ABSTRACT

Healthcare spending has continued to grow at an exponential rate in the United States. The United States spends more on healthcare than any other developed country. Yet, millions of Americans remain uninsured and access to quality healthcare is scarce. This research examines public opinion in how it pertains to the managing of healthcare spending to help pay for medical costs for those who cannot afford it. In an attempt to prove that public opinion in the United States influences healthcare spending, this project uses data from the American National Election Studies (ANES) 2016 Pilot Study. The study uses a variety of questions to analyze public opinion and the behavior of Americans at the beginning of 2016. This paper finds that public opinion influences healthcare spending in a way that negatively affects people of low socioeconomic status in their ability to pay for medical costs and obtain quality healthcare.

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I. INTRODUCTION

In a democratic society, public opinion is key, it is the operating force of a country like ours. Public opinion is also what shapes the political sphere of a society. The public's opinion is sought out in every aspect of government, because government is to be representative of its people. Researchers examine public opinion to make politics and policies that will have a direct impact on society. In this thesis, public opinion will be examined in how it pertains to the managing of healthcare spending in helping pay for medical costs of those who cannot afford it. This thesis will add to the discourse of how, when and if to increase healthcare spending to help those in need of assistance in covering the perpetually rising healthcare costs.

Healthcare in general is a well-documented issue in American politics, many presidents run on some kind of healthcare platform. President Obama's Affordable Care Act, commonly known as Obamacare and President Trump's anti-Obamacare reform are two very distinct views on how healthcare spending should be managed. One wishes to expand funding to healthcare and the other seeks to undo the expansion of healthcare funding. However, both these cases add valued rhetoric to the ongoing debate on how to "properly" fund healthcare. Both these cases, however, have different levels of public support. There are those who believe that the United States excels in a myriad of ways, yet, it lacks in providing adequate healthcare for its citizens. A great deal of why this occurs is attributed to those who wish to see less spending in healthcare. Thus, it is important to address why the differences in public opinion occur. Why does the public's opinion differ in this matter, what factors make one choose one side or the other?

The research question under examination in this thesis is; *How does public opinion in the U.S influence healthcare spending?* Public opinion is defined as a person's views, beliefs and attitudes. The thesis will examine public opinion on healthcare spending. This thesis contributes to the literature by, not only capturing what the public thinks about increasing healthcare spending to help pay for health insurance, but also why the public feels and thinks this way. The best way to represent the best interests of the people is by knowing what it is they want and what factors influence their desire.

This thesis argues that people of a low socioeconomic status are willing to increase healthcare spending more than people of a higher socioeconomic status. Typically, people of a low socioeconomic status consist of low-income racial minorities. People who live in impoverished areas will have a greater need for additional assistance with housing, food, and healthcare. Therefore, people in low socioeconomic areas will have a stronger desire to see an increase in healthcare spending to assist them with paying for health insurance.

My research design will come from a quantitative survey study, using data from the American National Election Studies 2016 pilot. The sample of this study was an online opt-in panel sample, conducted on the Internet. There were 1,200 respondents who answered over 170 questions on this survey. Respondents were matched to a national sample based on gender, age, race, and education to make the survey more representative of the national population. The average age of these 1200 respondents is 48 years. In terms of gender, the sample is 52.5% female and 47.5% male. This sample is not terribly well educated as the most frequent appearing category of the education variable is those who have obtained a high school diploma at 34.3%. The percentage of the sample who

has obtained a bachelor's degree (or higher) is 27%. For income, the majority of the sample (55.1%) earns less than $50,000 per year. In terms of race there are 875 (72.9) white respondents, 135 (11.3%) black respondents, 113 (9.4) Hispanic respondents, and 23 (1.9) Asian respondents. For party identification, 48.5% of the sample identifies as Democrats, 34.6% identifies as Republican, and 17.1 % of the sample identifies as Independent.

II. LITERATURE REVIEW

This literature review will outline how socioeconomic status influences public opinion on healthcare spending. The literature on public opinion is extensive and diverse, studies examine public policy in many areas ranging from income to race. This research examines the effects of socioeconomic status and how it relates to public opinion. This thesis contributes to an ongoing debate on how public opinion influences healthcare spending in the United States.

Healthcare has long been an obstacle of the United States, despite the 3.3 trillion dollars spent on health expenditures (Center for Disease Control, and Prevention, 2017). Healthcare spending is too broad to look at as a whole. This thesis, specifically examines how public opinion controls spending. Scholars have done extensive research on public opinion and how it drives trends in healthcare spending. For far too long, many individuals have been pushed aside and left out of the equation. Research shows that affluent societies tend to need less assistance from the government, yet in the United States, despite their lack of need the wealthy often influence where and how much money

is allocated to healthcare. This leaves the less fortunate population, who tend to live in low-income communities in dire need of additional resources to cover medical expenses.

The following literature review examines four lines of scholarship. The first examines work that explores how healthcare spending in low-income communities is disproportionate to communities with higher incomes. The second examines research that explores public support for spending. The third examines scholarship that focuses on healthcare access and the fourth examines how party affiliation and representation affects healthcare spending. Previous research does not examine each of these lines of thought together, demonstrating a weakness in this research. This literature review draws from a variety of disciplines; however, the body of research highlights the expectations of how public opinion affects healthcare spending.

