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A Constructivist Study of Graduate Assistants' Healthcare Experiences in a Research University

Uttam Gaulee

University of Florida, gauleeutam@ufl.edu

Brenda Lee

University of Florida, brenlee@ufl.edu

Douglas Whitaker

University of Florida, whitaker@ufl.edu

Natalie Khoury Ridgewell

University of Florida, nkr@ufl.edu

Mirka Koro-Ljungberg

Arizona State University, ljungberg@asu.edu

See next page for additional authors

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Abstract

This constructivist study explores 16 graduate assistants' (GAs) healthcare experiences and uses grounded theory to create a model of graduate assistants' experiences with university-provided healthcare in a large research university. The model is composed of four broad components: (a) systems; (b) access, care and coverage; (c) knowledge, quality and cost; and (d) self. Graduate assistants' needs and expectations constantly negotiate various systems in the model. Expanding upon the limited research regarding graduate student healthcare, this study provides implications for higher education administrators and policy makers. Based on our study findings we argue that it is not sufficient for university administrations to simply provide paid health insurance "options" without robust support systems on campus. Because students are often stressed out, lack time and energy, and find it hard to navigate the complicated systems of profit-driven health care industry, the lack of direct support in graduate students' day-to-day healthcare needs can cause tremendous loss on their success and productivity. Hence, universities have tremendous opportunities to better understand and address their graduate students' real needs so as to add value to institutional success and productivity.

Keywords

Graduate Students, Healthcare, Qualitative Research, Union, Constructivism, Higher Education, Student Benefits, Administration, Policy, Learning environment

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Authors

Uttam Gaulee, Brenda Lee, Douglas Whitaker, Natalie Khoury Ridgewell, Mirka Koro-Ljungberg, Dayna M. Watson, and Colleen Butcher

A Constructivist Study of Graduate Assistants' Healthcare Experiences in a Research University

Uttam Gaulee, Brenda Lee, Douglas Whitaker, and Natalie Khoury Ridgewell
University of Florida, Gainesville, Florida, USA

Mirka Koro-Ljungberg
Arizona State University, Tempe, Arizona, USA

Dayna M. Watson and Colleen Butcher
University of Florida Gainesville, Florida, USA

This constructivist study explores 16 graduate assistants' (GAs) healthcare experiences and uses grounded theory to create a model of graduate assistants' experiences with university-provided healthcare in a large research university. The model is composed of four broad components: (a) systems; (b) access, care and coverage; (c) knowledge, quality and cost; and (d) self. Graduate assistants' needs and expectations constantly negotiate various systems in the model. Expanding upon the limited research regarding graduate student healthcare, this study provides implications for higher education administrators and policy makers. Based on our study findings we argue that it is not sufficient for university administrations to simply provide paid health insurance "options" without robust support systems on campus. Because students are often stressed out, lack time and energy, and find it hard to navigate the complicated systems of profit-driven health care industry, the lack of direct support in graduate students' day-to-day healthcare needs can cause tremendous loss on their success and productivity. Hence, universities have tremendous opportunities to better understand and address their graduate students' real needs so as to add value to institutional success and productivity. Keywords: Graduate Students, Healthcare, Qualitative Research, Union, Constructivism, Higher Education, Student Benefits, Administration, Policy, Learning environment

A telephone call disrupts Rozita (a composite character), a third year doctoral student at a large research university, who is trying to concentrate and finalize an important research report after having graded 72 undergraduate papers. She hasn't slept well and her eye-sight is blurring. She is wearing a pair of eyeglasses; unfortunately, one of the lenses has been broken for the past three days. It's been years since she had her eyes checked, so she is wondering whether to order a new pair of glasses or just have the old one fixed this weekend. It's been a tiring week for her but a sudden flash of smile is visible on Rozita's face as she remembers an important term from her appointment letter: INSURANCE PROGRAM. What this means to her is that healthcare is provided for by the university, and she is pretty sure that anything she may need would be covered – including an eye examination and eyeglasses. "I'll probably have my eyes checked and have a new pair ordered," murmurs Rozita proudly as she reaches her phone to answer the call. What is heard on the phone immediately snatches away the momentary flash of happiness from her face. She finds that the call is machine recorded message from a debt-collection company asking her to pay \$450 for some outstanding bills: bills for the deductible and coinsurance from her last hospital visit. She now doubts whether her eye-checkup would be covered. She realizes that her regular dental checkup is overdue by

six months. So she wants to line up the dental check up with eye check up to save time. But she wants to make sure it will be covered. She calls the dentist's office to ask if dental checkup is covered by her insurance. After taking note of all the information from Rozita, the dentist's secretary says that coverage depends on many factors including pre-existing conditions but she encourages Rozita to visit the clinic anyway. How to make sense all this? Rozita is not sure at all.

