WEALTH OVER HEALTH?
AN ANALYIS OF MACRO-LEVEL FACTORS THAT INFLUENCE PUBLIC OPINION ON HEALTH CARE POLICY

by

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ABSTRACT

Currently, the U.S. reports some of the worst health outcomes while spending the most money on health care when compared to other developed countries in the Organization for Economic Co-operation and Development (OECD). In 2018, Americans took out $88 billion in debt to cover the cost of medical care and approximately 28.5 million individuals remained uninsured. Despite poor health outcomes across the country, health care reform is a highly controversial issue and has been for the last century.

Historically, elites in the Republican party have aligned themselves with New Right political philosophies, which stand for a privatized health care system with minimal government involvement. Elites in the Democratic party have aligned with Pluralist political philosophies, which is an orientation that encourages government oversight to protect the health of its citizens. Recently there has been a rise in political polarization that has stemmed from the asymmetric movement of the Republican Party further to the right escalating the controversy around health care reform. In addition to growing polarization, recent studies have found that politicians are more responsive to the affluent classes while concurrently accumulating an influx of wealth. When neglecting to vote with the majority of their constituents, politicians have tried to change public opinion rather than address it. These short-term manipulation strategies have been found to confuse constituents more than mobilize them, contributing to the controversy around health care reform today.

This project aims to understand how macro level structures affect public opinion on government funding of health care utilizing the thermostatic model and the works of Nicos Poulantzas and Michel Foucault as theoretical frameworks to understand how political structures influence public opinion and how political structures are shaped within Capitalistic societies. Specifically, the current study examines how the political leaning of Congress and

the Presidency, total lobbying dollars contributed by the top five medical industries, and the number of health care bills passed per year affects public opinion on government funding of health care between 1986 and 2018. The data were accumulated from multiple sources including the General Social Survey, OpenSecrets.org, GovTrack.us, and the Senate, House, and White House websites. After completing bi-variate and multi-variate autoregressive integrated moving average (ARIMA) models the only variable that was found to impact public opinion was the political party of the Presidency.

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CHAPTER I: INTRODUCTION

In the United States, the cost of medical care contributes to almost half of all bankruptcies (Himmelstein et al. 2009). In 2018 alone, Americans took out an estimated $88 billion in debt to cover health care costs (Gallup 2019). It is estimated that about 40% of unnecessary deaths per year, or the death of about 84,000 people per year, are attributed to a lack of health insurance coverage despite the fact that the United States has one of the most complex and expensive healthcare systems when compared to other developed nations (Fix It: Health Care at the Tipping Point 2015; Levey 2013). Specifically, the United States spends a significantly larger portion of its gross domestic product (GDP) on healthcare than other countries in the Organizations for Economic Co-operation and Development (OECD 2017) while ranking 30th in infant mortality and having one of the lower life expectancies (Barton 2009). The United States spends about $10,224 per capita, while the next two leading countries in per capita spending, expend $8,009 and $5,728 per capita respectively (Swayer 2018). Many of these other countries in the OECD that spend less GDP and have better health outcomes, have a single-payer or universal health care systems in place, ideas that have not gained ground in the United States.

Currently, health care in the United States is paid for by four basic modes, (1) out of pocket payments, (2) individual private insurance, (3) employment-based group private insurance, or (4) government financing (Bodenheimer and Grumbach 2009). Through direct and indirect costs, the United States spends about $3.3 trillion a year, or 17.9% of the nation's GDP on healthcare (Centers for Medicare & Medicaid Services 2016). The largest portion of government spending on healthcare, about 34% of the total GDP, comes from payments to private health insurance companies (Centers for Medicare & Medicaid Services 2016).

Due to the complexity, lack of accessibility, and overall cost of health care in the United States, health outcomes vary significantly among different socioeconomic groups within the

country (Orgera and Artiga 2018). Specifically, uninsured rates are at the highest in groups that are at or below the poverty line (The Henry J. Kaiser Family Foundation 2018). In 2017, approximately eight in ten uninsured individuals were in families with incomes below 400% of the poverty line (The Henry J. Kaiser Family Foundation 2018). In 2019, for a single individual to be at 400% of the federal poverty line their income would need to be $49,960 and for a family of four the total household income would need to be at $103,000 (Paying for Senior Care 2019). In addition, uninsured rates vary by race and gender. Hispanic and Black Americans have the highest rates of being uninsured when compared to non-Hispanic White and Asian Americans (Oregra and Artiga 2018). In 2017, 19% of nonelderly Hispanic adults were uninsured and 11% of nonelderly Black adults were uninsured compared to 7% of nonelderly White and Asian adults (The Henry J. Kaiser Family Foundation 2018).

Despite the astronomical cost and unequal distribution of care, there has been an ongoing political debate over access to and the affordability of healthcare over the last few decades. In 2010, the Affordable Care Act (ACA) was passed through Congress under President Barrack Obama. The ACA was one of the largest health care reform bills to pass through Congress since the passage of Medicare and Medicaid in 1965. Shortly after the implementation of the ACA, the rates of uninsured Americans drastically dropped from about 49 million uninsured Americans in 2008 to approximately 28.2 million uninsured Americans in 2015 (Hoornbeek 2018; National Health Statistics 2017; Obama 2016).

While our health care system has evolved significantly over the last half-century due to multiple reform efforts and President Obama's most recent large-scale health care reform (the ACA), the debate around health care is still heavily present in political discourse today. Republicans in office have been trying to dismantle the ACA and keep the structure of healthcare financing in a free market, while Democrats have been arguing for the expansion of healthcare, including letting the ACA stand and expanding health care access through a national

health care system. Evident in the opposing positions the two parties take toward health care, the debate has only been becoming more exaggerated due to increased polarization due to the asymmetric movement of the Republican party further right (Broockman 2018; McCarty 2015).

Not only have the parties become more polarized, but the total lobbying dollars given to Congress have nearly doubled over the last decade, which has resulted in the influx of wealth by individual members of Congress. This has caused an increase in distrust among the public toward political figures and the system as a whole due to the concern that politicians have big corporations, like the Pharmaceutical industry and the American Medical Association, in mind when making policy decisions opposed to the constituents they are supposed to be representing. In fact, recent studies have shown that over the last decade political representatives among both parties, have deviated from voting with the majority of their constituents and often make political decisions based off of those in the upper echelon of society (Jacobs and Mettler 2011; Gilens 2005; Jacobs and Page 2005). Instead of voting with the majority of their constituents, studies show that political elites often try to change the opinions of the public through tactful media strategies (Jacobs and Mettler 2011; Page and Shapiro 1992; Jacobs and Shapiro 2000).

That said, this study will be using neo-Marxist theory by Poulantzas, the theory of discourse by Foucault and the thermostatic model, which is a tested model that explains what factors influence public opinion on policies, to examine macro-level factors that influence public opinion on government funding for healthcare throughout the United States. The macro-level factors that are explored include party in power of Congress and the Presidency, lobbying influence by the medical industry, and the number of health care bills passed per year. The data were pulled from the General Social Survey (GSS), OpenSecrets.org, the official websites of Congress and the President.

CHAPTER II: LITERATURE REVIEW

History of Medical Care in the U.S.

Prior to World War II. The basis of Colonial American medicine was derived from the medical practice and body of scientific knowledge in Europe in the late 17th century. Despite European influence, up until the mid-19th century, Colonial American medicine "lacked a substantial body of usable scientific knowledge and was highly underdeveloped when compared to its European counterpart" (Conrad and Schneider 1992; Rothstein 1972). At that time, medicine was primarily practiced in the home and was negotiated strictly through the patient and practitioner (Conrad and Schneider 1992). There were very few physicians who had standard educational training and those who did usually practiced medicine part-time (Conrad and Schneider 1992).

Around the mid-19th century, a group of educated physicians founded the American Medical Association (AMA). The main goal of these physicians was "to promote the science and art of medicine and the betterment of public health" (Coe, 1978: 204; Conrad and Schneider 1992). In addition, the AMA set out to create and regulate the standards and ethics of the practice of medicine. In doing so they aspired to achieve "exclusive professional and economic rights to the medical turf" (Conrad and Schneider 1992).

Over the next few decades, the AMA began to formalize and professionalize the practice of medicine through science and creating and structuring new laws and licensing procedures that regulate the practice and virtually eliminated any competition within the medical field (Conrad and Shneider 1992). The laws that guided medical education, licensing, and practicing dictated the type of medicine that was practiced and how it was practiced in the U.S. This allowed medical professionals to gain autonomy across medical, economic, political, cultural, and social circles.

Despite the desire of the AMA to maintain autonomy, different forms of providing medical care began to develop in the early-20th century, including the introduction of company doctors and private insurance companies. Company doctors were initially employed by railroad companies around the late nineteenth century. In its early formation, the role of the company doctor was to solely "surgically repair victims of industrial accidents" (Starr 1982: 200). Overtime as the political dynamics shifted, including the creation of state workmen's compensation laws around 1910, company doctors began conducting "pre-employment health examinations and became more concerned with the health supervision of workers" (Starr 1982: 200).

By the 1920s, larger companies, including lumber, mining, and railroad corporations, were staffed with medical departments and over the course of the next two decades they even began to devote services to mental illness and alcoholism. Originally, companies did not want to bear the cost of medical services for their employees nor pay for the hidden cost of disease among their workers, but this shift in the involvement of doctors in larger companies reflected the shift in corporation's mentality towards medicine. Employers began to understand and accept the popular belief of the usefulness of medicine. The shift to employee medical programs soon became known as "welfare capitalism" (Starr 1982).

Most of the companies that hired company doctors and began forming medical departments throughout their organizations were located in more isolated, rural areas. This was because there weren't many doctors or hospitals in isolated regions, companies in urban areas did not face this same issue, so company doctors were not as prominent throughout urban areas. As the medical departments in these rural companies expanded, they began to build their own hospitals and clinics. Companies who did not have their own facilities arranged for their workers medical care through independent physicians. Whether it be an independent physician or company doctor, many employees did not like the fact that the company controlled the doctor

they were able to see, and they also did not like payroll deductions for the use of company doctors.

At that same time, a "deviant" group of industries and firms became increasingly interested and involved in financing and managing medical services (Starr 1982: 201). These companies developed on a small scale due to legislation that was passed in the early 1900s, that prohibited "profit-making medical corporations in most jurisdictions" and also inhibited the "commercial practice of medicine" (Starr 1982: 204). Despite the passage of these laws, for-profit hospitals were still able to operate, and company doctors were still employed by large corporations. While there were few contracted physicians, the overall attitude towards company doctors by the medical society was grim. Physicians and medical societies didn't like that industrial/contact doctors were working at a reduced rate, which drove down the price of medical labor overall. After reaching its peak in the 1920s, corporate control over doctors and their employees' access to health care began to decline once the Great Depression hit in the early 1930s.

Between the end of the nineteenth century and the early-twentieth century, the American hospital system was largely reconstructed due to the economic expansion of the late-nineteenth century (Starr 1982: 146-148). Up until the early-twentieth century, hospitals in America were primarily utilized as non-profit institutions to provide medical care to the poor. With the economic expansion in the late-nineteenth century hospital care was turned into a for-profit industry that served professionals and a wide variety of patients, not just the poor (Starr 1982: 146-148).