Socioeconomic Status and Healthcare

Socioeconomic status is an important indicator of the need for increased healthcare spending within certain regions. This section discusses the disparities within different socioeconomic status and how these disparities contribute to the lack of healthcare spending amongst regions of low socioeconomic status. The United States Census is an important tool in helping identify those regions. The United States Census (2011) identifies regions of low socioeconomic status and helps identify characteristics of each of those regions. The U.S Census is used not only to count the population but also to measure factors such as poverty, income, and levels of health insurance. The Census tells a descriptive story about who the people living in the U.S are. The Census does, however, have some limitations. Not everyone is accounted for, many people do not participate due

to systematic failures or merely by choice. The 2011 U.S Census findings state that people with low levels of education tend to stay or move into a lower quintile of income. People with low education levels are prone to live in regions that are low in resources. The Census also identifies Hispanics and African Americans to be on the lower end of the spectrum in terms of income. Their household annual income ranges between $38,624-32,229. In 2017, the Census reported that whites were among the lowest rates of uninsured, Hispanics had the highest uninsured rate at 16.1 percent, Blacks were second highest at 10.6 percent uninsured and Asians 2.3 percent uninsured. These and additional findings support the argument that people with fewer resources lack healthcare.

Disparities in socioeconomic status have long been a primary issue with obtaining and influencing healthcare. Andrulis (1998) examines the disparities between access to healthcare across socioeconomic groups and how it relates to the health status of the rich and poor. Andrulis addresses the critics who believe that financial barriers alone will not fix the healthcare system. She finds that a major factor in access and quality to healthcare is socioeconomic status. Her findings make a connection amongst low socioeconomic status, being uninsured and having difficulty financing health services.

Education is another important socioeconomic factor that is pertinent in the discussion of access to healthcare and the influence of healthcare spending. Yoo (2012) examines the relationship between higher education and healthcare spending. The literature argues that people with higher levels of education will be less likely to support an increase in government spending because they tend to not need healthcare as much; Therefore, people with higher levels of education do not need or care for advocating in favor of additional government spending for healthcare. Yoo's findings support the

literature's argument, that people with higher levels of education are more likely to pay for additional health-related costs on their own and rely less on the government's involvement.

The socioeconomic status says a lot about a region and the Census helps contribute to the knowledge of regions. The Census contributes to the literature of who the population living in the United States is and what their needs are. It measures important factors such as, poverty, education and income that can then be used to address socioeconomic disparities and also allocate recourses such as health spending based on necessity.

Public Opinion & Government Spending

This section discusses the powerful role that public opinion and income play in government healthcare spending. Both public opinion and income take a leading role in shaping policies that dictate how much, where and on what funding is spent on. Public opinion is a tremendously influential factor of government spending on healthcare and opinion varies depending on who one is and what their values are. Blendon, et al. (2006) address the public's opinion on the healthcare system. The study reviews the past 25 years of public polls dealing with the public's satisfaction with the healthcare system. The authors found conflicting results, Polls indicate that the public is dissatisfied with the healthcare system as a whole but somewhat satisfied with their own healthcare. However, when asked about raising taxes to provide additional healthcare spending, the majority of people rejected policies that would increase taxes, even if that policy

benefited them. Blendon et al. also touch on income inequality and the role income plays in being the driving force of public policy.

Income is an important indicator as it typically affects how the upper- and middle-classes influence policies. Lanford (2017) conducts three studies: the first study examines the link between public opinion and the influence it has on policymaking, the second study examines the relationship amongst program structure, public opinion, and policy outcome, and the third addresses class-based representational inequalities. Lanford's first study finds that racial sentiments play a powerful role in shaping policy. His second study finds that the design of Medicaid does attract racial and ethnic antipathy and carries a uniquely powerful influence on policy outcome. Furthermore, in his third study, Lanford finds that policy responds to the political preference of the affluent and not the unaffluent.

Policy responds to those who yield power; therefore, it is no surprise to see communities of lower socioeconomic status suffer from disproportionate funding for healthcare. Bradley, et al. (2016) look at healthcare spending across the states, examining the variation of spending amongst each state. This research supports this argument in that it brings awareness to the disproportionate amount of spending among states. This study is amongst the few to research the association between state-level health outcomes and state spending on healthcare as well as other social services. Bradley et al. find that states with a higher ratio of social to healthcare spending had better health outcomes.

Government funding for healthcare varies amongst states as well as local government. Paul (2018) examines the difference between local health department healthcare spending and the overall health outcomes of the population. Paul examines

this relationship by looking at the per capita of Local Health Department (LHD) spending to rates of mortality, sexually transmitted diseases, and tobacco control. He finds that the health of a population varied across local poverty levels revealing that there is a need for a stronger relationship between LHD spending and population health.

