Is Health Care Reform Contested in the U.S.?
Public Attitudes Toward Government Involvement in Health Care, 1973-2010

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Abstract

Health care reform is a complex issue that is impacted by multiple factors. Political sociologists have often focused on the role of culture, institutions, and politics in explaining whether specific policies succeed or fail. More recent scholarship has underscored the role of public attitudes in impacting welfare state development and policy in general, and health care policy in particular. Using data from the General Social Survey from 1973 to 2010, we evaluate whether the American public has become more or less supportive of government involvement in health care, captured by their attitudes toward government responsibility in paying for health care as well as the appropriate spending levels. We also explore the cleavages that exist regarding opinions on government involvement and if they have changed over time. We find that public attitudes toward government involvement appear cyclical, where a drop in support follows increased support. The main cleavages present are based on age, income, gender and race and it appears that race may be the most consistent predictor of health care attitudes, specifically that blacks are consistently more supportive of government intervention in health care, as compared to whites. Our findings help shed light on the relationship between politics and the public within the health care domain and may help us understand why it has been almost impossible to pass universal health care in the United States.
Is Health Care Reform Contested in the U.S.? Public Attitudes Toward Government Involvement in Health Care, 1973-2010

Ever since the introduction of Medicare and Medicaid, American presidents have aspired to introduce major changes to the health care system. Not surprisingly, the proposed changes have often been related to the political affiliation of the President and in general, Democrats have strived to make the system more universal whereas Republicans have worked toward making the system more private. While the passing of any major reform is always a vulnerable political issue, health care reform has proven particularly difficult in the United States, leading to a reality where the U.S. is the only advanced, industrialized country without some form of coverage for all citizens (Quadagno 2004). Yet, and perhaps ironically, the U.S. spends the greatest on health care while having some of the worst health outcomes among advanced, industrialized nations (OECD 2010). Importantly, every attempt for health care reform is embedded in the complicated reality of acceptable solutions that are available within a given institutional context, and debates about health reform often include an argument about what kind of a nation we live in as well as what kind of people we are (Morone 2010).

There are multiple reasons for why health reform has consistently failed in the U.S. Scholars have pointed out the role of culture, politics, and institutions. Early on, many argued that the absence of universal health insurance in the U.S. was due to the unique political culture (Anderson 1972; Jacobs 1993; Rimlinger 1971), leading to a focus on American exceptionalism. Here, researchers argued that Americans simply like the government less than citizens in other countries, resulting in meager social policies in general and lack of universal health care in particular (Lipset 1991). Others have pointed out that health care reform has consistently been avoided due to the interest of powerful interest groups, showing that those who traditionally
oppose health care have been better financed and better organized, than those who favor such reform (Alford 1975; Poen 1979; Navarro 1976). More recent scholarship has focused on the interplay between various factors, including politics and culture. In an effort to explain why some health care reform has passed and other failed, Quadagno (2004, 2005) offers a stakeholder approach as an explanation. She argues that the key to understanding health reform is the alignment of the most powerful stakeholders and whether they are for or against specific reform. As an example, the American Medical Association was historically an important obstacle to the passing of universal health care, but at least significant fractions of medical doctors currently support some form of universal coverage. However, insurance companies have emerged as an important stakeholder opposing health care reform and played a role in the failure of the Clinton plan.

It is clear that culture, politics and institutions matter for health care reform. The alternatives that current policymakers have are impacted by the institutional trajectory that each nation has travelled, making some options easily available whereas others are nearly impossible (Pierson 1994). Recent research has highlighted the role of public attitudes as an important factor shaping what kind of policies are possible within a given context (Brooks and Manza 2006, 2007; Steensland 2006) and even showed that public attitudes have as strong impact on welfare state development as other factors generally considered important, such as economic and political factors (Brooks and Manza 2006, 2007). Focusing specifically on Clinton’s attempt at health care reform, Skocpol (1996) argues that the key explanation for why the plan was unsuccessful was the failure of the administration to get their message effectively out to the public, while simultaneously allowing its’ opponents to “educate” the public about the plan. Regardless of the relative role of public attitudes in shaping policy, we argue that, at a minimum,
they provide a window into understanding what citizens have come to expect regarding health care. Individuals’ views reflect past and current trajectories of the health care system and help predict the current and future pressures that national policy makers must take into account when reconfiguring their health care system.

