Healthcare in the news media: The privileging of private over public

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Abstract

This paper reports on a discourse analysis of the representation of healthcare in the print news media, and the way this representation shapes perspectives of healthcare. We analysed news items from six major Australian newspapers over a three-year time period. We show how various framing devices promote ideas about a crisis in the current public healthcare system, the existence of a precarious balance between the public and private health sectors, and the benefits of private healthcare. We employ Bourdieu's concepts of field and capital to demonstrate the processes through which these devices are employed to conceal the power relations operating in the healthcare sector, to obscure the identity of those who gain the most from the expansion of private sector medicine, and to indirectly increase health inequalities.

Key words:

News media, healthcare, Bourdieu, framing theory, field, capital.

Healthcare and the news media

A major feature of the Australian healthcare system is Medicare, a universal public health insurance scheme which provides free or subsidised healthcare for all citizens. Citizens have the option to purchase private health insurance to help finance access to services in the private sector (Anonymous 2015b). Government policies (e.g., taxation penalties and rebates) offer incentives to purchase private health insurance, but individuals are not required to use their insurance. All have the right be covered by Medicare and treated as public patients in public hospitals (Anonymous 2015b). In this mixed, private/public system, choices about whether to seek a public or private service provider, and whether to purchase private health insurance, have become prominent issues for Australian citizens. Moreover, the availability of balanced information upon which to base one's choices has come to be of critical importance (Anonymous 2016, 2015b).

We suggest that the news media play an important role in the construction of public understandings of healthcare. Journalists and editors see their role as working in the interests of audiences by providing information about health (Hodgetts et al. 2008), and mediating between the views of different interest groups (Hallin and Briggs 2015). What is considered newsworthy is also influenced by the agendas of news outlets, which in turn may reflect broader political, cultural and financial interests (Anonymous et al. 2014). Consequently, media representations of healthcare comprise an arena of contestation between different actors (e.g., editors, journalists, health professionals, policy-makers and consumers) (Shoemaker and Reese 1996). These actors use the news media to serve their own interests (with differing levels of success), but the media itself also operates as an agent, with its own interests and agendas. The combination of these two

processes can bias the kind of media messages and relevant information available to the public and silence opposing voices.

Critical media literature has consistently emphasised media owners as important in shaping the ideas represented in the news, due to their significant cultural and economic power. Researchers have tracked the way prominent news organisations use their media power to advance political and commercial agendas (Cryle 2008; Hobbs and McKnight 2014). However, given that the motives of news owners are not necessarily transparent; it can be difficult for readers to interpret media messages in context (McBride and Rosenstiel 2013). Economic ownership remains important, but only partially explains the influence of the news media on the choices citizens make about their healthcare.

In this article we examine the presentation of information about healthcare in Australia in the print news media. We extend media framing theory by employing Bourdieu's concepts of capital and field to provide a more contextual account of the prominent messages about healthcare. Our aim is to show how news media shapes individuals' healthcare perceptions, and thus choices.

Theoretical approach

Media framing theory is regularly used to examine the influencing of audience perceptions. It can be used to investigate the presentation of healthcare events to direct audience attention towards what is included in the frame, and away from what is absent (Reese et al. 2001). Framing theory attends to the characterisation of issues, the identification of causes and solutions, and the way various interest groups compete for media influence (Entman 1993). Despite its pervasiveness, this approach is less able to explain the tendency to use certain frames, the privileging of

particular viewpoints, or the oversimplification of stories by failing to place them in context. As Bourdieu (1998) contends, issues reported in the news are typically framed in ways that lack contextualisation – being 'fragmented, deracinated, de-historicized... without a beginning or an end'. This makes it difficult for readers to situate and make sense of reported events (see also Stones 2015).

