

**Who Cares About Health Care?
Sociodemographics and Attitudes Toward
Government's Role in Health Care Across Germany,
Great Britain, and the United States**

Undergraduate Honors Thesis
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I. INTRODUCTION

The health care system of the United States is a peculiar case in comparison to those of other developed nations. Although health care systems around the world are facing similar burdens—rising costs, aging populations, and increased burden of disease—the United States is unique in its response to these growing pressures. The American system is by far the costliest per capita, and yet the increased spending does not translate into more coverage or better access to care. According to the Organization for Economic Cooperation and Development (OECD), the average OECD nation's total health expenditure per capita by both public and private sources was \$2984, compared to the \$7290 spent per capita by the United States (OECD 2009). Health care spending as a percentage of gross domestic product (GDP) is also the highest in America (16% versus the 8.9% OECD nation average). Additionally, 15.9% of the American population is without health insurance, and over half of below-income individuals in the U.S. reported having unmet health care needs (Commonwealth Fund 2008).

One crucial difference between the United States and other developed nations is the variation in the funding and organization of health services (Armour and Coughlin 1985; Navarro 1989). Though all western industrial nations share similar political traditions, the extent of the social protections provided by the state differs greatly (Navarro 1989). The United States is the only major western industrialized nation that lacks national health insurance and any form of universal and comprehensive government health care program. In 2007, almost every OECD nation, with the exception of Germany, completely subsidized core health services. The majority of people in the United States have private insurance as their primary source of coverage, while private insurance coverage is either supplementary or complementary to guaranteed public insurance in other countries (OECD 2009). The U.S. also spends a lower share of its national

income on social welfare than other European nations (Mommson 1981; Armour and Coughlin 1985; Abrahamson, Anderson et al. 1986).

However, what is most puzzling is that U.S. citizens have expressed support for universal coverage for all Americans in the past. Public opinion polls going back to the 1970s and 1980s show the majority of citizens feel the government is spending too little to improve and protect the nation's health and favor national health insurance financed by tax money (Blendon and Benson 2001). Like other countries, Americans place high value upon good health for those who fall ill and support an active governmental role in providing health care for the needy (ISSP 1992, 1996). Despite this enduring support, opinion polls in February 2010 revealed that half of Americans were against the United States' first piece of major health care reform legislation that would extend coverage to the uninsured, and only 36% of Americans approved President Obama's handling of health care policy (Kaiser Family Foundation 2010; Newport 2010). This begs the question of what influences public attitudes, and whether public attitudes toward a more ideological question—government's fundamental role in the social welfare system of health care—gets to the core of the issue.

This paper investigates comparative public attitudes as a mechanism to explain American welfare state “exceptionalism” in health care funding. Lee (1982) defined a health care system as “a set of ideas, practices, and organizations which have been developed to deal with problems of health and illnesses in the society” (Lee 1982). Thus it is crucial to understand the social and institutional constraints that both policy makers and the public face in response to the current health care crisis through public opinion. A growing body of research is reevaluating the role of citizens' policy preferences in shaping social policy (Burstein 1998; Stimson 2004; Brooks and Manza 2006b). Public attitudes reflect the local pressures facing policy makers in the creation of national health policy, and the public's legitimization of specific actions of the welfare state can

reveal preferences (Kikuzawa et al. 2008). Additionally comparing cross-national similarities and differences provides useful analysis across critical variables and dimensions of social policy (Ragin 1978).

There is increasing interest in investigating how sociodemographic indicators predict public attitudes toward the social programming of health care, and whether they differ across countries. Numerous scholarly works have discussed public attitudes toward health care in their research, but usually only in the context of single-nation case studies (Blendon and Donelan 1989; Skocpol 1996; Blendon and Benson 2001; Quadagno 2005; Berk et al. 2006). Comparative analyses of health care regarding the U.S. normally use Canada as the comparative case or center around national-level characteristics of the health care system, such as political institutions and the comparative politics of reform (Mommsen 1981; Lipset 1990; Maioni 1998; Blake and Adolino 2001; Hacker 2004). As well, the case studies looking at national public attitudes toward health care usually reference specific health care reform episodes rather than general, enduring attitudes toward government's role in health care (Blendon and Donelan 1989; Jacobs 1993; Skocpol 1996; Bernstein and Stevens 1999; Altenstetter and Busse 2005). That said, one seminal piece of research conducted by Kikuzawa and colleagues (2008) look at public attitudes toward government intervention in health care across 21 nations. They tested associations of national- and individual-level variables to public attitudes, providing a comprehensive view of how similar health care pressures are reflected differently across countries. In the present study, I plan to revisit their research. More specifically, I will concentrate on expanding their set of individual-level sociodemographic variables that may influence public attitudes as well as constraining the cross-national comparison to three key exemplary countries of Germany, Great Britain, and the United States.

This study will investigate two related research questions. First, what are the relationships between sociodemographic characteristics and attitudes toward government involvement in health care? Second, how do these relationships differ across the three representative countries? Studying predictors of social policy enables us to better understand the social bases of public support, as well as to decipher how policies shape constituencies of beneficiaries and general attitudes about the role of the state in society. Examining these relationships cross-nationally provides leverage by comparing different policy regimes and how the policies interact with factors such as national culture, institutional structures, and ideologies and interests of powerful groups.

The paper proceeds as follows. First, I review the importance of public attitudes in policy formation and legitimization. I follow up with a discussion of the major theoretical frameworks that explain the trajectory of health care reform across countries. Second, I propose a key set of demographic variables for my research. Third, I empirically test the relationships between the indicators and public attitudes toward government involvement in health care. I conclude with a discussion of how the relationships revealed through the analysis shed light on how American policy makers should approach health care reform moving forward.

II. THEORETICAL BACKGROUND

The Importance of Public Opinion

Public attitudes, in general, are useful in helping us to: 1) understand the circumstances under which public services operate, 2) evaluate which population sectors support public programs, and 3) dissect how policy reactions are reflected through general support for political and medical systems (Katz et al. 1975). With regards to policy, public opinion has become

increasingly important. In the latter half of the twentieth century, policymakers' perspective on the public qualitatively changed. Legislators became more sensitive to public opinion, partially due to politicians' struggle for electoral advantage and institutional position (Jacobs 1993). Public officials understand the views of those utilizing the health care system cannot be discounted in the policy design process (Blendon et al. 2001). Brooks and Manza (2006b) argue that despite previous predictions of overall welfare state decline, citizen's attitudes toward social policy is one account for the persistence of welfare states. More specifically to the United States, research also show that public attitudes toward governmental role in health care are consistent with support for national health care insurance. Research by Burndorf and Fuch (2008) reveal that individuals favorable toward government economic redistribution and intervention are more likely to support national health insurance.

Furthermore, research has also shown that public preferences are notably significant in democracies. Representative governments are more likely to carry out the desires of their citizens, in particular when the public reiterates the importance of a certain issue and expresses their social positions clearly (Pierson 1996; Burstein 1998). A growing body of work discusses the relevance of "public deliberation" that emerges out of democratic deliberative theory (Carpini et al. 2004). In contrast to voting-centric views of democracy, in which fixed preferences and interests compete via fair mechanisms of aggregation, deliberative democracy focuses on the communicative processes of opinion and will formulation that precede voting (Chambers 2003). In this more expansive view of representative democracy, public attitudes play a great role in informing policy makers and the cumulative policymaking process.

Lawrence Jacobs (1993) highlights the importance of public opinion polls from a different angle, suggesting that attitudes are the strongest measurements of "culture," defined as the mediating factor between environmental conditions and human behavior. Spread through

membership in institutions such as interest groups, culture is well captured through public sentiments. Lawrence found public opinion to be the only critical factor that consistently varies with changes in interest group influence over health care (Jacobs 1993).

Theoretical Explanations of Health Care System Divergence

Path-Dependency Theory

The theory of path dependency, which take into account historical-comparative perspectives, explain how current realities reflect past decisions, such that key political decisions in policy formation create expectations among citizens. It is also argued that early social policy development propels nations on distinct trajectories that are hard to reverse (Brooks and Manza 2006b). Because history informs expectations and preferences, the cultural explanations and institutionalization of health care policy is worth understanding in addressing the interactive development and feedback cycle that guides development of social programs (Skocpol 1996; Mettler 2002).