In this paper, we use data from the General Social Survey (GSS) and focus on public attitudes toward government involvement in health care in the U.S. from 1973 to 2010. We capture government involvement in health care by two questions, capturing two of the four dimensions considered important to understand welfare attitudes, government responsibility to pay for health care and appropriate spending levels (Andreß and Heien 2001). We ask three interrelated questions: 1) How supportive have Americans been of government involvement in health care between 1973 and 2010; 2) what are the major cleavages that emerge regarding support for government involvement in health care; and 3) are there over-time changes in which groups are most supportive for government involvement in health care.¹ Our paper proceeds in four steps. We begin by discussing why public attitudes matter and our expectations for support for government involvement in health care. Second, we evaluate changes in public support over time and consider whether they mirror major political changes in the U.S. Third, we empirically test what cleavages are present among the American public in each year available. Rather than presenting the full tables, we present figures with the key findings for each dependent variable. We conclude by discussing the implications of our findings for the relationship between the public and politics in the contemporary U.S., as well as the insights our analysis provides for the ongoing struggle to pass universal health care in America.

¹ This draft does not include a statistical test of whether the over-time changes are significant, only the years in which a specific cleavage is present or absent
THEORETICAL BACKGROUND

Government Intervention in Health Care

All advanced, industrialized societies are undergoing major challenges regarding the social organization of health care. These challenges have led policymakers and citizens to debate the appropriate role of governmental involvement in health care. Importantly, national health care systems are embedded within the larger social organization of the welfare state (Quadagno 2004). Our two dimensions of government involvement (support for the government’s responsibility to pay for health care and opinions about future spending levels) represent two of four main dimensions of welfare state attitudes - the function and the financing of the welfare state (Andreß and Heien 2001). The former refers to what citizens view as appropriate for states to do; the latter to how much they should spend on what they do. Both dimensions are critical when thinking about public attitudes toward government involvement in health care over-time.

Previous research on public attitudes toward government involvement in health care often focuses on issues of spending and performance (Blendon, Kim, and Benson 2001; Blendon et al. 1990; Donelan et al. 1999; Mossialos 1997; Pescosolido et al. 1985). While these measures provide important information on issues relevant to policy making, they may not be as theoretically useful as attitudes toward government responsibility to pay for health care in the first place, a domain that has received scant attention. Some have argued that attitudes toward responsibility may be more comparable across context than other indicators because they reflect deeper ideological commitments to a specific organization of health care present at different points in time (Andreß and Heien 2001). We argue that a similar argument can be made for over-time evaluation of public attitudes as this measure reflects broader ideological commitment to the social organization of health at different points in time, rather than being confined to specific
debates happening at that moment. Andreß and Heien (2001) conclude that what the public views as being an appropriate function (e.g. responsibility for health care) is fundamental, since it captures whether citizens view a specific domain (e.g. health care) of the welfare state as legitimate. Although it can be argued that responsibility captures a more profound ideological commitment, it is also important to consider attitudes toward spending as those concerns often dominate health care discussions, especially as health care cost has spiraled out of control (Mechanic and Rochefort 1996). Together, these measures provide insights into how citizens feel about government responsibility to pay for health care in general, and then shed light on how citizens feel about one of the key issues regarding the social organization of health care, appropriate spending levels.