With the rising cost of hospital visits due to the expansion of for-profit hospitals, a new form of payment for medical care arose in the early-twentieth century at Baylor University Medical Center (Rosenthal 2017; Bodenheimer and Grumbach 2009). A few years after its foundation, Baylor University Medical Center found itself with a significant amount of unpaid

hospital bills. So, Baylor decided to offer the local teachers union a deal to provide a 21-day stay at the hospital, with all treatment costs included, for $6 a year or 50 cents a month with a deductible (Rosenthal 2017; Bodenheimer and Grumbach 2009). This was the start of insurance as we know it today. This model formed the Blue Cross Association, which was formed as a non-profit, charitable organization. The Blue Cross Association would later be split into Blue Cross and Blue Shield. Blue Cross refers to hospital insurance, while Blue Shield refers specifically to insurance for doctors' services and durable medical goods. Blue Cross Association expanded throughout Dallas, Texas where Baylor was located, and throughout other cities across the country through the American Hospital Association (Bodenheimer and Grumbach 2009). By 1939 around 6-million people had signed up for Blue Cross plans (Bodenheimer and Grumbach 2009).

During World War II, as the major insurance providers at the time, Blue Cross and its partner Blue Shield, expanded as companies began to offer employer-based medical insurance to provide incentives to employees after the National War Labor Board froze salaries during and after the war (Rosenthal 2017). As companies faced severe labor shortages, they provided health insurance to contract employees as a way to get around the National War Labor Board restrictions (Rosenthal 2017). To encourage employment growth, the federal government decided that it would not tax money that was used to pay for employee's health benefits (Rosenthal 2017). Initially, these insurance plans solely provided financial relief for severe illnesses to mitigate extreme financial strain on patients. After the war, Blue Cross and Blue Shield expanded rapidly, one providing coverage for hospital visits and the other for doctors' visits. Between 1940 and 1955 the number of Americans with health insurance rose from 10% to 60% (Rosenthal 2017).

At this point in time, the medical industry expanded rapidly because of a burgeoning economy and increased faith in science and medicine due to the research efforts during the war

that successfully produced radar, the atom bomb, and penicillin (Starr 1982: 334). Private for-profit companies and the government became more involved in the financing of the medical industry including the creation of health insurance companies, the government sharing medical costs and funding programs like Medicare, and Medicaid. This era was dominated by the shift in political philosophy to pluralism, which is an orientation that the government should work to protect the health, life, and property of citizens. This time period is also largely referred to as the liberal years due to the rapid expansion of social programs and increased interest in having the government involvement in economic and social life.

Due to the vast economic expansion and the growth of insured Americans, for-profit insurance companies and for-profit medical organizations began to develop. This eventually led to the corporatization or bureaucratization of the practice of medicine. While the Blues were considered charitable insurance industries, the growth of for-profit insurance agencies proliferated as the rate of insured Americans grew shortly after World War II (Rosenthal 2017). These companies began creating different policies for different age groups and health status. They charged different rates for the different types of policies and through this structure the modern American for-profit insurance was developed. In addition to the growth of for-profit insurance, modern medicine became bureaucratized into large corporate structures including the health insurance industry, the medical schools, and the American Hospital Association, opposed to single physician practices where payment and service was handled strictly between the patient and the provider, which were most common up until this time (Conrad and Schneider 1992; Mechanic 1976; Ehrenreich and Ehrenreich 1970).

During this time the U.S. also saw an influx in federal funding to medical organizations, like the Public Health Service, and the creation of other organizations, like the Office of Scientific Research and Development (OSRD), the National Science Foundation (NSF) and the National Heart Institute, which later became the National Institutes of Health (NIH) (Starr

1982: 342-343). Prior to World War II, the Department of Agriculture was the leading, most funded, agency of the federal government (Starr 1982: 339). While the Department of Agriculture's research team yielded notable medical advances (Starr 1982: 339), real growth and expansion in medicine occurred after World War II when the government began investing more money in the medical field and medical research directly (Starr 1982: 240). Between 1941 and 1951 the federal budget for medical research grew from about $3 million to $76 million (Starr 1982: 343). The NIH research budget alone, grew from $180,000 to $4 million between 1945 and 1948 (Starr 1982: 342) and by 1960 the budget hit an astonishing $400 million. Even with an increase of governmental aid, leaders in NIH still let medical investigators/researchers have the freedom to work on the issues that they choose. This freedom spoke not only spoke to the faith the public put in science, but it expressed the autonomy within the scientific research medical professions, similar to the same autonomy physicians had through medicine.

The Roosevelt administration also advocated for the construction of hospitals, not only to benefit local community health and provide access to care, but to increase employment opportunities. That said, two hospital programs burgeoned after World War II: (1) an expansion of Veterans Administration (VA) hospitals, and (2) an increased aid to the nation's community hospitals (Starr 1982: 348). These two programs contributed to the expansion of medicine in different ways. The VA, which is paid for by federal dollars as a form of public health insurance for Veterans, applied its resources to expand medical schools and expand their role in running American hospitals. At the same time, the expansion of aid to the nation's community hospitals increased the number of beds in low-income communities in an attempt to match the number of beds in higher income communities (Starr 1982).

Post-war opportunities to create new social welfare programs and policies, specifically in regard to health care, continued on into the 1960s. Criticism at the time was centered around the government's lack of understanding of community needs (Starr 1982: 365). Following

Roosevelt's expansion of medical spending, President Kennedy (1961-1963) made a point to address community needs in his platform as President. Around the same time, medical reform was gathering momentum and there was a new emphasis on expanding education throughout the health profession to assure there were enough health professionals to meet society's demands (Starr 1982: 364). After President Kennedy's death, President Lyndon B. Johnson announced a "war on poverty in America," with medical care being a subset of this anti-poverty program , particularly in light of new scientific knowledge linking poor health to a "cycle of poverty," a shorthand way of discussing perpetual generational poverty (Starr 1982: 366). In addressing health care through the war on poverty, Johnson referenced Medicare as a form of health insurance for the elderly, who at the time had some of the highest rates of poverty, and, in addition, expansion of training for health professionals.

In 1965, Medicare and Medicaid were signed into law by President Johnson (Starr 1982: 369). The original Medicare and Medicaid reforms put into place by Johnson have been reformed multiple times throughout the last few decades but they lay the foundation of the programs that are still in place today. Medicare is set to finance the medical care of people over 65 years old (Bodenheimer and Grumbach 2009). Anyone over the age of 65 years old is automatically enrolled to Part A of Medicare. People who are permanently disabled and have been receiving Social Security disability benefits for 24 months are also eligible for Medicare (Bodenheimer and Grumbach 2009). Those who have chronic renal disease requiring dialysis or a transplant are also potentially eligible for Medicare part A benefits (Bodenheimer and Grumbach 2009).

Medicaid provides financial assistance for medical care for "(1) Low-income families with children who meet certain eligibility requirements; (2) Most elderly, disabled, and blind individuals who receive cash assistance under the federal Supplemental Security Income (SSI) program; (3) Children under age 6 and pregnant women whose family income is at or below

138% of the federal poverty level; and (4) School-age children (6-18) whose family income is at or below the federal poverty level" (Bodenheimer and Grumbach 2009). Medicaid is administered by states individually but relies on a large sum of federal government funding (Bodenheimer and Grumbach 2009). Congress continued to expand health services over the next few years, including the development of community health centers in low-income neighborhoods. Between 1960 and 1970 a large number of proposals were introduced and many analysts believed that by the 1980s America would have made the shift to a universal health care system (Conrad and Leitter 2013: 355), but this progress began to come to a halt in the 1970s due to the growing concerns of the rising percentage of the gross domestic product (GDP) that was being attributed to health care costs due to the recent large scale funding for the medical field as a whole.

From Johnson to Obama. With the growth in the medical industries and the associated increased costs, health care would not be sustainable without cost reforms, particularly in light of the growth of overall medical spending as an ever increasing percentage of the GDP. Government officials became increasingly more apprehensive due to the large role the government played in financing health care and the increased cost directly related to an increase in government spending. In order to deal with this issue, there was discussion of a new round of health care reforms, primarily in the form of cost containment, which would require the government, insurance providers, and employers to renegotiate their relationship with practitioners (Starr 1982: 388). The criticism and apprehension throughout the country played a large role in electing more conservative officials, who aimed to return tax money to citizens and government functions to the private sector, to office in the late 1970s (Starr 1982: 417).

Going into the 1980s, the United States's healthcare system began to shift again in response to the national political philosophies shifting to "New Right" philosophies. The "New Right" perspective "is distinguished by its strong laissez-faire attitude and antipathy toward

state intervention in economic and social life" (McKinlay and Marceau 2002). In 1980, Ronald Reagan ran for President on the platform of conservative reforms, specifically to increase military spending, cut taxes, reduce federal spending, and restrict federal regulations (Campbell 2017). In 1981, Reagan immediately passed the Economic Recovery Tax Act, which cut federal taxes by about 27% effectively reducing the funds available to federally run programs (Campbell 2017). Over the course of the next eight years, the Reagan administration passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, along with other bills, which also cut Medicaid expenditures by over 18% and cut the budget for the Department of Health and Human Services by 25% (Campbell 2017). Throughout the Reagan era, millions of children were denied free and reduced school lunch, about 600,000 people lost access to Medicaid, millions lost food stamps, Women, Infants, and Children (WIC) could only serve a third of its client population, pregnancy rates and mothers not receiving prenatal care skyrocketed, hospitals in rural areas closed at alarming rates, and the total poverty rate increased (Campbell 2017).

Since the Reagan era, there have been consistently opposing views between the political parties and controversial discourse around the affordability of and access to healthcare in the United States. After the creation of Medicare and Medicaid in 1965, there have been a few other federally sponsored healthcare reforms including the Children's Health Insurance Plan (CHIP), the Medicare Modernization Act of 2003, and the Patient Protection and Affordable Care Act, often referred to as Affordable Care Act (ACA), or simply as Obamacare (Patel and Rushefsky 2014).

After the creation of Medicare and Medicaid in 1965, there have been a few successful healthcare reform efforts. Health care was one of the most important issues for the Clinton administration (1993-2001), and despite pushback from the Republican party and millions of dollars given to key legislators by lobbyists (Light 2011; Hacker 1997; Quadangno 2005;

Skocpol 1996), President Clinton was able to pass SCHIP (State Children's Health Insurance Plan) through Congress. While this was not the large-scale reform Clinton originally intended on passing, it provided insurance coverage to millions of children across the country. SCHIP was passed in 1997, shortly after President Clinton's comprehensive health care reform bill failed in 1993.

SCHIP was the first major step in increasing access to health care specifically for children after the passage of Medicare and Medicaid. In conjunction with the First Lady, bi-partisan Senate support helped design SCHIP to provide health care for children whose families could not afford private insurance but did not qualify for Medicaid (Lambrew 2007; GoHealth 2019). Despite being created and partially funded through the federal government, SCHIP provides state governments the ability to structure their own SCHIP programs. Dependent on each state's legislatures, "SCHIP can provide coverage through an expansion of Medicaid coverage, an entirely separate SCHIP program, or a combination of the two" (GoHealth 2019). As of 2017, approximately 9.4 million children were covered under SCHIP (Centers for Medicare and Medicaid Services 2019).