Path-dependency research focuses on the cultural values and institutional structures embedded in a given country, looking into how certain sets of social norms dictate public sentiment. America has arguably a unique political culture in comparison to other democracies. As a nation founded on individual responsibility and personal freedom, the United States upholds those views by promoting liberal values and free-market mechanisms (Navarro 1989; Lipset and Marks 2001; Quadagno 2005).¹ Furthermore, there is a record of American citizens' distrust in greater government control over a larger share of health care infrastructure. A longitudinal

¹ These arguments can trace back to the fact that America lacked many of the institutions and traditions of previously feudal societies, including mercantilism, statist regulations, church establishments, aristocracy, and sharp status cleavages that other post-feudal countries inherited. The United States was created as a reaction to the tyranny of a unified, central state and in response established a constitutional system of checks and balances to divide powers and limit government authority.

analysis of public polls reveals that although citizens generally support national health plans and increased national health spending, health is never on the top of the agenda—most people are satisfied with the care they are receiving or do not believe in the government to effectively bring about change (Blendon and Benson 2001).

American political institutions are also biased against national health insurance. Steinmo and Watts (1995) make this case by tracing political reform from the Progressive era up until congressional reform in 1970s. They concluded that the history of reform in the United States has created a fragmented political power structure within the government, and this institutional bias ultimately blocked reform efforts of the past. A similar explanation was put forth by Weissert and Weissert (2002), who attributed the lack of health policy reform to the fragmentation and decentralization of Congress over the past few decades. Furthermore, the political party structure in the U.S., made up of two contending political parties, and the electoral party system leave little maneuvering space for policy negotiations (Lipset and Marks 2001; Weissert and Weissert 2006).

To place this explanation into comparative perspective, similar research by Hacker (2004) looked at statistics on health spending and the characteristics of medical financing in five countries—Britain, Netherlands, Germany, Canada, and U.S.—in conjunction with the major political developments in health reform of each country. He found that it is easier for governments with consolidated authority (e.g. Britain, Canada) to enact major reform, but consequently these nations have a harder time reshaping the hierarchical medical structure. On the other hand, governments with decentralized political structures (e.g. Netherlands, Germany, U.S.) struggle to pass rapid/decisive policy change, but ground-level shifts still take place within existing policy arrangements (Hacker 2004). Thus, specific institutional characteristics restrict

policy reform and ultimately shape public opinion about perceived expectations of health care reform.

The type of democracy is also reflective of key institutional differences toward welfare support. Mass policy preferences were also found to be greater predictors of welfare state persistence within European social democracies (e.g. Scandinavian states) and Christian democracies (e.g. Germany and Italy) than in liberal democracies like the United States and the United Kingdom (Brooks and Manza 2006b). Additionally, Christian democracies and social democracies have higher levels of welfare preferences in comparison to liberal democracies (Brooks and Manza 2006a).

Variation across health care models has been a strong predictor of public attitudes (Kikuzawa et al. 2008). Kikuzawa and colleagues grouped the health care model into three categories based off Stevens' (2001) research: *Insurance model* (e.g. the United States, Canada, Germany, and France), *National Health Service (NHS) model* (Great Britain, Sweden, Australia) and *Centralized Insurance model* (Russia, Poland, Hungary).² Past research shows that generally people in centralized health care models, who already have an expectation that their governments provide health care, want much more public spending on health care, while citizen under the Insurance Model countries are less likely to want increased government spending. Respondents in centralized and NHS countries are also more supportive of government responsibility and spending in health care than individuals in countries with the insurance model of health systems

² Under the *Insurance Model*, social insurance is funded by premiums paid for by employers and labor union, and patients pay an insurance premium to fund the sick. The provisions of services, however, is left to the discretion of medical professionals and charity organizations. The *Centralized Model* countries allow for privatization, but they secure access to free health care through publicly owned hospitals. The *NHS Model* is similar to the Centralized system, with the main difference being that the medical professionals in the NHS countries have a more independent position.

(Kikuzawa et al. 2008). This finding reiterates policy entrenchment as a means of informing individual's ideological preferences through the policy feedback process.

Ideologies and Interests

There are a number of influences on how and why individuals and groups hold certain beliefs about the role of government beyond path-dependency theory. The “self-interest” hypothesis has been used to explain differences across sociodemographic predictors. It postulates that people support public programs more strongly if they may rely on the public programs at some point in time (Navarro 1989; Schlesinger and Lee 1993). An “individual vulnerability” hypothesis was found to be true in Kikuzawa and colleagues' study: disadvantaged groups (i.e. older, female, low income, low education) will be more in need of public services, and hence more willing to show support. However, the self-interest hypothesis is not consistent across nations and may be mediated by institutional structures. For example, women were more supportive of health care spending in West Germany, Italy, and Australia but not in the U.S. or Great Britain (Kikuzawa et al. 2008).

The influence of powerful interest groups has been a strong promoter (or roadblock) of health care reform. Navarro explains this in his “power group theory,” where a few key power groups are able to wield enough influence to block reform that would benefit the larger general public (Navarro 1989). In the U.S., special interest groups such as insurance and pharmaceutical companies have had increasing sway in shaping social policy through the mobilization of powerful lobbies. Weissert and Weissert (2006) also highlight local interest group lobbies, in addition to the structure of the U.S. government, as a factor influencing the policy and politics of health care.

Class power is another useful explanation of national health care policy. The economic and political strength of the working class has been a critical force in bringing about social insurance (Navarro 1989). Working class representation in the political system has been key in moving health care reform ahead in Germany and Great Britain. Historically, America has never had a political party that has represented the interests of the working class and allied popular forces (Navarro 1989; Lipset and Marks 2001; Quadagno 2005).

III. DEMOGRAPHIC PREDICTORS

Given the theoretical importance of individual and group ideology in the formation of social policy, the following section discusses research that connects sociodemographic differences across public attitudes to health care research and other representative social welfare programs. Kikuzawa and colleagues (2008) looked at *age, sex, education, and income* as individual-level predictors of public attitudes. In my research, I will expand the list to include the following characteristics that are informed by previous social welfare research: *occupation, public sector, marital status, children in household, community type, church attendance, political affiliation, and union membership*.

Age is a predictor in past research of public opinion toward social programs. Studies in the United States have found that older voters are least supportive of greater government involvement in health care (Shapiro and Young 1989). Another study showed that while elderly Americans are less supportive of government involvement in health care than the younger generation, the differences are less pronounced than they are for other governmental involvement (Schlesinger and Lee 1993). This difference could be linked to the older American's favorable outlooks on the Medicare program. In my comparative research, because Germany and Great

Britain provide universal coverage for all, age will most likely have different patterns across the various health care models.

Adding to the previous discussions of women in the labor force serving as a predictor of stronger social welfare programs, *sex* is an influencer of public attitudes. Research by Inglehart and Norris (2000) showed that the sex gap in electoral behavior has been growing the past two decades. Based on a variety of questions that ask women to rate themselves on a political spectrum, women are moving to the left of men in advanced industrialized countries (Inglehart and Norris 2000). Women also tend to be overrepresented in social welfare programs, such as Social Security in the United States, and tend to be more indirectly incorporated into the welfare state based on their husbands' contributions (Orloff 1993). Additionally, with regards to health care women have reported greater support for government intervention in health care in America and cross-nationally (Schlesinger and Lee 1993; Kikuzawa et al. 2008). In Germany and Great Britain, where there is greater social welfare programming in health care, I would expect higher degrees of support from women compared to those in the United States.

Education and *income* have had confounding effects in previous research. Individuals with higher income and education have generally been less supportive of government intervention in health care (Schlesinger and Lee 1993; Kikuzawa et al. 2008). Additionally, citizens in countries with more overall education who live in countries spending more on health care are less likely to support government responsibility for health care compared with individuals living in countries spending less (Schlesinger and Lee 1993). I would predict that there will be significant differences across education levels in all three countries, but particularly in Great Britain and Germany, because the two governments spend more money per capita than does the United States government. Based upon these previous findings, citizens of the European

nations, who have higher overall education, should be less likely to find that the government is responsible for health care.