Public Attitudes as Cultural Markers

Research on health care systems often takes a macro-level approach (Frenk 1994; Gonzalez-Block 1997; Mechanic 1975; Mechanic and Rochefort 1996; Ruggie 1996; Stevens 2001). We argue that public attitudes help to map the cultural landscape of a country, reflecting the local pressures facing policy makers when they formulate national health care policies. They reflect cultural expectations that citizens have about the appropriate relationship between the market, the state, and the medical profession in the social organization of health care. March and Olsen (1989) argue that history and culture produce shared understandings about appropriate behavior. Regardless of whether institutions shape attitudes or attitudes shape institutions, public attitudes matter for how health care policies are formulated and executed. Policy makers have to take into
account previous arrangements that, at least in part, set the stage for how the public thinks about health care at a particular point in time (Pierson 1996, 2001).

This renewed sociological interest in public attitudes suggests why attitudes matter for health care policy. According to Stevens (2001), the course and direction of policies that set priorities and determine rationing are influenced by a nation’s dominant belief system (see also Somers & Block 2005). Citizens’ views allow for (1) understanding the climate within which public programs operate, (2) evaluating which segments of the population support public programs, and (3) marking how policy reactions relate to general support for political and medical systems (Katz et al. 1975:200). Burstein (1998) corroborates, noting that democratic governments often do what their citizens want, especially when the public realizes the importance of an issue and expresses its wishes clearly (see also Erikson, Mackuen and Stimson 2002, Jacoby 1994; Pierson 2001; Stimson, Mackuen and Erikson 1995). Further, Inglehart (1997) contends that democratic societies are more likely to produce individuals who are skilled at participation in politics, set higher standards for their political leaders, and become more issue-oriented rather than party-oriented.

Turning specifically to how public attitudes may impact success or failure of health care reform, scholars have looked at the failure of the Clinton plan. Of course, there is never a simple explanation for why such overarching attempts to change policy fails and multiple factors matter. Not surprisingly, that is what Skocpol (1996) argues, pointing out both practical and political factors. From a practical standpoint, being a president is time consuming and any attempts regarding new policies may be interrupted due to sudden crisis. From a political standpoint, she argues that Clinton may have overestimated the willingness of Republicans to compromise, the

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2 Scholars differ in their stress on the interaction of culture and institutions. Some focus on the ways institutions shape attitudes and behavior (e.g. Skocpol 1992; Jackman and Miller 1996). Others focus on how attitudes and beliefs shape institutional arrangements within societies (Inglehart 1997).
failure of Democrats to agree on a coherent plan, and the complex reality of multiple stakeholders involved in the health care field. Yet, she concludes that the most important reason was the failure of the administration of selling their plan to the public. One of the main concerns of those involved in creating the plan was to have it just right when introduced to other politicians and the public, creating a vacuum that allowed those who opposed the plan to impact public opinion. For example, they were able to do so successfully through negative advertisements that evoked fear that the average American would be worse off in terms of health care. Research has shown that while the public was initially supportive of Clinton’s plan, a significant drop in support quickly followed. Yet, public opinion research also showed that many Americans continued to be supportive of the plan as long as it was not labeled as the Clinton plan, indicating that those who opposed the plan may have been successful in making the public suspicious toward the overall plan, even though they liked many of the individual pieces. It will never been known whether the U.S. would have universal health care had the public continued to support the plan, but it seems likely that the administration would not have abandoned it so quickly had public support remained high. At a minimum, this example shows that there is a relationship between the public and politics, and our key concern here is to further explore this relationship in the U.S. over-time.

