EFFECTS OF BLACK RACIALIZATION OF PUBLIC OPINION ON SUPPORT FOR GOVERNMENT FINANCED HEALTH CARE

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ABSTRACT

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This thesis examines the relationship between black racialization of public opinion and support for government financed health care. Four hypotheses are tested. Previous research has provided evidence of the impact of elite cuing as a mechanism to racialize public opinion. This issue is examined using the 2012 American National Election Survey Time Study (ANES) and ordinary least squares regression. Elite cuing is a contributing factor to the racialization of public opinion. The trend toward conservative ideology is often exacerbated black racialization. Results of this thesis support the hypotheses and are consistent with previous reports that public opinion is affected by use of racial cuing. Implications of the findings are discussed.

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CHAPTER I

INTRODUCTION

Government financing of health care has a complex history in the developed world. To date, all industrial societies have some form of public financing of health care (Hoffman 2003; Olafsdottir and Pescosolido 2010; Pfiffner 1995; Quadragno 2004). The United States maintains a somewhat fragmented health care financing system which consists of a combination of private insurance mainly obtained through employers, and government financing of health care via Medicare for the elderly, and Medicaid for the poor or disabled members of the population. The Veterans Administration (VA) provides medical benefits for current members of the military plus civilian government employees including their dependents. VA health service benefits began in the post-World-War II era, while Medicare and Medicaid originated in the mid-1960s, as addendums to the Social Security Act of 1935 (Olakanmi 1965).

The government sponsored TriCare for Life program provides benefits for former members of the military and their dependents. Kaiser Family Foundation survey data from 2013 indicate that approximately 50 percent of those insured receive coverage through employer-provided benefits, while 5 percent are insured through privately purchased insurance plans. According to the Centers for Medicare and Medicaid Services (CMS) 2009 calculations, approximately 25 percent of government financing of health care is undertaken through the Veterans Administration's (VA) health care

services, CHIP (Childrens' Health Insurance Program), and Medicare and Medicaid. The CMS predicts that the government share in the provision of health care financing is on the rise, reported as 44 percent of total health care expenditures by all participants as of 2009 (CMS 2011). Twenty-five percent of insured Americans are financed through the VA, Medicare, Medicaid and other government employee insurance plans. Taking into consideration the 25 percent of citizens with government financing of health care, the remaining 20 percent have no health insurance protection. The aim of the Affordable Care Act is to reach this 20 percent of the population that are uninsured, underinsured, or have only intermittent coverage.

Even without job loss, insurance plans can be cancelled at any time, leading to gaps in coverage not to mention adding the risk of being unable to obtain coverage due to presence of a pre-existing condition. At the very least, if coverage is obtained, the premiums are likely to be extravagant. Despite COBRA (Consolidated Omnibus Budget Reconciliation Act) provisions for health insurance portability between jobs, many Americans are unable to afford the extremely high premiums coinciding with periods of loss of income. Less publicized is that actual costs to the taxpayer far exceed those incurred through direct government spending. Federal tax subsidies provide freedom from taxation for all employer-based and private insurance plans. A significant loss of government tax revenues is derived from these tax incentives. This loss of tax revenues far exceeds the costs of direct government spending for the Medicaid program for the poor. The federal portion of these tax subsidies in 2009 was $265 billion dollars,

exceeding federal government costs for all Medicaid services (Conover 2011; West 2013).

American attitudes toward government involvement in the financing of health care are complex and seemingly contradictory. Studies have suggested that expression of attitudes toward health care financing is highly dependent on the manner in which questions are posed by researchers (Jones and McBeth 2010). Depending on the structure of questions, diametrically opposed responses may be obtained from those elicited through other forms of wording (Jones and McBeth 2010; Tesler 2012;). Recent literature suggests that an important factor affecting attitudes toward government financing of health care is negative black racialization of public opinion. Racialized opinion is defined as a process that triggers negative black racial stereotypes (Tesler 2012; West 2013). Triggering of negative stereotypes is a tool frequently used by powerful elites to influence attitudes toward social, political, or economic issues (Harell, Soroka, and Ladner 2012; Jacobs and Mettler 2011; Tesler 2012; Winter 2006). While some studies (e.g. Tesler 2012; West 2013) have addressed this issue, the impact of racialization of opinion on attitudes toward government financing of health care remains underexplored in the American context. This is a significant limitation, given that studies have argued that the presence of an African-American president has contributed to a significant increase in racialization with specific reference to the heated health care debate in the United States (Gollust and Lynch 2011; Tesler 2012).