There have been few formal studies conducted on the topic of graduate student healthcare (Lenssen, 2010; Markowitz, Gold, & Rice, 1991; Smith, 1995). The largest population in the United States that lacks health insurance is young adults (between the ages of 19 and 29) with 13.2 million (29 percent) lacking coverage in 2007 (Nicholson et al., 2009). There is substantial overlap between the population of uninsured young adults and the population of graduate assistants (GAs), but the specific needs and experiences of GAs – and graduate students more broadly – have not been researched or documented. Securing better healthcare services for GAs and teaching assistants (TAs) is one of the priorities of graduate student unions (Rhoades & Rhoads, 2003). For example, the graduate student union (UNION) at the INSTITUTION, a large public university in the Southeastern US, won health insurance benefits for its graduate assistants in 2006. At INSTITUTION, graduate students who are employed as graduate teaching assistants or graduate research assistants have a tuition waiver as part of their compensation and are eligible for some benefits, including health insurance. Graduate students who are not eligible for tuition waivers are not eligible for this health insurance benefit. Instead, these students – along with undergraduate students – are eligible to purchase a health insurance plan, different from the one described in this study, through the university. This health insurance plan has undergone several transformations since its inception and is undergoing another substantive change during the 2014-15 academic year. The health insurance plans offered by INSTITUTION to all employees are currently being moved 'in-house' and additional benefits such as dental and vision coverage for GAs are planned (UNION, 2013). Since UNION is interested in ongoing development of healthcare system to better meet the needs of graduate students, the researchers approached the union leadership conducting a study of GAs' healthcare experiences. The specific research question is: How do graduate assistants at a large public university in the Southeastern US describe their experiences with their university provided health insurance?

Graduate Assistant Benefits

GAs represent a considerably large population at higher education institutions. At the INSTITUTION, there are approximately 16,000 graduate students. While the proportion of these students that are GAs in the benefits-eligible sense is not known to us, it is substantial, and both GAs and non-GAs face challenges with regard to health insurance. Inadequate and/or nonexistent health insurance coverage opportunities adversely affect graduate students who are no longer eligible to continue on their parents' coverage (Moon & Cowdry, 2009; Smith, 1995). To meet the goals of higher education institutions, particularly research universities, it is important to enable them to achieve their potential and maximize learning, which is not possible without optimizing their wellbeing. In order to increase these employees' working efforts, policymakers should address their unmet needs (Eisenberg, Golberstein, & Gollust, 2007), which mainly consist of fulfilling salaries, healthcare services, hiring and distress practices, and working conditions (Hendricks, 2005; Rhoades & Rhoads, 2003). Schmid (2001) found that one of the most prominent needs is satisfactory access to healthcare services, a finding that served as a catalyst for this study. Moreover, graduate students' satisfaction with the healthcare plans largely depends on (a) the available financial resources, (b) sufficient information about the insurance plans and their coverage, and (c) available medical services

(Lenssen, 2010). Thus, the access to healthcare services varies widely among individuals (Goldrick-Rab & Sorensen, 2010). In addition, health insurance is a critical part of the context in which GAs work, and a review of related literature is provided in the following section.

As noted earlier, there is a substantial gap in the literature with regard to GAs' perspectives on the healthcare services (not) available to them, and literature related broadly to GAs' healthcare needs is sparse. Many studies and reviews, rather than focusing on individuals, have focused on graduate student unions and how health insurance relates to their bargaining proposals (Hutchens & Hutchens, 2003; Rhoades & Rhoads, 2003; Rhoads & Rhoades, 2005; Singh, Zinni, & MacLennan, 2006). Evidently, young people traditionally have poor access to healthcare services, in large part because they no longer have access to insurance through their parents or spouse (since the majority of the young adult population is unmarried). Other contributing factors are their relatively low incomes and high enrollment in college, an activity that, for many, precludes full-time employment and the healthcare benefits associated with it (Markowitz, Gold, & Rice, 1991).

Additionally, many universities already charge student fees to provide healthcare—distinct from health insurance—for their students (Schultz & VanDeHey, 2012). Hornak, Farrell, and Jackson (2010) report that some students without health insurance rely on university-provided clinics as their source of healthcare. Hendricks (2005) reports that roughly three of every four GAs benefit from employer-provided health insurance, and specifically points out that this figure does not address GAs' dependents. Similarly, Eisenberg, Golberstein, and Gollust (2007) conducted a quantitative study on 2,785 students at a public university in the Midwest, to understand their help seeking behaviors, and their use and access to mental healthcare services and found that 95% of undergraduates and 93% of graduate students had some form of health insurance. Of the graduate students that had health insurance, 56% had insurance through a plan offered by the university, 13% had health insurance through an employer, and only 15% had health insurance through their parents' health insurance plan; 85% of undergraduates had health insurance through their parents' plan (Eisenberg, Golberstein, & Gollust, 2007). The sources and specifics of health insurance plans for graduate students appear to be highly context-dependent and inconsistent across universities.

Eisenberg et al. (2007) also found that most students did not seek help for mental health problems. Students' lack of perceived need, lack of knowledge of services or insurance coverage, doubt about the effectiveness of services, low socioeconomic status, and being Asian or Pacific Islander were predictors for not seeking help from mental healthcare services (Eisenberg et al., 2007; Park, Attenweiler, & Rieck, 2012). Yan and Berliner (2013) found that Chinese students often do not have sufficient health insurance due to financial barriers and were unprepared for serious illnesses. Russell, Thompson, and Rosenthal (2008) investigated international students' use of university health and counseling services. This quantitative study consisted of 979 international students. They found that the perceived need led to consequent actions. In their study, some international students were not asking help from university health and counseling services due to their cultural beliefs and perceptions. However, respondents' within-person variables were stronger predictor than culture in students' help-seeking decisions.

