Antigovernment Sentiment and Support for Universal Access to Care: Are They Incompatible?

Raymond L. Goldsteen, DrPH, Karen Goldsteen, PhD, Jennie J. Kronenfeld, PhD, and Neil E. Hann, MPH, CHES

ABSTRACT

Objectives. Attitudes toward universal access to medical care were examined to determine whether support for it among people opposed to government involvement in health care was modified by three proxy measures of self-interest: being uninsured, in poor health, or a high user of medical care.

Methods. Data on support for universal access, attitudes toward government involvement in health care, and the indicators of self-interest were obtained from a representative sample of adult Oklahomans (n = 1547) surveyed between October 1992 and December 1994. Forced-order multiple regression with interaction terms was the data analysis technique.

Results. People opposed to government involvement in health care were found to be less likely to favor universal access to medical care, but poor health, lack of insurance, and high usage of medical care moderated this effect.

Conclusions. The findings support the view that antigovernment sentiment need not foreclose the public option for health policymakers. Other considerations such as self-interest may modify the effect of unfavorable attitudes toward government. (*Am J Public Health.* 1997;87: 25–28)

Introduction

Recent events, such as the Republican party's success in the 1994 elections and the bombing of Oklahoma City's federal building, have encouraged the view among policymakers that the public opposes government involvement, particularly federal, in all but a narrow range of activities. Even the Democratic president appeared to accept this premise when he declared in his 1996 State of the Union address that the era of big government is over. This perception is especially troublesome for the public health community. Public support is usually critical for the passage of health care legislation,[1] and it will be difficult to achieve the objectives of public health without involving government substantially. Moreover, while many direct services currently offered by public health agencies might be shifted to the private sector under managed care, conversion of population activities into private sector functions would seem an unrealistic and ineffective approach. Achieving universal access to medical care is another case in which government involvement appears necessary. The current strategy of allowing reform to occur or not within each state is a retreat from a coordinated public effort to secure universal access. There is little reason to believe that 50 different plans will result in full and equal access for all Americans.[2]

We know, of course, that many people favor government involvement in health care. For example, polls conducted in 1992 and 1993 by the Kaiser Family Foundation and the Commonwealth Fund of New York found wide support for government involvement in health care delivery.[3,4] An issue that has received less attention is the relationship between unfavorable attitudes toward government and support for public health goals and policies. It is generally accepted that the two are incompatible because of public health's reliance on government interventions. The basis of this assumption of incompatibility is that antigovernment sentiment is the dominant evaluative criterion and other factors do not modify its effects. To examine this issue empirically, we studied the influence of antigovernment sentiment and self-interest on support for universal access to medical care.

Methods

Model

Health insurance status, perceived health status, and use of physician services were used as proxy measures of self-interest in universal access to medical care. It was hypothesized that unfavorable views toward government intervention would be associated with lower support for universal access but that being uninsured, in poor health, or a high user of nonpreventive medical care would modify this effect. Self-interest is a relevant moderating factor because, to an individual, health care is usually a personal problem rather than an aggregate national one.[5]

Raymond L. Goldsteen is with the Masters in Public Health Program, Wichita State University, Kan. Karen Goldsteen is with the Institute for Health Policy Studies, University of California, San Francisco. Jennie J. Kronenfeld is with the Department of Health Administration and Policy, College of Business, Arizona State University. Neil E. Hann is with the Office of Tobacco Use Prevention, Oklahoma State Department of Health.

Requests for reprints should be sent to Raymond L. Goldsteen, DrPH, Masters in Public Health Program, Wichita State University, 1845 N Fairmount, Wichita, KS 67260-0043.

TABLE 1—Means and Standard Deviations for Representative Sample (n = 1418) and Characteristics of Total Population (n = 2 308 578), Oklahoma

	Representative Sample		Total Oklahoma Population
	Mean	SD	
Control factors			
Age	48.35	17.90	44.80
Female[a]	0.61	0.49	52.3
White[a]	0.85	0.36	84.3
Education[b]	4.65	2.15	
Married[a]	0.58	0.49	
Unemployed[a]	0.04	0.20	
Date of interview			
Quarter 4, 1992 (omitted category)[a]	0.25	0.43	
Quarter 1, 1993[a]	0.13	0.33	
Quarter 2, 1993[a]	0.11	0.31	
Quarter 3, 1993[a]	0.09	0.29	
Quarter 4, 1993[a]	0.08	0.28	
Quarter 1, 1994[a]	0.07	0.26	
Quarter 2, 1994[a]	0.10	0.30	
Quarter 3, 1994[a]	0.13	0.34	
Quarter 4, 1994[a]	0.04	0.18	
Self-interest factors			
Physician visits	2.35	3.42	
Perceived health status	3.65	0.74	
Uninsured[a]	0.15	0.35	
Opposition to government	2.84	0.84	
Support for universal access	6.94	1.32	

[a]These are dichotomous variables so that the mean equals the percentage of the sample with that characteristic.
[b]Education is coded as follows: 1 = 8th grade education or less; 2 = some high school; 3 = high school or general equivalency diploma; 4 = some technical school training; 5 = technical school degree; 6 = some college education; 7 = college degree; 8 = postgraduate or professional degree.