Following the healthcare reforms of the 1990s, the next major reform was the Medicare Prescription Drug Improvement and Modernization Act (MMA) a multi-faceted piece of legislation that was passed through Congress in 2003 under the administration of George W. Bush (2001-2009). It's main objective was to provide "coverage of outpatient prescription drugs for Medicare beneficiaries" through reforms to Medicare, called Medicare Part D, as a response to the rising cost of prescription drugs between the 1990s and the early 2000s (Barton 2010: 103; Brinckerhoff and Coleman 2005; Kaiser Family Foundation 2003). Due to the rising cost of prescription drugs in 90s and early 2000s, benefits to cover the cost of prescription drugs through Medicare were rolled back, which lead to about 25% of Medicare beneficiaries having no coverage for prescription drugs (Brinckerhoff and Coleman 2005).

The creation of Medicare Part D was a response to the lack of coverage for prescription drugs and allows Medicare recipients to opt-in to a program which provides comprehensive plans or stand-alone prescription drug plans (PDPs) (Kaiser Family Foundation 2003). In addition, it provides subsidies to sponsors of retiree plans that provide qualified drug coverage for their Part D eligible enrollees" (The Henry J. Kaiser Family Foundation 2003). All of Medicare is contracted by the Department of Health and Human Services (DHHS) through private insurance companies (The Henry J. Kaiser Family Foundation 2003).

In addition, there have been a handful of laws that have been enacted between 1965 and 2003 that have also affected the dynamics of health care system. They have shaped not only the financing of health care, but the quality of health care as well (Barton 2010: 102-103). A few of these pieces of legislation include the Prescription Drug User Fee Act of 1992, which allowed the FDA its own budget and allowed it to charge fees to drug developers to secure extra funds to be able to add additional staff to streamline the review process of drugs (Barton 2010: 102). In 1986 the Emergency Medical Treatment and Active Labor Act (EMTALA) was enacted and allowed individuals who lacked insurance and financial means to seek and receive emergency treatment if needed. The EMTALA also intended "to protect against patient dumping," which refers to healthcare facilities discharging or transferring ill patients usually due to their inability to pay for care (Barton 2010: 103).

While all of these reforms were not nearly as robust as the original implementation of Medicare and Medicaid in 1965, they each attempted to fix pieces of the health care system particularly where healthcare costs were concerned (Marmor and Oberlander 2011; Conrad and Leitter 2013: 355). Each of these "piecemeal" attempts to reform health care have had powerful intended and unintended consequences, like the astronomical cost to the federal government that came with Medicare and Medicaid (Conrad and Leitter 2013 :355). Unfortunately, a successful, large-scale health care reform that attempts to fix the healthcare system as a whole

instead of attempting to address consequences of the current system lay dormant from 1965 to 2010 when the Affordable Care Act was passed through Congress (Skocpol 1996; Starr 1995; Conrad and Leitter 2013: 355).

The Patient Protection and Affordable Care Act. The Patient Protection and Affordable Care Act, or the Affordable Care Act (ACA) for short, was the first major piece of comprehensive healthcare reform legislation to pass since the original creation of Medicare and Medicaid in 1965. While other large-scale reforms had been discussed in the past, success was limited due to opposition from "the axis of opposition," which historically has included healthcare providers, the American Medical Association (AMA), the American Hospital Association, the insurance industry, and the business community (Hoornbeek 2018; Brown 2008, 2011). Under the Obama administration (2009-2017), the ACA was a multi-dimensional piece of legislation that aimed to control the ever rising costs of care and reduce the number of insured persons in America through different measures, but "one key element included building cooperation from key groups that had stymied healthcare reform in the past" (Hoornbeek 2018; Brill 2015; Jacobs & Skocpol 2010; Quadagno 2011).

Aside from attempting to build support from the industries that are against healthcare reform, the ACA expanded access to care in a handful of ways. The Kaiser Family Foundation breaks the ACA up into thirteen major sections, (1) individual mandate, (2) employer requirements, (3) the expansion of public programs, (4) premium subsides to employers, (5) tax changes related to health insurance or financing health reform, (6) health insurance exchanges, (7) benefit design, (8) state role, (9) cost containment, (10) improving quality/health system performance, (11) prevention/wellness, (12) long-term care, and (13) other investments (The Kaiser Family Foundation 2013).

Hoornbeek (2018) best sums the different sections of the ACA in six categories. The first major section of the ACA requires each individual American to buy health insurance. This

section is often referred to as the individual mandate and penalizes individuals for failing to have insurance. The individual mandate also enabled development of health insurance exchanges by state, so individuals could buy insurance policies that comply with the mandate. The second section of the ACA requires employers with over 50 full-time employees to provide health insurance for their employees. A second portion of this section also provides subsidies to employers that have less than 50 employees to accommodate with the extra costs to provide their employees coverage. Third, "the ACA expanded eligibility for Medicaid to include more low-income individuals, specifically childless adults" (Hoornbeek 2018).[1] The fourth portion of the ACA that Hoornbeek (2018) explains regulates requirements for health insurance companies. Some of the regulations included prohibiting discrimination against individuals with pre-existing health conditions, it required the insurance companies to cover children up to the age of 26 on their parent's insurance plans, and it also required policies to have a base, essential set of benefits per plan. The fifth aspect of the ACA "provided federal subsidies to lower- and middle-income individuals through insurance premium tax credits and cost sharing payments (Hoorbeek 2018). Lastly, the ACA was an attempt to reduce health care costs and increase the quality of health care as an essential health care reform (Hoornbeek 2018).

The ACA was not an easy piece of legislation to pass due to the partisanship of the legislature (Obama 2016). After many sacrifices to get the legislation through Congress, including moving away from a single-payer framework to appease the "axis of opposition" and "embracing redistributive financing" (Oberlander 2010), the ACA was far from its original form and intentions (Patel and Rushefsky 2014). While past reforms, such as CHIP, SCHIP, and Part D of Medicare all played a role in expanding access and improving quality

[1] Forcing states to adopt the ACA was ruled unconstitutional by the Supreme Couty, but states can opt-in to voluntarily participate in the Medicaid expansion.

of care, the ACA was the first major reform to drastically reduce the rates of uninsured Americans as a whole since 1965 while at the same time undertaking cost containment measures (Obama 2016).

In 2008, prior to the passage of ACA, approximately 1 in 7, or 49 million Americans were uninsured (Obama 2016). In 2015, after the passage of the ACA, along with multiple small-scale reform efforts, the country saw its lowest number of uninsured persons at 9.1% or 28.2 million American (Hoornbeek 2018; National Health Statistics 2017; Obama 2016). Research suggests that this large decline in uninsured persons is mostly attributed to the ACA, rather than other factors like the growing economic opportunities at the time (Obama 2016). Despite the many different successes of the ACA, the United States saw another shift to the "New Right" in 2016 when Donald Trump was elected President. Since then many different aspects of the ACA have been repealed such as, the individual mandate, and Republicans are continuously making efforts to repeal or completely dismantle the law as a whole.

The Affordable Care Act Post-Trump. Although Donald Trump ran his campaign on the repeal and replacement of the Affordable Care Act, he has not been able to fully repeal the ACA as of July 2019. There are still millions of uninsured Americans, who are struggling to pay the increasing cost of medical expenses, leaving healthcare cost reforms at the forefront of conversation during the most recent election cycle in 2018. After the Tax Cuts & Jobs Act of 2017, which eliminated ACA's individual mandate , America's uninsured rate has begun to climb for the first time since the initiation of the ACA (Henry J Kaiser Family Foundation 2018). In 2017 alone, the number of uninsured Americans rose by nearly 700,000 people (Henry J Kaiser Family Foundation 2018).

More recently, during the 2018 midterm elections, many Republicans flipped their positions from dismantling the ACA completely, to refraining from revoking coverage for those with pre-existing conditions due to public support (Itkowitz 2018). A large number of

Democrats took a different, more progressive approach to healthcare reform in 2018 and even in the 2020 platforms for Presidential nominees, pushing for a universal health care system (PBS 2019). Most of the progressive platforms have developed from Bernie Sanders Medicare-for-all plan, which would only allow the government to provide insurance and would eliminate all private insurance companies. While some 2020 Democratic nominees support expanding access to health care each has taken their own spin on Medicare-for-all. Kamala Harris, Elizabeth Warren, and Cory Booker have all taken a stance in support of Medicare-for-all, but instead of eliminating all private insurance companies, they would allow Medicare-for-all to be a cheaper buy in option (PBS 2019). While today it appears as if public discourse around health care has again moved toward providing a more comprehensive reform, over the last century, discourse around health care reform has continuously shifted back and forth between comprehensive health care reform and cost containment of federal funding on medical expenditures.

Current U.S. Health Statistics and Expenditures

Currently, the United States spends the most on health care per capita when compared to other developed nations in the Organizations for Economic Co-operation and Development (OECD 2017). Through direct and indirect costs, the United States spends about $3.3 trillion a year, or 17.9% of the nation's gross domestic product (GDP) on health care (Centers for Medicare & Medicaid Services 2016). Despite having one of the most complex, advanced, and expensive systems, the United States ranks significantly lower than other countries in the OECD when accounting for different variables like, life expectancy and infant and maternal mortality rates. When comparing the United States health care system to other countries in the OECD, the United States spent just over 17% of its GDP on health care while Switzerland only spent about 12.3% of its GDP on health care. Not only does Switzerland have a universal health care system, they also have a significantly higher life expectancy than the U.S. at about 85.6 years, while life expectancy in the U.S. is about 81.1 years.

Further, due to the lack of access to care, in the United States, health outcomes vary significantly based on one's social status (Orgera and Artiga 2018). When accounting for gender, race, and socio-economic status (SES), health outcomes in marginalized groups are notably worse Each of these variables can independently affect an individuals' access to care, but they also intersect and create more barriers to receiving care. Barton (2010) calls these factors predisposing factors and they act as a form of health care rationing, which Callahan (2011) argues occur based on an individuals' ability to afford health care.

Public Opinion v. Public Policies

The Partisanship of Politics. Within the last few decades, there has been a rise in political polarization (Broockman 2018). Many scholars attribute this heightened polarization to the asymmetric movement of the Republican Party to the right, and deeper into "New Right" philosophies that see the government as the problem, not the solution to society's ills (Broockman 2018; McCarty 2015). To support this, Broockman (2018) notes that in a study conducted between 2008-2016, 69% of Democratic House members voted with the majority of their constituents, while Republican House members only did so 52% of the time. Similar studies by Hall (2015) found that Republican candidates take more extreme positions than would be electorally optimal, while Democrats do so less often. Patel and Rushefsky (2014) add that Congress is "operating as a parliamentary-oriented system" due to partisanship getting in the way of passing legislation and due to legislatures constantly threatening to shut down the government when both sides can't come to an agreement. Polarization on policy issues has proliferated since the passage of the ACA, with the most recent government shut down, in January of 2019, breaking the record for longest government shut down in history. While the government shut down of 2019 was not over health care policy, the government was shut down for 17 days in 2013 due to difference in opinions on funding for the Affordable Care Act between Democrats and Republicans. The shutdown has been attributed to Republicans, led mainly by Ted Cruz and supported by the conservative Heritage Foundation (Matthews 2019).