In addition to education and income, *occupation* should also be considered, given that class power has been a crucial mobilization factor of health care reform (Navarro 1989). Job type has been found to be a consistent measurement for lifetime income. Furthermore, we should take into account whether citizens work in the *public sector*. Given the individuals' ties to the government, I presume they will most likely feel more inclined to support social programs.

Additionally *marital status* and the presence of *children in the household* may influence attitudes toward government's role in health care.³ In countries like the United States, health care is not a citizenship right—rather, it is one based upon marital ties and employment. Individuals can be covered under their spouses, and children can be insured under their parents. This puts an immense pressure on individuals to sustain constant employment because, the U.S. government provides no safety nets. Thus, I would expect those in a marriage and households with children to be more supportive of universal health coverage and government responsibility in health.

The *type of community* a person lives in has been shown to have a strong correlation with attitudes toward government role in health care. In the United States, the size of they has been positively correlated to greater government intervention. Residents of larger metropolitan areas are most supportive and rural dwellers are the least supportive, particularly of health care (Schlesinger and Lee 1993). The metropolitan inhabitants may be more receptive to public-sector involvement because they are more likely to be exposed to concentrated social distress. It will be interesting to see if these findings hold across Germany and Great Britain, countries where population density is greater.

³ Elderly in the household was also considered as an independent variable, but this data was not available for all three countries in the ISSP 2006 survey.

With regards to *church attendance*, there is interesting literature on how religion influences social welfare views. Belief in God upholds a tradition where certain standards of right and wrong are upheld, in this case with regards to the government's role in welfare (Wolfe 1998). In Alan Wolfe's research (1998) on middle-class Americans, a growing body of the population, he found that religious belief gave a foundation for a strong sense of altruism and obligation that anti-welfare rhetoric could not eliminate. Thus, using church attendance as a measure of religiousness and belief in a moral sense of right and wrong, I predict that those that attend church more will express greater favorability toward government responsibility in health care in America, but perhaps not government spending in health care. I cannot conclude the same outcomes in Germany and Great Britain.

Political identification and *labor union membership* is inherently linked to specific views of governmental responsibilities. However, adjustments for the difference in party structures across Great Britain, Germany, and the United States would need to be made, because the U.S. only has two dominant political parties. Instead, it would be interesting to see if there are variations in party identification and public attitudes across the three nations. Differences between political parties were among the most consistent subgroup differences observed that did not vary across sociodemographic variables in America (Berk et al. 2006). These findings bear great implications for health care, because party identification may carry implicit ideologies for public attitudes. Following this logic, *labor union membership* should also be taken into account. The labor movement, through the political instrument of socialist parties, has been a major force in establishing national health programs in its pursuit of the welfare states (Navarro 1989). Thus looking at both political identification and labor union membership will be useful for my research.

IV. DATA AND METHODS

I have chosen to restrict comparisons of public attitudes to three countries—Germany, Great Britain, and the United States. The three countries represent three distinct health care models that allow for useful comparisons. As mentioned above, although other types of health care models exist, such as “centralized” health care models existing in Bulgaria and Russia, I wanted to limit my scope to more fully developed countries (Kikuzawa et al. 2008).

Kikuzawa and team grouped the German and American health care system under the same categorization of “Insurance model,” but I feel this categorization is limited in scope and may not fully encapsulate the differences among the insurance types. Instead, I will complement this classification with a separate model laid out by Hacker (2004). In his modeling, the major public health care system types are denoted by 1) public or mixed private-public funding and 2) single-payer or multi-payer. Under this classification, Britain (“national health services,” consisting of single-payer and predominantly public), Canada (“national health insurance” consisting of single-payer and mixed public-private), and Germany (“corporatist health insurance,” consisting of mixed public-private and multi-payer) represent three distinct models (Hacker 2004). The United States is an outlier in this modeling, because it does not have a public health care system, with a predominantly private insurance model that is multi-payer. Despite the fact that the German and U.S. health care system may both fall under “Insurance model,” the presence of public health infrastructure in Germany is a key difference that needs to be accounted for.

Canada, which seems like a logical choice for a comparative analysis of health care research with the United States, was excluded from my research for several reasons. One being there has already been a great deal of research contrasting the United States and Canada models (Lipset 1990; Hacker 1998; Maioni 1998). Secondly, the two neighboring nations share a similar

federal government structure and a common history of introducing government insurance to select population groups, like the elderly, or a specific service, such as hospital care (Lipset 1990; Jacobs 1993). Thirdly, the British NHS and the Canadian national health insurance are in key ways more alike than different (Hacker 2004). Instead, I will focus on comparative research of dissimilar institutions, in this case the United States, Great Britain, and Germany.

The United States has an almost entirely private-sector run health care system, with health provisions left to the discretion of medical professionals in the private practice. The country does not have a national health care system or some form of national health insurance, but it does publically finance certain services such as Medicare and Medicaid. On the other hand, Great Britain has a strong National Health System (NHS) that was initiated under a sweeping measure, the British National Health Service Act of 1946. The public health care system is managed completely under the central government, and the single-payer system relies heavily on tax financing. Germany lies in the middle of the health system spectrum—it has a mixed public-private system that was brought about through incremental policy reform. The German system has a mix of compulsory social insurance for about 77% of its population and voluntary insurance for approximately 23%. However, private insurance is heavily regulated. The German model also stands out in that its central regulation is designed to promote local self-government of health care (Hurst 1991). The three distinct models will provide useful comparisons in discussing my findings.

Looking at the health care characteristics in Figure 1, we see that Germany and the United States share several similar system characteristics, but the health care modeling of the two countries, as mentioned above, is still relevant. However, these parallels can inform further research and insight into institutional-level changes, which my paper discusses only briefly.

Figure 1. Health Care System Characteristics of Germany, Great Britain, and the United States

| | <i>Germany</i> | <i>Great Britain</i> | <i>United States</i> |
|---|------------------------------|--------------------------------|----------------------|
| <i>Public Health Care Type (Hacker 2001)</i> | Corporatist Health Insurance | National Health Services | N/A |
| <i>Health Care System Type (Kikuzawa et al. 2008)</i> | Insurance Model | National Health Services (NHS) | Insurance Model |
| <i>Financing System</i> | Multi-Payer | Single-Payer | Multi-Payer |
| <i>Ownership of Medical Facilities</i> | Mixed Public-Private | Public | Mostly Private |
| <i>Structure of Medical System</i> | Decentralized | Hierarchical | Decentralized |
| <i>Structure of Decision Making System</i> | Veto-ridden | Veto-free | Veto-ridden |

International Social Survey Program (ISSP)

This cross-sectional study draws upon previous research conducted by Kikuzawa and colleagues (2008), specifically their individual-level analyses of public attitudes. Their research compared public attitudes across 21 countries using the 1996 International Social Survey Program Role of Government (ISSP-RGIII) module. The ISSP is a long-standing collaboration among survey researchers, wherein each module is designed collectively and tailored by national research groups for comparability. Every survey includes questions about general attitudes toward various social issues (e.g. the legal system, sex, and the economy), along with more specific questions regarding a special topic (e.g. the environment, the role of government, and social inequality). The ISSP is powerful because we are able to compare nations and test social science models across societies, as well as pinpoint international trends and whether there are parallel models across nations (Smith 1992). Topics are slated for yearly or biannual fielding,

and after a standard English questionnaire is agreed upon, the participating countries translate the questions into their respective languages (ISSP 2010). The survey is self-administered according to each country's fielding methods. The ISSP requires surveys to be conducted on nationally representative samples.

The last available year for data on government services and health care systems is the 2006 Role of Government (ISSP-RGIV) module. This allows me to replicate the research of Kikuzawa and team to compare results while revisiting public attitudes in light of policy changes and health care reform that might have taken place within the 10-year time span. Additionally, 2006 is an exemplary year for conducting the survey, because there were no major political events or shifts in power, and no new pieces of health care legislation were introduced or being considered. Thus, the attitudes collected from respondents should be based upon their fundamental ideologies and not reflective of issue-specific viewpoints.