EXPLAINING PUBLIC ATTITUDES

Overall Support and Political Climate

Some form of universal health care has long been of an interest of politicians. Roosevelt originally wanted to include health care in his passing of social security, but was unable to do so. In the domain of health, the introduction of Medicare and Medicaid represent the most successful passing of health care reform, at least until it is possible to evaluate the success of the Obama
administration. In many ways, the difficulties to pass health care reform in the United States are related to the unique relationship between the state, the market and the public. Unlike their counterparts in other societies, American doctors had virtually complete control over the medical jurisdiction, often referred to as professional dominance (Freidson 1970). The American public therefore became accustomed to a fee-for-service system, with the underlying ideology that rather than everyone deserving some form of health care, everyone deserves the best health care he or she can pay for. This, combined with Americans general distrust of government, has consequences for how difficult it has been to pass major health reform in the United States. This may have been reasonable during the earlier attempts of health care reform, when the public was enthusiastic about major advancements in medicine and envisioning a future where everyone would have some sort of coverage. But in the 1970s, the practice of medicine came under attack as a profession that was more concerned with its own interests and agendas, as compared to patient’s welfare (Haug 1973) and a reality where the working poor (Seccombe and Amey 1995) and even the middle class was left without adequate or even any health care protection. It can therefore be argued that health care reform has become a more critical issue for a large proportion of Americans, which should increase support over-time. Conversely, research has also shown that public attitudes toward government involvement in health care are largely embedded within a specific policy context (Kikuzawa, Olafsdottir, and Pescosolido 2008), which may result in non-linear trajectories of public attitudes as they may reflect the current health care debates and realities. Consequently, we proposed two hypotheses for over-time changes in public attitudes: First, The Increased Support Hypothesis (H1a) expects that lack of health care coverage has become a more important public issue in the U.S. over time and this is reflected in public attitudes; and second, The Embeddedness Hypothesis (H1b) expects that public attitudes

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3 At least in comparison to citizens in many other advanced, industrialized nations
reflect the major health care discussions in each time period that would show a non-linear relationship of support going up and down repeatedly over-time.

**Public Attitudes and Self Interest**

According to prior research, individuals are guided by self-interest. Those who benefit more from welfare policies in general, and health care provision in particular, are more likely to be supportive of government intervention (Andreß and Heien 2001; Blekesaune and Quadagno 2003; Hasenfeld and Rafferty 1989;). This may be particularly relevant within the U.S. context, as research has shown that attitudes toward inequality and the welfare state are often related to broader ideological packages (Sachweh and Olafsdottir 2011), but that this relationship is weaker in the United States as compared to other liberal welfare states, at least in the domain of family policy (Bolzendahl and Olafsdottir 2008). On the whole, empirical results support this argument, finding that individuals in more disadvantageous positions are more supportive of health care policies. Specifically, those with low income, low education, or who are older or female are more supportive of health care (Blekesaune and Quadagno 2003; Hayes and VandenHeuvel 1996; Kikuzawa et al. 2008; Pescosolido, Boyer, and Tsui 1985; Pettersen 2001).

Therefore, based on current theoretical insights and empirical research, our *Individual Vulnerability Hypothesis (H2)* expects disadvantaged groups to be more in need of public services, and as a result, express greater support for government involvement in health care. Specifically, we expect that women, the elderly, the unemployed, minority groups, the less healthy, those with lower levels of education, and/or lower income will be more supportive of government involvement in health care.
Politics, Religion and Public Attitudes

As to be expected, political beliefs have a strong association with how individuals feel about government involvement across multiple domains. The power resource perspective is one of the more prominent perspectives to explain welfare state development, arguing that having left parties in power increases welfare state spending (Huber and Stephens 2001; Korpi and Palme 1998). Therefore, it does not come as a surprise that those who are left in politics tend to be more supportive of government involvement and those who are toward the right. While religion may play some role in politics in many countries, the association between religion and politics has become especially strong in the U.S. during the past decades, with the alignment of those who are religiosity conservative and those who are politically conservative. Consequently, our Ideological Hypothesis (H3) expects that Democrats are more supportive of government involvement in health care, while Republicans and those who attend religious services more frequently are less supportive.

DATA AND METHODS

size exceeds 1,000 in 16 out of 27 years. Following Allison (2009), we use listwise deletion of missing cases, and the percentage of missing cases ranges from 5.75 in 1975 to 17.19 in 2000.

