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# The Health Reform Advertisements: What are they all about and what will they mean to you?

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In June and July of 1993 the Ministry of Health in Aotearoa/New Zealand spent $2.5 million on "informing" the public about health reforms. Part of this information campaign involved four newspaper advertisements. This study uses discourse analysis to examine some of the functions of these advertisements beyond providing information. Focusing on the provision of subject positions, we consider contradictions and inconsistencies within the texts. The devices of exclusion, invisibility, deferment and reconciliation are identified and their effects on resistance to the health reforms are considered. We conclude that the advertisements provide persuasive texts which smooth the shift from "the caring society" to an emphasis on business practice and profitability.

The New Zealand government recently spent $2.5 million to tell the population of Aotearoa/New Zealand about the new Health Service that came into effect on July 1, 1993. These health-system changes are being wrought in pursuit of efficiency and value for money and prior to their introduction a mass media campaign of television and newspaper advertisements was funded by the government to explain what the changes are 'all about'. The television advertisements focused on the need for change and these were followed by a series of full-page national, press advertisements which outlined how the new Health Service is structured and how tax money will be used to get "the best possible health and disability support services for everybody" (Ministry of Health, 1993c p.11).

As a government-sponsored health service message, dealing with both medical and public health concerns, the advertisements offered potential insights into the social and political contexts in which the new system would operate. The text also provided a vehicle through which the government sought to 'sell' its message to a potentially resistant public. The health reform press advertisements were, in fact, a major political mass communication exercise and as such deserve analysis which goes beyond a simple evaluation of the obvious 'message'.

As academics we have an interest in the health reform advertisements because one of our functions is to provide critical social comment. As psychologists we are aware that many of our colleagues are already practising in the new health care environment and will be directly affected by the reforms. Primarily, however, we are interested in the advertisements as examples of techniques of persuasion. We recognise that persuasion does more than change attitudes—it also affects people's status and rights. This paper seeks to critically analyse the use of language in the health reform press advertisements and to explore the dominant ideologies which are represented. We aim to probe beneath literal meanings and the manifest content of the text to look at the symbolic and latent meanings of the message system.

Given our aim, it seems appropriate to adopt a methodology which "looks at the subtle ways in which language orders our perceptions and makes things happen" (Potter & Wetherell, 1987, p.1). A discursive approach is suitable for an analysis of textual devices as social processes. The strength of this approach is that it encourages an examination of how text is constructed and how it functions. Discourse analysis has been usefully applied to a wide range of areas, e.g. court proceedings (Atkinson & Drew, 1979), attribution and memory (Edwards & Potter, 1992), agenda-shifting procedures used by interviewees (Greatbatch, 1986), scientists' discourse (Gilbert & Mulkay,

1984) and majority group representations of race relations (Wetherell & Potter, 1986). Also, a discursive approach emphasizes an action orientation' to language, seeing text as a social practice rather than an neutral transmitter of information (Heritage, 1984; Potter and Wetherell, 1989). Thus, language is viewed as achieving particular social ends.

Readers more used to the positive paradigm of scientific research may assume that discourse analyses are too subjective in that they rely on individual interpretations of the text. However, as Lupton (1992) notes, proponents of discourse analysis make no claims as to the objectivity or universal truth of their insights.

> Rather, they assert the need to acknowledge the speaking subject as inevitably positioned within a sociopolitical context. (Lupton, 1992 p.148).

In adopting a discourse analytic approach we suspend belief in the core assumptions of the natural sciences and reject the assumption that objectivity and 'truth' are free of the effects of context, power dynamics and sociopolitical values.

> Discourse analysis theory openly acknowledges the inevitability of a theoretical position being context- and observer- specific; indeed the role of discourse analysis as a critical tool requires that the commentator's particular perspective be made explicit. (Lupton, 1992 p.148).