Dependent Variables

Three items in the 2006 ISSP-RGIV survey reveal public preferences regarding government's role health care. The first addresses government spending in health care. Respondents were asked, "Whether you would like to see more or less government spending" in health. Responses include to spend "Much Less" (recoded as 1), "Less" (2), "The Same As Now" (3), "More" (4), and "Much More" (5). Government spending is a strong predictor of an individual's willing to pay. The survey explicitly reminds participants of this fact: following the question, the survey states, "Remember that if you say 'much more,' it might require a tax increase to pay for it."

The second item measures government responsibility in health care. Respondents were asked, "On the whole, do you think it should or should not be the government's responsibility to

provide health care for the sick.” Responses include “Definitely Should Not Be” (recoded as 1), “Probably Should Not Be” (2), “Probably Should Be” (3), and “Definitely Should Be” (4). This question looks into respondents’ view of the general function of the government and its responsibility to social welfare.

A third item, which was not available in the 1996 questionnaire, measures citizen’s views of government efficacy. The question asked, “How successful do you think the government in [your country] is nowadays in providing health care for the sick?” Responses include “Very Unsuccessful” (recoded as 1), “Quite Unsuccessful” (2), “Neither Successful Nor Unsuccessful” (3), “Quite Successful” (4), and “Very Successful” (5).

Higher scores indicate greater support for government intervention in health care in spending, responsibility, and efficacy. The dependent variables are ordinal measures.

Independent Variables

To evaluate the sociodemographic predictors across the three countries, individual-level variables that have been correlated to influencing public attitudes were taken into account. As noted above, the variables were chosen based upon theory and previous literature.

Age and *Age-squared* were measured in years, ranging from 15 to 96.

Sex was measured as a dummy variable (1=female, 0=male).

Education was measured through three dummy variables. High school education level was the reference group, and “less than high school,” “vocational school,” and “college and above” was established through country-specific recodes that ISSP has completed.

Income was adjusted for household size, by dividing reported income by the square root of household member. Then, the new income was converted into country-specific z-scores, in order to account for currency difference across nations.

Occupation was measured using the International Standard of Classification of Occupations 1988 (ISCO88) occupation schema. Occupations were coded from 0 to 10000, and each group of thousands broadly captures a different job type.⁴ For example, 0 to 999 is armed forces, and 1000 to 1999 is legislators, senior officials, and managers. Nine occupation dummies were created to account for jobs, and service workers and shop and market sales workers were the reference group.

For *employment type*, private sector was the reference group, and “public” and “self-employed” were coded separately.

Marital status was coded with two separate variables. The reference group was individuals that were never married (including single and cohabitation), and variables “married” and “previously married” (including divorced, separated, and widowed) were created.

Children in household was coded as 1 if respondents has one or more child.

Community type was measured with urban city dwellers as the reference group, and “suburb” and “rural” were coded as separate variables.

Church attendance was grouped into two categories: “regularly attend church” was coded as 1 if individuals went to church more than once a week, and “never attend church” was coded as 1 if respondents attended church less than once a year. The reference group was church attendance within those two ranges.

Labor or trade union membership was recoded as a dummy variable, “currently a member” and “once a member” coded as 1 and “never a member” as 0.

⁴ Occupation groupings: 0s=Armed Forces; 1s=Legislators, Senior Officials, and Managers; 2s=Professionals; 3s=Technicians and Associate Professionals; 4s=clerks; 5s = Service Workers and Shop and Market Sales Workers; 6s=Skilled Agricultural and Fishery Workers; 7s=Craft and Related Trade Workers; 8s=Plant and Machine Operators and Assemblers; 9s=Elementary Occupations

Political affiliation was determined using the ISSP standardized political party schema across countries. Two dummy variables were created: “Left-wing political affiliation” were coded as 1 if respondents identified as “far-left” or “left, center-left,” and “right-wing political affiliation” was coded as 1 if respondents identified as “right, conservative” or “far right, etc.”

Descriptive statistics for all dependent and independent variables are displayed in Appendix I.

Methods

Given the nature of our dependent variables, I used Ordered Logistic Regression (ordered logit) modeling. Ordered logit is commonly used for ordinal dependent variables. The dependent variables are ordinal, meaning they are ranked within a specific range (e.g. 1 to 4). However, this does not presume that the space between different ranges is equal. For example,

$$Y_{ah}(\text{attitudes}) = \alpha + \beta x (\text{independent variable}) + \varepsilon (\text{error})$$

The 2006 ISSP-RGIV surveys for Germany (N = 1287 to 1304), Great Britain (N = 776 to 783), and United States (N = 1270 to 1284) were completed between March 2006 and November 2006. The United States survey was administered in conjunction with the ISSP 2005 'Work Orientations' questionnaire. The sample sizes of the 2006 cross section are slightly smaller than the 1996 survey, but still robust enough to provide useful comparisons.

V. RESULTS

Descriptive Patterns

Table 1 shows the percentage of respondents reporting whether they felt the government should spend more or less on health care. There was significant variation across countries ($\chi^2=162.43$, $p<0.001$). More individuals from the United States (35.09%) thought that the

government should spend “much more” on health care than in the U.K. (30.28%) and Germany (19.77%). Only 66.46% of Germans thought that the government should be spending “much more” or “more on” health care, compared to 83.37% in the U.K. and 80.53% in the U.S. More Germans wanted to maintain the same amount of government health care spending than compared to the other respondents (almost 28% of the German respondents, versus the 15% in Great Britain and 14% in the U.S.). This could suggest that they are more satisfied with the current status of health care, or that there are other issues they consider of greater public concern. It could also be that Germans are satisfied with the hybrid private and public health system—with the option to purchase additional private coverage, Germans may not feel as strongly for more public health spending.

Table 1. Descriptive Statistics for Dependent Variable: “Whether you would like to see more or less government spending” in health

| | <i>Germany</i> | <i>Great Britain</i> | <i>United States</i> | <i>Total</i> |
|------------------------|------------------|----------------------|----------------------|------------------|
| <i>Much Less</i> | 10 0.77% | 2 0.26% | 10 0.78% | 22 0.78% |
| <i>Less</i> | 70 5.38% | 9 1.26% | 61 4.75% | 140 4.15% |
| <i>The Same As Now</i> | 356 27.38% | 118 15.21% | 179 13.94% | 653 20.25% |
| <i>More</i> | 607 46.69% | 412 53.09% | 573 44.63% | 1,592 46.85% |
| <i>Much More</i> | 257 19.77% | 235 30.28% | 461 35.90% | 953 27.98% |
| <i>Total</i> | 1,300 100.00% | 776 100.00% | 1,284 100.00% | 3,360 100.00% |

Pearson Chi-square = 162.4335

p = 0.00

Note: N = 3,360

Table 2 shows the percentage of respondents reporting whether they believed the government should be responsible for health care. There is significant variation across the three countries ($\chi^2=163.70$, $p<0.001$). Most striking, though, is that almost 90% of Americans felt that the government “probably” or “definitely should be” responsible for health care. This goes against conventional wisdom of American welfare system exceptionalism. That being said, a greater number of Americans (10.29%) thought that the government “definitely should not be” and “probably should not be” in charge of health care compared to German (3.60%) and British (0.78%) survey participants.

Almost all U.K. respondents, with the exception of less than 1%, overwhelmingly felt that health care is the government’s responsibility. The largest percentage of U.K. respondents—almost three quarters—noted that the government “definitely should be” responsible, while only half of the German and United States respondents expressed the same preference. This difference could be reflective of the NHS system in place, and views of government responsibility are a product of the policy feedback cycle and the normalization of social norms.

Table 2. Descriptive Statistics for Dependent Variable: “On the whole, do you think it should or should not be the government’s responsibility to provide health care for the sick?”

| | <i>Germany</i> | <i>Great Britain</i> | <i>United States</i> | <i>Total</i> |
|---------------------------------|------------------|----------------------|----------------------|------------------|
| <i>Definitely Should Not Be</i> | 6 0.46% | 2 0.26% | 33 2.57% | 41 1.22% |
| <i>Probably Should Not Be</i> | 41 3.14% | 4 0.52% | 99 7.72% | 144 4.28% |
| <i>Probably Should Be</i> | 534 40.95% | 197 25.39% | 432 33.70% | 1,163 34.59% |
| <i>Definitely Should Be</i> | 723 55.44% | 573 73.84% | 718 56.01% | 2,014 59.90% |
| <i>Total</i> | 1,304 100.00% | 776 100.00% | 1,282 100% | 3,362 100.00% |

Pearson Chi-square = 163.6989

p = 0.00

Note: N = 3,362

In looking at the distribution of respondents who thought their government was doing a successful job of providing health care, Table 3 shows significant differences across countries ($\chi^2=257.22$, $p<0.001$). Public attitudes in the United States are more negative than positive. Almost half (46.85%) of respondents felt that the government was “very unsuccessful” or “quite unsuccessful,” and one quarter (24.17%) considered the government to be successful to some degree. In contrast, 40.56% of German respondents considered government health care “quite successful” or “very successful,” and over half of the British respondents (57.72%) deemed public health care as more successful to some degree.