Although there has been ample research done to identify how public opinion influences government spending on healthcare, it is a growing and evolving phenomenon that yet has a solution. Boyer (1989) addresses the lack of research dealing with government spending in the health sector. There is a lack of literature that examines healthcare spending by the federal government. Boyer focuses on healthcare spending in relation to three different factors: health and medical services, medical facilities and medical research. His research seeks to explain what socioeconomic, budgetary and political factors play a role in shaping government healthcare spending. Boyer finds that the determinants of government healthcare spending differs across levels of government and brings attention to the much-needed future research in the politicization of health spending at the state levels of government.

Other factors to consider in the literature are biases and potential Z factors. A bias exists within the literature, and it argues in support of raising taxes to help fund healthcare. Shapiro and Young (1986) examine the public's opinion on support for government assistance in medical care. Shapiro and Young outline the public's growing support for medical care by the government despite the growing cost of healthcare. They find that the public is in support of the government's intervention in helping cover costs for medical care so that all can have access to it. Their findings also discovered that the

public is willing to pay more taxes in order to have more medical benefits and access to quality access.

The literature also includes public opinion on immigrants and public spending. This is pertinent because of the growing population and the need to address them in healthcare. Many scholars argue that immigrants are a factor in the growth of healthcare costs. Eschback, Stimpson, and Wilson (2010) examine the comparisons of the trends in public spending on healthcare of adult naturalized citizens and noncitizens immigrate from Latin America, to U.S natives. The 2010 study is linked to previous surveys done in the year prior to the year being studied, taking the study back nearly 10 years. Eschback, Stimpson, and Wilson are addressing a common argument in which immigrants are the driving force of higher healthcare costs. According to their findings, non-citizen immigrants use less public financial services, in regard to their medical care, than U.S natives and naturalizes citizens.

Public opinion as it relates to policy making is a powerful tool. Those who have sway over policy making are typically upper and middle-class citizens. Thus, the relationship between the wealth and increased healthcare spending in regions of higher socioeconomic status is no surprise. This leaves the fate of the poor up to people who do not know the needs and struggles the poor face. This makes for inequality in health spending among the wealthy and the poor.

Access to HealthCare

Access to healthcare determines the overall quality of healthcare provided to a region. The lack of access can mean, limited access to affordable health plans, and or

limited access to quality care. Typically, a lack of access can be credited to lack of government funding. Citizens across the country who are uninsured because they cannot afford to pay for insurance and do not have government assistance to subsidize the cost, have a restriction to healthcare access. Limited access can be by means of being uninsured or having to drive a long distance to receive care. People living in remote rural areas would considered to have limited access to healthcare. Ayanian, et al. (2000) examine the comparison between the unmet health needs of the uninsured and those of the insured. This study creates a positive association between the uninsured and the long-term effects being uninsured creates. The study finds that 44,000,000 of Americans lack health insurance. The study's focus on the uninsured is intended to create support for more federal and state efforts in improving access and funding for healthcare. Among those who have access issues and are uninsured are immigrants and their children. Ku and Matani (2001) examine the disparities in access to healthcare between non-citizens, their children (sometimes even U.S born) and native citizens and their children. This study is in support of my argument, access to quality is based on socioeconomic status. Ku and Matani find that the highest uninsured ethnic group in the United States are Latinos. Latinos are disproportionally low-income and uninsured. However, they also find that even the insured faced non-financial barriers to access. Such as living in remote rural areas with limited access to healthcare.

Racial sentiment adds to the lack of access and quality of healthcare some receive, including government spending on healthcare. Loggins, Griffin, & Averhart (2018) examine racial disparities and access to quality healthcare among white and black women. The authors found that black pregnant women were typically of lower

socioeconomic status and faced higher rated of institutional racism compared to white pregnant women did. White pregnant women were usually married, of higher socioeconomic status; meaning they were educated and had higher income levels. They also tended to have private insurance and did not have a need to rely on government-funded programs. The study also showed that black women are less likely to smoke or use alcohol. The findings show that black women are more likely to need government assistance to cover their healthcare coverage and less likely to have their own private insurance. Martinez-Hume et al. (2017) examine the healthcare stigma associated with public insurance coverage that is commonly experienced by low-income public insurance beneficiaries. Martinez-Hume et al. find that the stigma behind government healthcare programs leads to poor access and quality of healthcare. By using an intersectional approach, they were able to find that the stigma of public insurance was associated with other sourced of stigma including socioeconomic status, race, gender, and illness status.

Access to healthcare is as important as having sufficient healthcare spending. Being able to have access to quality healthcare creates long term effects directly related to health, longevity and the quality of life. Access to healthcare helps narrow the gap between the wealthy and the poor. Providing access to care is as important as funding it, you cannot have one without the other.

Party Affiliation and Political Representation

Party affiliation strongly affects healthcare spending. Democrats and Republicans are inclined to vote one way or the other when it comes to government spending on healthcare. Democrats will typically vote to increase spending and Republicans will vote

against it. Democrats are also more likely to have a different experience with healthcare

than Republicans. According to Wolters Kluwer Health (2016) there is a difference in

opinion, between Democrats and Republicans and their perceived experience with the

quality of healthcare they receive. Wolters Kluwer Health is based from a study done by

the Journal for Healthcare Quality that compares the relationship between Democrats and

Republicans personal experience with healthcare. The study found a greater percent of

Democrats perceive the quality of healthcare to be an issue. However, no relationship

was established with personal perception of healthcare quality and party affiliation. Both

parties agree that there is an issue with the healthcare system overall, and that it is due to

government policies and government regulations.