An example of racial triggering of stereotypes, cited by Howard and Parente (2010), is seen with reference to the "Cadillac health care plans." The term "Cadillac" alludes to expensive health benefit plans provided to many in the upper earnings sector of the American workforce. These generous health plan packages are tax free and are part of the total employee compensation package. The "Cadillac Tax" (Howard and Parente 2010; West 2013) with reference to the Affordable Care Act, is a negative trigger useful to call attention to the tax of 40 percent to be placed on these high dollar plans, scheduled to begin in 2018. This taxation is perceived by high earning individuals as designed to their making a contribution toward financing of Affordable Care Act provisions. Historically, Americans tend to reject any mention of tax increases (Quadragno 2004; Tuohy 1999). Needless to say, upper income earners object to taxation of what is considered part of their total earnings over and above current rates of taxation. By extension, proposed taxation of high-dollar insurance plans raises the ire of many conservative individuals. Mention of "Cadillac" in reference to luxury health care coverage plans evokes negative black racial stereotypes by stimulating ideas of undeservingness and wastefulness that have long been linked with negative racist thoughts toward blacks. Stereotypes such as these call to mind those who are thought to be exploiting the government while living an extravagant lifestyle including driving luxury Cadillac automobiles which are known by many to be among the favored automobiles among blacks (Howard and Parente 2010). Therefore, use of such a racial cue is intentionally employed by conservative elites to promote a negative opinion of the

Affordable Care Act. Ironically, these expensive "Cadillac" insurance benefits are mainly enjoyed by more affluent members of society, those whose earnings far exceed incomes of most American, black or white. As a result, far fewer blacks have access to these tax free benefits.

A significant factor in the formation of attitudes toward government financing of health care is embedded within the larger corpus of attitudes concerning the role of government in providing services for citizens. Complex, deeply entrenched moral values concerning personal responsibility, success, failure, and ideologies underlie attitudes toward government (Banks 2013; Lakoff 2002). These often diametrically opposed core values provide a foundation for public attitudes toward government involvement in the lives of citizens. Individuals who have been raised with a "Strict Father" moral value system (Lakoff 2002), including many conservatives, believe that government should play only a minimal role in the lives of citizens who should be self-reliant, taking care of their own needs without the aid of the government. Government interference in the life of an individual possessing such a moral value system is vehemently rejected since it is thought to promote weakness by taking away the desire to help oneself. On the other hand, individuals raised in families with a "Nurturant Parent" moral value system (Lakoff 2002), mainly the more liberal-minded, believe that giving help to others less fortunate is part of living in society. Between these two extreme models lies a wide range of variation which can explain the diverse attitudes toward social programs designed to help those in need. Conservatives believe that hard work brings both reward and success and

that anyone may achieve the American Dream if he or she is willing to work hard enough. Conversely, liberals believe that not everyone has access to the same opportunities and therefore may not be able to achieve an improved standard of living or have access to educational opportunities. Extensive research on correlates of public attitudes is entangled within these highly complex belief systems (Lakoff 2002).

RESEARCH PROBLEM

With respect to support for government financing of health care, the complexity of relevant issues becomes especially intense. To address this gap in the American literature on the impact of negative black racialized opinion on public attitudes toward government financing of healthcare, this thesis examines the relationship between racialization of public opinion and support for government financing of health care in the United States. This thesis employs the 2012 data from the American National Election Time Study (ANES), previously known as the National Election Study. The ANES Time Study has been conducted in presidential election years since 1948. Face-to-face interviews are conducted during the two months preceding the November election. These same respondents are then re-interviewed during the two months following the election. For the first time in the history of the ANES, in 2012, face-to-face interviews are supplemented with data collection via Internet. Data collection is conducted independently in each of the two modes. The 2012 ANES has the largest sample size, 5,916 respondents, more than any previous study in the history of the ANES Time Series.