Table 3. Descriptive Statistics for Dependent Variable: “How successful do you think the government in [your country] is nowadays in providing health care for the sick?”

| | <i>Germany</i> | <i>Great Britain</i> | <i>United States</i> | <i>Total</i> |
|--|------------------|----------------------|----------------------|------------------|
| <i>Very Unsuccessful</i> | 51 3.96% | 44 5.62% | 172 13.54% | 331 8.36% |
| <i>Quite Unsuccessful</i> | 319 24.79% | 150 19.16% | 423 33.31% | 1,052 26.50% |
| <i>Neither Successful Nor Unsuccessful</i> | 395 30.69% | 184 23.50% | 368 28.98% | 1,112 28.01% |
| <i>Quite Successful</i> | 435 33.80% | 371 47.38% | 251 19.76% | 1,261 31.76% |
| <i>Very Successful</i> | 87 6.76% | 34 4.34% | 56 4.41% | 213 5.37% |
| <i>Total</i> | 1,287 100.00% | 783 100.00% | 1,270 100.00% | 3,340 100.00% |

Pearson Chi-square = 257.2195

$p = 0.00$

Note: N = 3,340

Models

Government Spending in Health Care

Table 4 presents the odds ratios and significance levels for the sociodemographic indicators as relating to respondents' desire for greater or less government spending for health care. "Much Less" government spending is coded as 1, "Less" as 2, "The Same As Now" as 3, "More" as 4, and "Much More" as 5.

Table 4. Ordered Logistic Regression of Public Attitudes Toward Government Spending to Provide Health Care by Country (2006): Odds Ratios and Z-Scores in Parentheses.

| | <i>Germany</i> (<i>N=1300</i>) | <i>Great Britain</i> (<i>N=776</i>) | <i>United States</i> (<i>N=1284</i>) |
|----------------------------------|-------------------------------------|--|---|
| Age | 1.017 (0.81) | 1.033 (1.29) | 1.033 (1.65) |
| Age Squared | .9998 (-0.89) | .9997 (-1.44) | 0.9996* (-2.18) |
| Sex | 1.497** (3.28) | 1.660** (2.99) | 1.076 (0.60) |
| Less than High School | .824 (-0.33) | 1.641* (2.32) | 1.003 (0.02) |
| Vocational School | .971 (-0.05) | 1.194 (0.67) | .729 (-1.47) |
| College and Above | .660 (-0.70) | .801 (-0.81) | .634** (-2.88) |
| Income, standardized | .754*** (-4.68) | .713*** (-3.63) | .941 (-0.88) |
| Public Sector | .919 (-0.48) | 1.323 (1.53) | 1.059 (0.38) |
| Self-Employed | 1.050 (0.24) | 1.461 (1.56) | 1.106 (0.57) |
| Married | .957 (-0.24) | .658* (-1.99) | .814 (-1.29) |
| Previously Married | .824 (-0.90) | .687 (-1.48) | .963 (-0.21) |
| Children in Household | .925 (-0.54) | .818 (-1.07) | .877 (-1.01) |
| Suburban | .973 (-0.13) | .911 (-0.33) | 1.140 (1.02) |
| Rural | .867 (-0.97) | 1.067 (0.25) | .573*** (-3.93) |
| Regularly Attend Church | 1.044 (0.20) | .676 (-1.47) | .749* (-2.30) |
| Never Attend Church | 1.371** (2.74) | 1.026 (0.15) | .893 (-0.78) |
| Left-Wing Political Affiliation | 1.205 (1.50) | 1.087 (0.49) | 1.577*** (3.58) |
| Right-Wing Political Affiliation | .864 (-1.08) | 1.044 (0.23) | .463*** (-5.42) |
| Union Membership | 1.078 (0.46) | 1.109 (0.57) | .849 (-0.90) |

* $p < .05$

** $p < .01$

*** $p < .001$

Note: Constants not shown. All models include dummies for 10 occupational categories based on the 1988 ISCO schema. References = High School, Urban, Never married (including cohabitation), Private Sector, Occasional church attendance.

In Germany, being a woman ($p < .001$) and never attending church ($p < .01$) increased the odds of wanting much more spending in health care, compared to men and people who attend church, respectively. Having a higher income, on the other hand, decreased an individual's odds of greater public spending on health care by a factor of 1.3 ($p < .001$).

Sex and income had a similar effect in the U.K. Being female increased the odds ratio of supporting more spending by a factor of 1.7 ($p < .01$). Individuals with higher incomes had less support for increased spending by a factor of 1.3 ($p < .001$). Education and marriage were also significant. Individuals with less than high school education had greater odds of supporting government spending by a factor of 1.6 ($p < .05$). Surprisingly, being married also significantly decreased the likelihood of pro-government spending by an odds ratio of 1.5 ($p < .05$).

In the United States, the most important difference was the significant correlation of political affiliations as a predictor of support for government spending. People who identified with left-wing political ideologies had 1.6 times the likelihood to feel that the government should spend more on health care ($p < .001$). In contrast, right-wing identification increased the odds of wanting much less public funding for health by a factor 2.16, over two-folds ($p < .001$). Age was significant after a certain age—after that turning point, the odds of someone older not wanting greater health care increases by an odds of 1.0004 ($p < .05$). Like Great Britain, education was also a mediating factor in the United States. Respondents with a college education or above had increased odds of 1.6 for not supporting higher government spending in health care ($p < .01$). Likewise, living in rural areas increased likelihood of favoring less public health expenditure by a factor of 1.7 ($p < .001$). In contrast, regularly attending church enhanced the likelihood of individuals being against higher public allocation to health by an odds ratio of 1.3 ($p < .05$).

Looking at how public attitudes toward government spending were affected by individual-level indicators, a greater number of sociodemographics had a strong effect on

perceptions among the American respondents compared with German and British individuals. It should also be noted that all variables that were significant were in the European countries were not significant in the United States.

Political affiliation was found to be significant, and the trends support past research that shows liberals want more spending and conservatives, less. Additionally, higher education, regularly attending church, and living in rural areas were also significant predictors of individuals who want less government spending. Sex and income, which were highly significant in Germany and Great Britain, were not significant among American respondents. Additionally, Germans who never attend church are more likely to support higher public spending, signifying that secularism plays a role in how people view the government. For the British who have lower education levels, they feel the government should spend more on health. This can be supported by the self-interest hypothesis suggested earlier, that more disadvantaged groups, such as lower income and females, rely more on public programs and are thus more supportive of them.

Government Responsibility in Health Care

Table 5 illustrates the odds ratios and z-scores for models of public attitudes toward the desired degree of government responsibility to provide health care across Germany, Great Britain, and United States. “Definitely Should Not Be” was coded as 1, “Probably Should Not Be” as 2, “Probably Should Be” as 3, and “Definitely Should Be” as 4.