Representation is a key aspect in how party affiliation is related to healthcare

spending. Democrats will support an increase in government spending, where

Republicans are more likely to not support increasing health are spending to cover those

who cannot afford healthcare costs. Representatives of those parties should, however,

represent the people's interest. Zenz (2015) argues that political representatives have a

duty to represent the public opinion in policy making, in a truly democratic system of

government. Zenz examines political representation and what it means in terms of

respecting public opinion and policymaking. Zenz also examines how to balance public

opinion and policy deliberation. This research will help assess how and if public opinion

is used to deliberate policy.

Voting behavior is also important to study, in terms of how voters behave,

including what they do, what their ideologies are and what influences them. Ziegenfuss,

Davern, and Blewett's examine the relationship between voting behavior and access to

healthcare. The study uses data from the American National Election Study. Ziegenfuss, Davern, and Blewett's find that those who vote for the Democratic candidate are also likely to have difficulties with healthcare access. Those people also tend to be 25-44 years old, black, and with little education. Schmidt (2009) also explores the associations of health, healthcare, policy, party affiliation, and their voting trends. She found that there is a heavy focus on voting behavior as an indicator of how and why the public votes on healthcare. Schmidt also, found that income is the key factor in influencing the studied variables. Her research is composed of polling data, the U.S 2006 census, and the conceptual model.

Democrats and Republicans represent two different kinds of people, view and values. They each have constituents that that they represent and have to answer to. Democrats typically seek to increase funding while Republicans do not see a need for it. For regions of lower socioeconomic status, it is important to seek representation who will represent their interest and increase healthcare funding. Having representation that shares ones values and will advocate for them is a key component of democracy.

The Cost of Healthcare

The cost of healthcare can be burdensome especially to those of low socioeconomic status. Yet, for years the cost and spending of healthcare have been rising, but why? There is ample literature that focuses on healthcare spending, socioeconomic factors, public opinion on healthcare, but not much on what it actually costs and why it varies. Arora, Moriates, and Neel (2015) examine the cost of healthcare and how that translates to what a physician or a hospital can charge. They find that the costs of

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healthcare are difficult to address because it is inclusive of many factors, including personnel, equipment, tests, labs, physician service fees, facility services fees, and the service fees themselves. The cost of healthcare varies from institution to institution. According to Arora, Moriates, and Neel, there is a large variation of cost within hospitals that are within the same areas. The authors do not include any reasons for the disparities in cost in their article but rather give suggestions on how cost can be made more transparent so that patients to end up with large out of pocket cost for services not fully covered by Medicare.

According to Public Broadcasting Services (PBS) (2015), there are seven leading factors to what is driving up the price of healthcare in the United States, they are: doctors, the population is getting older and sicker, medical innovation, insurance costs, lack of knowledge in making medical decision among people, hospital administration, and excessive and wasteful care. Many of these factors have a direct relationship to socioeconomic status: the sicker, lack of knowledge and insurance. It is not to say that the blame lies with people of lower economic status, but that there is a systematic failure that needs to be further addresses. Spending money is not always the solution, there is money, however the money seems to not be allocated in the best way.

Although there is a lack of literature that focuses on what healthcare costs, and what contributes to the cost. The literature does reveal that the cost of healthcare has been rapidly increasing through the years. Little has been done to address the rising cost, and the disparities that the increasing cost is creating between those who can afford the cost and those who cannot. However, there is much ongoing debate about the rapid rising cost

of healthcare and the need for governments assistance in regulating and subsidize it to make it affordable to those who cannot afford it

Conclusion

This paper argues that public opinion influence on healthcare spending is swayed by a vast number of factors. As the scholarship continues to evolve and move toward an understanding of how and what influences public opinion, scholars should pay closer attention to party affiliation, quality and access to healthcare as well as create additional research that answers the disparities of minorities and how government spending is allocated to their communities.

III. HYPOTHESIS

Based on the information gathered from scholars in various disciplines, it is evident that public opinion and socioeconomic status hold a powerful role in the increasing and decreasing of health spending. Consequently, the hypothesis is as follows:

H1: People of a low socioeconomic status are willing to increase healthcare spending more than people of a higher socioeconomic status.

IV. RESEARCH METHODOLOGY

The research methodology used to conduct this research is data analysis. Quantitative studies have high external validity because they include a large number of cases. External validity refers to the representativeness of the research design and its

ability to generalize findings across populations. In an attempt to prove that public opinion in the United States influences healthcare spending, this thesis uses data analysis provided from the American National Election Studies (ANES) 2016 Pilot Study. The study uses a variety of questions to analyze public opinion and their behaviors at the polls. The ANES is a collaboration between Stanford University and the University of Michigan, the ANES strives to produce research that effectively explains Americans voting behavior on Election Day. The study helps address public's attitudes towards healthcare spending.