RATIONALE

This thesis contributes to literature on government financing of health care. In addition, this study addresses the gap in research on the impact of negative black racialization of public opinion on support for government financing of health care in the United States. It further builds on earlier research by Tesler (2012), specifically the elite cue theory. This thesis differs from the work of Tesler since it is conducted using only secondary data whereas Tesler used a combination of both secondary data and qualitative measures including face-to-face forums in various parts of the country to compile a more comprehensive study of the topic. By incorporating racial resentment and black stereotyping variables, this thesis examines to what extent this phenomenon persists in its influence on public support for government financing of health care. Additionally, this research provides information for policymakers who may wish to develop effective strategies to build support for expanded government involvement in health care financing. Furthermore, it provides useful information for researchers seeking to understand the intensity of opposition to the Affordable Care Act and other proposed policies by illuminating the role of elite cuing of negative black racialization as a tool to shape attitudes toward health reform measures as well as other social issues of concern in our current times. Finally, it may contribute to activists for health care reform in the development of a more effective, theoretically grounded understanding of public attitudes toward the role of government in health care provision.

Research has shown how negative black racialization of public opinion has been successfully used by powerful groups in America to achieve an overarching agenda aimed at discrediting efforts toward health care reform (Jacobs and Mettler 2011; Tesler 2012; West 2013; Winter 2006; and others). Racialization of opinion has been especially strong since the election of Barack Obama, our first African-American president (Tesler, 2012; West, 2013). Powerful forces attempt to block efforts of the Obama Administration seemingly on all fronts with health care reform as only one example. Another area explored is the impact of negative black racialization of opinion on minorities, especially blacks and Hispanics, attitudes toward government financing of health care. This area has been unexplored in previous studies, therefore, it may add to the body of research on racialization of opinion. Admittedly, it is next impossible to eliminate all traces of possible negative black racial trigger words through elite cuing. Rather, this thesis contributes to a heightened awareness that elite cues are used to achieve the more subtle agenda of powerful interests who wish to maintain the status quo regarding health care financing (Funigiello 2005; Tesler 2012; Tuohy 1999; West 2013).

PLAN OF WORK

Chapter 2 is a survey of the extensive body of literature on the historical evolution of health care reform efforts in the United States. The second section highlights milestones in social reform efforts. The third section surveys factors influencing the formation of opinion, specifically the effects of situational framing on the dynamics of public opinion over time. The fourth section reviews an extensive body of literature

concerning negative black racial stereotypes and narrative framing employed by powerful groups. The fifth section describes the current system of employer-based health insurance. The sixth section describes problems in the American health care system. The final section outlines the theoretical framework and lists hypotheses.

Chapter 3 provides a detailed description of the data and methods. Chapter 4 discusses findings, conclusions, and implications of research findings. Chapter 5 summarizes findings, discusses implications, limitations, and recommendations.

CHAPTER II

LITERATURE REVIEW

This literature review surveys the historical development of health insurance programs in the United States. Intertwined with health care reform efforts is a persistent theme of racism in America, specifically the triggering of negative black racial stereotypes with links to welfare abuse, government programs, deservingness, negative black work ethic, and the increasingly black face of poverty in general. A discussion of major milestones in the health care reform process will then be presented. Elaboration of historical trends in public attitudes toward government financing of healthcare delivery, including factors that have either enhanced or impeded progress toward health care reform is followed by an explanation of Tesler's elite cue theory with specific reference to mass cuing of stereotypes by media. Tesler refers to the process as the spillover of racialized opinion into attitudes toward government finance of health care (Tesler 2012). Examination of the current employer-based health insurance coverage is followed by a description of problems with the current health care system and motivations for reform efforts. To conclude this section, a discussion of the underlying theoretical framework will be followed by a listing of hypotheses to be tested.

HISTORY

Prior to the early 1900s, Americans had only minimal awareness of individuals having no access to medical care due to financial reasons. Consequently, it was easy to

overlook blacks since they had been historically invisible to white society (Gilens 1999). Black poverty has been largely ignored by white American society throughout most of American history (Funigiello 2005). In the early years of the 20th century social reformers and researchers sought to describe and analyze the conditions of the poor. It was at this time that racial distinctions first surfaced. However, even then the focus was on those of European descent and not blacks. Gilens (1999) argues that racial stereotyping plays a central role in generating opposition to welfare, particularly the centuries old stereotypes of blacks as lazy stemming from the defense of the institution of slavery. Such stereotypes remain credible subconsciously for large numbers of white Americans. Furthermore, these stereotypes have been perpetuated over time, passed down from generation to generation, and contribute to persistent economic disparities between black and white Americans. Over succeeding decades this problem has been exacerbated by the emergence of a highly visible black urban underclass that has come under intense media scrutiny. Thus, media are complicit in the alteration of perceptions of white Americans concerning blacks, including their numbers in society. Statistics have shown that blacks comprise only 12 percent of the population of America (Funigiello 2005; Tesler 2012). Furthermore, their numbers have remained fairly constant throughout history. Blacks do comprise, however, 27 percent of America's poor. Thanks to media, however, many Americans surveyed report that blacks make up 50 percent of the poor in America. Thus, the linkage between blacks and poverty has been exaggerated.