Bourdieu (1998) argues that a focus on individual agents in the media tends to obscure the extent to which individual agents are themselves manipulated, even though they may be unaware of that manipulation. Focusing on individual perspectives also diverts attention from the 'field' in which such individuals live or work, and obscures the operation of symbolic violence – the capacity to dominate the field and enforce a particular set of values (Bourdieu 1998: 16-17). Preferable then, is an analysis of the mechanisms in the news media that shape the stories that are written. Thus, it is crucial when analysing the news media to consider *both* the discourse used in news stories *and* the extent to which stories are contextualised (Bourdieu 1998: 20-21). This is not to suggest that audiences do not respond in differing (and unexpected) ways to news discourse, but that their perspectives 'are not formed in a vacuum but in relation to a particular contextual field' (Stones 2015: 5). Drawing on Bourdieu, Stones (2015: 17) suggests the incorporation of a social-theoretical framework in the examination of the news, thus embedding healthcare events within a contextual field, and attending to the structural position of actors. Adopting this approach means being able to explore the *social relations* of news media stories and the way perspectives are shaped (Stones 2015: 15-17).

Bourdieu's interrelated concepts of capital and the field are particularly useful for explaining how medical, political and economic forces in the healthcare arena contribute to

specific media discourses (Bourdieu 1984, 1983). For Bourdieu, a field is both a social space and a ‘network of relations with a specific distribution of power’ (Anonymous 2015b: 690), where differentially positioned social actors seek to preserve or shift values and practices (Bourdieu 1983: 30; Anonymous 2015b). It is an arena in which actors struggle for control over its conditions and what is valued, influencing, for instance, (in the healthcare field) the availability of healthcare services and the very meaning of health itself (Anonymous 2017), and in the journalistic field, the production of news media discourses (Hallin and Briggs 2015).

For Bourdieu, an actor's position in the field is determined by access to economic (e.g., money and other material assets) and cultural (e.g., knowledge, education, class, reputation, prestige) resources. Actors with access to the forms of economic and symbolic capital that are most appropriate to the particular field in question, have greater capacity to influence the production of discourse and to benefit from this (Bourdieu 1984; Anonymous 2015b). With Bourdieu's concept of the field, we can introduce the context in which these actions take place. By connecting discourses to social structures and offering insights into the changes that have occurred within both journalism and medicine, we can show how these have impacted on the kind of stories that appear in the print media and the presentation of these stories. Since the 1980s, for instance, the health field has become more commercialised and politicised, with patients increasingly referred to as 'clients' or 'consumers' (Benson 1998: 476). In the journalist field, the print media has lost 'its pre-eminence' to commercial television (Benson 1998: 476). Specialist journalists (such as medical reporters) have declined in favour of generalists, with the latter often ignorant of scientific principles and unable to weigh up alternative ideas. Instead, they offer stories that give 'voice to every dramatic or moving testimony, no matter how

scientifically dubious' (Benson 1998: 477) – and, we would add, no matter how *factually* dubious.

Methods

Our study of the Australian print news media is part of a larger project examining navigation of healthcare from the perspectives of individuals (Anonymous 2016) and gatekeepers such as doctors, nurses, and policymakers (Anonymous 2017). To understand how media messaging shapes healthcare choices, we conducted an analysis of print news media. We employed the method of discourse analysis to examine the issues being presented in news coverage of healthcare; the sources that were used for stories; the way spokespersons were represented; and the techniques used to construct messages – with particular attention to the way language frames messages and shapes perspectives (Lupton 1992; Cheek 2004; Van Dijk 2005; Machin and Mayr 2012).

Articles from six major Australian newspapers were sampled during the period January 1, 2011 to December 31, 2013 (inclusive). Selection of a three-year time period permitted us to track changes in news coverage, capturing healthcare events, issues and policy changes, and the potential impact of changes in government. Our study sample represents newspapers with high circulations and includes a mix of tabloid and broadsheets from various locations. We sampled papers from News Corporation and Fairfax (the major newspaper owners) to ensure coverage of different audiences. In general, broadsheets and Fairfax newspapers are marketed toward a more educated and higher income audience, particularly business leaders, than the tabloids or News Corporation papers (Fairfax website). Both Fairfax and News Corporation seek to present themselves as influential. For instance, one of the News Corporation papers, *The Australian*, is

advertised as 'the news brand with exclusive access to Australia's wealthy and powerful' (*The Australian* website). News Corporation is well known for advancing its own business interests and its conservative political and cultural agenda (McKnight 2010). (see Table One for newspaper characteristics).