It is worth emphasizing that the aforementioned studies have been quantitative in nature, and they paint neither a clear nor rich picture of healthcare for GAs. Young adults' — including college students and Gas' — access to healthcare varies widely, with some, particularly single parents, making decisions that entail foregoing health insurance entirely. Although graduate students have better access to healthcare services today than previously (Goldrick-Rab & Sorensen, 2010), there still might exist factors that influence their degree of satisfaction with healthcare services (Andersen, 1995). Furthermore, most studies that report any pertinent information focus on graduate students rather than GAs and are addressing a

different, specific aspect of healthcare such as mental healthcare (e.g., Eisenberg et al., 2007; Hyun, Quinn, Madon, & Lustig, 2007). Additionally, studies have also focused on the experiences of specific subpopulations such as international graduate students, including their experiences with mental healthcare (Hyun et al., 2007) and health insurance (Perrucci & Hu, 1995). The explorations of the specific aspects of health insurance that contribute to GAs' experiences are needed to clarify and expand the limited, and sometimes inconsistent and decontextualized, literature. Our study addresses this gap in the literature and adds more detail to the complex topic of healthcare. More specifically, the purpose of this paper is to explore GAs' experiences with and perspectives on the university healthcare services as an attempt to inform the research community on this issue, and consequently, to provide a diagnostic report for policymakers. We are hopeful that UNIONS will make the most out of this evidence based research on GA's healthcare needs.

Methods

We are a team of six graduate students, working under the supervision of a faculty member. Hence, six of us are also GA's of some kind (either a teaching assistant, or a research assistant). Therefore, we empathize with and share many of the experience of the participants and learning more about participants' experiences seemed as an appropriate theoretical framework for this study. More specifically we used constructionism as the epistemology for this study. Crotty (1998) describes *constructionism* as an epistemological approach that describes the construction of meaning as a product of interaction between an object(s) and an individual. While experiences with the healthcare services can be understood as a phenomenon, we focus on GAs' individual interactions with healthcare services and how their meaning construction occurs out of this interaction (Flick, 2009). Furthermore, we used a constructivist theoretical lens, in which "the meanings [in this case, of healthcare] are thus at once objective and subjective, their objectivity and subjectivity indissolubly bound up with each other" (Crotty, 1998, p. 48). We believe that there might not be a *true* definition of healthcare for GAs, and our task of studying the topic is to consider the interaction of the participants with the healthcare services and consider the processes they have undergone to construct meaning about the matter for themselves (Koro-Ljungberg, Yendol-Hoppey, Smith, & Hayes, 2009). By examining how GAs evaluated their experience related to healthcare, we can share their tendency to repeat or avoid certain experiences, which adds to the meaning of healthcare for GAs. In addition, we build on generalizability within this context and thus our arguments are generalizable within the boundaries of this study.

Data Collection Process

After IRB approval, we established contact with the graduate assistant union at INSTITUTION (a large public research university in the South) which contacted the potential participants for us. Officers from the UNION emailed our invitation to participate in the survey via their email list. Following basic questions regarding demographics and health insurance, participants indicated their willingness to participate in the interview process and provided contact information. Out of the pool of willing GAs, interview participants (N=16) were purposefully selected aiming to gather the overall scenario of graduate students' healthcare experiences in research universities in the United States of America. Those self-nominating non-unionized GAs included international and domestic students, males and females, and those with and without dependents. We used semi-structured interviews to solicit participants' experiences and perspectives on university healthcare. The interview protocol included questions that asked the participants to describe their experiences accessing student

health services, how they learned about the graduate healthcare service, how the graduate healthcare affected their ability to access the healthcare service they needed for themselves and their families, what aspects of the graduate healthcare service were the most problematic for them, and what aspects of the graduate healthcare service were they most satisfactory. Interviews, lasting approximately one hour, took place in a meeting room on the university campus. As required by IRB protocol, each participant gave informed consent prior to the recording of the interview. Sixteen interviews were completed and transcribed verbatim.

Data Analysis Process

As described by Charmaz (2006) and Starks and Trinidad (2007), grounded theory often begins with different levels of coding and constant comparison between the codes (Leech & Onwuegbuzie, 2007). Grounded theory analysis was chosen because it enabled data reduction, constant comparison, and theorizing of core concepts. Glaser (1978) defined grounded theory as “a detailed grounding by systematically analyzing data sentence by sentence by constant comparison as it is coded until a theory results” (p. 16). During grounded theory analysis various coding levels, constant comparison, and memoing are used to ensure that the resulting theoretical model and the study conclusions are grounded in the data (e.g., Charmaz, 2006; Glaser & Strauss, 1967; Strauss & Corbin, 1998). Consistent with this method, first, verbatim open-ended survey responses were typed into a database, read and open-coded. As part of the open-coding process, the researchers annotated chunks of the transcript. For example, an interviewee said:

So while that's happening if I had to go to another doctor let's pretend that I didn't have to go to the allergist [...] I had to go to a knee specialist or an eye specialist or a nose specialist it would look to them during that lapse in time as though I don't have any insurance so it's a really inconvenient period God forbid anything happen.

The annotation for this chunk mentioned that there was a “concern about need to go to other specialist during gap in coverage.” After open coding, we formed selective codes and core categories. All selective codes were constantly compared with each other with the intention of reducing and selecting them further to develop theoretical codes (Bryant & Charmaz, 2007; Holton, 2007). Related to the previous example, that particular open-code then fell into to the selective code of specialized care and issues related to a gap interval. When comparing the codes to each other, the researchers then considered the selective codes including specialized care and a gap interval formed a theoretical code of the graduate students’ particular experience of access, care, and coverage simultaneously constantly comparing existing and emerging code and interview transcripts. The most prevalent theoretical codes were used to generate a model of graduate students’ healthcare experiences (see Figure 1). The codes were continuously revised, modified, and clarified by our coding team, resulting in 261 codes and four overarching categories.