Table 5. Ordered Logistic Regression of Public Attitudes Toward Government Responsibility to Provide Health Care by Country (2006): Odds Ratios and Z-Scores in Parentheses.

| | <i>Germany</i> (N=1304) | <i>Great Britain</i> (N=776) | <i>United States</i> (N=1282) |
|----------------------------------|----------------------------|---------------------------------|----------------------------------|
| Age | 1.003 (0.15) | 1.072* (2.25) | 1.013 (0.64) |
| Age Squared | .9999 (-0.00) | .9995 (-1.57) | .9998 (-1.19) |
| Sex | 1.227 (1.53) | 1.425 (1.74) | 1.346* (2.28) |
| Less than High School | 1.651 (0.78) | 1.070 (0.26) | 1.781** (2.95) |
| Vocational School | 1.319 (0.39) | .858 (-0.50) | .849 (-0.69) |
| College and Above | 1.422 (.54) | .871 (-0.44) | .597** (-3.08) |
| Income, standardized | .790*** (-3.55) | .768** (-2.41) | .864* (-2.06) |
| Public Sector | .967 (-0.18) | 1.156 (0.63) | 1.523* (2.50) |
| Self-Employed | .701 (-1.65) | 0.984 (-0.05) | .913 (-0.48) |
| Married | 1.312 (1.39) | .900 (-0.42) | .876 (-0.78) |
| Previously Married | 1.168 (0.68) | .853 (-0.50) | 1.084 (0.41) |
| Children in Household | 1.028 (0.18) | 1.060 (0.26) | .781 (-1.78) |
| Suburban | 1.210 (0.83) | 1.396 (0.98) | 1.063 (0.45) |
| Rural | .725* (-2.04) | 1.172 (0.52) | .754 (-1.83) |
| Regularly Attend Church | .935 (-0.30) | 1.003 (0.01) | .828 (-1.40) |
| Never Attend Church | 1.093 (0.71) | 1.228 (1.02) | 1.123 (0.73) |
| Left-Wing Political Affiliation | 1.013 (0.10) | 1.120 (0.54) | 1.369* (2.24) |
| Right-Wing Political Affiliation | .849 (-1.11) | .847 (-0.74) | .395*** (-6.33) |
| Union Membership | 1.175 (0.88) | 1.123 (0.52) | .986 (-0.07) |

* $p < .05$

** $p < .01$

*** $p < .001$

Note: Constants not shown. All models include dummies for 10 occupational categories based on the 1988 ISCO schema. References = High School, Urban, Never married (including cohabitation), Private Sector, Occasional church attendance.

In Germany, respondents living in rural areas had bigger odds of feeling that the government does not have a responsibility in providing health care by a factor of 1.4 ($p < .05$). People with higher incomes were also more likely to prefer less government responsibility by a factor of 1.3 ($p < .001$).

In Great Britain, people with higher income were also found to have significant odds of preferring less government intervention in health care ($p < .001$). Older individuals were more likely to think that the government should be in charge of health care by a factor of 1.1 compared to younger respondents ($p < .05$).

In the United States, however, both education and political affiliation were found to predict public attitudes significantly. American respondents with less than a high school education were more likely to support government health care by a factor of 1.8 ($p < .01$). Individuals with a college education or above were more likely to think that the government should definitely not be responsible by a factor of 1.7 ($p < .01$). For those that identified as politically left winged, the odds of favoring more government responsibility in health care were increased by a factor of 1.4 ($p < .05$). For those that were politically right, the odds to not favor public intervention in health were increased by a factor of 2.5 ($p < .001$).

Additionally, being female increased the odds of supporting public health care ($p < .05$). Working for the public sector also augmented odds of preferring more government health by a factor of 1.5 ($p < .05$). Having a higher income also increased the likelihood of wanting less government responsibility in health care by an odds ratio of 0.86 ($p < .05$).

Across all three countries, income was the only consistent factor to increase the odds ratio of one's perceptions toward government responsibility to health care. Sociodemographics had a stronger effect among the American respondents on multiple platforms. Education levels and working for the public sector were only significant among the American respondents. One

explanation for this is the path-dependency argument: because Germany and Great Britain institutionalize universal health care, the public has come to expect the government to care for the sick. Furthermore the political left and right dichotomy was only significant in the United States. In contrast to the two-party system in American, the European states have greater political variation, and most tend to be relatively more left leaning. It is surprisingly that age was not as strong of a predictor as imagined, because the elderly are more likely to have greater health problems and thus greater dependence on health care across all three countries.

Government Success in Providing Health Care

Table 6 displays the odds ratios and z-scores for models of public attitudes regarding the success of government health care delivery across the three countries. “Very Unsuccessful” was coded as 1, “Quite Unsuccessful” coded as 2, “Neither Successful Nor Unsuccessful” coded as 3, “Quite Successful” coded as 4, and “Very Successful” coded as 5.

Table 6. Ordered Logistic Regression of Public Attitudes Toward Government Success in Providing Health Care to the Sick by Country (2006): Odds Ratios and Z-Scores in Parentheses.

| | <i>Germany</i> (N=1287) | <i>Great Britain</i> (N=783) | <i>United States</i> (N=1270) |
|----------------------------------|----------------------------|---------------------------------|----------------------------------|
| Age | .899*** (-5.23) | .911*** (-3.76) | .956* (-2.37) |
| Age Squared | 1.001*** (4.97) | 1.001** (3.38) | 1.0004* (2.46) |
| Sex | .862 (-1.24) | .756 (-1.72) | .885 (-1.06) |
| Less than High School | 1.562 (0.76) | 1.194 (0.89) | 1.635** (2.93) |
| Vocational School | 1.325 (0.44) | 1.368 (1.25) | .863 (-0.74) |
| College and Above | 1.824 (1.01) | 1.378 (1.21) | 1.022 (0.14) |
| Income, standardized | .993 (-0.12) | .949 (-0.59) | 1.006 (0.10) |
| Public Sector | 1.160 (0.87) | .942 (-0.34) | .725* (-2.21) |
| Self-Employed | 1.172 (0.82) | 1.057 (0.24) | .820 (-1.16) |
| Married | 1.887*** (3.55) | 1.240 (1.06) | .976 (-0.16) |
| Previously Married | 1.274 (1.18) | 1.356 (1.24) | 1.025 (0.15) |
| Children in Household | .856 (-1.12) | .827 (-1.05) | 1.145 (1.10) |
| Suburban | .794 (-1.14) | .955 (-0.17) | 1.134 (1.04) |
| Rural | .864 (-1.03) | .927 (-0.31) | 1.014 (0.10) |
| Regularly Attend Church | 1.038 (0.18) | 1.531 (1.63) | 1.165 (1.26) |
| Never Attend Church | .847 (-1.48) | .990 (-0.07) | .695** (-2.62) |
| Left-Wing Political Affiliation | 1.138 (1.06) | 1.700** (3.26) | .537*** (-5.04) |
| Right-Wing Political Affiliation | 1.271 (1.81) | .750 (-1.62) | 1.637*** (3.62) |
| Union Membership | 1.126 (0.72) | 1.301 (1.47) | .858 (-0.88) |

* p<.05

** p<.01

***p<.001

Note: Constants not shown. All models include dummies for 10 occupational categories based on the 1988 ISCO schema. References = High School, Urban, Never married (including cohabitation), Private Sector, Occasional church attendance.

Among the German respondents, age was significant. Being older increased odds of believing the government was unsuccessful in providing health care by a factor of 1.1 ($p < .001$). However, age squared shows us that after a certain point, public attitudes shifted and the elderly viewed the health system as more successful ($p < .001$). Marriage was also significant—being married increased odds of approving of public health by a factor of 1.9 ($p < .001$).

In Great Britain, age had similar effects, and older respondents had greater odds of expressing dissatisfaction ($p < .001$) up until a certain age ($p < .001$). Left-wing political affiliation also increased respondents' likelihood of viewing public health programs as successful by a factor of 1.7 ($p < .01$).

Within the American sample, several factors were significant. First, comparable to the other two countries, being older increased odds of feeling the government was unsuccessful at delivering health care by 1.05 ($p < .05$), until the individuals reached a certain age where they viewed public health delivery positively ($p < .05$). Education was also important--having less than a high school diploma significantly increased the likelihood of supporting government health care by a factor of 1.64 ($p < .01$). With regards to employment, public sector workers in America were 1.38 times more likely to consider the government as doing a poor job in delivering health care ($p < .05$). People that never attended church were also significantly different; they had greater odds of believing, by a factor of one-and-a-half, that the government has not succeeded with health care ($p < .01$). Political affiliation had the strongest influence in the United States once again. Unlike the left-leaning respondents in Germany and Great Britain, who felt that health care in their countries were relatively successful, the liberals in American were more inclined to think negatively about government success in health care by an odds of 1.9 ($p < .001$). In contrast, right-leaning individuals in America were more likely to feel that health care was quite successful ($p < .001$).