The ANES was established in 1948 and has continues to grow strong today. The ANES was the first study to examine the trends of American voting behaviors on a national level. The ANES is of significant importance to scholarly work, it is the foundation of many books and journal articles. Over the years it has proven to be a useful tool for research in the social science community. It is among the best resources to conduct research on a large scale because of it high external validity. The ANES reaches a large range of people of different, socioeconomic status, education, gender, race, age and party affiliation (American National Election Studies,2016). The questionnaire was conducted in two languages, both in English and Spanish and conducted in all 50 states. It is intended to serve as a large representation of a population such as this nation.

Participants and Design

The 2016 Pilot Study is a questionnaire that began and ended in January of 2016. The sample size was about 1,200. Respondents had to meet two criteria in order to be eligible, they must be U.S citizens and 18 years or older to participate. The sample of this

study was an online opt-in panel sample, conducted on the internet. There were 1,200 respondents who answered questions on this survey and has over 170 variables/ questions. This survey was conducted between January 22 and January 28, 2016. The survey respondents volunteered to take this survey and they were paid an average of 21 to 50 cents for taking the survey. Respondents were matched to a national sample based on gender, age, race, and education to make the survey more representative of the national population. Because of this, we can be confident that the sample has high external validity.

The sample can be described in a number of different ways. The average age of these 1200 respondents is 48.06 years. In terms of gender, the sample is 52.5% female and 47.5 % male. This sample is not well educated as the most frequent appearing category of the education variable is those who have obtained a high school diploma at 34.3%. The percentage of the sample who has obtained a bachelor's degree (or higher) is 27%. The sample is relatively on the lower rate of the income scale, the majority of the sample (55.1%) earns less than 50,000 per year. In terms of race the majority of the participants are white, there are 875 (72.9 %) white respondents, 135 (11.3%) black respondents, 113 (9.4 %) Hispanic respondents, and 23 (1.9%) Asian respondents. In terms of party identification, the majority of the participants are registered democrats, 48.5% of the sample identifies as Democrats, 34.6% identifies as Republican, and 17.1 % of the sample identifies as Independent.

Variables of interest used to conduct this research came from three different types of questions related to socioeconomic status, healthcare and underlining questions that measure the relationship between socioeconomic and healthcare spending. Questions

related to socioeconomic status tell the researcher about the participant, who they are and some background insight including age, gender, race, education and income. Questions about healthcare measure the participants attitude toward increasing or decreasing healthcare spending. Using spurious (Z) variables allows for the researcher to examine the correlation between the first two variables which is important in measuring and explaining their relationship to each other.

The questions used to measure the different aspects of socioeconomic status are: how old are you, are you male or female, what racial or ethnic group describes you, how important is being (race) to your identity, what is the highest level of education you have completed, thinking back over the last year what was your family's annual income? To measure attitudes on healthcare spending the questionnaire includes questions that include, some people think the government should provide fewer services even in areas such as health and education in order to reduce spending; do you favor an increase, decrease, or no change in government spending to help people pay for health insurance when they can't pay for it all themselves? (health_spending). Z variable are also taken into account for this research, those questions include: does the federal government treat whites better than blacks, treat blacks better than whites, or treat them both the same, what is your state of residence, generally speaking, do you usually think of yourself as a Republican, a Democrat, an independent, or what, do you think of yourself as closer to the Republican Party or to the Democratic Party, when people from other countries legally move to the United States to live and work, is this generally good for the U.S., generally bad for the U.S., or neither good nor bad, how many advantages do white people have that minorities do not have in this society and do you think the difference in

incomes between rich people and poor people in the United States today is larger,

smaller, or about the same as it was 20 years ago?

V. DATA ANALYSIS

Within this section, I will reveal the findings gathered for the research question. As stated at the beginning of this theses the research question under examination is: *How does public opinion in the U.S influence healthcare spending?*. I expected to find the hypotheses to be true; People of a low socioeconomic status are willing to increase healthcare spending more than people of a higher socioeconomic status. To my surprise, key variables of low socioeconomic status such as race held not to be significant to healthcare spending. In fact, the research shows that public opinion and the influence it has on healthcare spending varies. The next several pages will use tables to interpret the findings of this study and explain how they concluded to the inconclusive hypothesis.

With the help of SPSS, I used chi-square to test the significance of the independent variable to the dependent variable. A chi-square test is conducted when the independent variable and dependent variable are nominal or ordinal, it is a two-tailed non-directional test. The chi-square test will examine the distribution of the variable and how one is related to the other. The chi-square test will provide, a Pearson chi-square number that examines the relationship between the independent variable and the dependent variable. It will also, provide a degree of freedom number which will help us find the critical value to interpret the chi-square. Most importantly the chi-square test will provide a significance value that will lead to the significance of the relationship between the independent variable and dependent variable. Interpreting the significance value given by the chi-square test will

determine whether to accept the hypothesis or reject it. The significance value follows three rules, significance value is between 0 and 1, a relationship exists only if the significance value is under .05/ 5% and if the significance value is above .05/ 5%, then the relationship is due to chance. A chi-square test was used to conduct Tables 1- 4.