[INSERT TABLE ONE HERE]

Articles were retrieved from the database Factiva using a combination of key words (Health Insurance OR Public Hospital* OR Private Hospital* OR Medicare OR Health care OR Healthcare OR Health System). After the exclusion of duplicates, irrelevant articles, and letters to the editor, 1717 articles remained. Purposive sampling was then employed to obtain a sub-sample (n=436) for detailed analysis of the key healthcare and health policy messages produced during the time period. We identified clear peaks in coverage and any events/issues which might explain these peaks. Twelve events were identified which were reported across multiple newspapers. All articles reported over a two-week period from the first mention of each event were selected.

Differing Messages: Broadsheets or Tabloids, News Corp or Fairfax?

A comparison of key messages reveals some important differences in news media reporting about private versus public sector medicine. For instance, coverage of *public* healthcare focuses on issues of safety, quality and access, while the most prominent issue in stories about *private* healthcare is out-of-pocket costs. There are also marked differences in the messages offered by the tabloids and broadsheets, and according to media ownership. Across newspapers, almost two-thirds of all news items about healthcare are negative in tone (n=285/436, 65%) –a feature of

healthcare reporting more generally (Smith et al. 2005) – but this tendency is considerably greater within the tabloids, than the broadsheets. Likewise, while a similar number of sampled articles report on public healthcare (n=165/436, 38%) and private healthcare (n=161/436, 37%), tabloid articles are more likely to report on private healthcare (n=56/161, 46%) than public (n=38/165, 31%); while broadsheet newspaper articles, in contrast, are more likely to focus on public healthcare (n=127/165, 41%) than private (n=105/161, 34%). This pattern is also found when comparing News Corporation and Fairfax owned newspapers, with the former more likely to report on private healthcare (n=91/161, 40%) than public (n=78/165, 34%), and the latter more likely to report on public healthcare (n=87/165, 42%) than private (n=70/161, 34%).

Our analysis also reveals the prominence of the more powerful interest groups appearing in reports on healthcare: the private hospital and insurance sectors (n=83/436, 19%), high profile doctors' associations (n=67/436, 15%), and to a lesser extent, consumer advocacy groups (n=52/436, 12%). Table Two provides more detail about the prominence of issues and spokespeople in the various newspapers.

[INSERT TABLE TWO ABOUT HERE]

Variations across the newspapers are associated with differences in the ownership of the various media outlets. Despite sharing the same field (in Bourdieusian terms) the outlets have diverse locations within this, with some closer to the cultural or journalistic axis (the broadsheets) and others to the economic axis (the tabloids). This positioning reflects the aims of the broadsheets to focus on quality and independent journalism, while in contrast the tabloids must subordinate these ideals to the maximisation of advertising income and broad circulation (English 2016: 1002,1007; Bourdieu 1998). Another way to describe this is to state that broadsheet journalists

tend to rely on symbolic forms of capital (e.g., their high level contacts in specialist fields) and seek to build relatively greater amounts of symbolic capital – prestige and recognition – through investigative reporting; while those in the tabloids must sacrifice journalistic capital to build economic capital by seeking ratings and visibility through more 'dramatic' and captivating forms of reporting that will result in market gains (Bourdieu 1998: 73; English 2016: 1003).