Regarding the health reform press advertisements, we believe they were designed to have a persuasive impact and reduce the possibilities of opposition to health care reforms. We also believe that they participate in a wider social and discursive phenomenon: a process of social reform and public debate concerning administration, politics and ideology in contemporary Aotearoa/ New Zealand. We assume that this broader context informs readers' interpretations of the advertisements. In particular, there are alternative, and sometimes conflicting ways of talking about government provision of services and associated issues. One of these alternative ways of speaking is used in the following quote:

> In the sequence of social reforms that have taken place to date, health is the last and to many people its reform is seen as dismantling the last vestiges of the caring society. (Network Communications, cited by Fountain, 1993 p.23).

In our analysis of the advertising texts we explore conflicting ways of talking about health care services—in particular the anomalies that emerge from using the language of a 'business model' and the language of a 'social care model' of service provision.

When we use the term 'discourse' to describe these languages we are not suggesting that there are discrete ways of talking about health service provision. The language of a 'business model' and the language of a 'social care model' are not mutually exclusive nor do they have unique distinguishing characteristics. 'Discourses' do not generally conform to scientific notions of an 'object' of study. We use the term 'discourses' to refer to these ways of speaking as a heuristic device which enables us to talk about configurations of metaphors, analogies and connotations. Such 'configurations' are described by Potter and Wetherell as "recurrently used systems of terms used for characterizing and evaluating actions, events and other phenomena" (1987 p.149).

Given the 'indistinct' quality of discourses, discourse analytic approaches tend to contrast discourses so as to focus on the relations between them rather than on their absolute characteristics. Parker (1992) suggests that examining the interrelationship of discourses through contrasting their different ways of speaking about the same phenomenon is an important phase in discourse analysis. Also important is examining the way in which different discourses may use similar ways of speaking—but in reference to different phenomena. The sometimes complex interrelationship between discourses within the same text often involves inconsistencies, incompatibility and contradictions which discourse analysts use in tracing the function and effect of particular ways of speaking.

Although the health reform press advertisements were designed as a persuasive public relations message, we do not believe they are consistent in using only one way of speaking about the health reforms. In this paper we analyse the text of the advertisements, firstly to review the structure, rationale and information they present and then to consider the functions of the discourses we find at work in these texts.

## The Advertisements

There were four health reform advertisements, each of which was a full newspaper page. They were sponsored by the Ministry of Health and were all headed "The New Health Service". Each advertisement had a specific heading identifying the topic area. The first advertisement was titled, "The New Health Service. What is it all about, and what will it mean to you?" The second dealt with "Ten Important Questions about the new

Health Service". The third advertisement covered the topic of "Regional Health Authorities, what they are and what they do". The final advertisement was tailored for each region and was entitled (in our series) "Central Regional Health Authority—your RHA". There was a total of 31 subheadings, 24 of which were framed as questions.

The stated rationale of the advertisements was to inform the public. This rationale was supported by claims about the importance of understanding and the ability of these advertisements to answer questions as well as complement the television campaign. For example,

> Television alone cannot give you all the information you need.

The implication here is that television has not provided all the necessary information and therefore the newspaper advertisements will fill an information gap. On the surface it would seem the identification of, and subsequent filling of this information gap was a laudable exercise.

However, do the authors of these advertisements know what information the readers need? The answer is, of course, they do not. But they have invoked an authoritative discourse which reassures (my informational needs are being met) and does not encourage critical examination of basic assumptions (how do they know what my needs are?). Questions about the needs of those who neither read these advertisements nor saw the television advertisements are not addressed. The irony of this last point is underscored by the claim regarding the importance of understanding.

> It's important that *everyone* understand what is happening, and the reasons behind it (*emphasis added*).

The importance of understanding is restated in the second advertisement, where we are told,

> It is important that the new changes are understood by everybody.

The advertisements also claim to be able to answer many questions that you or I may ask. The prevalence of questions was never more obvious than in the second advertisement entitled "10 important questions about the new health service". The number '10' connotes a complete set, although these questions may not have been the most useful or informative questions to ask. Furthermore, the answers may not be helpful.

In advertisement one the text states that the series of advertisements

> ... will provide answers to the many questions you may have ...