The dependent variable holds constant throughout this section. The dependent variable used in this research is health_spending. It is a categorical variable and it is also an ordinal variable. For this dependent variable, mode is the central tendency used. The mode for health spending is 7- increase a great deal. The most appropriate variability measure is range because the variable is ordinal. The range is 6- increase moderately. The independent variables will change and will be addressed as they do.

(Insert Table 1 about here)

Table 1 is a combination of the outcomes of all the independent race variables. A chi-square test was conducted for each independent variable (Asian, Black, Hispanic and White) and the dependent variable healthcare spending. In using a chi- square test, I was able to identify the relationship between the independent variable, and the dependent variable. Table 1 shows how race, a factor of socioeconomic status, relates to healthcare spending. The data analysis in table 1 indicates that being black and being white is significantly related to health spending. However, being Asian and being Hispanic is not significantly related to health spending. Results are as followed:

The chi-square value for the relationship between Blacks (info_black) and healthcare spending (health_spending) is 37.337. The significance value between info_black and health_spending is 0%. Being black is significantly related to healthcare spending. The possibility that this relationship is due to change is 0%, therefore a relationship exists. There is a relationship between being black and healthcare spending. The chi-square value for the relationship between Asians (info_Asian) and health_spending is 10.747. The significance value between info_asian and health_spending is 9.7%. Being Asian is not significantly related to health_spending. The possibility that this relationship is due to change is 9.7%, therefore no relationship exists. There is not a relationship between being Asian and health spending. The chi-square value for the relationship between Hispanics (info_hisp) and health_spending is 9.768. The significance value between info_hisp and health_spending is 13.5%. Being Hispanic is not significantly related to health_spending. The possibility that this relationship is due to chance is 13.5%, therefore no relationship exists. There is no relationship between being Hispanic and health spending. The chi-square value for the relationship between Whites (info_white) and health_spending is 22.313. The significance value between info_ white and health_spending is 1%. Being White is significantly related to health_spending. The possibility that this relationship is due to chance is 1%, therefore the relationship is significant. There is a relationship between being white and healthcare spending.

(Insert Table 2 about here)

Table 2 represents the finding of the independent variable: education (info_edu) and the dependent which remains the same, health_ spending. My independent variable has 6 categories, that range from no high school education to post-grad education. The most appropriate measure of central tendency for education is mode because it is an ordinal variable. The mode for education is reported as, 2- high school graduate. The most appropriate measure of variability is range 5- 4-year degree. The chi-square value for the relationship between info_edu and health spending is 49.282. The significance value between info_edu and health spending is 1.5%. Level of education is significantly related to health spending. The possibility that this relationship is due to chance is 1.5%, therefore the relationship is significant. The crosstabulation showed that those participants who reported being in favor of an increase in government to help people pay for health insurance also reported their education level as high school graduate. Those who reported in favor of decrease a great deal, also reported their education to be a 4-year degree. The most frequent response of those 410 participants who reported being high school graduates also reported favoring no change. Education as a factor of socioeconomic status is significantly related to health spending.

(Insert Table 3 about here)

Another important component of socioeconomic status is income, Table 3 identifies the relationship between the dependent variable, health_ spending, and the independent variable, Income (info_ income). Income has 16 categories to choose from that range from 1- less than $10,00 to 16- $500,000 or more. The most appropriate measure of

central tendency for income is mode. The mode for income is reported to be 3- $20,000-$29,000. The most appropriate measure of variability is range 15- $350,000- $499,999. The chi-square value for the relationship between info_income and health spending is 129.049. The significance value between info_income and health spending is 4%. Income and health spending are significantly related. The possibility that this relationship is due to chance is 4%, therefore the relationship is significant. The crosstabulation showed that of the 149 participants who reported their income to be $20,000-$29,000 (mode), the majority also reported favoring a moderate increase in government spending to help people pay for health insurance. These results help support this thesis and are aligned with scholar's theory that income is a key factor of influence in health spending.

(Insert Table 4 about here)

Table 4 examines the relationship between party identification (info_pid) and health spending, my independent variable is party identification. It is also an ordinal variable with 7 categories ranging from, strong Democrat (left) to strong Republican (right). The dependent variable stays the same, health spending. Again, ordinal variables are best measured by mode as its central tendency. The reported mode for party identification is 1- Strong Democrat. The best measure of variability is range. The range is reported as, 6. Again a chi-square test was used to test the relationship between the two variables. The chi-square value for this test statistic is reported as 413.352. The significance value is, 0%. The probability that this relationship is due to change is 0, therefore the relationship is significant. The crosstabulation shows that the strong Democrats are most likely than

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any other group to favor increasing health spending a great deal. It's no surprise that of the 300 participants that reported being strong Democrats also reported favoring a great increase in government spending to help people pay for health insurance. The second highest group of participants reported being Independent. Most of those participants reported favoring no change in government spending to help people pay for health insurance. 45 of the 158 strong Republican participants reported in favor of "decrease a great deal" of government spending to help people pay for health insurance. Overall 28% of strong Republicans favor some kind of increase in government spending to help people pay for health insurance. Compared to only .02% of strong Democrats who favor no increase of any kind, great, moderate or little. These findings are strong indicators of how party affiliation is positively related to health spending.