Findings

Based on our analysis of GA's description of their healthcare experience, four broad components of their experiences were constructed:

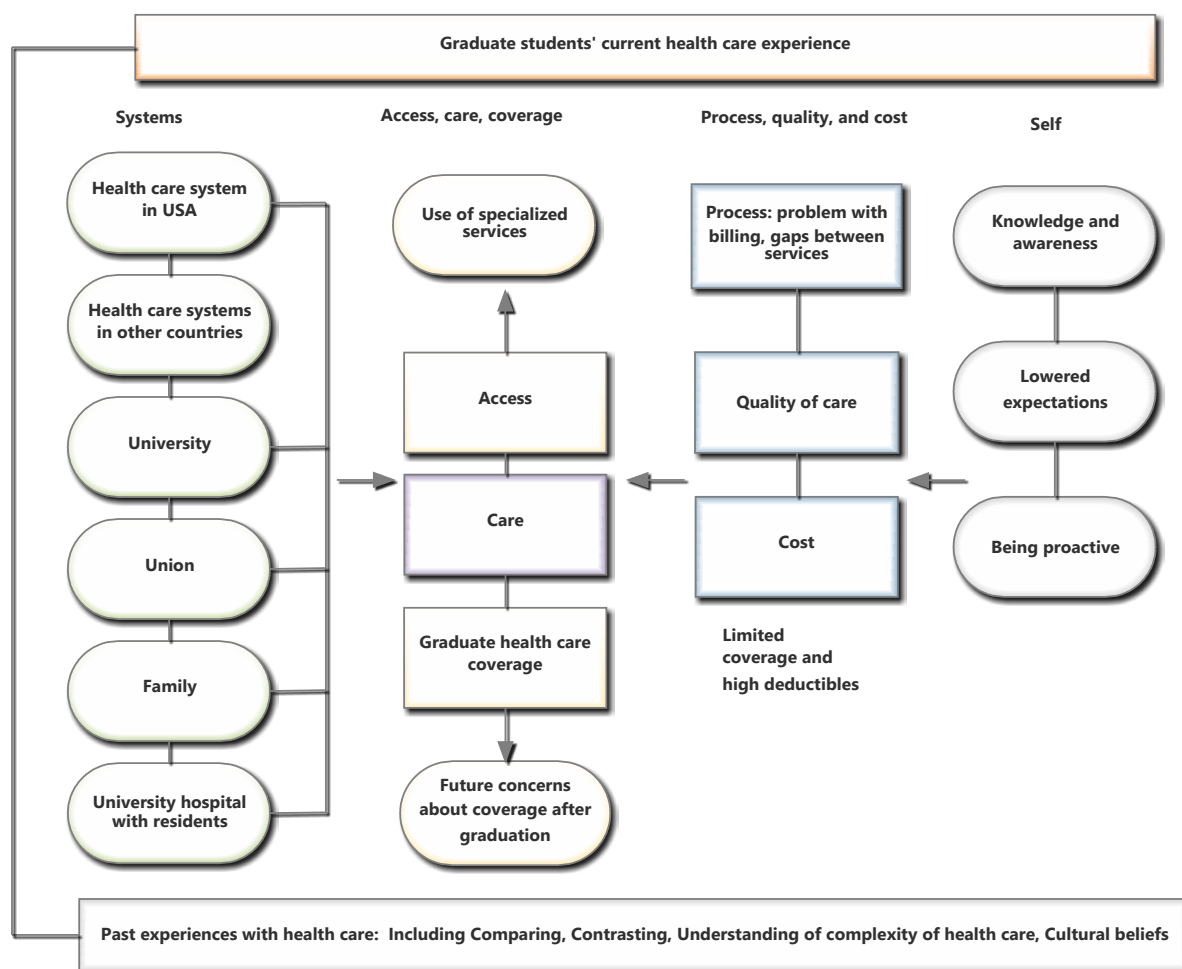
1. Systems
2. Access, care and coverage

3. Knowledge, quality and cost
4. Self

A model relating these four components and past experiences to current experiences is given in Figure 1.

The model depicted in Figure 1 shows a GA's journey toward care by negotiating a complex terrain of systems and processes interacting constantly with GA's self (consisting of cultural perceptions of healthcare, knowledge, expectations). Once obtaining a token of clearance from the institutional elements, GAs enter the system with a range of services and choices that interact with their needs, expectations, and perceptions where most of their healthcare experiences are created. How GAs' needs and expectations meet with the service delivery defines a satisfactory or unsatisfactory healthcare experience. But the overall experience is more complex than that. If GAs can receive a better quality of service than the level of expectation, they tend to be more satisfied and grateful. Additionally, as an individual (possibly with a family) living on a student budget, a GA's ability to cover dependents is associated with a better healthcare experience. However, GAs associated any (and often unpredictable) financial liability with a bitter healthcare experience. Having health coverage from the university reassures GAs, though this feeling can quickly dissipate when one discovers limits to coverage, high deductibles, and other bureaucratic hurdles.

Figure 1: A model of graduate assistants' experiences with university-provided healthcare



Systems

Several systems emerged as influencing component of the healthcare experiences of the GAs at the INSTITUTION. Even though we tried to understand the GAs' experiences in the immediate context of the institution, participants (coming from various backgrounds) kept bringing their distal experiences to construct their healthcare experiences by associating, comparing, and contrasting their current experiences with what they had already experienced. Having navigated diverse healthcare systems associated with families, other institutions, states, cultures, and countries around the world (while gaining experiences), interactions of various systems (e.g., the graduate union, families of GAs, and the university hospital with residents) and the complexities thereof influenced access, care, and coverage.

