Research Article

"We Cannot Let Them Die": Undocumented Immigrants and Media Framing of Health Deservingness in the United States

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Abstract

Based on a systematic qualitative analysis of articles published by *The New York Times* (2009–2017), this article presents the main media frames that support the access to government-sponsored health care by undocumented immigrants, just before and after passage of the U.S. Affordable Care Act in 2010. Under the umbrella of "selective inclusion," this study highlights a "compassionate frame" that conveys sympathy toward severely ill, undocumented immigrants. This approach is reinforced by a "cost-control" frame that underlines the economic benefits of providing health care to the undocumented immigrant population in the United States. Supported by both humane and market-based approaches, these frames make a compelling case for the inclusion of particular groups into the U.S. health care safety net. Ultimately, these findings contribute to our understanding of the media framing of undocumented immigrants' right to health care on the basis of deservingness.

Keywords

Media framing; immigrants; health care; illness and disease; Latino/Hispanic peoples; marginalized or vulnerable populations; stigma; social construction; discourse analysis; interpretive methods

Introduction

The extent to which the U.S. government should provide health services to undocumented immigrants has been a topic of heated debate in recent years. While human rights frameworks support the notion of universal access to health care, neoliberal positions argue for individual responsibility and self-sustainability as the basis of deservingness. Although the latter stance has traditionally been mainstream in the United States, the increasingly large presence of undocumented immigrants has made public policy more contentious in recent years. The right of the undocumented population to health care in the United States was fiercely debated by Congress before the passage of the 2010 Patient Protection and Affordable Care Act (i.e., the ACA; Public Law 111-152, 2010). The ACA was signed into law with the explicit purpose of providing accessible and affordable health coverage to the uninsured population in the United States. It also mandated that, with rare exceptions, U.S. citizens and legal permanent residents had to have health insurance coverage—or pay a fine. Through the creation of state-based health exchanges, the ACA promised to help individuals and small businesses purchase coverage, with or without subsidies, and states had the option of expanding Medicaid to a larger pool of individuals.

Despite its claims of universality, the ACA ended up barring all undocumented immigrants from any type of government-based medical care, including the federally subsidized health exchanges and Medicaid (Marrow & Joseph, 2015). As a result, it left out some 11 million undocumented individuals, 76% being Latino, 59% of those being Mexican (López, Bialik, & Radford, 2018; Sanchez et al., 2011). Thereafter, much of the U.S. media debate on health care reform revolved around the exclusion of undocumented immigrants from all public and federally subsidized health and social programs (Menjívar & Kanstroom, 2013; Viladrich, 2012). As of today, undocumented immigrants are ineligible for any federally funded public health insurance programs in the United States, including the Child Health Insurance Program (Berlinger & Gusmano, 2013; Galarneau, 2011). Meanwhile, state and local governments have continued to spend their own funds to protect certain vulnerable groups, including

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pregnant women and children. Several of these state-run health programs now include undocumented youth participating in Obama's Deferred Action for Childhood Arrivals as well as recent immigrants (e.g., from Africa and the Caribbean) suspected of carrying infectious diseases (Patler & Cabrera, 2015). The provision of health benefits to specific groups within the undocumented population, as shown in these state policies, begs the question of how the media shapes and disseminates messages aimed at enlisting public support on their behalf.

The literature on media framing has produced an extensive body of work on the interrelated ways in which the media defines and constructs a problem, diagnoses its causes, and provides solutions to it (Aalberg & Beyer, 2015; Esses, Medianu, & Lawson, 2013; Figenschou & Thorbjørnsrud, 2015; Kim, Carvalho, Davis, & Mullins, 2011; Lakoff, 2006; Newton, 2009). The media has been widely acknowledged as a key mediator in the production and transmission of images, perceptions, and narratives of illness (Bengs, Johansson, Danielsson, Lehti, & Hammarström, 2008; Haynes, Merolla, & Ramakrishnan, 2016; Sontag, 2001), especially when it comes to labeling particular conditions (e.g.., infectious diseases) as "foreign illnesses" (Esses et al., 2013; Reitmanova & Gustafson, 2012; Soffer & Ajzenstadt, 2010). Medical and scientific organizations also play a key role in shaping and reinforcing social images, mostly through reports and press releases they furnish to media outlets, that then disseminate scientific data and research results to a wider public (Carpenter, 2009).

The media prompts their audiences to align with a specific vision on a controversial topic, as when supporting a humanitarian approach (i.e., immigrants deserve compassion) or when conveying the idea of a threat (i.e., immigrants are dangerous subjects). Even when unaware of it, we assess reality through packages of predigested information that induce us to interpret and take a position, both intellectually and emotionally, on controversial topics (Fryberg et al., 2012). There also exists a close relationship between framing and labeling as the use of certain key words and short phrases has a strong impact on both sensorial and intellectual evaluations of a given topic (Knoll, Sanborn, & Redlawsk, 2011; Ommundsen, Larsen, van der Veer, & Eilertsen, 2014). For instance, terms such as "amnesty" and "illegal," commonly used when discussing the legal status of the undocumented population in the United States, suggest the pardon of a crime (Lakoff, 2006).