In order to test the correlation between socioeconomic variables and health spending in Table 5, a regression was used. Table 6 is also a regression; it tests for Z variables that are also considered for this research. A regression can predict the value of the dependent variable, can be used to compare variables to each other and identify which variables are significant predictors of the dependent variables. The regression will produce three important values: beta coefficient, significance value and r-square. The beta coefficient identifies the strength and direction of the relationship in question. The significance value as explained before tells us if the relationship exists, a significance value below 5% tells us that there is a relationship and any value higher than 5% tells us that there is no relationship. The R-square tells us how well the relationship is predicting the dependent value. A value above .60 is a good model with strong predictive power anything below .60 is considered a poor indicator.

(Insert table 5 about here)

Table 5 takes a different approach than the previous tables, it tests all the variables together in a regression. The independent variables are info_black, info_asian, info_edu, info_hisp, info_income, info_pid and info_white. The dependent variable remains the same, health_ spending. When put into a regression there are some noticeable changes in significance value. Race, as defined by being Black, Asian, Hispanic or White, as a whole is not significant or a strong predictor of health spending. Yet, when tested individually in a chi-square test, being White and Black were significantly related to health spending. As the table above shows, info_black has a significance value of .088 and a beta coefficient is .499. The beta coefficient indicates that for every unit increase of info_black, there is a corresponding .499 unit increase in health_spending. The relationship between Info_black and health_spending is not significantly related. The probability that the relationship is due to chance is 8.8%, therefore there is no significant relationship. The beta coefficient of info_asian is -.271, this means that for every unit increase of info_asian, there is a corresponding .271 unit decrease in health_spending. The significance value of info_asian and health_spending is .557. this indicates that the probability that the relationship is due to chance is 55.7%, therefore the relationship is not significant. The beta coefficient of info_hisp is .538, which indicates that for every unit increase of info_hisp, there is a corresponding .538 unit increase of health_spending. The significance value of the relationship is .075. The probability that the relationship between info_hisp and health_spending is due to chance, is 7.5%, therefore the

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relationship is not significant. The beta coefficient of info_white is .316, this signifies that for every unit increase in info_white, there is a corresponding .316 unit increase in health_spending. The significance value is .211. The probability that the relationship between info_white and health_spending is due to chance is 21.1%, therefore it is not significantly related. This regression does not find variables of race to be related to health_ spending.

In Table 3, when conducted by a chi-square test, income is significantly related to health spending. It is also true under regression, income is shown to be significant. The beta coefficient of info_income is -.077. For every unit increase in info_income, there is a corresponding .077 unit decrease in health_spending. The significance value of income is .000. There is a 0% probability that the relationship is due to chance, therefore the relationship is significant. When held constant, education is not significantly related to health_spending. Education has a beta coefficient of .014. For every unit increase in info_edu, there is a corresponding .014 unit increase in health_spending. The significant value of the relationship is .704. There is a 70.4% probability that the relationship is due to chance; therefore, the relationship is not significant. Party identification is proven to be a significant relationship with health_ spending in the regression as well. Info_pid has a beta coefficient of -.418. For every unit increase in info_pid, there is a corresponding .418 unit decrease in health_spending. The significant value is .000. The probability that, the relationship between info_pid and health_spending is due to chance is 0%, therefore the relationship is significant. The party identification of a respondent remains significantly related to health spending.

The R-square value for this regression shown in Table 5 is .262. The constant variables (info_black, info_asian, info_edu, info_hisp, info_ income, info_pid and info_white) predict that 26.2 % of the variation in health_ spending. 26.2% is a poor predictor of the model. For a model to be a good predictor it must be above 60%. Anything below 60% is considered a poor indicator. Since the R-square value is below 60% we can conclude that this model is a poor predictor of health_spending.

(Insert Table 6 about here)

Table 6 contains all the independent Z variables tested for health_spending: info_age, info_gender, govern_service, info_calif, info_ideo, info_interest, race_identity, and white_inequality. The results indicate that the model is a poor predictor of health_ spending. The R-square value of the model is .517. This value indicates that the model predicts 51.7% of the variation in the dependent variable (health_spending). As previously stated, an R-value below 60% is a poor predictor, anything above 60% is a strong predictor of the model.

The self- reported age of respondent (Info_ age), is used to identify the respondent by age, the average age of respondent is 48 year. Info_age has a beta coefficient of .002, indicating that for every unit increase of info_age, there is a corresponding .002 unit increase in health_spending. The significance value of the relationship between info_ age and health_ spending is .440. There is a 44% possibility that the relationship is due to chance. The significance value is well above 5%, which indicates that the relationship is not significant.

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Gender or respondent (Info_gender) is used to identify how men and women relate to health spending. Info_gender has a beta coefficient of -.089. The beta coefficient indicates that for every unit increase in info_gender, there is a corresponding .089 unit decrease in health_spending. The significance value of the relationship between info_gender and health_spending is .379. The probability that the relationship is due to chance is 37.9%. The significance value is well above 5%, the relationship is not significant.