Healthcare system in the US. One system that emerged from participant interviews was the US healthcare system. When asked about healthcare services specific to their experiences at the university, many participants included dialogue about the broader system of healthcare service delivery. Participants shared descriptions of past and current interactions with healthcare as delivered in the US, expressing that “compared to other insurance, [graduate student insurance] is not high [cost].” In addition, “in my prior health insurance my out of pocket payment for all that I've had this past couple of years would have been much less...I think that the deductible and the co-pays are much higher” with the university healthcare. Some GAs even compared their current university healthcare experience to their “prior university healthcare experience” and that currently they “may not have...as complete of healthcare” as they had previously.

Healthcare system in other countries. Often dialogue regarding the US healthcare system was paired with dialogue on the healthcare systems of other countries. International student participants offered a comparison of healthcare in their home countries versus healthcare in the US, primarily based on their own personal experiences navigating each system. Specifically, one participant explained, “The system is the worst. This is the fourth country I have lived, and this is the worst system without any doubt.” Another participant stated, “I would rather wait for like you know for a year to go back home” rather than accessing healthcare services provided by the university. Other participants expressed confusion about how the healthcare system and insurance benefits worked here in the US, as their home country had a dramatically different system.

The University. The university as an institution is another system that emerged from participants' interviews. As each participant is a graduate student, his or her healthcare experiences depends on whether the university grants or denies them insurance benefits.. Examples of the impact of this system includes administrative decisions that lead to changes in coverage or benefits and institutional rules that impact availability of healthcare services to graduate students' families. Specifically, some participants experienced a transition from one insurance provider to another as part of their university provided health insurance. When describing some past issues with the university provided healthcare, one participants explained, “there's been a shift so as of right now with Blue Cross and Blue Shield it seems like that has been solved but I wouldn't say that that means they wouldn't go to somebody else in the next couple years and then it would be happening again.” This statement indicates a certain sense of participants feeling that their healthcare coverage is at the mercy of the university itself. Similarly, participants discussed that the current health insurance provided by the university does not offer any sort of options for customizing coverage; instead, the coverage is determined by the university decision-makers.

Graduate student union. The graduate student union was identified as a fourth system impacting participants' views of healthcare. The union served as a lobbying body to advocate for changes in GA compensation and benefits. Specifically, participants discussed the role of

the union in lobbying for insurance benefits for all graduate students, as well as lobbying for dental benefits to be included in the university provided health insurance. The discussion of dental health coverage appears both in the graduate student union system element of the model as well as the element involving coverage of specialized services. For example, one participant said, “the new healthcare has promised one gum-cleaning per year, which is ridiculous because you go to any dentist and they’ll tell you that in the best case scenario you need at least two a year.” Participants expressed support for the graduate student union lobbying for dental coverage, as many participants described dental coverage as expensive but necessary for overall health.

Family. Participants’ own family systems seem to impact their perspectives on the healthcare experience. Family considerations seemed very important to many participants, as evidenced by one participant saying, “Graduate students is a special population. They may be with families. Families’ health is crucial for their success.” While many participants described family health as a major consideration, many participants were unhappy with the coverage provided for their families, and several described the family insurance coverage to be cost prohibitive. Other participants discussed a complex decision-making process when determining whether participants’ families would be covered by university provided health insurance or to simply go without insurance coverage.

University hospital with residents. The university hospital as a teaching hospital employing resident doctors developed as the final system impacting participants’ experiences with healthcare. This system seemed to emerge in two different ways. First, some participants expressed concern over being seen at a teaching hospital. As one participant stated, “let’s say I had some sort of serious ailment I have cancer that comes up on one of my testing screens. I don’t want to go to a person who is still learning something.” Other participants reported that due to involvement with medical staff in training, the participant’s hospital stays or doctor’s visits took longer than the participants viewed necessary. The second way this system emerged was through participants ideas about how to solve some of the coverage issues discussed in other parts of the model. For example, one participant suggested that instead of charging hefty fees for covering GA family members the university should provide healthcare to GA dependents through the many residents and medical students in the university’s hospital.

Access, Care, and Coverage

In addition to the influence of the above discussed systems, participants’ experiences were shaped by access to healthcare services, the care received through those services, and the coverage of their university-provided health insurance.

Care. At the heart of this category was the theme of care. Participants described specific instances when the participant or their family members received care or failed to receive needed care through the university-provided health insurance. Care seemed to be interconnected with many other elements of this category – access, use of specialized services, graduate healthcare coverage, and future concerns about coverage after graduation – and those interactions influenced the participants’ perceptions of their own healthcare experiences.

Access. Like with other themes discussed in this model, the theme of access influenced participants’ experiences in a few different ways. Some participants described increased access to quality healthcare thanks to university provided insurance and services. For example, one participant expressed that “the access to healthcare through INSURANCE PROGRAM has gotten easier” and, instead of having to go through the Student Health Center, GAs now had more options when it came to accessing their care. Conversely, some students expressed satisfaction with the services offered through the Student Health Center, stating, “I think it’s great that we have access to that facility so just to be able to go over there and get seen usually

pretty quickly. It's much more convenient than trying to find a provider in the area." Regardless, satisfaction with increased services and coverage was expressed.

However, other participants discussed limited access to quality healthcare due to university provided insurance or services. Several participants stated that with the number of students – over 50,000 – it was unrealistic to expect that the services and facilities offered could “really provide availability for everybody.” Other participants noted that the large number of students at this university may have limited the quality of their healthcare experience. For example, one participant felt that students are matched up with doctors according to “whose schedule is open” rather than on personality or belief compatibilities, and that there are “a lot of student at this campus... and a very small number of spots open.”