**Dependent Variables**

We use two dependent variables. The first asks whether the respondent thinks that the government should help pay for medical care. The variable has five response categories, ranging from people should help themselves (1), agree with both (3), and government should help (5). The second asks whether the government is spending too much (1), about right (2), or too little (3) on medical care.

We use 14 independent variables, capturing social location in general as well as further exploring the role of politics, religion and health status. Age is a continuous variable. We use a binary variable to measure gender (1=female), marital status (1=married), whether respondent has children under six (1=has young children), education (college=1), and work status (1=employed full or part time). Race is measured with two binary variables, blacks and other race where whites serve as the reference category. Number of children is measured with a continuous variable ranging from 0-7 where the highest category represents 8 or more children. Family income is measured in thousands of dollars. We created two binary variables from a variable measuring political affiliation on a scale from a strong Democrat to a strong Republican. Our variable for Democrat is composed of strong Democrats and not strong Democrats and the same strategy is used for Republicans. The references category includes independent, near Democrat; independent; independent, near Republican; and other party. Our measure of religion

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4 Due to the split design ballot of the GSS, the sample size is smaller in some years. In addition, there was experimentation with different ways of asking the questions in some years. We currently only use the questions that are asked in exactly the same manner, but I am currently thinking about what to do about the years with very small sample sizes.

5 Future analysis will compare findings from listwise deletion to findings using multiple imputations
asks how often respondents attend religious services, ranging from never (0) to more than once a week (8). Finally, we measure health status with a binary variable where 1 represents those who report poor or fair health and 0 represents those in good or excellent health.

**Analytical strategy**

We use ordered logit for each year to evaluate what cleavages emerge among the public. This allows us to evaluate what impacts public attitudes in each year but does not allow us to evaluate whether the impact of each coefficient is significantly different between years. Rather than presenting our individual tables for each year analysis, we summarize the most important results using graphs that show significant cleavages over time. We only present findings for coefficients that appear to have somewhat consistent relationship with public attitudes toward government involvement in health care. Given how closely politics and religion are associated with preferences regarding government involvement, the original models for social location exclude those characteristics, as well as health status. Therefore, there are three set of models that: 1) include only the variables for social location; 2) include the variables for social location, politics, and religion; and 3) include the variables for social location and health status.

**RESULTS**

*Are there Over-Time Changes in Public Attitudes?*

Figure 1 shows that there are changes in the level of support for government responsibility to pay for medical care from 1975-2010, although support ranges only from a low of 3.4 to a high of

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6 For such an evaluation and to capture age-period-cohort effect, future drafts will use the random-effects hierarchical age-period-cohort model, which has been suggested most appropriate to analyze micro-datasets in the form of a series of repeated cross-section sample surveys (Yang and Land 2006, 2008).

7 For example, having children was significant for attitudes regarding government responsibility to pay for medical care only in 1975, 1993 and 2008.
3.71. This indicates that throughout the time period, Americans have been leaning slightly toward the responsibility of the government, as compared to agreeing with both statements. The figure also shows that there is not a consistent pattern of either increased or decreased support, rather there appears to be upward trajectories followed by downward trajectories. Americans appeared to be most supportive in the early 1990s and least supportive in the early 1980s. Mapping on to specific presidents and policy implementations, support declined during the Ford administration, hitting a low in the early years of the Reagan administration, followed by a rather consistent increase into the early years of the George H. Bush administration. Perhaps surprisingly, support was relatively low when Clinton was elected but again rose steadily during both the Clinton and George W. Bush administrations. Finally, Obama came into office during relatively high levels of support which then dropped in 2010.