Should the government provide few services or more services to people (govern_service), has a beta coefficient of .514. This value indicates that, for every unit increase in govern_service, there is a corresponding .514 unit increase in health_spending. The significance value is .000. There is a 0% possibility that this relationship is due to chance. The significance value is below 5%, the relationship is significant.

California residents (info_calif) was used to identify the significance between Californians and health_spending. Info_calif has a beta coefficient of -.034. This value indicates that for every unit increase of info_calif, there is a corresponding .034 unit decrease in health_spending. The significance value of the relationship is .848. This indicated that there is an 84.8% possibility that the relationship is due to chance. The significance value is well above 5%, the relationship is not significant. There is no significance between info_calif and health_spending.

The Ideology of a respondent (info_ideo) has a beta coefficient of -.378. This value indicates that for every unit increase of info_ideo, there is a corresponding .378 unit decrease in health_spending. The significance value of the relationship is .000. There is a

0% possibility that the relationship is due to chance. The significance value is below 5%, the relationship is significant.

Political interest of respondent (info_interest) has a beta coefficient of -.026. This value indicates that for every unit increase of info_interest, there is a corresponding .026 unit decrease in health_spending. The significance value of the relationship is .679. There is a 67.9% possibility that the relationship is due to chance. The significance value is well above 5%, the relationship is not significant.

How important is your race to your identity (race_identity) has a beta coefficient of .057. This value indicates that for every unit increase of race_identity, there is a corresponding .057 unit increase in health_spending. The significance value of the relationship is .112. There is an 11.2% possibility that the relationship is due to chance. The significance value is above 5%, the relationship is not significant.

How guilty do you feel about social inequalities between white and black Americans (white_inequaliy) has a beta coefficient of .146. This value indicates that for every unit increase of white_inequality there is a corresponding .146 unit increase in health_spending. The significance value of the relationship is .004. There is a 4% possibility that the relationship is due to chance. The significance value is below 5%, the relationship is significant.

VI. CONCLUSION

This thesis intended to add value to the complex, multifold argument of government health spending by examining multiple lines of scholarship. By examining the question under review, *How does public opinion in the U.S influence healthcare spending?*, it is

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concluded that socioeconomic status is not a definitive factor of public opinion in regards to having an influence on health spending. Although certain factors of socioeconomic factors are significantly related to health spending such as income. There are others such as race as a whole (as defined by black, Asian, Hispanic and white) and education that are not significantly related to health spending.

Finding that education is not significantly related to health spending is detrimental to the hypothesis. Education is an important indicator of socioeconomic status, the ANES reported that the majority of respondents were high school graduates. High school graduates compared to their counter parts are generally less well of. It is surprising to conclude that education is not related to health spending in this study because the literature states otherwise.

Income, as expected, is proven to be significant to health care spending. The most reported income in the ANES was $20,000-$29,000 per year. This indicates that people who make 20,000-$29,000 per year need or at least are in favor of government funding to pay for healthcare. Lower class is considered to be those who make roughly $39,000 or less per year. The majority of respondents according to the research are of low-economic status. Thus, this finding does partly support the hypothesis, people who make less money will be more influenced to support government health spending. This finding falls in line with Schmidt argument that income is a key factor in health spending.

Party identification also showed to be a significant factor in health spending. Public opinion is influenced by ideologies and values and that then contribute to how one identified politically. Democrats tend to be less affluent and supported by minorities, they tend to push for more government funded social programs. Whereas Republicans tend to

be affluent and the majority are white. Republicans tend to not support or want as a lot of government funded programs that support the less fortunate.

Despite race and education not proving to be significant to health spending in this research, both income and party identification are significant. It can be concluded that when it comes to public opinion, the socioeconomic factors that influence it are mixed, some socioeconomic factors are influential, and some are not. Therefore, the hypothesis: People of low socioeconomic status are willing to increase healthcare spending more than people of higher socioeconomic status is inconclusive.

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APPENDIX

Table 1: Pearson Chi-Square for Health Spending and Race

Variable	Chi-Square Value	Significance Value
Info_black	37.337	.000
Info_asian	10.747	.097
Info_hisp	9.768	.135
Info_white	22.313	.001

Table 2: Chi-Square for Health Spending and Education

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	49.282	30	.015

Table 3: Chi-Square for Health Spending and Income

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	129.049	90	.004

Table 4: Chi-Square for Health Spending and Party Identification

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	413.352	36	.000

Table 5: Regression for Health Spending and Socioeconomic Variables

Variable	Beta Coefficient	Significance Value
Info_black	.499	.088
Info_asian	-.271	.557
Info_edu	.014	.704
Info_hisp	.538	.075
Info_income	-.077	.000
Info_pid	-.418	.000
Info_white	.316	.211
R-Square	.262	

Table 6: Regression for Health Spending and Z Variables

Variable	Beta Coefficient	Significance Value
Info_age	.002	.449
Info_gender	-.089	.381
Govern_servive	.514	.000
Info_calif	-.034	.848
Info_ideo	-.378	.000
Info_interest	-.026	.679
Race_identity	.057	.112
White_ inequality	.146	.004
R-square	.512	