus Christ...would have quoted Deuteronomy, and tried to figure out how does that fit, that vision that a person is entitled to have their immediate, basic needs met. It's not an overreaching, global entitlement. People are entitled to have their needs met, but in a reasonable, local, very targeted and focused kind of way. It doesn't become a lifetime, immutable, under all circumstances, birthright. (Joel, 55-year-old white salaried employee)

I *don't* think health care is a right. In the Book of James, it talks about how the true religion is to take care of widows, and orphans. Right? So I believe that Jesus is saying, "You need to take care of people who can't take care of themselves." You need to be your brother's keeper in that sense. Right? I don't think Jesus Christ would take care of anyone who was trying to take him for a ride. Because he would know. He'd be able to look in their heart and know: "Do you not have money for health care because you're spending it on liquor, or drugs, or a nicer house than you should be living in?" We're not content with what we have. Right? *We think we deserve* more. You know what? We don't. We don't deserve more. If you want that passage in James, it's Chapter one. It's at the end. (Shirley, 47-year-old white salaried employee)

Another worker, Bill, a 60-year-old white retired tradesperson, stated firmly that health insurance should not be extended unconditionally to those who did not work. Those who were able to work but did not do so did not merit help covering health care costs; those who were out of work, but who were actively seeking employment or who were, "Willing to do some community service",

deserved help covering the costs of health insurance, because, as he explained, “We help those who help themselves. That’s what the Bible says.”⁶ For interviewees such as these, ideas about the boundaries and conditions of morally legitimate access to health insurance were framed in biblical and Christian terms, which offered metaphors of fairness (Lakoff 1996). Scripture was referenced as a guideline for making moral distinctions between those who could claim morally legitimate access to health insurance, and those who could not. It was also referred to in defining the *amount* of health insurance – what Lakoff (1996) refers to as a “scalar” model for fairness -- to be provided to the temporarily unemployed: enough to meet one’s basic needs, but little enough to serve as an incentive to seek employment.

In analyzing the prevalence of biblical and Christian references in the responses of those interviewed, Robert Bellah’s concept of a “deep cultural code” (2006:335) is helpful. Bellah posits that there are cultural codes embedded in national cultures, and that these cultural codes, “however transformed over time, are ultimately derived from religious beliefs” (2006:335). He adds that “deep” cultural codes are those that are “most likely to be derived from religion” and that they are relatively un-malleable (Bellah 2006). Bellah (2006) suggests that the United States’ roots in early Protestant sects provide the source of this deep cultural code, and that this “Protestant code” pervades the public sphere in the United States. As such, the United States is a society “whose public language has continuously drawn on religion from the beginning to the present” (Bellah 2006:339). It should not be surprising, then, that so many of the people I interviewed framed their understanding of morally legitimate access to health care in biblical or Christian terms. However, Bellah (2006) notes that language need not read as explicitly biblical in order to be such; rather, the language of Protestantism can persist, even when it is not

recognized as overtly religious. Secular discourse that privileges the importance of work, self-sufficiency, productivity, and the related moral associations may, in fact, be interpreted as secular manifestations of a “deep cultural code” of Protestantism in the United States. At the heart of this deep cultural code, and the Protestant ethic from which it derives, is the normative injunction that one should work dutifully and methodically in order to avoid sin and to demonstrate one’s moral worth. The Puritan settlers were encouraged to “shun worldly pleasure, mortify their appetites, and conform to ‘Godly ways’” (McClosky and Zaller 1984). For the Puritans, work offered a means of purification through labor; personal sacrifice through work, and the resulting accumulation of wealth, were viewed as signs of Divine Grace. This view of work and sacrifice appears to have been widely incorporated into the American value system (McClosky and Zaller 1984). Secular references to personal sacrifice and the dutiful accumulation of wealth by those interviewed may reflect the absorption of such values into dominant discourse. In my research, there were repeated references to such themes, even when religion, the Bible, or Christianity were not explicitly discussed by the participant. Jerry, a white 62 year-old a retired tradesperson explained that:

We have a moral obligation to provide health care, but it can’t just be given out. You’ve gotta work for it. Everybody should have to contribute to it; a free ride is not the answer. When I was working and raising my family, I gave up a lot of things that other people had: snowmobiles, a new car. I made sacrifices. I saved. But now I can afford a \$140 doctor’s visit. So for others to slide along in life, I don’t agree with it.