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Figure 1 about here

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Figure 2 shows a similar pattern for public attitudes toward government spending on health. Again the range is relatively narrow, or from a low of 2.45 to a high of 2.74. This indicates that Americans are, on average, supportive of more government spending on health care. Again there is not a consistent pattern, but highs and lows throughout the time period. When spending is mapped on to the political administrations in power, a similar pattern emerges as before. Ford came into office with preferences for an increased spending, followed by a decline that reached a low point during the early Reagan administration. Again, preferences for increased spending increased during the Reagan and George H. Bush administrations, followed by a drop in the
early Clinton years. Then again, there is an increase in public support for spending, that drops somewhat drastically in 2010.

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Figure 2 about here

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The Role of Social Location and Health Status in Shaping Attitudes toward Government Responsibility in Paying for Medical Care

Three socio-demographic characteristics stand out as having somewhat consistent relationship with public attitudes toward government responsibility in paying for medical care throughout the time period: age, income, and race. Figure 3 shows the relationship between age and support for government responsibility in paying for health care from 1975 to 2010. In general, those who are older are less supportive of government involvement with paying for medical care and the relationship is significant in 13 out of 19 years available. Specifically, they are less supportive in 1975, 1984, 1986, 1987, 1989, 1990, 1991, 1993, 1994, 1998, 2004, 2006, and 2008. In order to give an example of what this means substantively, figure 4 presents the predictive probabilities for the average American at different points in the lifecourse in 2008 when a fairly strong age cleavage was present. Here, an individual who was 20 in 2008 had a probability of .41 of saying that the government should pay for medical care (category 5), compared to an individual who was 80 in that same year who had a probability of .27.

8 Other significant findings are that women are more supportive in 1998 and 2000; married respondents are less supportive in 1996 and 2002; those with children are more supportive in 1989 and those with young children are more supportive in 1989; the college educated are less supportive in 1993; those in the labor forces are less supportive in 1975, 1987 and 1989; and those belonging to other race are more supportive in 1994, 1996, and 2010. Full tables available upon request.
Income emerges as a second consistent cleavage regarding support for government responsibility in paying for medical care. In fact, those who have higher income are less likely to think that the government should help pay for medical care in all years, except four (1988, 1990, 2002, and 2004).

Figure 6 shows that a consistent relationship between race and attitudes toward government responsibility in paying for medical care. Blacks more supportive of government involvement than are whites, in all years but three (1993, 2002, 2004). To illustrate the relationship more substantively, figure 7 shows the predicted probabilities for being in each category for whites and blacks. The results indicate that blacks have a .47 probability of being in the most supportive category, compared to a .25 probability for whites. Similarly, blacks have only about .10 probability of being in the two lowest categories, compared to a probability of .23 for whites. Therefore, it appears that race is one of the most consistent category associated with preferences for government involvement in paying for health care throughout the time period.
Finally, figure it appears that those who might be more in need of health care are often, but not always, more supportive of government involvement in paying for medical care. More specifically, there is a significant relationship between health status and public attitudes in 10 out of the 19 time points, or in 1975, 1984, 1987, 1988, 1996, 1998, 2000, 2004, 2006, and 2010. It appears that this relationship, present in the 1970s and 1980s disappeared in the early 1990s, but has been relatively consistent since 1996.

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Figure 8 about here

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The Role of Social Location and Health Status in Shaping Attitudes toward Government Spending on Health

Again, three socio-demographic factors have somewhat of a consistent relationship with public attitudes toward government spending on health. As with responsibility for paying, age and race matter, but gender is more consistently associated with public attitudes rather than income. As with government responsibility for paying, those who are older are less likely to want more spending in several years, but the relationship is not as consistent as it was with government responsibility for paying. More specifically, the elderly significantly wanted less spending in 1973, 1974, 1976, 1977, 1980, 1982, 1985, and 1994. Although this analysis cannot conclude

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with certainty that age matters less over time, the results nevertheless indicate that it may be the case.