Use of specialized services. Similar to descriptions of access, participants had a range of experiences with using specialized services through their university-provided health insurance. Some students expressed frustration with their ability to receive specialized healthcare services, from allergies, OB/GYN, rheumatologists, to sports medicine. One of the first challenges for GAs who need to see a specialist is that, in order for their treatment to be covered by INSURANCE PROGRAM, they must use the doctors at the research hospital or pay the fees associated with receiving care “out of network.” A limitation on treatment providers was not the only challenge GAs encountered: some also had difficulty scheduling appointments. One participant expressed, “so the other thing that becomes frustrating is to have access to the doctors at [the university hospital], I always have to go to the healthcare center first, [and] get a referral to then see my specialist . . . I have to redo that every single semester.” Another participant expressed, “to be able to access my allergist at that time was really difficult because I had to go through a referral service.” Still other GAs expressed that they could not even see a specialist for their specific healthcare needs and instead had to see general practitioners at the Student Healthcare Center. One participant's allergy tests “for a full month went completely unattended to in the Student Healthcare Center [and] I was coming in with bronchitis and sinus infections . . . and the best solution that they had for me was to stay indoors. . . There's that's the kind of care that I feel you can come to expect when you're going to people who are not specialized in problems.”

With the large number of students that need to be treated and the sometimes limited options available, it is not surprising that some GAs expressed frustration with wait time. There are often long wait times associated with waiting to see specialists once an appointment is scheduled. One participant, whose wife needed to see an obstetrics and gynecology (OB/GYN) specialist, reported, “my wife needed OB/GYN, they gave an appointment for three months later which with [their previous healthcare provider] we never waited more than two weeks to see a specialist there.” Another participant encountered a six-month waiting period to see a specialist and thus had “to be incredibly proactive to try and make sure that within the year I am seen and I am getting the tests done.”

Graduate healthcare coverage. Some participants had not anticipated receiving university-provided health insurance. One participant stated, “I was actually surprised that I had coverage through my GA position.” Some participants expressed a sense of gratitude for receiving university provided health insurance, and others wondered what other options may have been available for healthcare needs if the insurance was not provided by the university. Several participants expressed a sense of disappointment with the coverage provided by the university, and discussed ways that the coverage should be improved for graduate students.

Future concerns about coverage after graduation. As GAs neared graduation, they were concerned about the coverage after graduation. One participant wondered about future health insurance options, stating “I know next year I won't be a graduate student anymore,” and they were concerned about how to get coverage. Other students were very cognizant of the fact that they needed to find future coverage and even knew the future cost: “Next year I won't

be covered because I won't be in grad school so we'll create a family plan for \$3000." However, some students expected to receive better care after graduation, and were actually putting off paying for treatment now. One student was on schedule to graduate in the semester interviews were conducting and hoped that she will be able "have real health insurance and they will be in a regular location" with an established, a full-time job.

Knowledge, Quality, and Cost

Another component that influenced care (and thereby the overall experience) was the knowledge, quality, and cost. Given the complex nature of the overall system (with limited coverage and potential costs), GAs' prior knowledge and awareness of the processes, quality of care, and cost proved useful for receiving prompt services in a desirable manner. Even though GAs did not feel that they were tricked, many found that being proactive (which often involved fighting on the phone) helped sort out glitches occurring due to administrative staff errors. GA's ability to navigate systems influenced and shaped the kind of access and care they received – depending on the "coverage" as the key element – precipitated GA's healthcare experiences in unique ways.

Quality of care. While some GAs expressed satisfaction with the quality of care provided, others were dissatisfied. GAs noted their frustration with having to use the research hospital associated with the University when they needed healthcare and services. Some participants felt that they were not being treated by "real" doctors, only healthcare providers-in-training. One participant noted that when it came time to have stitches removed, "I could I should've [sic] done them myself" [and that] I should've just put a Band-Aid on myself because you're going there to see people who are still learning."

Knowledge and awareness. Participants expressed a range of existing knowledge and awareness of the university healthcare system and the university-provided health insurance. Some GAs were informed directly about the available university-provided health insurance, while other GAs seemed to stumble on the insurance information via the graduate school website or a university sponsored listserv. Many GAs described the health insurance as complicated or confusing. One participant stated, "it was really very difficult to understand. What all these issues mean when you have to what is out of the pocket what is inside in-network, out-network its very complicated its very very complex specially for somebody which has never lived under that system." Another participant made a connection between the complexity and quality of care, saying, "There is a lot of complexities that makes the service ... not very good."

Process problems. Many GAs discussed frustrating or disappointing experiences with the insurance billing process. Specifically, some participants noted that a gap in coverage occurs between semesters while GA eligibility is verified. One GA said, "If you have a health issue at that time [in between semesters, prior to confirmed enrollment] you may find yourself paying out of pocket or making a lot of phone calls to prove you have coverage or get that coverage sort of bypassed so that you can pay later." Several other participants shared experiences with uncovered doctor visit or prescription costs during the period between academic semesters. Other GAs expressed confusion about the billing process and coverage. A few participants reported cancelling medical appointments or spending hours on the phone attempting to sort out billing and coverage issues.

Cost. Most GA participants included discussions about costs associated with healthcare and university provided insurance. Discussions of cost included co-payments, out-of-pocket expenses due to coverage gaps, high costs associated with family coverage, and costs covered by health insurance in times of medical crisis. One participant suggested that the university should address the family cost concerns, stating, "They do allow family and dependent

enrollment, but they should subsidize more on that.” A few participants described the costs as reasonable or comparable to other insurance providers; one participant stated, “compared to other insurance in the US, and this in THE STATE that I tried to look out, it's not high and under the new one that they're bringing, it is even better – the costs are even a bit lower than what they are [now].” Despite these statements, many participants seemed to view the university provided health insurance as too costly.