Among the German respondents, age was significant. Being older increased odds of believing the government was unsuccessful in providing health care by a factor of 1.1 ($p < .001$). However, age squared shows us that after a certain point, public attitudes shifted and the elderly viewed the health system as more successful ($p < .001$). Marriage was also significant—being married increased odds of approving of public health by a factor of 1.9 ($p < .001$).

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Across all three countries, age was a strong predictor: older respondents had a greater odds of perceiving the government as doing a poor job of providing health care up until a point. This is inconsistent with past research, which did not identify a change in perceptions after a certain age. The change in perception may be attributed to the fact that the elderly have a greater dependence on public health as they grow older. This is particularly true in America, where individuals over the age of 65 qualify for Medicare, the social insurance program enacted in 1965.

Political affiliation was among the strongest predictor of attitudes in the United States. It was interesting that public sector workers did not feel the government to be successful in public health—this may be that the public health options provided are comparatively seen as not as comprehensive or good as private sector insurance. Furthermore, people with lower education feel that health care is successful in America, while those that never attend church have a higher likelihood of having negative views of public health.

No associations were found for union membership, kids in household, self-employment, vocational school education, and suburban community across all three dependent variables.

VI. DISCUSSION

There has been a growing body of work pointing toward cross-national differences of health care perceptions, but little research has explored the specific relationship between sociodemographics and public attitudes. Because past work has established that attitudes seem to be embedded within the social organization of health care systems, comparing individuals from Germany, Great Britain, and the United States will help to clarify the distinctions across institutions. Furthermore, little empirical evidence has looked into an extensive list of individual-

level indicators beyond age, sex, education, and income. Understanding how social, economic, and civic attitudes translate into support for or against public health care across countries is essential to adding upon the wide variety of literatures in the social sciences, and to making sense of the public policymaking process. Though my measures of sociodemographics indicators and measures of policy preferences do not exhaust the possibilities for examining this question, it provides useful connections in applying previous literature to initiate further development in this area of focus.

Unconventional Wisdom

Overall, there were significant difference across countries, but the majority of participants from Germany, Great Britain, and the United States felt that their governments have a responsibility to provide health care and that the government should be spending more on health care. Americans are, by and large, very supportive of public health: 89.71% of U.S. respondents would say that the government should be responsible for health care. Likewise, around three quarters of Americans desired to see more government spending on health. This contrasts with the low levels of support that public opinion polls showed during the time around the Affordable Care Act in March 2010, a bill which would have increased the public domain of health care and granted more citizens with health care coverage. Though other political and economic factors played into shaping public opinion regarding the Affordable Care Act, the ISSP survey provides a more comprehensive set of attitude measures that speaks to the broader underlying ideologies that extend beyond reactions to a particular piece of policy.

Respondents from Great Britain showed the strongest overall support for the government to care for the sick, which may be due to the fact that their health system is completely government run. The Germans, in general, were least enthusiastic about greater government

spending in health, which may reflect their satisfaction with the hybrid private-public model of health care.

The success of the delivery of health care, however, is not as strong in the European nations as anticipated, and a surprising portion of respondents—30.69% of Germans, 23.50% of British, and 28.98% of Americans—felt that health care is neither successful nor unsuccessful. Respondents from all three countries are generally dissatisfied with the current state of health care than expected, revealing that pressures on the health care systems (e.g. an aging population, rising costs, slow health care reform) affect attitude trends across all three countries in a similar fashion. That being said, almost half of respondents from the U.S. (46.58%) expressed dissatisfaction with the U.S. health care system.

With regards to individual-level indicators, the bipartisan polarization of the American political system stands out as the most salient finding. Political affiliation in the United States was the only individual-level indicator to predict greater odds of attitudes in government spending, responsibility, and success. This further supports the notion that health care is a highly politicized issue in America, greater than the left-right divide in Germany and Great Britain. One of the findings that stand out is that the conservatives saw that the government as successful in providing health, while the liberals believed health care to be more unsuccessful. This may be associated with the fact that conservatives tend to place more emphasis on free-market values, and consider the private-sector insurance as doing a great job. In this sense, the right-leaning individuals may think the government to be successful because they do not want to see further push for reform.

Beyond income, sex, and education, working for the public sector and church attendance provided some insight (though not consistent across all countries) into people's perceptions.

Individuals working for the public sector in America had greater odds of seeing the government

as being responsible for health care, but they also had a greater likelihood of feeling that the government was less successful at providing health care. People who work in the public sector must believe to a certain degree that their work is beneficial to society, so it is interesting to see that such employees strongly identified the government as being ineffective on this matter. This could be because they feel the government, at this point in time, is lagging significantly behind on this matter. For people that did not attend church regularly, they felt more greatly that they government was unsuccessful in delivering health care, while frequent attenders of church did not want to see more government spending. No clear conclusions may be drawn from this, but it is still important to note that church attendance was a significant sociodemographic, and further research should look into this link more comprehensively.

Limitations

Several factors should be taken into account when considering the findings. For one, limitations in the development of the sociodemographic variables could have influenced the data. For example, the classification of political parties across the three countries is not objective. Because the political parties are all relatively more left- leaning than the parties of the United States, the categorization of “left” and “right” are ill-fitting labels to correctly capture the spectrum of political parties in European nations. The same can be said about education—having a vocational education in Great Britain may not be the same as having a vocational degree in the United States or Germany. Thus, my measures may not accurately and fully capture the significance of sociodemographics across all three countries.

Public Opinion Polls As Flawed Technologies

Public opinion polls themselves are also imperfect technologies. The language and semantics of surveys influence the way people may interpret and answer questions. Additionally,

the measures for the questions can dictate different preferences. In research analyzing Americans' views toward health care over the time period of 1950s to 2000s, Blendon and Benson (2001) cautioned people against interpreting isolated public opinion questions. For example, positive public opinion about health care reform differed prior to and after the introduction of a specific proposal. In the case of the Truman and Clinton health reform, there was a lack of an underlying public consensus over the preferred type of national health plan: polls that offered only one plan as a possible solution often show majority support for that proposal, but when other alternatives were introduced, public support splinters (Blendon and Benson 2001).

In my research, although the findings showed that a vast majority of Americans favored greater degrees of spending and government responsibility in health care, my study could not capture the nuances of such reporting. For example, in what ways do citizens want to see government spending? How do they envision bureaucracy assuming the role of managing health care—would it be through subsidies of the private sector or through direct financing of public programs? These are important distinctions that my present study did not address, and this also speaks to the nature of public opinion polls, and the importance that language plays. Further research should look into different ways to frame public opinion surveys that might better capture certain implications of preferences.

Public attitudes themselves may not be ideal indicators of preferences in general. Schumpeter (1950) makes a point in saying the “popular will” has “little, if any, independent basis” and is heavily manipulated by the well organized and financially able. In the case of the proposed Clinton health reform in 1994, the majority of Americans supported fundamental health care reform and the establishment of universal national health insurance. However, strong opposing interest groups succeeded in pushing the public toward believing that reform would be

a form of government interference that would bestow upon the public a sense of personal risk and uncertainty (Jacobs 2001).

The seemingly volatile nature of the public will is perhaps hard to decipher. However, it should be noted that public attitudes least susceptible to manipulation tend to be fundamental policy preferences, such as spending on health care, which do not change significantly over time. Thus, the ISSP survey may be beneficial at capturing what Jacobs calls “operational liberalism,” while oppositional voices may evoke the “philosophical conservatism” seen in public opinion polls regarding specific pieces of health care reform (Jacobs 2001).

Implications for Health Reform and Public Policy

Developing Trust in Government Efficacy

One point that should be addressed is under what conditions is public opinion discourse most valuable. Several assumptions were made earlier in the paper, one being that popular values bring about policies in democracies, and that democratic political institutions are responsive to public preferences. However, these beliefs can only be upheld if the public feels that the government was truly representative. In America, this might not be the case. Most Americans, based upon their own experience and perceptions, believe that U.S. political institutions are not representative of the overall population, and that U.S. policies are a result of interest group politics swayed by economic and financial interests (Navarro 2003). Hence, the distrust of the U.S. general population toward the efficacy of the government to carry out the general will is prevalent, and can undermine true democratic values.⁵

⁵ These limitations can trace back to the U.S. democratic process, which is underdeveloped and underrepresented compared to other democratic nations. The majority system of the electoral process and the privatization of the political process undermine the democratic spirit (Navarro 2003).