This style of informational reassurance is a rhetorical device similar to that provided in the assertion that the advertisements would fill the gap created by television. One obvious problem with such reassurance concerns the apparent ability to answer (my) questions before they have been asked. The possibility of the agenda being set by those answering the questions becomes sharply focused at this point. Such agenda setting highlights the possibility that the advertisements may have been designed to persuade an apprehensive public and assuage public fear of change. In this case, these advertisements serve wider functions than merely filling an 'information gap'.

Individual readers must decide for themselves whether the advertisements fulfil the stated aims, or indeed provide a comprehensive answer to the question which forms the main heading for the first advertisement.

> What is it all about, and what will it mean to you?

In our own reading of the 'information' provided by the advertisements we were less than well informed and found that more questions were raised than answered. In terms of what was changing, we decided that the following areas of reform were explicitly covered.

Firstly, the new Health Service is a "different way of organising and paying for New Zealand's health and disability support services" (Ministry of Health, 1993a p.9). Prior to July 1, 1993 the government funded or subsidised all forms of health care and disability services through its various government departments. This included direct funding and subsidising of primary health care (i.e. general practitioners, physiotherapists, midwives, etc.) and public health services, and indirect funding of secondary health care through the 14 Area Health Boards (i.e. public hospitals and their associated services). Under the new Health Service four Regional Health Authorities (RHAs) are responsible for funding all health care "choosing between public and private health and disability support" services (Ministry of Health, 1993c p.11). The two main changes are a re-organisation of the hierarchical levels of funding and the inclusion of private health care as part of the government funded health service.

Given the wide ranging purchasing power of the new RHAs how is their role defined in the advertisements? "The job of an RHA is to spend the tax money it receives on services which the people in its region need." (Ministry of Health, 1993a p.9). Although the public's views will be

sought on what services it values, needs will apparently be determined by Community Health Groups to be established and funded by the RHAs. The role of the RHAs is to "keep people as healthy and independent as possible" (Ministry of Health, 1993b; p.12) and they aim to achieve this through ensuring access to the reviewed core servicesand purchasing services which offer value for money. However, there are hints that some health care responsibility may be moved back onto individuals and their social networks, for example:

> We want to reduce the time some older people spend in hospital and make it easier for them to go on living independently...
>
> We want to encourage a move away from institutions to more community based treatment...
>
> In some cases, the move will be towards more community and home based support services...

The role of Crown Health Enterprises (CHEs) is not made clear in the text but two key issues emerge. Firstly, the public hospitals (CHEs) have to be run in a more businesslike way with any profits ploughed back into health services[1]. Secondly, the CHEs "have to provide health and disability services" (which RHAs may or may not purchase), "show social responsibility in regard to the interest of the surrounding community and uphold ethical standards" (Ministry of Health, 1993b p.12). These social requirements are not apparently to be made of private health care providers who may therefore be able to offer better value for money, depending on how 'value' is interpreted.

## The Discourses

### *Contradictory Positions*

Throughout all four health reform advertisements a business discourse is widely used, in line with the new business model for the health service, as in the following example:

> From now on public hospitals will be run in a more businesslike way. Any extra money they make will be ploughed back into health services.
>
> The RHA's role is to keep the people in their regions as healthy and independent as possible by contracting only with providers who offer the best quality services at the best value.

Davies and Harré (1990) argue that the "constitutive force of each discursive practice lies in its provision of subject positions. A subject position incorporates both a conceptual repertoire and a location for persons within the structure of rights for those that use that repertoire" (p.46). The discursive provision of one subject position does not preclude the provision of others. Business discourses, for example, may provide positions for both consumers and producers as well as service providers, administrators, employers and employees. It is possible for particular individuals to occupy more than one subject position and for a text to address a reader as if they occupied different subject positions in relation to different message content.

When more than one discourse is at work in a text it is likely that the subject positions provided by the discourses will be contradictory and inconsistent. For example, there are many discourses which provide subject positions termed 'em-ployers' or 'producers' but the conceptual repertoires and the structure of rights associated with those terms are not consistent across different discourses. A reader may not only be positioned and re-positioned by the same discourse at work in a text, but may also be positioned and repositioned between discourses.