Self. GAs were found to constantly compare and contrast their existing healthcare with their past healthcare experiences, and this made them perceive the existing healthcare in unique ways. For example one GA coming from the Middle Eastern country said that having his family without healthcare coverage even for a week was out of his imagination while he was himself amazed to see that many American and other international students did not care much about having their family members covered. Some international students did not want to buy any healthcare insurance for their families due to the cost, but they had to do so to stay enrolled and to maintain their legal status as students. Understanding that culture is a complex factor with many domains, we have predominately used one-item racial/ethnic identity as a proxy for culture that may not capture the true identity of the individual (e.g. bicultural individuals). Identifying how individuals view themselves may serve a better guide to understand these disparities.

Being proactive. Being proactive helped some students get a fairer treatment or a better care. Taking a step to call the insurance company and asking about the amounts in their bills made a difference for some. One GA mentioned that she was billed many times more than normal but that she called the insurance company and explained the situation to have the extra amount taken off from her bills. Even though the healthcare of graduate students in the research university was supposedly covered, a desperate lack of their advocate was felt by most of the students. The Graduate Assistants Union's role was highly appreciated for having secured the care for students, but the graduate students were still feeling left on their own to figure out and make the best deals out of the package coverage offered.

Changed expectations. Tied with the code of being proactive was the story of expectation. Healthcare services received by the students from the healthcare providers (naturally) varied from case to case due to several reasons including availability of a range of choices and levels of services. What eventually shaped graduate students' overall experience was the expectation that students carried or (cultivated during the course of conversations). While some GAs became proactive (often fighting with the staff) to get what they wanted (even pushing the boundaries of choices and systems), others lowered their expectations to align themselves with the compromised care they ended up receiving.

Discussion and Implications

The purpose of this study was to understand GAs' experiences with their university-provided healthcare. From their responses, we learned that their experience can be described mostly as an assurance (as long as it is not used), a necessity (when in trouble), and a compromise (when actually used). Describing their experiences accessing student health services, GAs expressed their frustration with wait time and seemingly unnecessary documentation processes. Most of them learned about the INSURANCE PROGRAM from their assistantship offer letter. Furthermore, most participants think the INSURANCE PROGRAM insurance has met their health coverage needs to some extent and many are grateful that they have been saved from some egregious bills that would indebt them for lifetime.

While the GAs are quite satisfied with their ability to access the healthcare service they needed for themselves, they are very concerned about the lack of coverage of their family

members and the additional financial burden if they wanted to include family members. Most felt that the information dissemination aspects of INSURANCE PROGRAM were most problematic because understanding the language used was difficult and ultimately resulted in the GAs incurring copays or other financial burdens. Participants shared that many of their current healthcare needs, particularly the well-being services, were unmet with the current coverage, e.g. dental care, vision care, etc.

Participants were happy with two aspects of INSURANCE PROGRAM. First, they were generally satisfied with the quality of care and competence of doctors providing service. This can be explained by the quality and standard of TEACHING HOSPITAL, the primary service provider via INSURANCE PROGRAM. The second aspect that participants appreciated is the work done by the UNION, the bargaining agent of all GAs in the INSTITUTION. What UNION has been doing at INSTITUTION is consistent with what Rhoades and Rhoads found a decade ago, i.e., healthcare has been one of the priorities of graduate student unions (2003).

Overall, the GAs' painful navigation through administrative system to access healthcare services was complicated by the unintelligibility of information. The participants wished that INSURANCE PROGRAM could be simpler to understand, people responded promptly when a service was needed, and coverage had been expanded to include family members. Once they know what services are available and what they are eligible for, students must obtain administrative clearance (e.g., enrollment verification) to access providers offering various services selectively with their own list of restrictions (e.g., copayments, deductibles, and/or pre-existing conditions). The experience received depends both on the institutional framework of the healthcare system, students' cultural perceptions, backgrounds, needs, and expectations. Hence, the ultimate healthcare experience described by the GAs is an outcome based on system navigation as depicted in the model shown in Figure 1.

Our results also suggest that the healthcare experiences of GAs are a function of a complex interplay between the personal and institutional elements. Personal elements include various demographic features such as background, cultural experiences, perceptions toward healthcare, and various identities of the GA's self; institutional elements include the university staff, GA union, insurance providers, and the choices of services available to GAs. While most participants are grateful for the available healthcare coverage, they also have unique experiences informing this study.

Participants' expressions of satisfaction and dissatisfaction of coverage differed, with medical staffs receiving both praise and criticism. For example, Participant A described a doctor as "outstanding" and Participant B described a nurse practitioner at the university's student healthcare center (UHC) as "phenomenal" and the UHC's OB/GYN staff as "fabulous." Conversely, Participant C's experience with the UHC's specialists was less favorable, prompting them to say that she "would *never* step foot back there ever again" [emphasis in original]. Similarly, access to birth control was both lauded and derided by participants.

The financial obligations, that is, the copayments and deductibles, were also a voiced concern for many. The insurance plan at the participating institution was designed to be used by graduate students at the UHC, which is funded by a per-credit fee paid by students, or at the university's teaching hospital. Because of this, the deductible on the plan is substantial. Participant A perceived the \$3,000 deductible as high but, nevertheless, appreciated having the plan as his medical bills for that year topped \$100,000 – a sum that would be unable to be repaid without the help of insurance.