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Figure 9 about here

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Unlike attitudes for government responsibility for paying for medical care, gender emerges as an important cleavage as women are more likely to want more spending on health care than men. Specifically, they are significantly more likely to want increased spending in 1980, 1986, 1991, 1993, 1994, 1996, 1998, 2002, 2004, 2006, 2008 and 2010. This indicates that gender has become an important cleavage in American society where women have become more supportive of government involvement in health care. Figure 11 provides an illustration that can be interpreted for 2008, showing that the average woman had .83 probability of wanting more spending on health care, compared to the average men who had .74 probability of wanting more spending.

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Figures 10 and 11 about here

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Finally, as with government responsibility for paying for medical care, race is an important cleavage regarding spending on health care, and again blacks are more likely to want more spending as compared to whites. In fact, the relationship is significant in all years, except 1986, 1989, 1991, 1998 and 2000.
The Role of Politics and Religion in Shaping Public Preferences

Politics and religion\textsuperscript{10} have a strong relationship with preferences for government involvement in health care. Table 1 shows that, as expected, Democrats are more likely to support government intervention, as compared to those with weaker political identification, while Republicans are less supportive as are those who attend services more frequently. Being a democrat is significantly associated with being more supportive of government responsibility for paying for medical care in 15 out of the 19 years observed and has been a significant relationship since 1993. Similarly, Republicans are less supportive in 17 out of 19 years observed. Attendance of religious services does not have as consistent relationship, but those who attend services frequently are less supportive in 11 out of 19 years. Although the overarching relationships are similar for government spending for health care, the associations are not as consistent. Being a Democrat is significantly associated with wanting more spending in 10 out of 27 years while being a Republican is significantly associated in 18 out of 27 years. Finally, those who attend services more frequently are only significantly less likely to want spending in 7 out of 27 years.

\textsuperscript{10}I am not sure how appropriate it is to consider the role of political parties on attitudes toward government, given how closely aligned they are with preferences regarding government. It would also probably make more sense to use either Republicans or Democrats as a reference category, and possibly to code the variable differently. Attendance is a crude proxy for religion and if we go more into that direction, I would want to include more indicators, most importantly the appropriate religious domination.
DISCUSSION

Universal health care continues to be a contested issue in the United States at the beginning of the 21st century. While most other advanced, industrialized nations agreed on some version of the original British National Health Service idea that medical care should be “free at the point of service” (Marmot 2011), Americans continued to operate under a fee-for-service system and continued to believe that medical services belong in the market place, rather than being a right associated with citizenship. This has resulted in a political landscape different from what is observed in other countries, where the ruling administration does not only have to consider what specific policies to consider within a taken-for-granted reality of universal health care, but depending on the political party in power, try to sell the idea that health care is something that should be a right of every citizen or that universal health care equals communism.

Our findings indicate that despite more grim health realities in the U.S. over-time, Americans have not generally become more supportive of government involvement in health care, but that their attitudes may be embedded in specific health care debates at each time. It appears, at least in some cases, that Americans become more supportive leading up to either a specific policy being passed (e.g. Obama’s health reform) or an election that rewards politician with a strong emphasis on health care (e.g. Clinton). However, these upward trajectories are followed by a drop in support, possibly reflecting Pierson’s (1994) concept of path dependency. That is, when certain accomplishments happen, the importance of health care reform may diminish in the mind of the public, until it becomes clear again that the health care system is not working as well as people would like.

The vulnerable group hypothesis is consistently supported for income, race, gender, and health status, but the opposite relationship emerges for age. Not surprisingly, the wealthier are
more likely to oppose government responsibility to pay for medical care, which is consistent with their interests. They are in a position where they are living the underlying assumption of the American health care system by being able to buy the best health that they (or anyone) can obtain. And they may not be particularly interested in helping to pay for some form of health care for others. Here, they may be accurately calculating their best interests, as research has shown that the wealthy are able to transfer their position in society into better health outcomes in the U.S. Conversely, this is not the case in Iceland, a country with a strong welfare state where the wealthy can do very little, if anything, to take advantage of a better health care system to advance their own health (Olafsdottir 2007). Interestingly, this relationship does not appear for appropriate spending level, indicating that income mainly operates toward those who have more in American society fundamentally opposing the role of the government in providing health care, rather than creating divisions about appropriate spending levels.