The Partisanship of Health Care. Over the last century, it has become clear that the Republican and Democratic parties have different ideas for health care and health care spending in the U.S. The partisanship around health care is reflective of the current state of our political discourse. In 2010, the debate around health care shifted from whether there should be health care reform to evaluating the effects of the ACA (Corman 2016; Obama 2016; Patel 2014). Despite the narrative around health care changing, policy often shifts as the country's leadership changes. This was evident when Donald Trump won the 2016 election campaigning to repeal and replace the ACA and when the Republican administration attempted to repeal and replace the ACA over 60 times (Obama 2016). Hoornbeek (2018) argues that the back and forth rhetoric between parties is representative of the current trends in policymaking, that "policies create politics" (Lowi 1972; Schattschneider 1935). One example of this idea came with the passage of the ACA and the change in Presidency and Congress. The next President and Congress had the ability to construct the political narrative by either building on the growth and progress from the ACA or completely tear it all away. Once the 2018 election came around, the political narrative shifted due to favorable patient protections provided by the ACA. Since a majority of the public favored coverage of pre-existing conditions within the ACA, Republicans were forced to get on board or potentially lose re-election.

To further reiterate the point, while constructing the ACA, former President Obama had made many concessions to find a middle-ground between both parties. One such concession was using Mitt Romney's Massachusetts State health care reforms as a framework for the ACA (Oberlander 2010). Due to the two parties opposing views on health care reform, Patel (2014) and Obama (2016) argue that at the end of the day, neither party was completely satisfied with the final results of the ACA. There were even pieces of the ACA that Republicans believed were a good idea in 2003 but disliked when proposed by a Democrat in 2009-2010 (Obama 2016). During this time period, congressional Republicans voted against pieces of the ACA

that had immense public support, like regulating insurance companies and expanding assistance to seniors purchasing prescription medications (Jacobs and Mettler 2011). It is clear that the hyper-partisanship of healthcare and the partisanship in the current political climate is detrimental to any possible health care reforms. Obama (2016) makes a point to note that going forward more comprehensive healthcare coverage is necessary if we, as a country, look at healthcare as a right and not a privilege because the ACA in its final state did not provide equal access to care, despite its intention to ameliorate some of the most glaring inequalities and abuses in the healthcare market.

This may become difficult with the increasing polarization of the politicians in the two major parties (Broockman 2018; Poole 2004), especially if the Republican party continues to move further right (Broockman 2018; McCarty 2015). Since the Reagan era, the elites in Republican party have stood for a privatized insurance system with as little government involvement as possible. The elites in the Democratic party tend to lean toward a system that is at least partially funded by the federal government. More specifically, Republicans align with New Right political philosophies and have stood by having a health care system that runs through a free market economy with as little regulation as possible, while Democrats see health care as a basic human right. Democrats align more with liberal political philosophies and would like government oversight to expand access and coverage for health care and regulate costs, including cost of drugs by the pharmaceutical industry.

Jacobs and Mettler (2011) argue that members of Congress try to change public opinion rather than address it. When attempting to change public opinion politicians often utilize mainstream media outlets that reach millions of viewers. An example of this rests in the role the media has played in the conversation around the Medicare-for-all plans. Many mainstream conservative media outlets refer to Medicare-for-all as a form of socialism, which is often used as a trigger word amongst conservative media to promote fear among their base. The short-

term manipulation rarely changes public opinion though (Jacobs and Mettler 2011). They argue that this occurs due to a few factors including the fact that individual perceptions of government are generally stable and rarely change (Page and Shapiro 1992). To successfully alter public opinion, politicians need to control all sources of information and the media, which as a business of its own, tend to highlight conflict to draw viewers. While politicians attempt these practices, they are often unsuccessful and attribute this to individual ignorance. Research suggests that this is incorrect though, and that public confusion is the result of the political mobilization tactics themselves (Jacobs and Mettler 2011; Page and Shapiro 1992; Jacobs and Shapiro 2000). As a main concern of each party involved in the financing of health care, health care reforms are not spared in the ongoing battles to shape public opinion.

Lobbying and Wealth of Congress. One would infer that the party's stances on policy are formed through the opinions of their constituents, but as mentioned above recent scholarship on the polarization of politics have shown differently (Brockman 2018; Hall 2015). In addition to growing polarization between the two political parties, recent studies have found that over the last decade government responsiveness and policies have not been a response to the median opinion or general opinion of the public as a whole, rather studies found that it is the affluent that exert the greatest influence, if not exclusive influence, on policy (Jacobs and Mettler 2011; Gilens 2005; Jacobs and Page 2005). Bartels (2008) confirms this with data that show that decisions made by U.S. Senators are correlated with preferences of more affluent individuals in society, with virtually no responsiveness to the majority of Americans.

This trend of government officials attending to the preferences to affluent persons in society has gone hand in hand with the growing wealth of Congress as a whole. In 2012, a report was released from the Center for Responsive Politics that found a majority of the members in Congress were millionaires (Klick 2018). While there are many different explanations to the reasons Congress members are extremely wealthy, one distinct correlation

is the influx in lobbying dollars being given to Congress (Klick 2018). Klick (2018) elaborates by stating that Congress members may exploit their connections during their tenures, which explains their proliferation of wealth. Other explanations include that (1) as a country we select the most talented people to run for office and that along with their talent for the position comes the talent to manage their money well and (2) since the cost of running an election has increased, only extremely wealthy candidates are able to run in the first place (Klick 2018; Open Secrets 2018). While all explanations may be valid, Klick (2018) found that between 2004 and 2014, the wealth of congress members grew almost 7 times higher than those in the upper echelon in the United States. The average income of individual members of the House of representatives is in the multi-millions and continues to grow yearly (Klick 2018).[2] For example, the average income for the House of Representatives has grown from $5.2 million in 2004 to $7.5 million in 2014 (Klick 2018).

Public Opinion of Health Care. Research and polling data show that health care policy has been at the forefront of political discourse for the last few decades. While the nature of the conversation around health care changed after the implementation of the ACA, government funding of health care is still a largely controversial issue (Corman and Levin 2016). Research explains that during and after bad economic times the percentage of Americans who need governmental support increases (Corman and Levin 2016; Jacobs and Mettler 2011). After the 2008 economic recession Americans were in need of that support, and one of the outcomes was the passage of the ACA. With the hiccups the ACA faced, like issues with the launching of its website and partisan efforts to ensure the ACA was unfavorable (as mentioned above in the Partisanship Around Health Care), distrust in the system dropped again. The distrust for ACA

[2] These results were only found for members of the House, not the Senate.

was largely evident in the 2016 election with Republican candidates running on a platform to dismantle the ACA.

Despite all of the negativity and controversy around the ACA, a recent poll conducted by Pew Research Center (2019) shows that health care is the second most important policy issue behind the economy, with about 69% of respondents expressing the need for health care to be a priority for the President and Congress. Further evidence of the shift in public opinion around health care was evident in both the 2018 elections and the Presidents' State of the Union speech in 2019 with Republicans changing their stance on critical health care issue, like coverage for pre-existing conditions.

The Thermostatic Model to Explain Public Opinion of Health Care

Similar to the explanation of Jacobs and Mettler (2011), Corman and Levin (2016) found that the thermostatic model for evaluating public opinion of health care policy is seemingly the most effective. Based on the work of past researchers, the thermostatic model states that public opinion on healthcare is a "path dependent function of policy, prior opinion, and elite/media persuasion" (Corman and Levin 2016; Chard 2004; Carmines and Stimson 1980). When conducting their research Corman and Levin (2016) used to two approaches, but the one used for this research, the thermostatic model, was the most successful.

The thermostatic model is a more general model used to explain trends in public opinion based on the notion that public opinion is constructed based on the policy, prior opinion on healthcare, and the tactful strategies instilled by the elite and the media. The thermostatic model states that with original implementation of a new policy public opinion is likely to decrease at first, but once the policy reaches a steady state, public opinion will return to stasis.

That said, the purpose of this current study is to explore whether macro-level factors affect public opinion on government funding of health care using the thermostatic model, neo-Marxist theory by Poulantzas, and the theory of discourse by Foucault. The literature has shown that public opinion is formed by many different influences and with the changing nature of

politics and creating new policies, it is important to address the macro-level factors that construct government representation to the actual opinion of the public.

CHAPTER III: THEORETICAL ORIENTATION

There are two theories that can be applied as the theoretical framework to this research. These theories provide two different perspectives to the way macro-level factors affect public opinion of health care using the thermostatic model. The thermostatic model explains that the prior opinion of health care policy, the policy being enacted, and the elite and media all play a role in how public opinion on health care is formed. First, the work of Nicos Poulantzas, a neo-Marxist, political sociologist, can be used to the macro-level phenomenon that affect the existing structures in the U.S. health care system and how those existing structures impact how public opinions are formed. The second theorist that can explain the micro-level phenomenon that takes place when individuals form their perceptions of health care policy is the work of Michel Foucault.

Based on traditional Marxist theory, the work of Nicos Poulantzas focuses on the role of the state in a capitalistic society. In traditional Marxist theory, the state operates as an agent of the bourgeoisie, enacting laws that are favorable of protecting wealth- like property laws and harsh penalties for economic crimes against capitalistic industries (i.e.: bank robbery and destruction of property). Poulantzas builds on traditional Marxism and notes that "the state should not be viewed simply as a state in a capitalist society but must be understood as a capitalist state" (Poulantzas 1969). Poulantzas asserted that although the state is relatively autonomous from the capitalist class, it still functions to ensure the smooth and successful operation of society as a whole, which will remain capitalist in nature. Therefore, by default, the state benefits and in some respects works for the capitalist class. As a structural Marxist, Poulantzas acknowledges that the state remains structurally constrained by the system of capitalism and must work to advance the interests of capitalism to a certain extent.

On the other hand, Poulantzas' structural Marxism differs from traditional Marxism because he believed that to maintain its power, the state cannot neglect the submissive classes.

He asserts that the state must maintain balance to avoid a socialist revolution and this is accomplished through the state also actively working to obtain consent of the oppressed on policy decisions. The state maintains an alliance with the oppressed or submissive classes, while at the same time working toward maintaining the capitalist society, they are a part of. This is reflective of socialist legislative reforms, like labor laws, that are passed through the state despite living in a capitalist society.

The work of Poulantzas takes into account the fact that contemporary political structures must address the capitalist climate that it is a part of, while still attempting to meet the needs of the masses. Unfortunately, due to the capitalist constraints, contemporary politicians often take into account and act on the positions of the affluent classes more than the masses. As mentioned above, this notion has been supported in recent research which shows that as a whole politicians today are more responsive to the affluent class in America as opposed to the majority of the working classes (Brockman 2018; Hall 2015; Jacobs and Mettler 2011; Gilens 2005; Jacobs and Page 2005). The work of Poulantzas backs this point when he notes that politicians have to take into account and work around the constructs of the capitalistic society, they are situated in.