Two specific claims are evident across all news coverage: 1) the public healthcare system is in a 'state of crisis' and in 'need of a solution'; and 2) a precarious ‘balance’ exists between the public and private sectors. Evident in the themes identified is the threat posed to the health and safety of public patients in the current system, and the necessity of a ‘robust’ private healthcare sector for the health of both individuals and the healthcare system. Also evident is a concern that we are witnessing the growth of a ‘two-tiered’ system in which patients who can finance their own healthcare through private health insurance will receive better care than those who cannot. We discuss these prominent claims in the following two sections.

A public system in crisis – a problem in need of a solution

The notion of a public system 'in crisis' is evident across all newspapers, particularly in relation to public hospitals. Alarmist headlines and language are used routinely in articles to describe public hospitals as ‘overcrowded’, ‘overloaded’, at a ‘breaking’ or ‘crisis point’, and in a state of ‘emergency’. An illustrative example of how a 'crisis' is accentuated in an article in the *Sunday Herald Sun* with the headline ‘Our health system in intensive care’. It begins by asking readers to imagine themselves as a nurse in a public hospital:

> Arriving for work at 7am to find the emergency department already full with patients who may have been waiting up to eight hours to see a doctor. And then you have to tell them no beds are available because wards have been closed to save money. And perhaps there would not be any doctors anyway because they are so concerned for the safety of patients in under-resourced, overcrowded emergency departments that they may be out on strike (October 16, 2011).

Negative events in public hospitals are presented as routine occurrences across the entire public system, rather than one-off events. As the following news items illustrate, single events are used to negatively frame the entire public healthcare system:

> My baby agony: Our health system shame (Headline, front page, *Herald Sun* February 17, 2011)

> Several inquiries into deaths in Australian hospitals… found the system had been unravelling long before the final, fatal error occurred (*Sydney Morning Herald*, August 17, 2011).

Across the newspapers, almost five times as many negative stories concern public hospitals. Negative stories about experiences of patients in private hospitals are rare. Where they appear, these are presented as 'one off' events or the outcome of the actions of a 'rogue' practitioner responsible for 'gross negligence'. For example:

> Scarred for life: patients blow whistle on a cosmetic surgeon banned in the US – EXCLUSIVE
> A PROMINENT cosmetic surgeon with a record for gross negligence in Beverly Hills, California is under investigation …for allegedly disfiguring some Australian patients, fabricating their records and misusing drugs (Headline and lead paragraph, *The Australian* October 25, 2011).

While positive experiences of care in the private system are assumed as the 'norm', positive stories in the public healthcare system are not only rare but usually qualified. For example, in *The Age*, a woman somewhat ambivalently described her positive experience of maternity care within a public hospital as perhaps being ‘lucky’. This practice of systematically not reporting on positive experiences reinforces the idea for readers that positive experiences in the public system are uncommon.

Statistics are used selectively and cleverly incorporated to persuasively frame arguments. For example, data supporting private interests is used to claim that private hospitals are more transparent than State government-operated public hospitals. These statistics are purported to provide ‘patients, doctors and staff’ with comparative information about private and public hospital performance:

> Patient care no longer a secret (Headline).
>
> According to Healthscope [Australia’s second biggest private hospital company] figures, **which are collected on the same basis as those for public hospitals**, their patients are at significantly lower risk of suffering hospital acquired infections... Healthscope hospitals report a rate of 0.36 cases per 10,000 while Victoria’s public hospital rate is more than twice that and NSW’s more than three times (Emphasis added, the *Sydney Morning Herald*, November 5, 2011).

However, such statistics are rarely placed in context. In this case, it would be more accurate and truthful to provide additional information to readers pointing out that such discrepancies might be explained by differences in the characteristics and needs of patients treated in public and private hospitals. Public hospitals are more likely to treat patients with more complex health conditions, in poorer health, in need of multiple or more complex treatments, and more likely therefore to

suffer post-surgical infection. Private hospitals, in contrast, tend to have less serious cases with only single medical needs (Productivity Commission 2009: 29, 55). Also absent from coverage is the number of patients with more severe conditions who need to be transferred from a private to a public hospital (Cheng et al 2015).