Contemporary mainstream immigration frames, which mostly penalize undocumented immigrants, are concordant with paradigm shifts that have been taking place since the 1960s. From welfare programs that addressed the structural causes of poverty, the media gradually switched to images of migrants as trespassers, criminals, and welfare thieves who illegally, and routinely, enter the United States to take advantage of its health and welfare programs (Rose & Baumgartner, 2013; Yoo, 2002). When it comes to the health field, the widespread frame of immigrants as a "burden" (an image popularized by conservative media) highlights the abuse of public services—including hospitals and schools—by undocumented immigrants (López-Cevallos, 2014). In contrast to these images, social science scholars have been lately challenging the construction of illegality as one of the unintended outcomes of a connected world in which human beings are denied basic necessities such as health care (Castañeda et al., 2015; Schrecker, Chapman, Labonté, & De Vogli, 2010; Willen, 2012).

This study is aligned with this latter perspective by focusing on the specific ways in which the U.S. media constructs and disseminates news frames that support the access of undocumented immigrants to health care. This article fills a gap in the literature as there have been few studies on the news coverage of undocumented immigrants (Patler & Gonzales, 2015; Thorbjørnsrud, 2015), with most published work addressing the rhetorical ways through which they are negatively portrayed by the media (Brown, 2013; McConnell, 2011; Sohoni & Bickham Mendez, 2014). Furthermore, little is known about the policy arguments and news representations that support immigrants' inclusion into the U.S. health care safety net. Media framing has the power to shape the opinion of wide audiences that ultimately fuel both pro- and anti-immigrant social movements (Freeman, Hansen, & Leal, 2013; Thorbjørnsrud, 2015). Therefore, an understanding of the main frames publicized by leading media outlets can shed light on the direction of public opinion toward supporting either progressive or regressive immigration policy.

This article reflects Viladrich's research trajectory on discourse analysis involving the study of health care and international migration (Viladrich, 2012; Viladrich, 2015; Viladrich & Baron-Faust, 2014). Based on a selection of articles published by *The New York Times* (NYT), this research piece presents a systematic analysis of media frames of undocumented immigrants following passage of the ACA. It first introduces the concept of deservingness as an overarching framework for understanding the inclusion of certain undocumented immigrant groups into the U.S. health safety net. The research design and main findings will be then presented, followed by an in-depth qualitative analysis of the "compassionate" frame—also defined here as "*The New York Times* effect." In this vein, special attention is paid to personal stories aimed at eliciting sympathy toward vulnerable foreign-born individuals.

Rather than a language of human rights, journalistic accounts tend to express compassion toward particular groups of vulnerable individuals (e.g., the terminally ill, accident victims, and the elderly). Following the precarious

lives of severely ill undocumented patients, the article then discusses the framing of compassion on the basis of their individual trajectories. This is combined with an analysis of a "cost-control" frame that highlights the financial incongruities that result from having an uninsured, and undocumented, immigrant population in the United States. Toward the end, this article addresses the relevance of the study findings with respect to a market-driven ideology that rests on the notion of deservingness as its primary ideological scaffold. This study ultimately hopes to advance our understanding of the framing of the right to health care as "selective inclusion," which, within a merit paradigm, prioritizes certain groups among the undocumented as eligible for health care and social benefits in the United States.

Deservingness as Selective Inclusion

The term "frames of inclusion" in this article refers to the particular traits that make certain immigrant populations deserving of publicly supported health care services. Rather than universal access, the principle of deservingness points to certain alleged characteristics (e.g., being young, innocent, or weak) as the *sine qua non* conditions for receiving publicly funded social welfare and health benefits. This approach is aligned with a growing literature in the field of immigrant deservingness, which has explored the paths to inclusion of undocumented immigrants—along with other disenfranchised ethnic minorities—into the welfare state of developed nations (Bonizzoni, 2018; Chase, Cleveland, Beatson, & Rousseau, 2017; Chauvin & Garcés-Mascareñas, 2014; Holmes & Castañeda, 2016; Kootstra, 2016).

Deservingness is certainly contrary to entitlement, the latter suggesting a universal right to timely, safe, and adequate health care (Huschke, 2014; Willen, 2012). Although entitlement to health care is conceived as a collective good—irrespective of any individual circumstances—deservingness rests on a moral continuum that is context and population specific (Gottlieb & Mocha, 2018; Willen, Knipper, Abadía-Barrero, & Davidovitch, 2017). Consequently, the framing of health-related deservingness implies a stratification of different categories of immigrants—some who are more and some less worthy. Scholars have also noted that, particularly in the developed world, deservingness categories are shaped by fear and anxiety toward the foreign born, with the public commonly considering as deserving those groups they identify with the most (Raven, Achterberg, & van der Veen, 2015).

Most national and international legislation leaves gray areas pertaining to those who should (and should not) be included into the health safety net, as well as the types of services they could be entitled to (Trummer & Krasnik, 2017). As noted by Gottlieb and Mocha (2018), even countries such as Israel and Germany—which are legally bound to universal health care—exclude certain groups (including most undocumented immigrants) from public health services. Therefore, public advocates, immigrant organizations, and progressive policy makers tend to highlight immigrants' socially valued traits (e.g., work ethics and dependability) in order to make them appealing for inclusion into the government's health system (Gottlieb & Davidovitch, 2017; Gottlieb and Mocha, 2018; Mladowsky et al., 2012).