Jerry’s narrative suggests that there is an inherent positive moral value in working hard, making sacrifices, and saving one’s money. That this perspective might seem self-evident and culturally logical is testimony to the deep rootedness of the Protestant cultural code. Bellah explains that deep cultural codes are “so taken for granted, and operate at such a level of generality, that they may be effective even when, perhaps especially when, they are not recognized as such” (2006:

335). Bellah's suggestion that American culture expresses a deep cultural code of Protestantism may not be surprising, but the implications may be unsettling to some because, as he notes, it "severely undermines the notion of a predominantly or exclusively 'secular public sphere' in America" (2006: 338).

Conclusion

My interviews with Lansing area GM employees offer some preliminary insight into the rationalities that reinforce and reproduce the cultural logic of the United States health care system. According to the majority of the workers and retirees with whom I spoke, deservedness for health insurance is determined by one's ability to *earn* health coverage. The narratives of those whom I interviewed suggest that this perspective is reflective of the personal experiences of the workers themselves. Having made significant personal sacrifices in order to secure some measure of personal wealth and health care coverage, they expect others, too, to make some level of sacrifice. The ongoing recession did not, in the opinion of those interviewed, alter the basic mechanisms through which health insurance should be obtained. Recognizing that the economic downturn constrained the job market, and thus access to health insurance, participants suggested that access to health care be contingent on one's active pursuit of employment, or that it be indexed to the amount of time one had spent in the workforce. Throughout, metaphors for morally legitimate access to health insurance focused on work, wealth, and accounting schemes for fairness. Personal narratives reflected the values of a so-called "enterprise culture", which cultivates an ethic of the self that emphasizes self-reliance, effort, thrift, independence, ambition, and the accumulation of wealth. This rationality normalizes the idea that health insurance should be purchased, or at least earned as a benefit of employment. Further reinforcing this rationality

(or perhaps informing it, if we accept Bellah's thesis) is the repeated framing of ideas about deservedness for health insurance in religious terms. Participants frequently presented ideas about morally legitimate claims to health insurance in biblical terms, citing scripture as a guideline for delineating between those who could make morally legitimate claims to health insurance, and those who could not. For some, the Bible and Christianity challenged the dominant model of health insurance in the United States: the predominantly private, employer based health care system. Scripture supported participants' beliefs that health insurance should be extended to all Americans, regardless of employment status. For others, the Bible clearly suggested that the receipt of health insurance should be contingent upon hard work, and that health care was not an inalienable right. The framing of moral discourses of health insurance in religious terms highlights Bellah's suggestion that contemporary American society speaks a language of ascetic Protestantism, which emphasizes the positive value associated with hard work, sacrifice, and the accumulation of wealth. Combined, neoliberal rationalities of the self, and the deep cultural code of the Protestant ethic, allow the link between employment and health insurance to seem culturally logical, and functionally rational. As these interviews with GM employees suggest, an "enterprising" understanding of the self, and the biblical framing of the moral value of work and personal sacrifice, may be integral to ideas about deservedness and responsibility for health insurance, and to the normalization of the primarily private, employer-based health insurance model that remains the dominant model for health insurance in the United States.

Notes

¹ The health care “safety net” typically refers to state-sponsored means-tested health care plans such as Medicaid, and the variety of services offered through county and state health programs. As Becker (2004) notes, however, this “safety net” is a patchwork of programs that often leaves the uninsured with inadequate care. For a critical examination of the concept of the US health care “safety net” see Becker 2004.

² Baba and Brondo (2010) note that some LGRA workers attribute the strong work ethic of fellow employees to their respective rural upbringings or residences. The Lansing area auto plants have historically drawn on local farming communities as sources of labor (Chinoy 1992).

³ Pseudonyms are used throughout the paper.

⁴ Perceptions of the “undeserving poor” are often associated with racial, gender, and class-based stereotypes (Benson-Smith 2005, Blank-Libra 2004, Gilens 2004, Harry 2004, Schram 2005) that demonize racial and ethnic minorities, women, and the poor. Possible relationships between perceptions of those who might be labeled “undeserving” of subsidized health insurance and racial, gender, and class-based stereotypes have yet to be determined in my analysis.

⁵ Some individuals noted that their job security, and the accompanying health insurance, was predicated on the security of the domestic auto industry. Others pointed out that not everyone had access to the same educational opportunities, and that racial and ethnic minorities faced discrimination in the job market. As such, certain segments of the population were disadvantaged in their pursuit of employment and accompanying benefits such as health insurance.

⁶ The phrase “God helps those who help themselves” is popularly associated with the Bible and Christian scripture. The phrase has, in fact, been attributed to various secular sources, including Benjamin Franklin’s Poor Richard’s Almanac (1900).

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