The idea of health care insurance originated in America during the post-World War I era (Blendon and Benson 2001; Olafsdottir and Pescosolido 2010; Quadagno 2004; Tuohy 1999). Prior to this there were but a few private efforts to initiate prepaid health insurance programs around the turn of the 20th century, however most were not very effective. The common opinion held by most citizens was that health care was obtained for the most part from charity hospitals, often where people went to die. America was rapidly industrializing at the turn of the 20th century and the "problem of sickness" was uppermost in the minds of employers, employees, and unions. Workers missed work due to illness, losing wages each time they became ill. Sickness, thereby, became a major cause of poverty. As part of their contracts, labor unions began to ask for protection of employees' wages in addition to protection against unforeseen medical costs. For these reasons, unions proposed a system of compulsory health insurance modeled on the German and British models (Tuohy 1999).

Efforts by the administration of President Theodore Roosevelt to provide employee health coverage were an attempt to replicate European efforts of social insurance programs. Alas, such efforts were interrupted by the rumblings of World War I that would begin a few years later in 1914. Roosevelt's concern about the probable need to provide financial assistance to Europe in a war led to derailment of his efforts toward a health care coverage plan. During the 1930s, America was in the grips of the Great Depression. Social reformers of the time, together with Franklin Delano Roosevelt (FDR) and his legislative allies once again pushed to institute health care reform. As the

Depression deepened, the focus on health care reform was diverted due to rapidly deteriorating economic circumstances and widespread unemployment. Depression-era social movements were formed by farmers, workers, unemployed, veterans, elderly, even socialists and communists. Grassroots groups such as these marched in the streets and marched on Washington for relief and justice. Their prime focus was directed toward seeking economic relief and security for workers and the aged plus relief from unemployment and the moderation of the effects of the national economic collapse. These social issues took precedence over health care reform so, once again, efforts dwindled (Funigiello 2005; Tuohy 1999).

The 1929 American stock market crash caused many citizens to lose a significant portion of their money and other assets. Baylor University health care facilities in Dallas, Texas became concerned that hospital bills would not be paid. In an effort to smooth out revenues during the Great Depression, Baylor instituted the first prepaid hospital health insurance plan that would guarantee Dallas teachers, a majority of whom were women, 21 days of hospital care annually, for only $6.00 per year payable at fifty cents per month. The rationale was that females would spend fifty cents for lipstick which would only last a short time; therefore it was surmised that these teachers would be willing to spend fifty cents a month for the guarantee of hospital care in the event of illness. The Baylor plan rapidly became popular and was extended to other employer groups in Dallas – and then across the country. The plan became known as Blue Cross and was a non-profit insurance scheme that did not discriminate because of age, gender, health status, or

pre-existing conditions. In 1939, Blue Shield was begun to provide coverage using the same Baylor model, for payment of physician charges. Thus was the formation of what is now called the Blue Cross/Blue Shield (BC/BS) Insurance Company (Lichtenstein 2012).

In 1935, the National Labor Relations Act (NLRA) was enacted by Congress. This legislation required management to bargain with labor over wages and conditions of employment. Thus, the NLRA became a catalyst for expansion of employer-driven health benefits. Learning of the success of BC/BS, employers across the country soon became interested in the provision of health care benefits. During World War II, wages were frozen by the federal government. There was a desperate shortage of workers due to the absence of large numbers of men away to combat. To be able to attract and retain workers, employers offered health coverage to employees. Therefore, the employer-based system of health care originates directly from Blue Cross/Blue Shield. The federal government provided incentives to employers to encourage them to provide health insurance coverage. These incentives came in the form of tax subsidies. In 1943, the Internal Revenue Service (IRS) declared that employer-based health care coverage was tax free for employees also (IRS 2013). As a result of this employer-driven health care model the numbers of insured workers swelled from an initial 12.3 million insured, a scant 9 percent of the population in 1940, to 122.5 million insured by 1960, nearly 75 percent of the population (Thomasson 2002). The popularity of the Baylor scheme was

spurred on largely by the tax subsidies benefitting both employers and employees (Funigiello 2005).