Rather than a universal model of deservingness, social categories of inclusion vary by country and are even applied differently across immigrant populations (Kootstra, 2016; Pérez Huber, 2015; Raven et al., 2015). For instance, pregnant women may be subject to a dual frame of deservingness or a moral paradox, whereby the fetus is typically framed as an innocent victim and the mother a sexual deviant that must be controlled (Chavez, 2013; Leon & Dos Santos, 2015; Viladrich, 2012). Deservingness is also framed in terms of the symbolic and legal distinctions between immigrants and refugees. For instance, Horton (2004) shows how, under Medicaid-managed care in the United States, financially strapped public hospitals have devised novel ideas of cultural citizenship that distinguish between "deserving" (Cuban refugees) and "undeserving" Mexican immigrants. On the basis of neoliberal paradigms that celebrate individual responsibility and self-discipline, Horton's research shows that the former are urged to become active citizens, whereas the latter are discouraged from speaking up on behalf of their health and civil rights.

Media frames that promote particular stereotypes (and stigma) define who the ultimate beneficiaries will be (Gee & Skovdal, 2018; Thomann & Rapp, 2018). In fact, public portrayals of immigrants as "abnormal" and "dangerous" have concrete consequences in people's lives, as in the case of restricting prenatal health care for Latina women (Chavez, 2013). In her study on printed media during the passage of the U.S. Welfare Reform in 1996, Yoo (2002) reported changes in the media framing of elderly immigrants through time—initially portrayed as unworthy, they became "elderly grandparents" after the bill was passed. At the time, the media played a key role in promoting a benign, compassionate portrayal of older immigrants, a stance that eventually led to a restoration of much of their former social and health benefits (Viladrich, 2012). More recently, media frames that highlight the virtues of undocumented youth in the United States have reinforced a hierarchical stratification of immigrants—with the "model" young immigrant depicted as culturally assimilated to mainstream society (Lauby, 2016; Nicholls, 2013; Nicholls & Fiorito, 2015). These distinctions are even more pronounced in mixed-status families, where citizen children have access to services, fellowship opportunities,

and benefits that may be denied to their undocumented siblings (Gómez & Castañeda, 2018).

Shared (and internalized) deserving categories also guide the discourses and practices of those working with vulnerable populations. For instance, medical practitioners and government officials are prone to distinguishing between those who are or are not considered deserving immigrants (Bowen, Mickus, & Rosales, 2018; Huschke, 2014). Health care personnel, in particular, tend to stereotype clients based on expected gender roles, as in the case of social service agencies that compel overworked immigrant women to perform as caregivers for their ailing family members (Sagbakken, Spilker, & Ingebretsen, 2018).

Not only do providers treat patients differently according to public notions of deservingness, but immigrants also internalize mainstream signs of worth to distance themselves from the figure of the unwanted foreign born (Alho & Sippola, 2018; Dhaliwal & Forkert, 2015; Huschke, 2014). For example, undocumented individuals may adapt their self-presentations to mainstream deservingness metrics (i.e., showing that they are industrious and accommodating) to make themselves more likely candidates for legal relief and public services (Gonzales, Sigona, & Muñoz Burciaga, 2016; Menjívar, 2016; Menjívar & Lakhani, 2016). In a similar vein, sick immigrants may avoid seeking health care for fear of being labeled a "public burden" and perceived as too demanding or uncooperative by government agencies (Chase et al., 2017).

As will be examined in this article, qualities such as presumed contributions to society, legitimate need, and innocence are key in determining which undocumented immigrant groups are more deserving than others and, thus, should be granted inclusion into the health safety net. By emphasizing the special circumstances in which certain immigrant populations are considered praiseworthy, the media reinforces meritocratic standards that support their selective inclusion into the U.S. government's health safety net.

Research Design: Defining the Frames

This study aligns with a turn in media analysis that acknowledges a paradigm shift from quantitative to qualitative studies in the study of news frames (Viladrich, 2012; Wodak & Busch, 2004). With regard to the print media, larger circulation newspapers tend to influence the framing of smaller ones (Grimm & Andsager, 2011). Frames about immigration policy—as well as their frequency—vary across mainstream, liberal, and conservative news sources (Haynes et al., 2016). Consequently, the NYT was chosen as it is considered the premier national source of news coverage in the United States, and largely progressive on matters of public policy. In terms of agenda setting, the NYT also sets the framing tone for other newspapers, both nationally and internationally.

The inquiry that follows is limited to NYT articles that explicitly address health-related stories involving undocumented immigrants in the United States. These news pieces were published between 2009 and 2017, a period marked by fierce debates regarding the passage and implementation of the ACA. Systematic searches were conducted based on search engines that included LexisNexis, ProQuest, and Access World News. Boolean terms (alone and combined) included the words "illegal alien," "illegal," "undocumented," "unauthorized," "immigrant," "affordable health care act," "ACA," "Health Act," "health care reform," "Obama's health care reform," and "Obamacare." Throughout this article, the term "undocumented immigrants" is used to refer to foreign-born individuals who reside in the United States without legal immigration status. This term includes those who either entered the country without proper authorization or with a legal visa that is no longer valid, as well as those who remained in the United States after their immigration or refugee petition was denied.