Another financial aspect of the plan that was discussed often was its use by GAs to insure their families. Participant C had explored adding a spouse to the insurance policy and repeatedly used the word "reasonable" to describe this potential cost. However, Participant D was in a similar situation – wanting to add a spouse and child – but felt that the cost was "pretty

high.” Ultimately, both participants decided that their families would be insured by outside providers for financial reasons.

Another common issue raised was unique to health insurance for graduate students (described above as “process problems”). Each semester, students are un-enrolled from the health insurance pending verification of their status as a student after the ‘Drop/Add’ registration week (typically the first week of the semester). This issue was universally criticized by the participants that spoke of it. For Participant C, the coverage gap is unacceptable. Due to a medical condition, this participant utilizes community providers through the plan and sees them frequently (ranging from biweekly to several times per week). During this time, people insured through the plan appear to medical providers as if they are entirely uninsured. Participant C has thus far been able to continue receiving services from the medical team because of an established relationship, but questions the level of frustration and paperwork that would be involved if insurance needed to be used in an emergency situation during the coverage gap.

Since healthcare is very personal and the outcomes are expected to meet expectations, these in-depth interviews provided us rich information for us to understand healthcare experiences in this particular context. It is possible that some of the participants might not have disclosed the adequate picture of their experiences due to emotional and/or cultural sensitivity associated with the healthcare. However, this could be a case with any sensitive research topic and even could be considered a “weakness” by some researchers (Gaulee & Jacob, 2013). Furthermore, for a more detailed picture of the GA’s healthcare experience, we could have also included interviews with administrators, insurance providers, or the healthcare service providers, who would have provided alternative and possible differing perspectives on the phenomenon. These affiliated participant groups can be further explored in subsequent studies. Also, since cultural perception of healthcare was noted in this study, replicating this research with more narrowly defined populations would be informative. Cuff and Vanselow (2004) wrote that culture (or a person’s background) impacts how individuals communicate, understand, and use health information, which is further complicated by interaction among illness and family dynamics. While our study was able to show a cultural influence on Graduate Assistants’ descriptions of their healthcare experiences, the ways in which various cultures shape their healthcare experiences and their subsequent responses to available healthcare could not be answered in this study.

From a holistic view of higher education, healthcare for graduate students is an important factor of their overall success and productivity. Particularly for large research universities that rely on the GAs to carry out their important missions of teaching, research, and service, commitment to graduate students’ healthcare needs should be a high priority. It is not sufficient for university administrations to simply provide paid health insurance “options” without robust support systems on campus. Given that graduate students like Rozita are often stressed out, lack time and energy, and find it hard to navigate the complicated systems of profit-driven health care industry, the lack of direct support in graduate students’ day-to-day healthcare needs can cause tremendous loss on their success and productivity. Rozita eventually learned to read asterisked and font-reduced letters and to understand the language play strategically written by the lawyers of the healthcare industry, and she indeed mastered the ins and outs of insurance policies well enough to pay less money out of pocket. But if she did not have to spend countless, stressful hours in fighting the service providers, that is, if there was an advocate on campus to mediate and facilitate her efforts, the university would tremendously gain in terms of her overall success and contribution through her teaching, research, and service. Thus, by shirking their responsibilities for direct support, universities not only undermine students’ professional development but also lose on their own institutional success and productivity. In-depth and culturally situated experiences of possibilities and

limitations of healthcare can inform future health care policies, practices, and procedures so as to improve the overall quality of educational experience.

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Author Note

Uttam Gaulee is Associate Program Director of Community College Futures Assembly at the University of Florida's Institute of Higher Education. His research interests include using qualitative and quantitative methods to study international higher education, entrepreneurship, and global engagement. Correspondence regarding this article can be addressed directly to: Uttam Gaulee at, Institute of Higher Education, PO Box 117049, 1215 Norman Hall, Gainesville, FL 32611-7049 or E-mail: gauleeuttam@ufl.edu

Brenda Lee is a doctoral student in Educational Technology at the University of Florida and a practicing instructional designer at Shadow Health in Gainesville, Florida. Her research interests include the practice of online collaboration and the role of epistemic beliefs with the use of technology. Lee can be reached at brenlee@ufl.edu

Douglas Whitaker is a doctoral candidate in Mathematics and Statistics Education at the University of Florida. His current research focus is on in-service statistics teachers' professional identities and assessing statistics Whitaker can be reached at whitaker@ufl.edu

Natalie Khoury Ridgewell is a doctoral candidate in Curriculum, Teaching, and Teacher Education at the University of Florida. Her current research focus is on how to best prepare pre-service teachers to help support the diverse needs of students. Ridgewell can be reached at nkr@ufl.edu

Mirka Koro-Ljungberg (Ph.D., University of Helsinki) is a Professor of qualitative research at the Arizona State University. Her research and publications focus on various conceptual and theoretical aspects of qualitative inquiry and participant-driven methodologies. In particular, Koro-Ljungberg's scholarship brings together theory and practice, the promotion of epistemology, and the development of situated and experimental methodologies. Koro-Ljungberg can be reached at Mirka.Koro-Ljungberg@asu.edu

Dayna Watson is a doctoral candidate in Counseling and Counselor Education at the University of Florida. Her current research focus is on issues of poverty and social class in mental health counseling. She can be reached at watsondm@ufl.edu

Colleen Butcher is a doctoral candidate in School Psychology at the University of Florida. Her current research focus is on caregivers' perspectives in psychological assessment. She can be reached at colleen.butcher@gmail.com

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