Medical doctors, particularly representatives from the *Australian Medical Association* (AMA, the peak body primarily representing specialists rather than GPs), are privileged in stories (n=67/436, 15%), especially those pertaining to the public system. To give them greater authority and credibility, these individuals are described as 'experts' 'leaders' and 'top doctors' (e.g., the AMA president is referred to as 'the state's top doctor'). Doctors are offered as key sources even when issues are not directly relevant. For example, in news coverage of an industrial dispute between government and nurses, the primary spokespeople were doctors' groups (e.g., Australasian College for Emergency Medicine and AMA). The voices of nurses or nursing associations (e.g., the Nursing Federation), or other health professionals, are less common (n=37/436, 9%), and when included, appear towards the end of news items:

> Emergency doctors said last night that while they agreed with the nurses' demands, they expected the closure of one in three beds to result in long delays for care (*The Age*, November 12, 2011).

Non-government public healthcare sector voices (e.g. a representative from a public hospital) are also less common and prominent, especially in News Corporation articles (n=13/230, 6%). Representatives from the private health sector, however, are prominent in negative reporting about the public sector, and their words evoke fear of long waiting times for public patients, implying public hospitals 'cannot keep up with demand'. Private sector actors also suggest private patients are prioritised by public hospitals, focusing negative attention on public hospital waiting

times, but fail to acknowledge the inequality of this situation. For example, the chief medical officer for Australia's second largest private hospital operator is reported as saying:

> Australia's public hospitals were failing to meet demands for elective surgery from public patients, but had significantly increased the private patient operations in order to generate extra revenue (*Sydney Morning Herald*, November 5, 2011).

In this we find the claim that people with private health insurance receive treatment more quickly than those without, and this is presented as a positive aspect of the Australian system. Private sector spokespeople quoted in stories also suggest private health insurance provides patients with access to safer and higher quality healthcare: the implication being that the public system does not.

There are articles which offer alternative messages. For instance, when consumer health organisations (e.g. Consumers' Health forum, Australia's peak consumer healthcare advocacy body) are used as sources in stories (n=52/436, 12%), we find narratives of patients from disadvantaged circumstances, thus drawing our attention to unequal access to healthcare because of increasing costs:

> Many Australians are slipping off the edge of a health system that is meant to be there to support them simply because they cannot afford the treatments they need (*The Australian* September 21, 2011).

Yet, like the nurses, also widely seen as patient advocates, these spokespeople tend to appear towards the end of articles, typically *after* the views of doctors or private sector are reported.

Patients are frequently presented as ‘victims’ in stories about poor or inferior treatment in public hospitals (n=58/436, 13%). Personal stories and images of vulnerable patients (e.g., pensioners, pregnant women, single mothers, children, and people with disabilities) are particularly prominent in tabloid articles and are used to convey long hospital waiting times for those without private health insurance:

> Christine Taylor has presented to the Launceston General Hospital's emergency department seven times in 14 months, often by ambulance, while on the elective surgery waiting list. Osteoarthritis has eaten its way through all the knee cartilage in one of her legs… Ms Taylor said the whole process would have taken just two months with private health insurance (*The Examiner*, October 21, 2011).

Although politicians regularly appear (n=211/436, 48%), they tend to be represented in a manner that implies uncertainty about what they are saying. The verbs used to preface government ministers’ quotes, for example, such as ‘claiming’, ‘talking up’, ‘playing down’, ‘conceding’ or ‘admitting’ are not neutral, but what Machin and Mayr (2012: 59-61) refer to as metapropositional expressive verbs. Their usage gives less credibility to their statements. Health ministers are consistently described as ‘wasting scarce’ healthcare resources, presented as ‘conflicted’ or ‘untrustworthy’, said to be offering ‘secret deals' and funding cuts, and accused of ‘concealing’ data about patient safety and the truth about waiting lists.