An initial corpus of 274 articles was gathered and, after ruling out repetitions and stories that did not directly address the main topic, the sample was reduced to 103 articles within the selected period. Twenty-one articles were removed later on as they did not contain identifiable frames, or only represented a story teaser that was later developed into a longer article. Therefore, the final sample consisted of 82 articles of which most were relatively short (500–800 words) with four articles being between 2,000 and 4,000 words. Two researchers carefully read the final sample of articles with a view toward identifying the most prevalent frames involving undocumented immigrants' entitlement to health care.

As has been the case with other framing studies (Boykoff & Laschever, 2011; McKay, Thomas, & Warwick Blood, 2011), this research project followed a critical, constructivist, and qualitative content analysis supported by grounded theory, in which articles were read multiple times for the purpose of identifying themes and common issues throughout the media corpus (Glaser & Strauss, 2017). The analysis was done manually by recording quotations and inferring specific frames that were entered into a Microsoft Excel spreadsheet. Although some articles relied on one single frame, most included two frames; nonetheless, a single dominant frame was identified in each of the articles.

Study Results

Two predominant frames were identified in the NYT news sample. The first one, the "compassionate" frame,

Table 1. Operationalization of Frames.

	Frame: Cost Control	
Frame: Compassion	Category: Cost Saving	Category: Cost Effective
Dimensions	Dimensions	Dimensions
Immigrants' trajectories of illness: chronic disease, serious conditions, and injuries Patients will die unless they receive medical treatment in the United States Undocumented immigrants do not 1. Have financial means to afford health care 2. Cannot receive adequate health care in their homelands	Prevention (e.g., screening and vaccines) and routine health care will 1. Avoid onset of disease 2. Allow early detection 3. Prevent costly emergency services 4. Save money to government and taxpayers Prenatal medical care will 1. Lead to healthy mothers and babies 2. Save money to government and taxpayers Federal insurance (e.g., Medicaid/Medicare) will provide 1. Timely and efficient health care 2. Save money to the U.S. government and taxpayers	The U.S. economy benefits from a healthy immigrant labor force Insured immigrants bring down insurance premiums for the larger American public Finding adequate facilities (nursing home instead of public hospital) saves money to the U.S. government and taxpayers

is defined by stories that convey a sympathetic view toward undocumented immigrants' health conditions. The second frame, "cost control," proposes a rational, budgetary narrative for providing health care to uninsured immigrants. This frame comprises two related categories: "cost saving" and "cost effective." The literature defines "cost saving" as the prevention and early detection of disease for the purpose of improving health outcomes—leading to healthier and longer lives—and saving money (Goodell, Cohen, & Neumann, 2009). A health program is considered "cost effective" when the anticipated benefits are greater than its expected costs (Teutsch, 2006). Given that the "cost-saving" and "cost-effective" categories are closely related—and often used interchangeably in the literature—they are combined here into a single "cost-control" frame. The project identified additional frames that were not as salient and were often combined in the media corpus selected. These include "the effortful immigrant" (i.e., the contributions of immigrants to the U.S. economy are greater than their health care costs), and the "population health" frame, which supports health coverage for undocumented immigrants to protect the American public from infectious diseases.

Table 1 presents the operationalized dimensions of the two main frames identified in this study. The "compassionate frame" is conveyed through personal narratives of undocumented immigrants that report a serious condition (e.g., a brain injury or cancer) and who need urgent and/or continuous medical care. For analytical purposes, as noted above, this research project brought together the cost-saving and cost-effective categories into one single frame (i.e., cost control). Screening and early treatment were two of the cost-saving interventions found in the study. Cost-effective stories included transferring chronically ill immigrants to a nursing home—rather than keeping them in an acute-care hospital—and subsidizing immigrants' health insurance.

Table 2 summarizes the frequency distribution of the two main frames according to their presence or absence in the news (i.e., primary, secondary, or other/indistinct frame). "Primary frames" are central in defining and supporting the main narrative presented by the NYT articles; secondary frames, however, are subsidiary to the story's main theme and development. As seen in Table 2, the "compassionate" and "cost-control" frames appear as either primary or secondary in most of the articles. For instance, news stories about renal patients usually have the compassionate stance as the primary frame, followed by the cost-control frame as the secondary one. This latter frame is usually deployed by the NYT to justify health provision to the undocumented to prevent higher health expenses in the long run. Articles that mostly focus on the financial troubles of public hospitals, particularly after passage of the ACA, usually present the cost-control argument as their primary frame, and the compassionate frame as secondary—especially to point out public hospitals' mandate to save human lives.

The study identified two groups as the main target populations (i.e., vulnerable and sick individuals) that, together, highlight the figure of the deserving undocumented immigrant. Vulnerable individuals are those who, although currently healthy, are likely to get sick if they do not receive timely screening and preventive health care (e.g., mothers and children, young students, gainfully employed immigrants). Under the "sick" category, the

Table 2. Frequency Distribution of Frames.