As private insurers witnessed the success of Blue Cross/Blue Shield, they rapidly came on board with their own private insurance plans to compete with them. BC/BS, a non-profit entity, as part of an agreement with state governments in order to maintain their non-profit status, was required to use a community rating scale that guaranteed the same premium rate for all insured. Commercial insurers were under no such obligation, therefore they used experience-rating, basing premiums on age, health status or pre-existing conditions, to justify higher premiums charged to those possessing less than perfect health. This, of course, excluded many potential clients (Thomasson 2002). Such a risk management technique virtually guaranteed vast profits for commercial insurers (Funigiello 2005). Over time, Blue Cross/Blue Shield observed that their model of community rating could not compete with private insurers. Therefore, they were forced to adopt the for-profit model with staggered rates for insured based on gender, age, health status, or the presence of pre-existing conditions. Throughout these adjustments to the insurance structure, the federal government provided tax incentives as encouragement to employers to provide health insurance coverage.

The New Deal program of Franklin Delano Roosevelt (FDR) included the Social Security Act of 1935, providing income security for millions of aged and disabled citizens. The public was overall in favor of this legislation although there was only limited understanding of the plan details (Sherman 1989). Opponents thought that Social

Security should only be available if there was proof of need. In reality, Social Security was, and continues to be, there for all who pay into the system. By the late 1930s, the economy began to show signs of stabilization and Americans were growing disillusioned with New Deal programs. The American Medical Association (AMA), staunch opponents of prepaid health insurance plans or any government intervention that would threaten their independent private practices and their cherished ability to charge fees established by them, redoubled efforts to defeat any measure toward health care reform (Funigiello 2005). With apparently unlimited financial resources at their disposal, the AMA was able to outspend and outmaneuver health reformers and liberal legislators. A campaign was undertaken to inundate FDR's White House with telegrams of protest. The AMA accused the Roosevelt administration of attempts to railroad universal health coverage through Congress (Hoffman 2003). It is unclear whether FDR was actually swayed by this campaign or whether the outbreak of World War II discouraged further efforts toward reform of health care during that era (Funigiello 2005).

Grassroots health reformers tried unsuccessfully to persuade physicians to support their opposition efforts. Doctors feared compulsory insurance would erode their incomes and take away independence in their practices. In addition to physicians' opposition to health care reform, businesses, insurance companies, and conservatives (who branded health insurance as Bolshevism) were united in efforts to maintain the status quo (Funigiello 2005; Tuohy 1999). The American Socialist Party endorsed a compulsory system of health insurance as early as 1904. This did little to allay fears of creeping

socialism prevalent in the population. Thus the label of "socialism" became attached to health care reform efforts (Lichtenstein 2012). Additionally, female trade unionists and suffragists were interested in health care reform, mainly because this would provide maternity benefits. By the 1920s, with continued vocal opposition by the AMA, the term "socialized medicine" was commonly used to describe all health care reform efforts.

In the midst of the Cold War it was an easy matter to convince the public that health care reform was a Soviet-inspired conspiracy at the very heart of the federal government. Opponents of health care reform used newspapers and academic journals to wage war against government-sponsored health care insurance efforts. Their efforts were directed toward the public using newspaper advertisements, television, radio, telegram, letter-writing campaigns, and lobbying of legislators who might also have been their own patients.

FDR died in 1945, succeeded by Harry Truman, another Democrat. Truman was interested in health care reform even more than FDR. He was determined to institute a universal medical insurance plan to be financed by tax dollars. Faced with a majority Republican Congress with no interest in health care reform, and coupled with AMA opposition, Truman's efforts were unsuccessful. Also of significance was that Truman lacked union backing for such a program.