Another illustration of the disparagement directed at government is found in the headline and lead sentence of an editorial for the *Sunday Age*: ‘End the deadly wait. The government needs to hurry up and fix the health system gridlock’ (July 21, 2013). In contrast, doctors and private healthcare groups are each positioned as advocates for patients. They ‘urge’ governments

to address ‘soaring gap fees’ (the gap between government rebates and doctors’ charges incurred by patients). The use of this directive metapropositional verb conveys legitimacy, but also that the situation is out of control (Machin and Mayr 2012). The AMA likens government 'inaction' on increasing patient costs to a ‘blame game on steroids’. The AMA president is quoted in a news item in the *Herald Sun*:

> Patients are paying up to $199 out of their own pocket to see some specialists and almost $27 to see a non-bulk-billing GP [a general practitioner who charges a co-payment for a consultation]… “The Medicare rebate [funding provided by the Federal Government for medical services] should be linked to what it costs to deliver the service, and that gap is widening”. “We'll be looking to both sides of politics to fix that” (February 27, 2013).

Invisible in these stories about rising costs is the role of doctors, healthcare providers, insurance companies and private healthcare corporations which all contribute to the ‘unaffordability of medical care’.

A precarious balance between public and private

Australian healthcare is positioned in the news media as delicately ‘balanced’ between the public and private sectors. Private health insurance and health services are portrayed as important elements of a viable healthcare system that should be supported. In stories about the increasing cost of private health insurance, journalists, corporations and lobbyists for the private health industry suggest that policy changes, particularly those which might reduce government subsidies for private health insurance, will upset this ‘balance’, and increase 'pressure' on public

hospitals. Such stories are especially prominent in News Corporation newspapers where almost one third of articles are devoted to this matter:

> Australians are winding back their health insurance in response to frequent premium increases and changes to government subsidies and surcharges, threatening the balance between the public and private systems... any devaluing of health insurance that results in people avoiding the private system will inevitably increase pressure on the public system around Australia (Health editor, front page, *The Australian* November 20, 2012).

'Meaning' in these stories is often conveyed by the lexical style employed. As Nelkin (1991:303) states: '[s]elective use of language can trivialise an event or render it important, marginalise some groups, empower others; define an issue as an urgent problem or reduce it to a routine'. Private healthcare groups, doctors' groups, consumer health organisations and politicians, all use the threat to patient safety to suggest that increasing the costs incurred by patients accessing private services will 'drive' patients out of private services and onto 'long public waiting lists'. Words such as 'urgently', 'risk', and 'service restriction' are also frequent, warning that there will be poorer outcomes for all patients should government cut funding to private services:

> We believe that if the government doesn't urgently intervene, patients risk facing up to an additional $100 per infusion, having access to chemotherapy services restricted, being forced to travel further for their treatments, and/or being forced onto potentially long waiting lists in the public health system (*The Age*, November 21, 2012).

Stories such as this contain an explicit message that the private sector reduces pressure on public hospitals, and hence private sector medicine should be supported. This claim is consistently

repeated despite a clear lack of evidence. Indeed, the evidence suggests the opposite, because increasing government support for private healthcare removes resources which could otherwise be used for the public system (Duckett and Jackson 2000; Anonymous 2015a). In a small market such as Australia, where most specialists operate in both the public and private sectors, any increase in private sector work (particularly where it is for private patients and elective surgery) diminishes the profession's capacity to attend to those in the public sector (Duckett 2005). Instead of reducing public waiting lists, growth in the use of the private sector leads to an increase in public sector waiting times. Research shows that in clinical specialities with long waiting times, surgeons are spending only a marginal proportion of their clinical time in the public sector (Freed et al. 2016). It is argued that this is because surgeons and other specialists receive higher remuneration from private hospitals creating a 'perverse incentive to maintain high waiting times in the public sector to encourage prospective patients to seek private care' (Duckett 2005: 88; see also Pratt 2005).