The following model was used:

$$S = OG + SI + (OG \times SI) + Z,$$

where S = support for universal access to medical care; OG = opposition to government involvement in health care; SI = the three proxy measures of self-interest—health insurance status, perceived health status, and use of physician services; $(OG \times SI)$ = the interaction of opposition to government with each of the proxy measures of self-interest; and Z = a vector of control variables.

Study Sample

Data were collected between October 1992 and December 1994 from a randomly selected sample of adults (18 years and older) residing in Oklahoma. Oklahoma is a fitting site for the study of attitudes toward public welfare and government involvement because of a considerable antigovernment tradition there that is tempered by obligation to the community, which is perhaps a holdover from the not very distant frontier experience.[6] Interviewing was conducted via telephone (refusal rate = 19.3%; n = 1547). Telephone numbers were computer generated so that every household with telephone service, including those with unlisted numbers, had an equal chance of being selected. Within the household, the adult to be interviewed was randomly chosen. As would be expected given the sampling method, the sample closely matched the population on characteristics such as age and race (1990 census). The analyses were performed on the 1418 cases for which there were no missing data.

Measures

Support for universal access to medical care. The measure of support for universal access to medical care is an index of two questions: (1) "On a scale of 1 to 5, where 1 = of no importance and 5 = of great importance, how important is it to you that our health care system in Oklahoma provide all Oklahomans with the health care they need?" and (2) "Which of the following statements best describes how you feel: (a) People are entitled to all the health care they need, regardless of their ability to pay for that care [scored 3]; (b) People are entitled to a basic level of health care, and they should get more only if they can afford it [scored 2]; and (c) People are entitled only to the health care they can afford to pay for [scored 1]." Responses to each question were summed. Thus, index scores can range from 2 to 8, and higher scores indicate more favorable attitudes toward universal access.

The measure does not indicate endorsement of a particular method of achieving universal access. Rather, it denotes strength of support for the basic concept underlying universal access: medical care as an entitlement rather than a commodity, with access based on individual attributes such as income.

Opposition to government involvement in health care. Opposition to government involvement in health care is indicated by the mean of the response scores for three statements: (1) "Private insurance companies should have government controlled rates"; (2) "I would be willing to pay a health care fee to the state government if my total health care costs were reduced"; and (3) "I favor a state tax on nursing homes, pharmacies, and hospitals which will return to Oklahoma from the federal government $3 for every $1 collected." Possible responses were strongly agree (scored 1), somewhat agree (scored 2), feel unsure (scored 3), somewhat disagree (scored 4), and strongly disagree (scored 5). Thus, scores can range from 1 to 5, with higher scores indicating a more unfavorable attitude toward government action.

While these statements refer to disparate policies with different objectives, government involvement is a critical feature of each policy. Thus, objection to government intervention in health care would deter a respondent from agreeing with any of these statements.

Self-interest in universal access to medical care. Three measures—perceived health status, use of physician services, and health insurance status—were used to indicate whether an individual had a personal interest in policy that ensured universal access to medical care. Perceived health status is indicated by the mean score for the following three questions: (1) "Overall, how would you rate

TABLE 2—Multiple Regression Results for the Full Model Predicting Support for Universal Access to Medical Care[a]

Independent Variable	Dependent Variable: Support for Universal Access to Medical Care								
	Interaction 1[b]			Interaction 2[c]			Interaction 3[d]		
	B	SE (B)	Beta	B	SE (B)	Beta	B	SE (B)	Beta
Physician visits	.002	.010	.006	−.074	.031	−.191*	−.001	.010	−.002
Perceived health status	.524	.158	.292***	−.172	.051	−.096***	−.170	.051	−.095***
Uninsured	.173	.092	.046	.153	.093	.041	−.505	.299	−.135
Opposition to government	.418	.206	.266*	−.575	.045	−.365***	−.548	.041	−.348***
Interaction 1	−.251	.054	−.733***	...	...	...	...	...	...
Interaction 2	...	...	...	.027	.011	.199**	...	...	...
Interaction 3	...	...	...	...	...	...	.249	.107	.184*
Adjusted R^2	.22			.22			.22		
Number	1418			1418			1418		
F	22.19***			21.20***			21.13***		

[a]Regression equations include all control factors although they are not shown in the table.
[b]Interaction 1 = Perceived health status × opposition to government.
[c]Interaction 2 = Physician visits × opposition to government.
[d]Interaction 3 = Uninsured × opposition to government.
*$P \leq .05$; **$P \leq .01$; ***$P \leq .001$.