While research shows that a majority of politicans take into account the beliefs and needs of the affluent class as opposed to the masses, politicians do listen to the masses and create legislation in favor of the masses, like labor laws and the financing of Medicare, Medicaid, CHIP/SCHIP, and the ACA. This is evident in the work of Broockman (2018), which notes that in a study conducted between 2008-2016, 69% of Democratic House members voted with the majority of their constituents, while Republican House members only did so 52% of the time. Another method politicians take to appease both the affluent class and the masses is to attempt to change the opinions of masses through large-scale media tactics (Jacobs and Mettler 2011). This allows politicians to appear as if they have the best interests of both the

masses and the affluent classes, while really only doing what is in the best interest of the capitalistic society. In sum, the work of Poulantzas takes in account the unique positions politicians are in within a capitalist society, in which they are forced to tread the line of what is best for the economy and what is best for the masses. In itself, the ACA attempted to balance capitalism and pluralism with the ACA by attempting to appease the axis of opposition and provide access to care to millions of uninsured Americans.

These macro-level processes that construct the narrative around health care directly impact what constituents talk about. This notion is backed by the work of Michel Foucault. Situated in the twentieth century, the work of Michel Foucault is centered around the historical changes in knowledge and "the creation of outsiders in society" (Cuff, Sharrock, and Francis 2006: 225). Foucault argued that knowledge goes hand in hand with power and combined power and knowledge are used to structure and scientifically define what is "normal." Thus, he argued that thoughts and language weren't constructed at an individual level, rather they were unconsciously formed through larger structures in society that yield power and knowledge to create "norms" and shape public opinion. Further, he asserted that these larger structures, like academia, the media, politics, the health care industry and economic structures, formed unconscious thought on a collective level, which shifted through different historical periods.

Foucault asserts that thought and language are constructed and situated within a specific epoch by the constraints of the unconscious influence from larger institutions or social structures in society mentioned above. An example of this was when the American Medical Association shaped the public's opinion on abortion and used it as a means to drive competition out of the market, create licensing laws, and crate a closed professional system with little external oversight. The constraints that were placed on the development of ideas and language throughout society are rooted in sociohistorical change and conditions, which Foucault coined an episteme. Epistemes are not internally formed nor are they always unified or coherent, which

allows for differentiation of thoughts and language within society, but they do construct a "matrix" or set of boundaries for thought and language. Epistemes only allowed for thoughts or language to develop through sets of rules or boundaries that coincide with sociohistorical change and societal conditions. The language and thoughts that are articulated throughout society Foucault calls discourse.

This directly aligns with the thermostatic model, which assert that prior opinion, media influence, and the policy being introduced all affect individual perceptions of health care. Further, research shows that public opinion is often stagnant (Page and Shapiro 1992), which can be explained by the work of Foucault. Foucault notes that individual thoughts on constrained to specific time periods, which explains why public opinion is stagnant unless larger structures or influential individuals introduce new discourse.

In sum, the work of Nicos Poulantzas and Michel Foucault provide a framework for this study, which examines how macro-level factors within the thermostatic model, like prior public opinion, media influence, and current policy shapes individual perceptions of health care. Based on traditional Marxism, which asserts that the state works for the affluent classes in society, or the bourgeoisie, Poulantzas' structural Marxism adopts those basic principles and adds that the state must also take the opinion of the masses into account as well in order to avoid a revolution. This is evident in contemporary American society as decisions made by the government are often influenced by large corporations, but yet policies have still been passed through Congress that benefit the masses, like Medicare Medicaid, and the ACA, which directly accounted for industry/bourgeoise interests balanced against the interests of the masses. Further, the work of Foucault provides additional support and understanding about how public opinion is shaped through structures that yield power and knowledge within society. These structures, like the medical industry, form acceptable discourse, which can

explain the back-and-forth compromises and shifts in health care reform in the United States.

CHAPTER IV: METHODOLOGY

This study aims to explore the macro-level factors that influence public opinion on government funding for healthcare throughout the United States. The macro-level factors that were explored include party in power of Congress and the Presidency, lobbying influence by the medical industry, and the number of health care bills passed per year. The purpose of comparing macro-level factors to public opinion on government funding of health care is to have a better understanding of what influences policy decisions, opinions on policy, the controversy around health care reforms and the difficulties associated with passing a comprehensive healthcare reform in the United States.

Data

The current study used a combination of quantitative data from the General Social Survey (GSS), Open Secrets, and the House, Senate, and White House websites. The GSS is a nationally representative survey collected through the NORC at the University of Chicago. Data obtained from the GSS included one variable that assessed respondents' opinions on government funding for health care. The question surveyors asked respondents was "whether the government should help fund health care?" The question was asked bi-yearly between 1986 and 2018 and data from each year was used to create the dataset.

Open Secrets was used to obtain data on lobbying dollars from the medical industry to support political candidates. Out of the top twenty lobbying industries overall, the researcher used the top five industries in the medical field which were, (1) pharmaceuticals, (2) insurance, (3) medical practitioners, (4) hospitals and nursing homes, and (5) HMOs'. The totals per year were available on Open Secrets due to federal disclosure laws, but data was only available between 1999-2018. They were then added to a spreadsheet and calculated for individual totals and added together to calculate the total of all five industries together per year.

Data on party in power of the House, Senate, and Presidency were derived from the House website, Senate website, and WhiteHouse.gov. The data were gathered yearly from 1986-2016 and added to the spreadsheet. Lastly, the researcher utilized GovTrack.us to acquire data on the number of healthcare bills passed per year. The researcher mined through bills regarding health between the years of 1986 and 2016 and added the data to the spreadsheet. Once all of the data were in the spreadsheet, it was manually input and analyzed through STATA.

Measures

Dependent Variable

The dependent variable that is measured in this analysis is public opinion on whether the government should help fund health care (hcsupport). 'Hcsupport' was mainly asked bi-yearly from 1986-2018, with approximately 1,800 to 2,500 individual responses per year. It was measured using a Likert scale by the GSS surveyors, giving respondents the following options: (1) government should help (2) (3) agree with both (4) (5) people should help themselves (6) don't know. Selections (2) and (4) had no labels assigned through the original GSS data, so they were labeled as follows: (2) government should help a little and (4) people should help a little.

To convert the variable to the thermostatic model, the scale was recoded from 100 to -100. Selection (1) was recoded as 100, (2) was recoded to 50, (3) was recoded to 0, (4) was recoded to -50, and (5) was recoded to -100. Once the variable was recoded, all 1,800 to 2,500 individual responses per year were collapsed into a single value that represented the mean within the thermostatic model. The mean of each year was input into the final data set. Within the final data set, the sample size was 20, which consisted of the yearly average of responses between 1986 and 2018. The overall mean of support of public opinion on government funding of health care is 28.24 with a standard deviation of 4.79 (as shown in Table 1). A mean of 28.24

expresses that the average of the opinion of the respondents fell between there should be little government support (50) and agree with both (0).

Independent Variables

The independent variables that were measured were macro-level factors that may influence public opinion of health care funding. The first three independent variables that were measured accounted for the party in power, either Democrat or Republican, in Congress and the Presidency from 1986-2018. Presidency, House of Representatives, and Senate were each individual variables within the final data set. Within each variable, Republican was coded as 1 and Democrat was coded as 2. All three variables consisted of 33 cases (as shown in Table 1). The office of the Presidency was held by a Democrat 48.48% of the time between 1986 and 2018, while a Republican President held office 51.52% of the time. During that same time period, Republicans controlled the House of Representatives 57.58% of the time and Democrats held the majority of the House 42.42% of the time. Lastly, Republicans held the majority of the Senate 45.45% of the time, while Democrats held a majority of the Senate 54.55% of the time.

The fourth independent variable that was measured was total lobbying dollars by year from the top five lobbying industries that are involved in health care. The total lobbying dollars by year were run independently for each group and then combined for a total dollar amount per year. The groups that were the top donors within the medical industry between 1998 and 2018 were insurance, pharmaceuticals, medical practitioners, hospitals and nursing homes, and HMOs, with the sample size of each variable being 21 (as shown in Table 1). The mean of lobbying dollars by the Insurance industry between 1998 and 2018 is $133,000,000, with a standard deviation of $34,100,000. The mean of lobbying dollars by the Pharmaceutical industry is $194,000,000, with a standard deviation of $69,000,000.

Table 1: Descriptive Statistics between 1986-2018

Variable	Time Period	%	Mean	SD	N
Presidency	1986-2018				33
Democratic		48.48%			
Republican		51.52%			
House of Representatives	1986-2018				33
Democratic		42.42%			
Republican		57.58%			
Senate	1986-2018				33
Democratic		54.55%			
Republican		45.45%			
Pharmaceutical Industry Lobbying	1998-2018		$194,000,000	$69,000,000	21
Insurance Industry Lobbying	1998-2018		$133,000,000	$34,100,000	21
Health Professionals Industry Lobbying	1998-2018		$71,300,000	$17,300,000	21
Hospital Industry Lobbying	1998-2018		$78,900,000	$25,900,000	21
HMO Industry Lobbying	1998-2018		$54,200,000	$23,700,000	21
Total Lobbying	1998-2018		$530,000,000	$168,000,000	21
Number of health care bills passed	1986-2018		31.88	20.63	33
Support for gov't funding of health care	1986-2018		28.24	4.79	20

The lobbying dollars by the Health Care Professionals industry has a mean of $71,300,000, with a standard deviation of $17,300,000. The mean of lobbying dollars by the Hospital industry is $78,900,000, with astandard deviation of $25,900,000. Lastly, the mean of lobbying dollars by the HMO industry was $54,200,000, with a standard deviation of $23,700,000. The mean of total lobbying dollars between all five groups is $530,000,000, with a standard deviation of $168,000,000.

The last independent variable that was measured was the number of health care bills passed per year between 1986 and 2018 (N=33). The total number of bills per year were calculated from Govtrack.us and then entered into the final dataset as number of bills per year. The mean number of healthcare bill passed across the 33-year period is 31.88 health care related bills per year, with a standard deviation of 20.63 (as shown in Table 1).

Analytic Strategy

Again, the goal of this research is to assess the influence political structures have on public opinion on the government's involvement in funding health care. To do this, the independent variables (political leaning of the House, political leaning of the Senate, political leaning of the Presidency, total lobbying dollars, and the number of health care bills passed per year) were independently run to test their relationship to the dependent variable (the mean of public opinion on government funding of health care) and then run all together accounting for the thirty-three year time period of the data.

To test whether party in power of the Presidency affected public opinion on government funding of health care an independent samples t-test was run. The independent sample t-test was used to examine the difference in mean support of public opinion on government funding of health care (hcsupport) between when Republicans (1) and Democrats (2) held office. Similarly, an independent sample t-test was run to test whether party in power of the House of Representatives and Senate affected public opinion on government funding of health care. A t-

test was appropriate to examine all three variables because the dependent variable is measured at the interval ratio level and the independent variable has two categories.