	Compassion				Cost Control			
	Vulnerable	Sick	Indistinct	Total	Vulnerable	Sick	Indistinct	Total
Main frame	24 (29.5%)	15 (18.5%)	0	39 (48%)	19 (23%)	14 (17%)	0	33 (40%)
Secondary frame	18 (22%)	14 (17%)	0	32 (39%)	24 (30%)	11 (13%)	0	35 (43%)
Other frames	0	0	11	11 (13%)	0	0	14	14 (17%)
Total	42	29	11	82 (100%)	43	25	14	82 (100%)

project identified individuals with chronic health issues, such as renal failure or a brain injury. The third and final category (i.e., other/indistinct) was included to account for articles where these frames were not present.

Of the 82 articles comprising the final sample, the compassionate rationale was a main frame in 39 of them (48% of the sample), a secondary frame in 32 articles (39%) of the total, and it was not found in 11 of the articles. The frequency of the "cost-control frame" (the column on the right) was similar across the articles, either as a primary or secondary frame (40% and 43% of the media corpus, respectively). This frame frequently appeared along with the compassionate argument, as either a primary or secondary one. The two population categories (i.e., vulnerable and sick immigrants) register similar frequencies across the frames. These findings support the close relationship between the two main frames identified in this study, which, together, provide a powerful rhetorical tool for building media support for undocumented immigrants' access to health care in the United States. This issue is the topic of the next section.

The Framing of Compassion: Putting a Human Face to Immigrants' Ordeals

> After a largely sleepless night, Cruz Constancia got up on Tuesday morning wondering whether this would be the day that she finally stopped receiving dialysis without charge. It was not. When Ms. Constancia, an illegal immigrant from El Salvador, arrived at her dialysis clinic at ten a.m., she was escorted promptly to her recliner. "I thanked God," she said after concluding the three-hour session, "because he is really the only one that will allow us to continue our treatments." (Sack, 2010)

The excerpt above is from one of several articles that were published just before the passage of the ACA in 2010. These stories poignantly describe the dire situation of a group of dialysis patients, mainly undocumented immigrants, whose lives were at risk due to the impending closure of the outpatient dialysis unit at Grady, one of Atlanta's public health hospitals. Following a judge's ruling in early September 2009, this safety-net hospital that was deeply in debt, quickly decided to close its doors. The NYT's reporting on this case brought up the contradictions of a health system that had failed to do two things: control costs and protect a particular vulnerable group of patients, many undocumented, who would die without their three weekly dialysis treatments.

An estimated 60 undocumented immigrants were affected by the closure of this money-losing dialysis clinic. These individuals showcased the fate of seven million undocumented immigrants who had been left without health insurance upon passage of the ACA and, thus, were ineligible for government programs such as Medicare and Medicaid. On closure of its dialysis unit, Grady Memorial was pressured by a lawsuit to continue paying for its patients who had lost their dialysis treatment (Sack & Einhorn, 2010). Reluctantly, the hospital agreed to pay for three months of the treatment while helping those patients seek care, either in their countries of origin or in states where they could qualify for emergency Medicaid. Follow-up reports told readers that some of the patients who returned to Mexico died—apparently because they did not receive the regular dialysis treatment they needed.

Few patients decided to go back home and, by February 2010, Grady officials agreed to continue paying for dialysis and relocation services. Grady's coverage extension did not become a long-term solution as it mostly intended to buy time while finding alternative locations for the uninsured. Patients interviewed by the NYT stated that returning to their homelands to receive dialysis treatment was not a viable option. Ms. Constancia, the patient quoted at the beginning of this section, bluntly argued that in El Salvador, her homeland, "People die very fast. The way it works there is that if you do not have money, they don't put medicine in your machine." One of those repatriated patients was Adriana Rios Fernandez, whose fate was recounted by reporter Sack (2009a):

> . . . a 23-year-old mother of two whose father said she died in Durango, Mexico on Nov. 28. Ms. Rios was receiving only two dialysis treatments a week, rather than the standard regimen of three, said her father, Adrian Rios Zuniga. Five or six hours after each treatment, he said, her lungs would fill with fluid, making it difficult to breath. Mexican nephrologists briefed on her case said it was possible that more dialysis would have made a difference.

Stories such as Constancia's and Adriana's were sympathetically presented by introducing these infirm immigrants as mothers, severely ill workers, and even young students whose lives depended on continuing their dialysis treatments. Sack's NYT article titled "Hospital falters as refuge for illegal immigrants" frames the call for a compassionate stand by showing how Grady Hospital failed to provide refuge to those who sought help when suffering from renal failure. In Sack's (2009b) words, "Each had crossed the border years before, smuggled across the desert by a *coyote*, never imagining the journey would lead to a drab and dusty clinic on the ninth floor of Grady Memorial Hospital in Atlanta." Taken together, these accounts were not about badly behaved freeloaders who came to the United States to take advantage of the health system, but hardworking individuals—many of whom had been tricked by relentless *coyotes* (smugglers). Overall, these articles highlight the incongruities of a health system that loses money by not taking care of vulnerable people in an efficient and timely manner.

Although not intending to change policy, these narratives did try to influence the courts to favor undocumented patients' right to dialysis in the United States. In one of the articles on this case, Sack (2009c) reports that the patient's lawyer, Lindsay R. Jones, planned to "persuade the judge to hear the stories of some of the dialysis patients" whom she had accompanied to a previous hearing. Ultimately, the judge disagreed that the uninsured patients had a constitutional right to receive dialysis treatment. However, thanks to the public attention brought by the patients' lawsuit, the hospital ended up contracting a private clinic (Fresenios) to treat the remaining patients for up to a year. This agreement was later extended to a second year.