The following analysis will show an example of these shifting subject positions in relation to the work of the business and health care discourses in the health reform advertisements. In this example we focus on two potentially contradictory positions constituted through the texts. The business discourse frequently addresses the reader as a "taxpayer" who is entitled to the careful and efficient use of taxes:

> This advertisement explains how the RHAs will use your tax money to get the best possible health and disability support service for everybody in your region.

Simultaneously, within the health care discourse, the reader is addressed as a "health user" who needs and is entitled to assurance that necessary services will continue to be available:

> RHAs want to ensure you continue to get the same level of quality care when you go into hospital...

The contradictions between these two positions are evident in both the way the text addresses the reader and the way in which issues of choice are discussed.

### *The Issue of Choice*

One clear example of the inconsistencies between the positioning of the reader as both taxpayer and health care user is in the possibili-

[1] Newspaper commentaries suggest that CHEs will be servicing market value or higher interest rates on loans taken to make the CHEs competitive (Otago Daily Times, 1993). We would question how much money could be "ploughed back into health services" while these loans need to be repaid.

ties for choice highlighted in the third advertisement. Here choice is available for the health user when the reader is positioned in this way, but is not when the reader is positioned as a taxpayer.

> RHAs want to ensure you continue to get the same level of quality care when you go into hospital and are able to use the general practitioner, or other health provider, of *your choice.*
>
> All the taxes that used to go to the Boards to run hospitals, or to GPs and other health professionals to meet some of their patients' costs, will now go directly to the four RHAs. The RHAs will use that money to buy health and disability support services for the people in their regions, *choosing between public and private* health and disability support providers (*emphasis added*).

Choice of health provider is offered as an important aspect of the issues concerning the reader as an individual health care user. However, for a taxpayer, the choice will be made by the new organisational structures.

*Addressing the Reader*

When addressing the reader many section titles imply that the advertisements will be for the individual who is concerned about the health service because s/he is a health user. While the questions asked address the reader as an individual, they are sometimes answered by addressing the reader as part of the community and wider public and as a taxpayer.

> *How will I have a say in health and disability support services?*
>
> RHAs will carry out surveys and do market research to test *community opinion* about health services and how they're provided.
>
> *How do I know the standard of service won't fall?*
>
> RHAs are accountable. They have to show, *publicly,* that they are buying good quality services (*emphasis added*).

Through these modes of address, health care users are individualised as concerned questioners (whose questions aren't directly answered), while the concerns of the taxpayer position are embedded in a sphere of public action.

***Techniques For Smoothing Potential Conflict***

The subject positioned as taxpayer is often reassured by the text that "your tax money" will not be wasted and that use of tax money will be more efficient from now on. Meanwhile the subject as health consumer must not become concerned that this tightening up of expenditure will mean depleted health services. This potential conflict is smoothed over by the text so that the changes in the health system will not seem disadvantageous from either position. Several methods are used to achieve this and we have focused on four: exclusion, deferment, invisibility, and reconciliation. In the following analysis these methods will be exemplified by considering modes of address, discussions of change and the exploitation of multiple referents for the word 'value'.

*Exclusion of Modes of Address*

Health care users are not always addressed but sometimes spoken about. This technique identifies the reader and the taxpayer position by addressing the taxpayer personally ("*you* might hear") and objectifying health care users as possessions of the new health service:

> An RHA, or Regional Health Authority, is a completely new organisation. You might hear RHAs called 'purchasers'. That's because their job is to purchase the services *their people* need, such as accident and emergency care, operations, GP services, Plunket nursing, rest home care, meals on wheels, Maori health services, mobile clinics, home help and so on (*emphasis added*).

In this case the reader as health care user is simply excluded as a subject of the discourse. The taxpayer's primary concern about the efficient provision of services is addressed and the user becomes an object of care. By relegating the user position to the 'third person' the taxpayer position is privileged as the principal position of address. The exclusion of the health user's position operates to disrupt any identity between the reader and the user and consequently 'smoothes' apparent contradictions.