Despite such evidence, private health fund representatives and private hospital associations use words such as 'fearful', 'worried' and 'concerned' to describe the consequences for patients of government funding cuts to private healthcare services. Here the choice of descriptive verbs encourages the reader to empathise with their viewpoint (Machin and Mayr 2012: 59). Private health fund executives also use 'end of the world' metaphors such as 'Armageddon', 'exodus', 'time bomb' and 'doomsday scenario' to forecast the 'disastrous' impact of health insurance reform. These actors seek to redirect blame for the rising costs of health insurance premiums away from the health funds and towards government. Private health insurance fund spokespeople, for instance, claim there will be adverse effects on people with

lower incomes and service provision in rural areas. These claims conceal the fact that the proposed policy changes would only affect higher income earners with private health insurance:

> [Private health fund managing director] said that Tasmanian health services were already in a parlous state and could not afford ‘even a small blip’. ‘This will affect everyone… because of the flow-on’. She was particularly concerned about older private health insurance holders like self-funded retirees. ‘They are frightened and they don’t need to be’ she said (*The Examiner*, February 16, 2012).

Also evident in the news media is a message about the potential benefits of allowing the private sector to have a greater role in healthcare delivery and policy decision-making (Daw et al. 2014). Private sector actors are said to have the ‘expertise’ and capacity to deliver efficient health services, and statistical 'evidence' from private healthcare groups is used to position the private sector as more efficient. An example of this comes from the CEO of Private Healthcare Australia (the peak representative body for the private health insurance industry), who claims the private sector is ‘propping up’ public hospitals:

> A spokesman for the health funds said the growing role of private hospitals contrasted with the failure of governments to recognize their role… while expenditure by public hospitals had risen faster - by 70 per cent compared with 58 per cent by the private hospitals - the increase in admissions by public hospitals of 25 per cent was eclipsed by the increase in private admissions of 73 per cent (*Sydney Morning Herald* February 17, 2011).

While this rhetoric implies the public system is reliant on the private sector financially, what is absent is evidence to show that in fact, the private system is dependent on the public system in a myriad of ways, including for staff education and training, research, and the regulatory apparatus that ensures high standards are maintained.

As a final point, the notion of 'balance' reappears in articles about the importance of private health insurance. The main message of these articles is that contributing to the financing of your own healthcare needs through purchasing private health insurance demonstrates a greater degree of civic responsibility. This message is particularly evident in News Corporation newspapers. For example, in a feature story for the *Daily Telegraph*, an editor argues that people should contribute to their healthcare costs by purchasing private health insurance (in addition to the Medicare Levy they pay through their taxes) to 'take the load off' the public system. In other News Corporation stories, it is implied that people with private health insurance who choose to go to a public hospital are not fulfilling their role as 'good citizens', for they are taking resources away from public patients:

> Private health insurance makes good sense. I have it, and I don't resent having it. Medicare should be there as a safety net for everyone, but if you can afford it there is no reason to rely solely on the public system when you can take the load off paying to cover yourself privately (*Daily Telegraph* November 20, 2012).

> Private abuse of public beds (Headline). Taxpayers spend $5.5 billion a year subsidizing private health cover, only for fund members to clog up public hospital beds (*Daily Telegraph*, August 17, 2013).

Concluding Comments

The field of the news media is, as we have demonstrated, a contested arena within which actors (individuals, organisations and institutions) seek to make claims about the healthcare system and counter the claims of others. The nature of the media field makes possible a full battery of strategies and devices that can be used to great effect. In this paper, we have seen the use of authoritative sources to give weight to specific claims; emotive language to engage the audience and underline the significance of issues; dramatic language to induce anxiety and fear in patients; judicious use of statistics to support particular claims; careful placement of powerful actors ahead of the least powerful in order to give the appearance of a balanced story while simultaneously devaluing the voices of subsequent speakers; the absence of information that would give context to a story and enable a reader to interpret the claim in an alternative manner; and the slanting of stories to shift blame to specific actors.