Following the end of their last contract, by September 2011, both Fresenios and Grady were still debating over who should continue taking care of the uninsured patients. This dialysis saga ultimately chronicled the paradoxical, desperate situation experienced by those whose lives depended on routine dialysis to survive. These stories also confirm the cost inefficiencies of the U.S. health system, which has continued to dig itself into a financial hole. Under current legislation, charity-based hospitals are mandated to both reduce costs and become financially accountable, principles that collide with these organizations' mission to serve the poor and uninsured. Not surprisingly, the compassionate frame is paramount in news stories that pinpoint "*The New York Times* effect" at its best—that is, putting a human face to individual illness narratives while exposing the cost inefficiencies of the U.S. health system as a whole.

NYT journalist Nina Bernstein (2011) joined in the reporting on immigrant patients experiencing kidney failure. In her articles published in late 2011 and early 2012, she chronicles the story of Angel, an undocumented restaurant employee in desperate need of a liver transplant. Angel was described as a beloved and dutiful restaurant employee, the father of two American-born children who even received financial support from his boss and customers eager to help him pay off his hospital bills. She eloquently explained the intricacies of health coverage on the basis of the cost-control frame (Bernstein, 2012):

> In New York, Medicaid, the federal-state health insurance program for the poor, covers the cost of dialysis, considering it an emergency measure, regardless of whether the patient is a legal resident of the United States. But while a transplant is far cheaper in the long run, Medicare, which does not extend to illegal immigrants, covers that procedure.

Under federal Medicare law, and with the exception of undocumented individuals, almost all individuals in the United States suffering from end-stage renal dysfunction are eligible for a liver transplant. Given the current organization of the health system, the U.S. government was not willing to finance a US$100,000 liver transplant for Angel. Instead, it would pay for a lifetime of dialysis (about US$75,000 a year) via Medicaid's emergency law, which covers certain undocumented individuals. In other words, not only would a transplant have saved Angel's life but also millions of U.S. dollars in the long run. On this issue, a doctor pointed out the following (Bernstein, 2011): "The ultimate irony is it's cheaper to put in a transplant than to dialyze someone for the rest of their life."

Bernstein's first story on Angel's ordeal drew more than 600 responses online and led to an unexpected inflow of cash donations from readers who were moved by his situation. After a cumbersome process, he ended up receiving a new liver from his brother, thanks to the voluntary aid of private individuals, including the doctors who treated him *pro bono.* Not only did the media persuade its readership to help pay for Angel's liver transplant but, more important, it exposed the labyrinthine bureaucracy of the U.S. government's health system.

The above NYT articles reveal the shortcomings of the ACA as an instrument of inclusion and its inability to reduce health care costs. These narratives combine compassionate stands with cost-control frames that call for more rational instruments to cover the uninsured while saving money along the way. The mainstream mandate to save public funds leads to NYT stories that eventually reinforce the economic advantages of insuring the foreign born. According to the NYT, by allowing undocumented immigrants to buy insurance with their own funds, state and local governments would experience a significant reduction in the demand for charity care—both in emergency rooms and long-term hospitalization. However, even if insured, most undocumented

immigrants will still experience exploitative and precarious working conditions in the United States. Therefore, a main point missing in the NYT stories reviewed here is a call for comprehensive immigration reform that would ensure not only safe, regular, and effective medical care to all individuals, regardless of immigration status, but also labor conditions that meet basic human rights principles.

Health Paradoxes: "Illegally" Here but Not Allowed to Leave

In a news article titled "Stuck in bed, at hospital's expense," NYT journalist John Leland (2011) tells the story of Raymond Fok, an undocumented immigrant who suffered a stroke on his way to a routine kidney dialysis treatment in New York City and was taken to the nearest emergency room. Although undocumented immigrants have been barred from buying medical coverage under the ACA's health insurance marketplace, hospitals are still obliged to render emergency care regardless of their patients' legal status. When this case was reported, the patient—who had no social security number, no insurance, and no family address—had been at the same facility for about a year and seven months, costing the hospital US$1,400,000 of which Medicaid only reimbursed US$114,000.

Despite the fact that Mr. Fok's condition was no longer acute, he still suffered from kidney failure, heart failure, and hypertension, all disorders that could have been appropriately cared for at a less intensive health care unit. Yet, the hospital was not permitted to discharge him and he did not have anywhere to go. Eventually, the patient received a legal certification (issued by the federal government) that made him a "permanent resident under color of law," a status that made him eligible for medical insurance. He was eventually transferred to a rehabilitation center in Brooklyn. Mr. Fok's health trajectory was reported by Leland (2011) as follows:

> Mr. Fok's immigration status never kept him from receiving treatment, but it helped make sure that his care would be delivered in the most expensive setting possible and in a place no one wants to spend more time than necessary. He was cut off from his family. On several occasions he showed signs of depression or expressed suicidal thoughts.
>
> If he had been insured or immediately eligible for Medicaid or Medicare, he might have gone to a nursing home after a week or two, where the average daily cost in New York is about $350—and where he might have had steady companionship. Or he might have received a home health aide in his apartment, which could have cost even less, depending on the required hours.