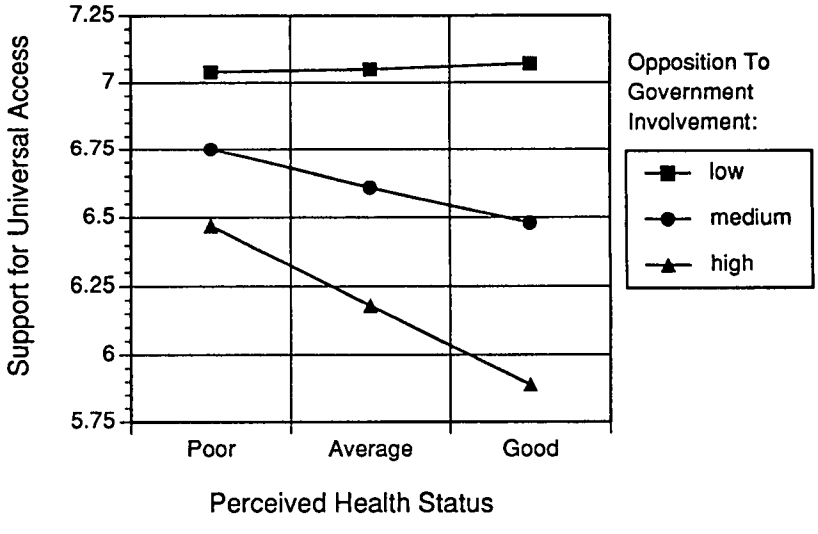
your health?" (scored 1 = poor, 2 = fair, 3 = good, 4 = very good, and 5 = excellent); (2) "In the past year, have any health conditions prevented you from meeting your obligations?" (scored 1 = always, 2 = very often, 3 = sometimes, 4 = rarely, and 5 = never); (3) "Overall, is your health much worse than four years ago (scored 1), somewhat worse than four years ago (scored 2), about the same as four years ago (scored 3), somewhat better than four years ago (scored 4), and much better than four years ago (scored 5)." Therefore, scores can range from 1 to 5, with higher scores indicating better perceived health.

Use of physician services is measured as the number of times during the past year that the respondent saw a physician for nonpreventive care or had been seen in an emergency room. Presence of health insurance is scored 0 if the respondent reported having health insurance and 1 if the respondent reported not having it.

Control factors. Other factors that might affect support for universal access to medical care were measured. These factors included respondent's age, sex, race, education, marital status, employment status, and date of interview.

Data Analysis

Forced-order multiple regression with interaction terms was used to analyze the data.[7] The variables were grouped and entered into the model as follows: the control variables, the three measures of self-interest, the measure of opposition to government, and one interaction term.



Note. Equations are solved at the mean value of each control factor.

FIGURE 1—Relationship between perceived health status, opposition to government involvement, and support for universal access to medical care in a representative sample of Oklahoma adults.

Results

Table 1 contains the means and standard deviations for the variables. The survey indicates much general support among Oklahomans for the basic concept underlying universal access to medical care, a finding consistent with many national polls conducted in the 1990s.[1,8,9]

Table 2 displays the regression coefficients for the models containing the interaction terms. The control variables are included in these models, but their parameter estimates are not shown in the table. Each interaction term is significant, indicating a nonlinear relationship whereby self-interest and opposition to government

jointly determined the level of support for universal access.

To understand the nature of the relationship between self-interest and attitude toward government intervention, we graphed the interactions using point estimates calculated from the regression equations. Each interaction took the same form, and Figure 1 illustrates this relationship for perceived health status. People who reported their health status as poor had a similar likelihood of supporting universal access to medical care irrespective of the strength of their opposition to government intervention. Respondents unfavorable to government and in good health were most likely to oppose universal access. Thus, people with an unfavorable view of government and a seemingly greater need for stable, certain health care coverage—those with lower perceived health status, higher medical care usage rates, or no health insurance—were more likely to favor universal access than people also opposed to government involvement but for whom universal access did not offer an immediate advantage.