Next, to test whether lobbying dollars affects the mean of public opinion on government funding of health care (hcsupport) a simple linear regression was run because the independent and dependent variables are both continuous. Similarly, to test whether the number of health care bills passed by year affects the mean of public opinion on government funding of health care a simple linear regression was run because both the independent and dependent variables are continuous.

Following, to account for the affects all the independent variables had on the mean of public opinion of government funding of health care (hcsupport), a multiple regression was run. First, a multiple regression was run solely examining the effects of total lobbying dollars and number of health care bills passed on the effects of government funding of health care (hcsupport). After running that model, a second model was run which took into account each of the independent variables including, total lobbying dollars, number of health care bills passed per year, party in power of the Presidency, party in power of the House of Representatives, and party in power of the Senate.

Lastly, the data set was declared as a time series for the final analysis. A time series analysis is necessary to examine these data set to accurately account for correlations between each year. While one of the assumptions of a linear regression is that all observations are independent of one another, when examining how macro-level factors influence public opinion on government funding of health care it is important to take into account dependencies that naturally occur over time. More simply put, it is crucial to understand that when observing public opinion by year, responses are not formed in a vacuum solely year by year but are directly influenced by prior year responses. Thus, each variable was run independently using an autoregressive integrated moving average (ARIMA) model to examine the effects on the

dependent variable, public opinion on government funding of health care (hcsupport). Following the bivariate analyses, each of the variables was input into a multi-variate ARIMA model fully adjusting for all variables.

CHAPTER V: RESULTS

Bi-variate Analyses

Table 2 shows the t-test results for the difference between means of public opinion on government spending of health care (hcsupport) by political leaning of the house of Representatives, the Senate, and the Presidency. Results indicate the political leaning of the House of Representatives (*p*-value = 0.196) and the Senate (*p*-value = 0.758) are not significant with a *p*-value well above .05. The mean of public opinion on government funding of health care (hcsupport) did not vary between a Democratic or Republican majority in either the House of Representatives or the Senate. When looking specifically at the mean of hcsupport by the political leaning of the House of Reprehensive, the t value was -1.34. When Republicans held office (N=9) the mean sat at 26.68, while when Democrats held office (N=11) the mean was 29.51. Results were similar when examining the mean of hcsupport by political leaning of the Senate (t= .31). When Republicans held the majority (N=8) the mean was 28.66 and when Democrats held the majority (N=12) the mean was at 27.96.Though there were differences in public opinion depending on who held the House or the Senate, the differences, were not significant.

However, political leaning of the Presidency was significant with a *p*-value of .000 and a t value of 4.48. When a Republican President held office (N=12) the mean of public opinion on government funding of health care was 31, with a standard deviation of 2.73. When a Democratic President held office (N=8) the mean public opinion on government funding of health care was 24.09, with a standard deviation of 4.21. The significance illustrates that during a Republican Presidency public support for government funding of health care was higher, meaning that respondents were more in favor of government funding health care in the United States.

Table 2: Independent Samples T-test of Factors Affecting Public Opinion

Variable	Republican	Democrat	
House of Representatives			
Mean	26.68	29.51	
Standard Deviation	4.99	4.24	
N	9	11	
95% C.I.	22.84 - 30.52	26.54- 32.48	
t			-1.34
df			18
sig.			0.196
Senate			
Mean	28.66	27.96	
Standard Deviation	3.15	5.75	
N	8	12	
95% C.I.	26.02 - 31.29	24.31 - 31.61	
t			0.31
df			18
sig.			0.758
Presidency			
Mean	31	24.09	
Standard Deviation	2.73	4.21	
N	12	8	
95% C.I.	29.27 - 32.73	20.57 - 27.62	
t			4.48
df			18
sig.			0.000*

Next, bi-variate simple linear regressions (shown in table 3) were run to test the relationship between the independent variables, total lobbying dollars (model 1) and number of health care bills passed (model 2), and the dependent variable, public opinion on government funding of health care (hcsupport).

In the first model, when testing the relationship between total lobbying dollars and the mean public opinion of government funding of health care no relationship was found with a *p*-value of 0.712 and a t value of -0.38. The predicted value for the mean of public opinion on government funding of health care was 29.5 when controlling for lobbying dollars. The R-squared shows that independent variable, total lobbying dollars, only accounts for 1.58% of the variation of the dependent variable, public opinion on government funding of health care.

The second model in table 3, which examines the relationship between the number of health care bills passed per year and public opinion on government funding of health care, was

also insignificant (p=.482) proving there is no relationship between those two variables. The model shows that regardless of the number of bills passed in any given year, public opinion remains the same. The R-squared further shows that the independent variable, number of health care bills passed only accounts for 2.8% of variation by the dependent variable, public opinion on government funding of health care.

Table 3: Linear Regression of Factors Affecting Public Opinion

	Model 1		Model 2	
Variable				
Total Lobbying Dollars				
Coef.	-0.0000000038			
t	-0.38			
p	0.712			
95% C.I.	-0.0000000265	0.0000000189		
Health Care Bills				
Coef.			0.0374	
t			0.72	
p			0.482	
95% C.I.			-0.072	0.147
Constant				
Coef.	29.464		26.927	
t	5.37		12.71	
p	0.00		0.00	
95% C.I.	17.043	41.004	22.475	31.379
Prob > F	0.7125		0.482	
R-squared	0.0158		0.028	

Multi-variate Analyses

Table 4 shows the results of two multiple regression models. The first model examines the relationship between two independent variables, (1) total lobbying dollars and (2) health care bills passed, and the dependent variable, public opinion on government funding of health care. The second model examines the relationship among five independent variables, (1) total lobbying dollars, (2) health care bills, (3) party in power of the Presidency, (4) party in power of the House of Representatives, and (5) party in power of the Senate and the dependent variable, public opinion on government funding of health care.

The results indicate that the first model, in table 4, is statistically insignificant (F = 0.696). The R-squared shows that the two independent variables, total lobbying dollars and number of health care bills passed accounts for 48.64% of the variation by the independent variable, which is the mean of public opinion on government funding of health care. Within the first model, total lobbying dollars was not significant (*p*-value = 0.101) with a t of 1.85, proving there was no relationship between those two variables. Despite the fact that the *p*-value of number of health care bills fell below .05, this was also insignificant given the insignificance of the whole model proving there is no relationship between total lobbying dollars, number of health care bills passed and the mean of public opinion on government funding of health care.

While the first model in table 4 is statistically insignificant, the second model is significant with F = 0.042. The R-squared shows us that all five of the independent variables account for 84.67% of the variation within the independent variable. Within the model, the only variable that was statistically significant was political leaning of the Presidency (*p*-value = 0.034; t = -2.9). The model shows that compared to a Republican Presidency, when there was a Democratic President the mean of public opinion on government funding of health care decreases by 6.686. Within the model, since none of the other independent variables were significant, they do not contribute to our understanding of public opinion on government funding of health care.

Table 4: Multiple Regression of Factors Affecting Public Opinion

	Model 1		Model 2	
Variable				
Total Lobbying Dollars				
Coef.	0.0000000234		-0.00000000264	
t	1.85		-0.18	
p	0.101		0.863	
95% C.I.	-0.0000000058	0.0000000526	-0.0000000402	0.0000000349
Health Care Bills				
Coef.	0.237		0.0694	
t	2.71		0.81	
p	0.027*		0.454	
95% C.I.	0.0352	0.4397	-0.151	0.289
President				
Coef.			-6.686	
t			-2.9	
p			0.034*	
95% C.I.			-12.61	-0.761
House of Representatives				
Coef.			3.437	
t			1.19	
p			0.288	
95% C.I.			-3.99	1-.86
Senate				
Coef.			-1.568	
t			-0.77	
p			0.474	
95% C.I.			-6.77	3.64
Constant				
Coef.	6.729		33.99	
t	0.72		3.23	
p	0.494		0.23	
95% C.I.	-14.930	28.387	6.965	61.015
Prob > F	0.0696		0.042*	
R-squared	0.4864		0.8467	

Time Series Analyses

Bi-variate models. After the data were declared as a time series by year, Autoregressive Integrated Moving Average (ARIMA) models were used to explore the relationship among all five independent variables and the dependent variable while accounting for the potential for correlated data. When examining the influence of each of the independent variables on the mean of public opinion on government funding of health care utilizing the ARIMA model, political leaning of the Presidency was the only variable the was significant, with a *p*-value= .000 (shown in table 5, model 3).

Table 5: ARIMA Models of Factors Affecting Public Opinion

	Model 1		Model 2		Model 3	
Variable						
Total Lobbying Dollars						
Coef.	-0.0000000038					
z	-0.35					
p	0.728					
95% C.I.	-0.0000000253	0.0000000176				
Health Care Bills						
Coef.			0.0374			
z			0.62			
p			0.536			
95% C.I.			-0.0811	0.156		
President						
Coef.					-6.911	
z					-4.68	
p					0.00*	
95% C.I.					-9.804	-4.019
Constant						
Coef.	29.464		26.93		37.912	
z	4.46		12.65		15.42	
p	0.00		0.00		0.00	
95% C.I.	16.517	42.411	22.755	31.099	33.093	42.731
Wald chi2 (1)	0.12		0.38		21.93	
Prob > chi2	0.728		0.536		0.00*	

The model shows that compared to a Republican Presidency, when a Democratic President was in office, the mean of public opinion on government funding of health care decreased by 6.91 points. This means that when a Democratic President is in office, public opinion is predicted to be 6.91 points lower compared to when a Republican President is in office.

Further, graph 1 shows the relationship between the shift in public opinion on government funding of health care (hcsupport) and political leaning of the Presidency. The graph shows that around the time of every shift to a Republican President, the mean of public opinion on government funding of health care increases. Around the shift to a Democratic President it appears as if the mean of public opinion on government funding of health care decreases.