In an article titled "Nowhere to go, patients linger in hospitals, at a high cost," NYT reporter Roberts (2012) describes a similar case concerning the hospitalization of another undocumented immigrant from China:

> Five years ago, Yu Kang Fu, 58, who lived in Flushing, Queens, and was a cook at a Chinese restaurant in New Jersey, was dropped off by his boss at New York Downtown Hospital, a private institution in Manhattan, complaining of a severe headache. Mr. Yu was admitted to the intensive-care unit with a stroke. "This gentleman cost us millions of dollars," said Jeffrey Menkes, the president of New York Downtown. "We try to provide physical, occupational therapy, but this is an acute-care hospital. This patient shouldn't be here."

Despite the fact that immigrants like Mr. Fok and Mr. Fu could have been transferred to rehabilitation centers or nursing homes, which are cheaper and more appropriate for such patients, those institutions would not have taken them because of their uninsured status. At a time when medical deportations of immigrants was beginning to gather momentum, a related case was reported by Sontag (2009) in her article titled "Jury rules for hospital that deported patient":

> A Mayan [sic] Indian from the highlands of Guatemala, Mr. Jiménez paid a smuggler to transport him to the United States about a decade ago so he could work as a gardener and send money home to his wife and two sons. He had been living in Stuart with Mr. Gaspar for just under a year when a drunken driver in a stolen vehicle plowed into his car in the winter of 2000.

Mr. Jiménez had suffered severe brain damage, could no longer walk and had the mental age of a child. He was taken to Martin Memorial Medical Center in Florida and was kept in its facilities for a few years. During that time, the hospital spent more than US$1,500,000 on his medical care. Mr. Jiménez's undocumented status ruled out the possibility of discharging him to a specialized nursing home. His hospital stay ended dramatically in 2003 when a state judge authorized the medical facility to send Jiménez back to Guatemala. The NYT visited him in the summer of 2009 and described his precarious living conditions as well as the fact that "he had not received medical care for over five years" (Sontag, 2009).

Along with the framing of "selective inclusion" introduced earlier, the NYT news analyzed in this article offer a striking testimony of the dire and dramatic circumstances of infirm immigrants whose conditions often worsened due to the insufficient medical care they received. Finally, not only do these narratives frame a compassionate stance toward undocumented individuals, but they also highlight the bureaucratic and financial incongruities of the U.S. health care system.

Discussion: The Framing of Compassion as Cost-Control Weaponry

The findings drawn from this study call attention to a recent paradigm shift in the U.S. progressive media—from the notion of the undocumented as a criminal and deviant to humanizing perspectives that spotlight their contributions and struggles, as well as the economic benefits of providing them with health insurance (Kim et al., 2011; Pourat et al., 2014; Stimpson, Wilson, & Su, 2013). Still, as portrayed by the NYT stories reviewed in this article, undocumented immigrants must prove their deservingness for public health benefits on the basis of their moral worth, vulnerability, and need. Thus, health rights are extended only to specific immigrant groups who fall under the category of the innocent victim and the effortful agent—this includes the elderly, the young, the weak, and the disabled.

This study coined the term "*The New York Times* effect" to describe reporters' compassionate approach to vulnerable immigrants' health needs, as well as the moral obligation of the United States to provide timely and efficient medical assistance. In line with the human interest frame (also called the episodic frame), the compassionate frame calls attention to individual cases that highlight the emotional aspects of a topic, while avoiding nonpersonalized and broader issues related to immigration (Aalberg & Beyer, 2015; Figenschou & Thorbjørnsrud, 2015). Contrary to the anonymous perceptions of the foreign born as criminal freeloaders and a threat to public health, the compassionate stance highlights the difficulties experienced by hardworking and infirm immigrants. Similarly, Haynes et al. (2016) observe that episodic framing, which depicts case stories in concrete places and times, is the preferred approach of liberal newspapers—the NYT in this case. Conservative outlets, instead, tend to favor thematic (and, thus, generic) anonymous accounts of immigration.

With the competition for news, journalists and editors hope to attract readers by developing expressive stories that presumably catch people's attention more easily (Figenschou & Thorbjørnsrud, 2015; Thorbjørnsrud, 2015). By letting immigrants speak for themselves, the NYT calls on its readership to have empathy toward them. In their analysis of news stories on undocumented immigration in France and Norway, Aalberg and Beyer (2015) also found that liberal news outlets tend to frame political issues by emphasizing emotional and personal cases. Far from cold statistics and impersonal numbers, media accounts describing the threats faced by hardworking and ailing human beings aim to trigger solidarity and compassion on the part of their audiences.

In contrast to the anonymous perception of immigrants as freeloaders and a threat to the American public, as fostered by conservative outlets, the NYT's compassionate frame stresses the personal aspects of immigrants' lives. Thus, it deploys a "person-positive bias" through which individuals are assessed more positively than the groups they represent (Sears, 1983). By the same token, immigrants' deservingness—defined on the basis of vulnerability, innocence, and need—becomes a powerful rhetorical tool deployed by the NYT toward supporting particular groups among the undocumented foreign born. By portraying undocumented immigrants as at risk but hardworking, the NYT lays the groundwork for justifying their inclusion into the U.S. health safety net.