This description of the media field could be compiled through the use of framing theory. With the addition of a Bourdieusian framework, however, we begin to explain why particular claims are dominant, and why there are some systematic differences in the claims of the various types of news outlets. Bourdieu's concept of the field brings to light the struggles of actors (whether individual journalists or news organisations) as they deploy field-specific forms of capital in response to field-specific struggles. In the Australian healthcare field, specific areas of contention concentrate around the very meaning of health itself – with the biomedical model dominant in these encounters – and around the best way to provide services: privately or through a public service (Anonymous 2017). These struggles are part of the very structure of the field, for the introduction of government support for private health insurance in the 1990s (Anonymous 2011), and the construction of low hospital insurance membership as a 'problem in need of a

solution' (Anonymous 2011), completely transformed the arena, ensuring the domination of private medicine, and allowing private sector actors to take a position in the field closest to the poles of power (Bourdieu 1983; Benson 1998:469).

In this study, we have investigated the intersection of the healthcare and media fields, seeking to demonstrate the role of the media in these field-specific struggles. An important insight gained from this study has been our capacity to distinguish between the messages produced by the various news media. While the negative slant of news coverage is unsurprising given negative stories are generally regarded as more valuable and more newsworthy than positive ones (Shoemaker and Reese 1996), our data indicates the dominant actors in the field – private health insurance companies, private hospital corporations, private sector lobby groups and associations, and doctors' associations – are consistently favoured in coverage. Moreover, although negative messages about the public healthcare system are common, there is a systematic absence of negative messages about the private system; even though many such events could be reported. This yields the impression that problems are 'normal' occurrences in the public healthcare system. And importantly, these stories are not just about individual patients but generally contain unsubstantiated claims about a public system 'struggling' - with its 'inefficiencies', 'inadequacies' and 'mistakes'. Yet there is a marked silence in the mainstream media about problems with private healthcare. We have demonstrated elsewhere that information in the healthcare sector is tightly controlled, with actors in the private sector able to significantly limit the collection of statistical data by government about private hospitals and the rising costs of premiums and services (Anonymous 2017). In this paper, our data indicates the critical importance of this facet of the field, for such practices severely limit the capacity of journalists to provide 'balanced' reports to the public. Indeed there is a general tendency for the media to be co-

opted by, and collaborate with, private sector interests in the promulgation of a discourse of 'choice' for patients, even though the underlying - and much stronger message hidden in this discourse - is not the promised smorgasbord of alternatives, but a command to 'go private'.

While all journalists and news outlets are constrained by the dynamic structures of the field, their relative positions within the field help to explain the greater tendency of the tabloids and News Corporation papers to offer stories that contain negative messages about public sector medicine, that denigrate government, and promote private medicine. In an increasingly competitive field, the media corporations and individual newspapers have had to fashion their businesses to draw on specific audiences and supporters. This has meant differentiating their products to ensure a positive reception. For the tabloids, this has meant obtaining a position proximate to the economic pole of power, where dramatic and anti-government stories can be deployed as a form of cultural capital readily transmutable into economic capital. In contrast, the broadsheets are positioned closer to the cultural pole, where journalistic and investigative stories operate as a relatively effective form of capital. These differences apart, all mainstream media operate within the same field, and thus even broadsheets must construct a proportion of their stories which conform to the 'rules of the (media) game' to attract economic capital. Equally, all media outlets are constrained by the inadequacies of information available in the field that are essential for 'balanced' reporting.

As a final note, it is important to state that we have based our conclusions on a field and discourse analysis, and not from interviews with journalists or editors. As such we do not intend to impute specific motives for the construction of news stories. Instead we point to structural tendencies across the field in both discourses and practices. We believe it would be of considerable benefit to media research if Bourdieu's concepts of capital and field were to be more

broadly applied, so that we might better understand the processes through which private sector stakeholders are able to set the agenda in healthcare and other fields.

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