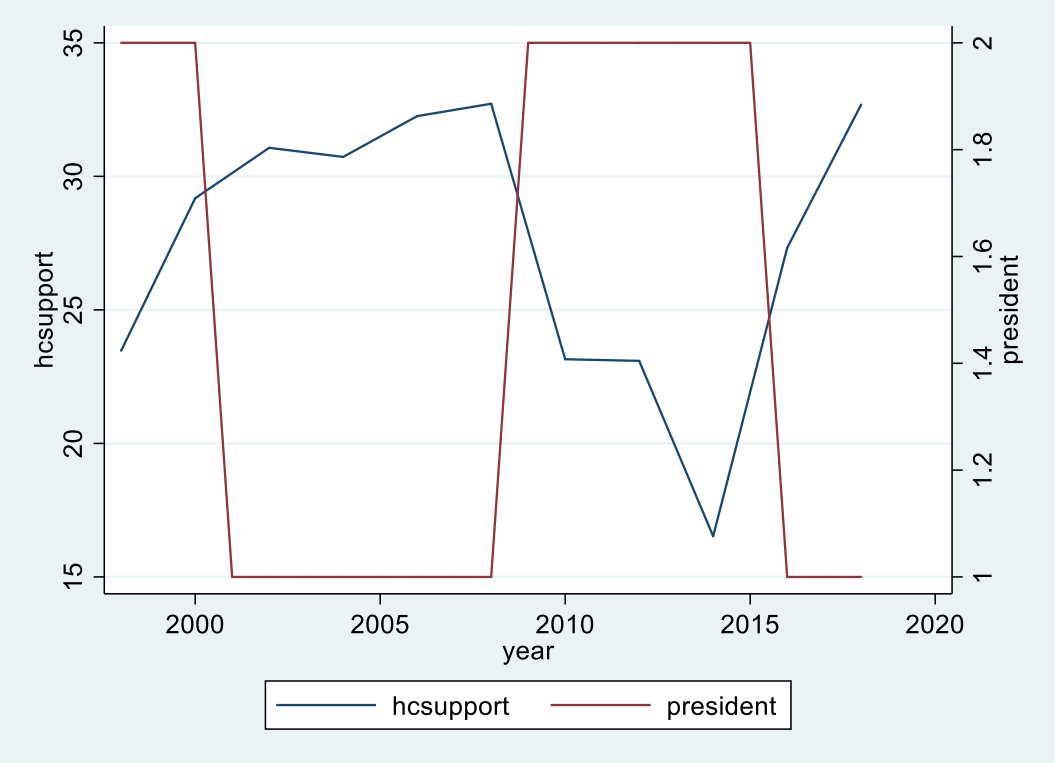

Figure 1: 'hcsupport' and political leaning of the President

Within table 5, model 1 shows the relationship between total lobbying dollars and the mean of public opinion on government funding of health care. The relationship is statistically insignificant with a *p*-value of 0.728 and a *z* of -0.35. Model 1 shows that there is no relationship between total lobbying dollars and the mean of public opinion on government funding of health. Model 2, which explored the relationship between the number of health care bills passed and the mean of public opinion on government funding of health care was also statistically insignificant with a *p*-value of 0.536 and a *z* of 0.62. This shows that there is no relationship between the number of health care bills passed per year and the mean of public opinion on government funding of health care. These two relationships are expressed below in graphs 2 and 3.

Graph 2 shows the relationship between the mean of public opinion on government funding of health care and total lobbying dollars by year, between 1998 and 2018. The graph shows a similar rise by both variables in the early-2000's, but while total lobbying dollars decreases slightly around 2008, the mean of public opinion on government funding of health care drops drastically and continues to drop until it reached its lowest point around 2014. Despite these trends, the analysis confirms there is no statistically significant relationship between these two variables.

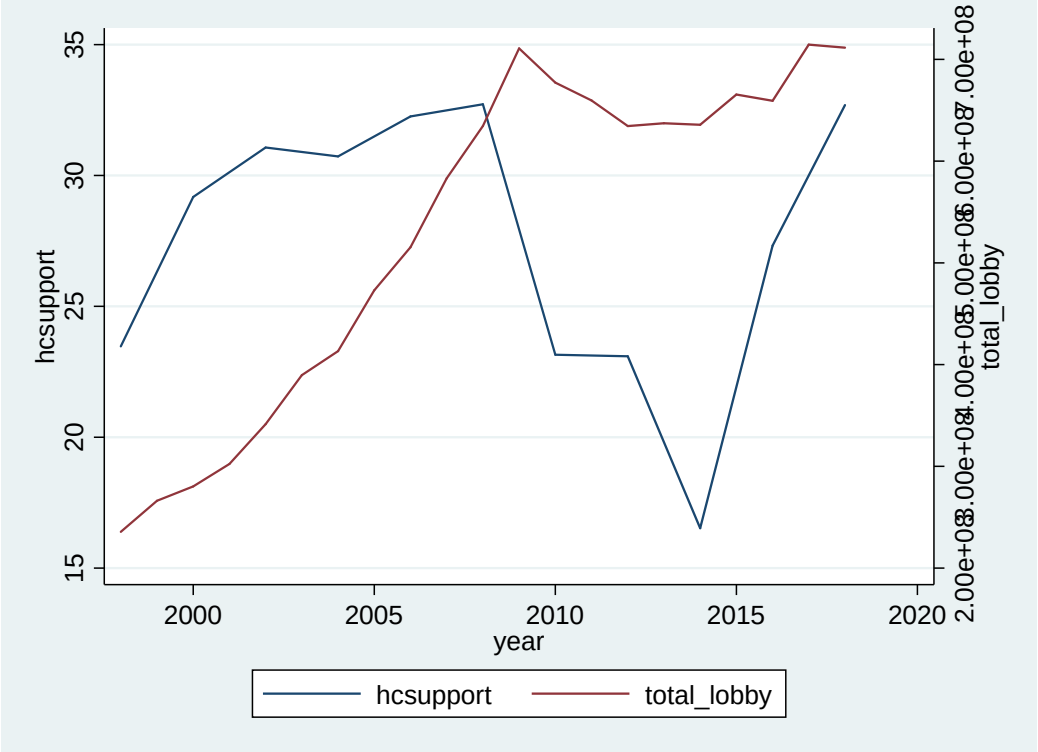

Figure 2: 'hcsupport' and total lobbying dollars

Figure 3 shows the relationship between the mean of public opinion on government funding of health care and the number of health care bills passed through Congress between 1998 and 2018. The graph shows a decline between both variables around 2008. Around 2009 and again between 2011 and 2012, the number of health care bills dropped to the lowest point, with close to 0 health care bills passing per year. The mean of public opinion dropped to its

lowest point around 2014, with the mean of public opinion hovering around 0. While the number of health care bills passed through Congress remains low, the mean of public opinion on government funding of health care began to rise around 2014. Again, while the graph illustrates different trends over time, the analysis shows no statistically significant relationship between the two variables.

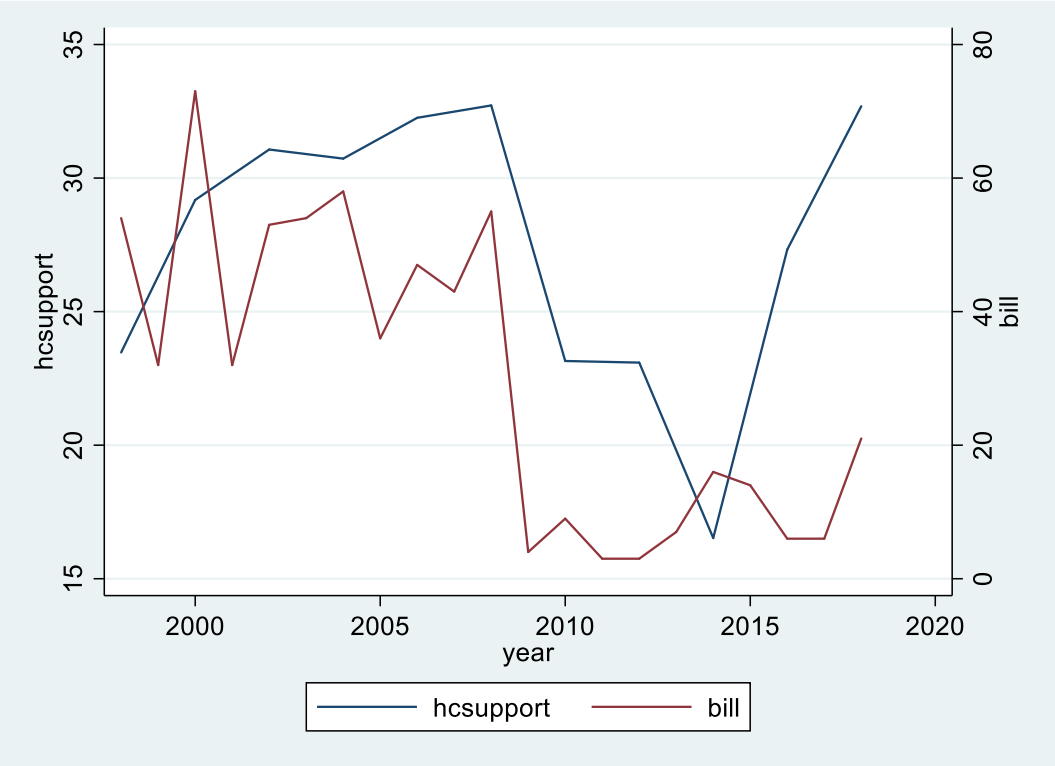

Figure 3: 'hcsupport' and number of health care bills passed per year

The remaining two bi-variate models are shown in table 6 below (models 4 ad 5). Model 4 explores the relationship between political leaning of the House of Representatives and the mean of public opinion on government funding of health care. The relationship between the political leaning of the House of Representatives and the mean of public opinion is statistically insignificant with a *p* of 0.164 and a *z* of 1.39, proving there is no relationship between these two variables. Graph 4 also shows the trends in these two variables over a 20-year span.

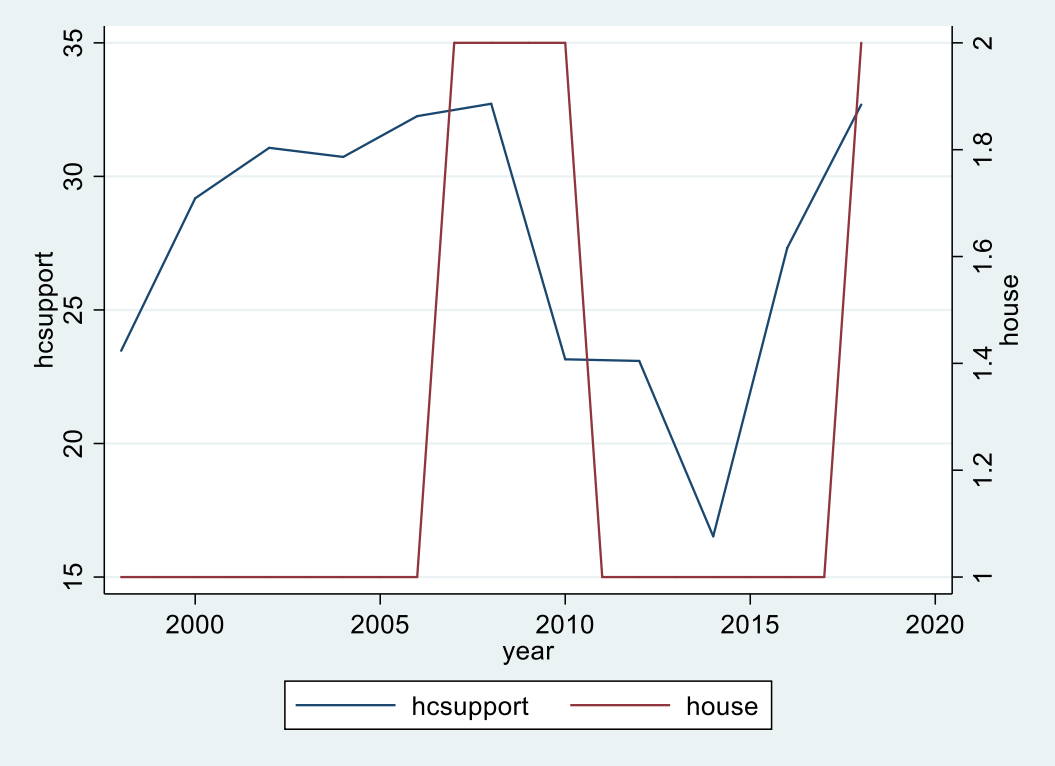

Figure 4: 'hcsupport and political leaning of the House of Representatives

Model 5 expresses the relationship between political leaning of the Senate and the mean of public opinion on government funding of health care. The relationship is also statistically insignificant with a *p* of 0.807 and a *z* of -0.24 showing that there is no relationship between these two variables. Trends between these two variables are also represented in graph 5, which shows the major decline in the mean of public opinion begin to drop shortly after Democrats took the majority of the Senate around 2006-2007. Then when Republicans gain back control of the Senate around 2015, the mean of public opinion on government funding of health care begins to drastically rise from around 15 to around 32 in 2018. Despite these trends, the analysis proves there is no statically significant relationship between political leaning of the Senate and the mean of public opinion on government funding of health care.