As illustrated in this article, personal narratives describing dialysis patients put a face to real-life immigrants with whom readers can emotionally relate to on the basis of learning about, and commiserating with, their health struggles. Concordant with the "selective inclusion" paradigm, these immigrants are portrayed as deserving of medical care as they are severely ill human beings who came to the United States to work hard and build a better future for themselves and their children; thus, they do not conform to the stereotyped depiction of a "criminal" or "illegal alien." This approach is also favored by nonprofits and social movement organizations hoping to garner support against deportation cases, as in the case of those advocating for the legal rights of undocumented immigrant youth (Gonzales, 2016; Ihlen, Figenschou, & Larsen, 2015; Nicholls, 2013).

Immigrants' stories also lay bare a financial conundrum as in the case of safety-net hospitals that provide uncompensated or free charity care. The NYT makes a case to show how uninsured individuals, namely, undocumented immigrants, receive expensive acute health care services—the cost of which could have been avoided if they had been enrolled in comprehensive insurance programs. By combining compassionate and cost-control arguments, the NYT weaves persuasive narratives on behalf of the undocumented foreign born. First, by introducing real-life individuals (e.g., mothers, children, restaurant workers), reporters draw empathy by putting a human face to a particular group of undocumented immigrants. Their trials and tribulations in seeking life-saving health care become a sort of tragic condemnation of what vulnerable individuals in the richest country in the world must go through to survive. Second, the NYT shows its readers how U.S. hospitals (and ultimately American citizens) end up paying for the uncompensated care provided to uninsured patients. Not only is their provision of health care exorbitantly expensive, but it could also be dramatically reduced—or even avoided altogether—with timely, preventive, and regular access to health care.

Rather than blaming the foreign born for the onerous public health care expenses, these media stories appeal to human kindness, mostly by exposing the cost inefficiencies

of a health and social security system that feeds on its own financial contradictions. In an attempt to exclude "illegal aliens" from access to health care, the NYT ultimately shows how the ACA has created its own Achilles' heel. Because the provision of emergency care cannot be denied to anyone in the United States, regardless of legal status, health insurance coverage would allow immigrants to receive preventive and regular health care—ultimately reducing the emergency-care expenses that hospitals regularly pay on behalf of their undocumented patients. Furthermore, had the latter been enrolled in government-sponsored insurance, emergency care would have been prevented and human lives would have been saved.

Nevertheless, focusing on the cost-control approach summarized above runs the risk of reifying the economic benefits of providing health care to immigrants, in detriment of social justice paradigms that endorse a universal right to health care. Under such right, all human beings—regardless of their legal status—should not only have access to adequate health care but also suitable living conditions conducive to optimal health outcomes (Willen et al., 2017). In tune with our findings, some authors have begun to critically discuss the shortcomings of prioritizing economic arguments to justify the provision of health care to uninsured immigrants (Gottlieb & Davidovitch, 2017). Finally, this article questions a rhetorical model of deservingness that runs contrary to human rights principles. What is missing in the media corpus examined here is a call for comprehensive immigration reform that challenges the inequality of the current U.S. economic system, which profits from a flexible, low-paid, and uninsured immigrant labor force. Such a reform should envision health care as part of a broader policy agenda aimed to overcome immigrants' "illegality" by acknowledging—and assuring—their legal, social, and political rights in the United States.

Conclusion and Future Steps

This study has intended to provide a timely contribution to the growing field of media framing on immigration, particularly regarding the inclusion of undocumented immigrants into the U.S. government's health safety net on the basis of deservingness. Although the exclusion of the undocumented foreign born from health care has been recognized as the most widespread consequence of the ACA, this article filled a gap in the literature by examining how the media—the NYT in this case—frames arguments in support of undocumented immigrants' access to government-supported medical care. By relying on two main frames, compassionate and cost control, the NYT articles examined here deploy convincing arguments toward shaping their readership's attitudes and beliefs concerning the undocumented population in the United States. Together, these frames make a plea for providing health care to particular groups of immigrants on the basis of market models that call for more financially prudent measures. In doing so, the NYT helps strengthen a "selective inclusion" paradigm pertaining the protection of specific undocumented individuals on the basis of justified need, merit, and/or vulnerability. These results underline the importance of understanding the compassionate frame in conversation with fiscal narratives that place the discussion of migration within a neoliberal market context.

Given the media's alleged role in shaping attitudes and behaviors on immigration, these results will hopefully expand our knowledge on media framing, with a view toward understanding the common scripts, metaphors, and images that back the access to health care (and health rights) of the undocumented foreign born in the United States. By understanding the rationale through which the media, the NYT in this case, frames their news, scholars—as well as public health advocates and professionals—will gain deeper insights on how the media influences public opinion either in favor or against immigrants' rights. Framing categories of inclusion have indeed very specific consequences on people's lives as they contribute to shaping public policy, finally determining the extent and type of social and health services immigrants may (or may not) receive.

Prospective work will replicate this analysis by including other key frames identified in this study (e.g., the effortful immigrant and the population frame) and comparing these results with other types of media (e.g., TV, Internet). Future research will also include conservative news outlets, including *The Wall Street Journal*, and will focus on specific immigrant groups (e.g., farm workers and domestic aids) with regard to their internalized feelings of deservingness and public entitlement.

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