Race and gender appear to be the most vulnerable groups in American society when it comes to supporting government involvement in health care in the U.S. Being black as compared to white increases support for government responsibility in paying for medical care as well as a support for increased spending, and this is the most consistent association throughout the time period. This may indicate a particular vulnerable position of blacks in American society, which is not surprising given the historical inequalities between blacks and whites in the U.S., as well as continued discrimination and racial inequality. Women are only more supportive of more spending and it appears that gender has become more important cleavage in the U.S. This aligns with the general welfare state literature, showing that women tend to be more supportive of various welfare policies as compared to men (Bolzendahl and Olafsdottir 2008; Svallfors 2007).
The negative relationship between age and support with government involvement in health care is contrary to expectations. This is especially interesting in the U.S. context, as those over 65 benefit more from government involvement in health care through Medicaid. This may be related to the political discourse that is sometimes evoked within the U.S. context that universal health care may somehow undermine Medicaid. There is a possibility that this stand may reflect some form of self-interest, although it is important to note that the relationship was more consistent for questioning the responsibility of the government to pay for medical care in the first place, rather than about appropriate spending levels. Not surprisingly, those who report worse health frequently are more supportive of government responsibility to pay for medical care, again reflecting self-interest, as they are more likely to need services more than their healthy counterparts.

Finally, politics and religion are associated with public attitudes in the expected ways, where Democrats are more supportive of government involvement and Republicans are less supportive. This is not surprising, but it is interesting that within the U.S. the political battle is not about specific policies or how involved the government should be, but that it should even be involved in providing health care for all citizens, and this is reflected in public attitudes. Given the alignment between those who are politically conservative and religious conservative in American politics. This may indicate that this constellation of interest will continue to be an obstacle to any major health care reform in the United States.

In conclusion, it is clear that a large proportion of the American public is supportive of some government intervention in health care and that some groups are more supportive than others. What is important is that the groups that are more opposed to government involvement in health care tend to have more power in American society and politics, regardless of whether they
have majority political power at any given time. But it certainly appears to be the case that
American politicians should not be afraid of the public as a major opponent of more government
involvement, and as the experience has shown in other countries, one of the best ways of
convincing the public is to show them that something works, just like universal health care
appears to work in every other advanced, industrialized nation, regardless of whether the
outcome is less cost, more effective health care system, or public satisfaction.
REFERENCES


Table 1. The Role of Politics and Religion in Shaping Public Attitudes toward Government Involvement in Health Care

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<th>Government Responsibility</th>
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Figure 1. Should the Government help pay for Medical Care? U.S. Means 1975-2010

Figure 2. Should the Government spend more on Health? U.S. Means 1973-2010
Figure 3. Age-Based Cleavage in Support for Government Responsibility for Health Care in the U.S.

Figure 4. Predicted Probabilities of Reporting that the Government should Pay for Medical Care in 2008, by Age
Figure 5. Income-Based Cleavages in Support for Government Responsibility for Health Care in the U.S.

Figure 6. Race-Based Cleavages in Support for Government Responsibility for Health in the U.S. (Blacks compared to Whites)
Figure 7. Predicted Probabilities for Whites and Blacks for Preferences for who Should Pay for Medical Care in 2010

Figure 8. Health Status Cleavages in Support for Government Responsibility for Health Care in the U.S. (Those in good health compared to those with bad health)
Figure 9. Age-Based Cleavages for Increased Government Spending on Health in the U.S.
Figure 10. Gender-Based Cleavages in Support for Increased Government Spending on Health Care in the U.S.

Figure 11. Predicted Probabilities for Gender Cleavages for Spending Preferences in 2008
Figure 12. Race-Based Cleavages in Support for Increased Government Spending on Health Care in the U.S.