*Deferment and Invisibility in Discussions of Change*

One of the most obvious contradictions is that for the health care user there are assurances of no immediate change within a text which is ostensibly informing the taxpayer of the details of a whole new health system. This contradiction is not 'smoothed' through exclusion of either the health care user or the taxpayer positions; instead changes are granted different status according to their effect on either the taxpayer or the health user.

When the "taxpayer" is given details of system changes the health care user is typically reassured that the change will be invisible. The first example of this occurs when readers are told the change will be in the way taxes are used to provide health and disability services. This is followed immediately by:

> If you find yourself in hospital on that day, or seeing a doctor, or being visited at home by a public health nurse, you probably won't notice any difference. That's because, for the first year or so, most of the changes will be administrative and they'll be happening behind the scenes.

The implementation of change is made less threatening by the reassurance that differences will not be noticeable. The reader as health care user is told that most of the changes will be administrative. This has an abstract, distant status when contrasted with the practicalities of being in hospital, seeing a doctor or being visited by a public health nurse. Thus the changes are not only invisible (happening behind the scenes), but they are also happening on a level which involves others (administrators) and will not be visible in the day to day activities in which health care users might find themselves involved.

Making the changes 'invisible' is not the only technique used to indicate the different status of changes in this example. The advertisement also implies that change in health care *will* be apparent after the first year or so. So the 'invisibility' of changes is temporary and the impact on the health care user is deferred into the future. The second advertisement reproduces these techniques:

> Most New Zealanders, including those receiving health care, won't notice any difference. For the first year or so most of the big changes to health and disability services will be happening behind the scenes.

The reassurance provided by the two techniques of invisibility and deferment are supported by the second advertisement, addressing those areas which are *not* changing:

> What is changing is not health care itself ...
> The changes won't affect user charges at all.
> Anyone getting disability support services, now, will go on getting the same services until at least 1995

In the areas of health care, user charges and disability support services, change is not occurring—at least at present.

Throughout the texts 'change' is used to privilege the organisational side of the health service, enabling health care itself to be separate and excluded from issues of concern to taxpayers. This separation constructs a contradiction between the position of taxpayer and that of health care user. For the reader as taxpayer 'change' is emphasized, while for the health care user 'change' is invisible:

> what is changing is not health care itself but the way we organise and pay for it as a country ...
> An RHA, or Regional Health Authority, is a completely new organisation ...
> The separation between the purchasers and the providers is the most important feature of our new health system.

In discussing 'change' the advertisements address both the taxpayer and health user positions, but the concerns of the health user are marginalized through the twin devices of invisibility and deferment. This marginalizing effect smoothes the contradictions between the two positions and, again, effectively privileges the taxpayer position.

*Reconciliation through use of Value*

To create one apparently coherent 'reader' out of multiple positions, interpretive devices are commonly used to reconcile anomalies and contradictions between discourses (Gilbert & Mulkay, 1984). In this text an example of such a device is the use of ambiguities in the meaning of the word "value". In common usage today "value" as a noun may refer to the worth of something in terms of money, or as a verb it may refer to an appreciation of the quality of many other things that people hold dear. It is these two usages that are interspersed in the text.

A predominant use of the word "value" is in the phrase "value for money" which is introduced in the first advertisement:

> RHAs will be able to buy services such as cataract operations from either public or private hospitals, whichever gives the best service. The only condition is that they do the operation well and they give *value for money* (*emphasis added*).

Another similar common use occurs in the phrase "at the best value" which is first used in the second advertisement:

> The RHA's role is to keep the people in their regions as healthy and independent as possible by contracting only with providers who offer the best quality services at *the best value* (*emphasis added*).

In these examples the reader is addressed as taxpayer and the dominant concern is that the money from taxes is well spent. These phrases very economically serve to position the taxpayer also as a consumer by using the familiar language of supermarket advertising.