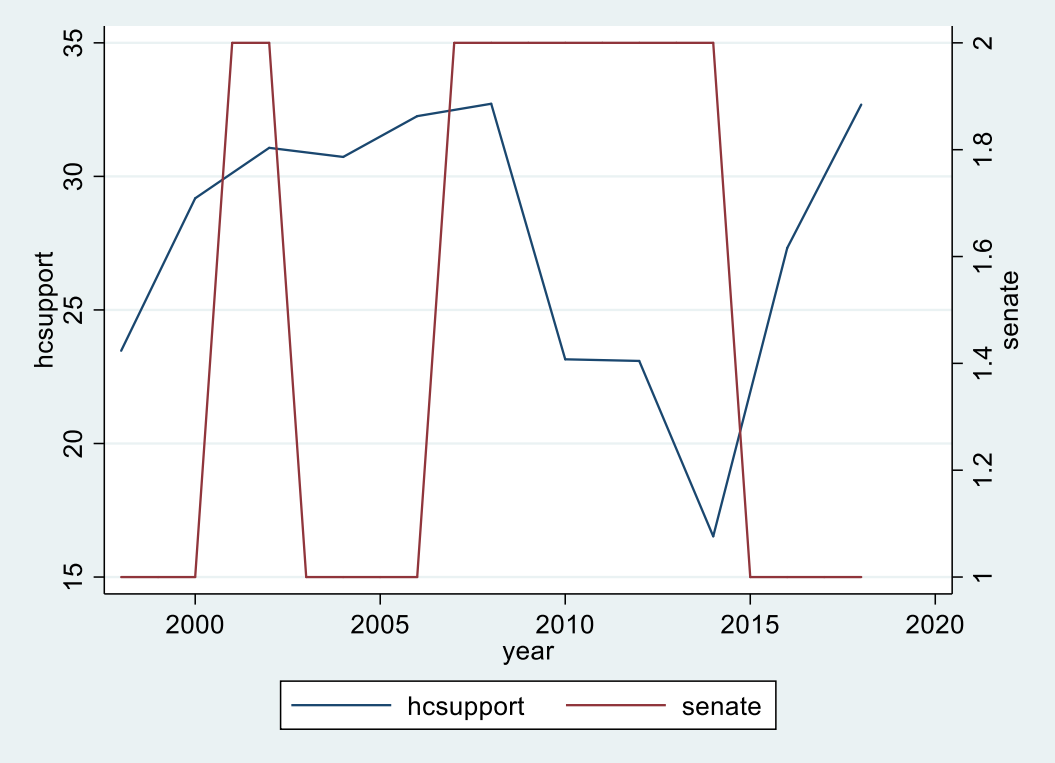

Figure 5: 'hcsupport' and political leaning of the Senate

Multi-variate models. Model 6 represents the final multi-variate ARIMA model, which explored the relationship between all five of the independent variables and the dependent variable over a 33-year period. Overall, the model was statistically significant with a *p*-value of 0.000. Within the model, the only variable that was statistically significant was political leaning of the President with a *p*-value of 0.013 and a *z* of -2.5. The model shows that for every shift to a Democratic President, the mean of public opinion on government funding of health care decreases by about 6.686 points. Each of the other variables was statistically insignificant when examining their effect on the mean of public opinion on government funding of health care over time. Total lobbying dollars had a *p* of 0.845 and *z* of -0.020, which shows there is no relationship between the two variables. The number of health care bills passed per year has a *p* of 0.38.

Table 6: ARIMA Models of Factors Affecting Public Opinion

	Model 4		Model 5		Model 6	
Variable						
Total Lobbying Dollars						
Coef.					-0.0000000026	
Z					-0.020	
p					0.845	
95% C.I.					-0.0000000291	0.0000000239
Health Care Bills						
Coef.					0.0694	
Z					0.87	
p					0.382	
95% C.I.					-0.086	0.225
President						
Coef.					-6.686	
Z					-2.5	
p					0.013*	
95% C.I.					-11.933	-1.439
House of Representatives						
Coef.	2.828				3.437	
Z	1.39				0.55	
p	0.164				0.580	
95% C.I.	-1.153	6.808			-8.720	15.594

	Model 4		Model 5		Model 6	
Variable						
Senate						
Coef.			-0.701		-1.568	
Z			-0.24		-0.40	
p			0.807		0.686	
95% C.I.			-6.333	4.931	-9.173	6.037
Constant						
Coef.	23.853		29.358		33.99	
Z	7.06		5.51		2.86	
p	0.00		0.00		0.004	
95% C.I.	17.233	30.474	18.918	39.798	10.733	57.247
Wald chi2 (1)	1.94		0.06		46.83	
Prob > chi2	0.164		0.807		0.00*	

CHAPTER VI: DISCUSSION AND CONCLUSION

Utilizing the thermostatic model, which is a tested model that explains factors that influence public opinion, this study aimed to investigate whether macro-level factors, like political party in power of the Presidency and Congress, total lobbying dollars by the top five medical industries, and the number of health care bills passed per year affects public opinion on government funding of health care in the United States. The purpose in exploring these relationships is to have a better understanding of factors that influence public opinion to have a more accurate depiction of how public opinion is formed and to understand the controversy around health care reform to this day.

Based on the thermostatic model, past literature, and the theoretical framework used in this study, the researcher assumed that larger political and social structures would have a significant effect on public opinion. Specifically, the thermostatic model assumes that public opinion is formed based on the policy being introduced, prior opinion on the issue (health care reform), and strategies instilled by the elite and the media (Corman and Levin 2016; Chard 2004; Carmines and Stimson 1980). This model aligns with previous literature that shows the that Congress members are increasingly more responsive to more affluent individuals as opposed to their constituents and instead of responding to their constituents' opinions, often Congress members try to change their opinions through different tactics including utilization of the media (Jacobs and Mettler 2011; Gilens 2005; Jacobs and Page 2005). In addition, the literature shows that as responsiveness to more affluent individuals increases, the individual wealth of Congress members and lobbying dollars being donated to Congress are also increasing (Klick 2018).

The work of Michel Foucault and Nicos Poulantzas further reinforces these ideas by focusing on power structures within capitalistic societies. Based on original Marxist theory,

Poulantzas notes that politicians in a capitalistic society are in a unique position where they must adhere to the needs of both capitalistic industries, that often exploit workers and the masses. This is evident in contemporary American society and shown in the literature, which notes that politicians tread between attempting to change public opinion on social issues to benefit the more affluent classes and responding to the masses with policies that benefit their well-being, like the ACA, Medicare, and Medicaid. Foucault also focuses on the structure of power and knowledge within society. Specifically, Foucault discusses the idea that discourse is shaped, within an episteme, by larger structures in society, like academia, politics, and the media. Thus, thoughts, ideas, and discourse are constrained by existing societal structures reinforcing the ideas within previous literature and the thermostatic model that state that public opinion is formed based on prior opinion, the policy being introduced, and strategies instilled by the elite and the media (Corman and Levin 2016).

Altogether, this led the researcher to believe that the political leaning of the President, the House of Representatives, and Congress, along with total lobbying dollars by the top five medical industries, and the total number of health care bills passed per year would influence public opinion on government funding of health care. After completing the analysis, using independent sample t-tests, linear regressions, and an ARIMA time series model, the results were mainly insignificant and showed no strong relationships among the political leaning of the House of Representatives, political leaning of the Senate, total lobbying dollars, number of health care bills passed per year, and the mean of public opinion on government funding of health care.

Despite the largely insignificant results, the political leaning of the Presidency did appear to affect public opinion on government funding of health care. The results showed that between 1986 and 2018, when a Republican President was in office, the mean of public opinion on government funding of health care was about six points higher on the thermostatic model

compared to when a Democratic President was in office. This finding can be backed by the thermostatic model, which shows that when a new policy is introduced public opinion often decreases and after a few years public opinion often reverts back to average (Corman and Levin 2016). Since two of the most impactful and comprehensive health care reforms were implemented under Democratic Presidents (the ACA and CHIP), the results showing that public opinion decreases during Democratic Presidencies seemingly makes sense. Further, this idea is reinforced by previous literature, which discusses the decline in trust for the government due to issues that arose during the implementation of the Affordable Care Act, like the malfunction of the website, and the use of the media and increased polarization by the Republican party to persuade constituents that the Affordable Care Act and health care reform would have negative consequences for the United States (Broockman 2018; Hall 2015).

Previous literature also discusses the notion that the percentage of Americans who are in favor of governmental support is likely to increase during and after bad economic times (Corman and Levin 2016; Jacobs and Mettler 2011). This can explain why public opinion was reported higher during Republican Presidencies since government-funded social programs were often cut during Republican Presidency, like Reagan and Bush. Also, under the Bush administration (2001-2009), the United States was undergoing one of the worst financial crises in history. This can also explain why public opinion on government funding of health care increased because Americans were in a state of crisis, with many losing their jobs, homes, and health care coverage.

Based on a study conducted by Pew Research Center in 2019, 69% of respondents believed that health care should be one of the top issues being addressed by the President and Congress. Given the importance of health care reform among Americans, the continual controversy around health care reform amongst politicians, and increased political polarization in the United States (Broockman 2018), it is important to continuously attempt to understand

how public opinion is formed throughout society. Although the results did not show much significance, this study does contribute to the larger body of knowledge about factors that may or may not influence public opinion on government funding of health care. This study also provides a framework of variables to consider for future studies.

While a majority of the variables used in the study did not affect public opinion on government funding of health care, future researchers could adjust these variables for time or acquire more data dating back further in time for each variable. If this model is used and adjusted for lags in time, future researchers can explore whether these macro factors affect public opinion later in time as opposed to immediately affecting it. Another limitation of this study was the limited time period that that data represented. The GSS only had data on the dependent variable, public opinion on government funding of health care, dating back to the mid-1980s and Open Secrets only had lobbying data dating back to the late 1990s. Future studies could attempt to acquire data that dates further back in time to account for more variation within each variable.

Going forward, it would also be important to consider adjusting the dependent variable, the mean of public opinion on government funding of health care. While the GSS provided approximately 1,800- 2,500 responses per year in a nationally administered survey, the bi-yearly responses were limiting when utilizing the ARIMA time series modeling. Since the data were sporadic and far from neutral, the ARIMA model works best when accounting for the difference between years, and since the data was bi-yearly, the researcher was unable to convert the data from the actual mean to the difference among years.

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