This research showed that the vast majority of Americans want to see greater government spending and greater government responsibility in health care, but that many did not see the government as being successful in carrying out health care services. Furthermore, those working in the public sector in the U.S. had greater odds of seeing the government as unsuccessful in providing healthcare. Thus, government efficacy hinders the perceptions of public institution's ability to effectively bring about changes to the health care infrastructure. This tension may be addressed through the government substantiating greater trust from the public. Further research should look into how to build this trust, and how the U.S. political system can legitimize itself in the eyes of its people.

Framing Health Care As An Issue of Urgency and Equal Opportunity

This research shows perceptions of government spending, responsibility, and success were highly correlated with left- and right-wing affiliation in the United States. In conceiving health care reform for the future, identifying and understanding the influence that political ideology has over the debate will be crucial.

One approach is to frame health care coverage as a matter of urgency. In particular, as America continues to struggle with economic instability, unemployment, disenchantment with the business community, and individuals' concerns for personal finances will become greater and greater considerations (Schlesinger and Lee 1993). These factors will impact both liberals and conservatives alike, so it may be beneficial to regard health care as a critical matter needing to be addressed.

Secondly, health care should also be thought of as a basic, fundamental right that will create equal opportunity for the public. The United States has always valued the notion of leveling the play field. In this way, health care could be likened to public education, a matter that

past research has shown three-quarters of the population supporting (Schlesinger and Lee 1993). By conceiving of health care as a human right rather than a privilege based upon employment or marital status will help detach health policy from further bipolarization of health care and health policy.

Mobilizing and Enfranchising Different Interest Groups

Mobilizing the support of women, the public sector, and those with lower than high school education may serve as another potential avenue for health reform. However, these groups are disadvantaged, in the fact that they do not have as much time and resources to devote to political engagement than other more financially endowed interest groups. Additionally, as mentioned earlier, working class mobilization has been one of the key factors in successfully passing health care reform in other nations. The United States has never had strong work class representation, and some argue that universal coverage can only occur if there is large-scale mobilization, led in particular by the labor movement (Navarro 2003).

Top-Down Approach to Policy Formation

A top-down approach to health policy may be most effective in ushering in reform and initiating the policy feedback cycle. In looking at the enactment of other national health plans, many were implemented in pre-democratic or authoritarian regimes—like Germany at the end of the 19th century—or through a hierarchical political process, such as the British National Insurance legislation of 1911 and the introduction of the NHS in 1946 (Immergut 2010). In both cases, the public did not play a significant role in ushering in change.

However, German and British citizens have now come to expect the government to provide health services in the country. Even though individuals with higher income expressed strong preferences against higher public spending in health care, universal health coverage still

exists in these two nations. Thus the institutional measures established play a strong role in public health implementation. It might be in the interest of America to establish policies, even if incremental and unfavorable in the beginning, that point toward increasing social welfare to push health reform forward, and even change the underlying ideologies that are embedded in public attitudes and expectations.

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APPENDIX

Appendix I. Descriptive Statistics for Independent and Dependent Variables

| Variables | Germany (N=1252) | | Great Britain (N=755) | | United States (N=1258) | | Total (N=3265) | |
|---|---------------------|---------|--------------------------|---------|---------------------------|---------|-------------------|---------|
| | Mean | SD | Mean | SD | Mean | SD | Mean | SD |
| Dependent | | | | | | | | |
| Government Spending | 3.79 | 0.85 | 4.12 | 0.70 | 4.11 | 0.86 | 3.99 | 0.84 |
| Government Responsibility | 3.52 | 0.58 | 3.73 | 0.48 | 3.43 | 0.74 | 3.53 | 0.64 |
| Government Success | 3.15 | 0.99 | 3.25 | 1.00 | 2.68 | 1.07 | 2.99 | 1.06 |
| Independent | | | | | | | | |
| Age | 48.89 | 17.16 | 48.29 | 17.27 | 46.66 | 16.22 | 47.89 | 16.86 |
| Age Squared | 2684.85 | 1735.88 | 2630.10 | 1774.72 | 2439.70 | 1659.46 | 2577.73 | 1719.12 |
| Sex | 0.51 | 0.50 | 0.58 | 0.49 | 0.52 | 0.50 | 0.53 | 0.50 |
| Less Than High School | 0.72 | 0.45 | 0.51 | 0.50 | 0.15 | 0.36 | 0.45 | 0.50 |
| Vocational | 0.03 | 0.18 | 0.15 | 0.36 | 0.07 | 0.26 | 0.07 | 0.26 |
| College and Above | 0.24 | 0.43 | 0.17 | 0.38 | 0.26 | 0.44 | 0.23 | 0.42 |
| Income, standardized | 0.01 | 1.01 | 0.00 | 1.00 | 0.00 | 1.01 | 0.00 | 1.01 |
| Children in Household | 0.28 | 0.45 | 0.29 | 0.45 | 0.33 | 0.47 | 0.30 | 0.46 |
| Suburbs | 0.11 | 0.31 | 0.23 | 0.42 | 0.27 | 0.45 | 0.20 | 0.40 |
| Rural | 0.72 | 0.45 | 0.69 | 0.46 | 0.20 | 0.40 | 0.51 | 0.50 |
| Married | 0.60 | 0.49 | 0.57 | 0.50 | 0.50 | 0.50 | 0.55 | 0.50 |
| Previously Married | 0.16 | 0.37 | 0.23 | 0.42 | 0.27 | 0.44 | 0.22 | 0.41 |
| Self Employed | 0.09 | 0.29 | 0.11 | 0.32 | 0.12 | 0.32 | 0.11 | 0.31 |
| Public Sector | 0.12 | 0.33 | 0.26 | 0.44 | 0.18 | 0.39 | 0.18 | 0.38 |
| Armed Forces | 0.01 | 0.09 | 0.00 | 0.06 | 0.00 | 0.06 | 0.01 | 0.08 |
| Legislators, Senior Officials, and Managers | 0.04 | 0.21 | 0.11 | 0.31 | 0.12 | 0.33 | 0.09 | 0.29 |
| Professionals | 0.10 | 0.30 | 0.14 | 0.34 | 0.17 | 0.37 | 0.14 | 0.34 |
| Technicians and Associate | 0.17 | 0.37 | 0.11 | 0.31 | 0.11 | 0.31 | 0.13 | 0.34 |

| Professionals | | | | | | | | |
|--|------|------|------|------|------|------|------|------|
| Clerks | 0.11 | 0.31 | 0.16 | 0.36 | 0.13 | 0.34 | 0.13 | 0.33 |
| Skilled Agricultural and Fishery Workers | 0.04 | 0.20 | 0.01 | 0.10 | 0.01 | 0.09 | 0.02 | 0.14 |
| Craft and Related Trade Workers | 0.16 | 0.37 | 0.09 | 0.28 | 0.11 | 0.31 | 0.12 | 0.33 |
| Plant and Machine Operators and Assemblers | 0.08 | 0.27 | 0.06 | 0.24 | 0.10 | 0.29 | 0.08 | 0.27 |
| Elementary Occupations | 0.07 | 0.25 | 0.12 | 0.33 | 0.08 | 0.27 | 0.09 | 0.28 |
| Regularly Attend Church | 0.07 | 0.25 | 0.10 | 0.30 | 0.31 | 0.46 | 0.17 | 0.37 |
| Never Attend Church | 0.36 | 0.48 | 0.64 | 0.48 | 0.20 | 0.40 | 0.36 | 0.48 |
| Left-wing Political Affiliation | 0.35 | 0.48 | 0.37 | 0.48 | 0.33 | 0.47 | 0.35 | 0.48 |
| Right-wing Political Affiliation | 0.26 | 0.44 | 0.29 | 0.45 | 0.22 | 0.42 | 0.25 | 0.43 |
| Union Membership | 0.12 | 0.32 | 0.21 | 0.41 | 0.11 | 0.31 | 0.14 | 0.34 |