In the second advertisement the word "value" is used three more times. The next two occurrences position the reader as health service user. Now the meaning of "value" has shifted to that of something necessary or important in life[2]:

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[2] In these examples note also the change in the pronoun to "we": this is now a community matter—and in this context relocating the 'user' in the 'community' operates to blur the boundaries between the two positions and enhance the effect of the double meaning of 'value'.

> It will publish books, hold public meetings and invite feedback from the community on what services *we value most*, and how we want to spend our health and disability support services money.
>
> It's a complex and important process. Core services aren't going to change overnight. But every year we will get a little closer to having the publicly funded health and disability support services we, as a community, really *want and value* (*emphasis added*).

Having established the importance of the health consumers (communal) needs and values the same advertisement repeats the use of the key phrases:

> RHAs will be looking for the best services *at the best value*. So an RHA wanting to buy cataract operations, for instance, may contract either with a CHE or with a private hospital, depending on who offers the most appropriate service and *value for money* (*emphasis added*).

The fifth use of value in this advertisement shows a further blurring of the two positions. In listing examples of the "quality" services expected, the text alternates the concerns of "user" and "taxpayer" positions evenly:

> Contracts between RHAs and health 'providers' will deal specifically with the quality of services—things like making sure all those who need the service can get it, that it's affordable, culturally appropriate and *value for money* (*emphasis added*).

The third and fourth advertisements provide several further examples of the usages of "value for money" and "the best value". Community concerns are once again related to concern with monetary costs, with the word 'value' present to help smooth the potential conflict between community needs and what "we can afford":

> Our mission to ensure that our communities have *the best value* health care and disability support services that we can offer (*emphasis added*).

The exploitation of the different referents of the word "value" allows the texts to position the subject ('you' who is sometimes part of 'we') as a "taxpayer" and "health user" and to reconcile the contradictions between the concerns of these two positions (while emphasising the concerns for monetary value). Once the use of the word in different positions has been established, the phrases that belong to the 'taxpayer' position can be used in apparently addressing the concerns of the 'user' position, so that the contradictions in the concerns of either position are apparently reconciled—their values are the same.

## Consequences

The four techniques of exclusion, deferment, invisibility and reconciliation identified in the health advertisements have been used to 'smooth' contradictions and inconsistencies between business and care discourses. It is apparent from the advertisements that contradictions and inconsistencies have not 'disappeared': the smoothing operates to move readers from one position to another while limiting opportunities for resistance. As the advertisements are constructed, resistance to such desirable outcomes as 'value for money', 'having what we can afford', 'the best service available', 'community consultation' and 'efficiency' seems unreasonable. It also seems unreasonable to object to changes which are 'invisible' and without consequences for health care services.

Each of the four techniques identified has also been used to privilege the reader's position as taxpayer. Consequently, the new health service/system is constituted primarily through the business discourse. This contributes towards dislocating the care discourse from its traditional position as the conceptual repertoire for constituting the health service/system in Aotearoa/New Zealand.

One of the implications of the movement from care to business discourses is eventually identifying both health user and taxpayer positions as "consumer" and therefore as a unified subject located in the one discourse. As Davies and Harré (1990) point out a "subject position incorporates ... a location for persons within the structure of rights for those that use that repertoire" (p.46). Consumers located within a business discourse have different status and rights from patients located within a care discourse. The health advertisements use techniques which draw the readers' attention away from these differences thus minimizing opportunities for resistance.

This analysis demonstrates that the health reform advertisements do a great deal more than simply fill an information gap. They provide persuasive texts which function to smooth the shift from "the caring society" to an emphasis on business practice and profitability. A business discourse dominates this shift, with consumers and users taking the place of patients, providers edging out doctors and nurses, and RHAs purchasing services rather than care. Health care has been reduced to a commodity and the hospitals of yesterday proudly sport new images designed to have impact on the market place. For many psychologists, this shift will inevitably impact on the manner in which they practice psychology. In

highlighting some of the rhetorical devices used to herald the health changes, we hope we have provided a backdrop against which some of the implications of the reformed health environment may be examined.

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