Discussion

Finding that the effects of unfavorable attitudes toward government intervention in health care were modified by self-interest provides evidence that antigovernment sentiment need not foreclose the public option for policymakers. The results also suggest that one strategy to increase public support for public health policies such as universal access is an appeal to self-interest. After all, in the case of universal access, nearly every American is vulnerable under the current system. The insured could lose their coverage through job loss, and most currently healthy individuals are at risk of sustaining a serious injury or developing a chronic condition that requires more medical care than they can afford. Perhaps a sustained effort to reveal to the public its self-interest in public health policies such as universal access could moderate the influence of antigovernment sentiment.

However, self-interest is not the only factor that might temper dislike of government intervention in health care. First, policymakers might appeal to the public's concern about the private sector. While apprehension about government power is a well-acknowledged feature of the American belief system,[2] policymakers mainly overlook Americans' distrust of private industry.[10] In the future, demand for more government intervention in health care could well develop as private industry involvement continues to increase[11–14] and choice as the public defines it continues to erode with increasing numbers of people being placed into forms of managed care.[15,16]

Second, policymakers might also appeal to the public's sense of obligation to the larger community. Although usually regarded as an unrealistic course of action, this option may not be doomed to failure since American individualism coexists with a longing for community.[17,18]

Evidence that antigovernment sentiment is not necessarily the public's primary consideration when evaluating health policies does not diminish the importance of Americans' distrust of government. Americans have specific concerns about government involvement that must be taken into account in policy development. In health care, these concerns take the form of "fears of bureaucratic red tape, of infringement on the doctor-patient relationship, and of erosion in the quality and timeliness of treatment,"[1(p636)] fears that contributed to the defeat of the Clinton health plan.[19,20] Therefore, achieving the goals of public health will require bringing about public judgment[21]—that is, awareness of the consequences of rigid antigovernmentism and resolution of conflicting values regarding government intervention in American society. The findings of this study provide evidence that seeking public judgment is possible. It would be useful, then, to replicate the model in other states. □

Acknowledgments

Data collection for this study was supported by the Oklahoma State Department of Health in Oklahoma City. We also wish to thank two anonymous reviewers for their helpful comments on an earlier draft of this paper.

References

1. Jacobs LR. Health reform impasse: the politics of American ambivalence toward government. *J Health Polit Policy Law.* 1993;18:629–654.
2. Morone JA. The bias of American politics: rationing health care in a weak state. *U Pa L Rev.* 1992;140:1923–1938.
3. Smith MD, Altman DE, Leitman R, Moloney TW, Taylor H. Taking the public's pulse on health system reform. *Health Aff.* 1992;Summer:126–133.
4. Fisher MJ. Health care survey finds mandate for major change. *National Underwriter.* November 22, 1993:3,8.
5. Blendon RJ, Hyams TS, Benson JM. Bridging the gap between expert and public views on health care reform. *JAMA.* 1993;269:2573–2578.
6. Morgan DR, England RE, Humphreys G. *Oklahoma Politics and Policies: Governing the Sooner State.* Lincoln, Neb: University of Nebraska Press; 1991.
7. Cohen J, Cohen P. *Applied Multiple Regression/Correlation Analysis for the Behavioral Sciences.* Hillsdale, NJ: Lawrence Erlbaum Associates; 1975.
8. Dowd M. Strong support for health plans. *New York Times.* July 20, 1994:A1.
9. McGregor D. Deciphering the polls on the health issue. *Cong Q Wkly Rep.* July 2, 1994;52:1846.
10. Jacobs LR, Shapiro RY. Public opinion's tilt against private enterprise. *Health Aff.* 1994;Spring:283–298.
11. Freudenheim M. Hospitals are tempted but wary as for-profit chains woo them. *New York Times.* January 4, 1995:A1,C5.
12. Myerson AR. Now, it's the Rick Scott Health Plan. *New York Times.* October 30, 1994;3:1,6.
13. Eckholm E. A town in Florida loses its hospital in the name of corporate cost control. *New York Times.* September 26, 1994:A1,B9.
14. Feder BJ. A hospital leader widens the gap. *New York Times.* October 6, 1994:C1,13.
15. Ginzberg E. Dissatisfaction guaranteed. *New York Times.* November 9, 1994:A27.
16. Stout H. Freedom to choose a doctor is dwindling, even before reforms. *Wall Street J.* February 10, 1994:A1,6.
17. Bellah RN, Madsen R, Sullivan WM, Swidler A, Tipton SM. *Habits of the Heart.* Berkeley, Calif: University of California Press; 1985.
18. Morone JA. *The Democratic Wish.* New York, NY: Basic Books; 1990.
19. Colford SW. Harry & Louise vs Billary. *Advertising Age.* February 14, 1994;65:1,40.
20. Skocpol T. From Social Security to health security. *J Health Polit Policy Law.* 1994;19:239–242.
21. Yankelovich D. *Coming to Public Judgment.* Syracuse, NY: Syracuse University Press; 1991.