During the 1950s and early 1960s, American culture underwent many dramatic changes, making it difficult to sustain any effort toward health care reform. The Civil Rights Movement, the Korean War, and the Vietnam War took center stage. Social

concerns such as lack of insurance coverage for the poor and aged, day laborers, employees of small businesses, and those who lost their jobs resulting in loss of health insurance coverage, were dwarfed by comparison. With the election of John Kennedy in 1960, the focus shifted once again to health care reform. Kennedy had been touched by the sight of Appalachian poverty while on the campaign trail. The faces of these impoverished were white. By this time private health insurance had been well-established in America. Kennedy knew that the only way to enact government-sponsored health insurance was to start slowly (Funigiello 2005; Tuohy 1999). He knew that a focus on the aged and the poor would be a good place to start since, in that era, there was compassion for these two groups, making it easier to obtain grassroots mobilization of support. In 1963, Kennedy was assassinated. However, his desires for health care reform did not die with him. Lyndon Johnson, in his Great Society agenda, specifically his War on Poverty, enacted Medicare and Medicaid legislation in 1965 to benefit the elderly and poor (Funigiello 2005; Tuohy 1999).

Once again the AMA had concerns, though they were never opposed to the notion that basic human health care was a right, as stated in the provisions of the United Nations Charter of 1948 (Olakanmi 1965). Though never completely disapproving of Medicare/Medicaid legislation, the AMA argument centered on two issues. The first was whether or not the aged did, in fact, need help with their medical bills. And second, assuming this need, they disagreed on the means to provide such help. Three government choices were proposed. The first choice was to provide government subsidies for private

insurance carriers. The second was for direct government payment for medical services for low income seniors' health care needs. The third proposal was health insurance provided through an expansion of the Social Security Act (Funigiello 2005; Tuohy 1999). So much controversy ensued relating to this proposed health care insurance reform that in the end the political process had to be used to resolve the issue (Olakanmi 1965). Elder groups were quite vocal, making a tremendous impact on the enactment of this legislation. At least part of the success of Medicare/Medicaid was due to its being an addendum to the Social Security Act which was, by this time, already wildly popular among the public. Though this was not the universal coverage Truman had envisioned, President Truman was sitting beside President Lyndon Johnson as he signed into law this monumental legislation. Without doubt, Medicare/Medicaid legislation, signed in 1965, is the most important American health care legislation of the 20th century. Interestingly, the AMA did back this legislation, but only because a deal was struck enabling them to continue to be reimbursed for charges for elderly and poor Medicare/Medicaid patients at the same rates charged to all patients.

Johnson gained the power of a Democratic super-majority in both houses of Congress upon his landslide election victory in November, 1964. This placed him in a powerful position to enact this landmark legislation. There were, however, forces afoot that influenced Johnson's decision to back away from universal coverage at that time. Primarily, Johnson, who planned on a possible second term, did not wish to alienate the electorates of the Southern States who were fearful of any possible interference with

racial issues or the South's low wage policies. A second factor influencing Johnson's putting the brakes on full universal health care coverage was the growing unpopularity of the Vietnam War. The years of 1964 to 1967 saw widespread chaos and civil unrest in the streets of America. The Civil Rights Act was signed by Johnson in 1964 followed a year later by the Voting Rights Act. Johnson was occupied with the implementation of these new and highly contentious laws and was simultaneously dealing with this massive civil unrest. While preoccupied with these issues the window closed on universal health care coverage for all Americans (Tuohy 1999). During 1964, Canada enacted universal health care coverage for all its citizens (Tuohy 1999). This same program is in operation today and is overwhelmingly popular with Canadians, though one may hear stories to the contrary.

Infrequently mentioned are the efforts toward health care reform undertaken during the Republican Nixon administration of the 1970s. Nixon implemented the formation of Health Maintenance Organizations (HMOs) in 1973 – including Cigna, Kaiser Permanente, Humana, and others. During the 1970s health care reform efforts were bipartisan. There were many compelling bipartisan ideas on universal health care coverage and much Congressional debate. However no bill ever reached the desk of President Nixon. Much of the dispute centered on the role of government. There was much in-fighting within the Democratic Party about methods of funding of health care insurance. By the time a proposition reached Nixon's desk, this coincided with the decision of Congress to investigate corruption charges against him for his participation in

the Watergate scandal. Once again, an opportunity was lost for health care reform and the window closed (Tuohy 1999).

A poor economic climate described as "stagflation" – meaning simply an inflationary period that was unchanging – coupled with a weak presidency, caused the Carter Administration to delay talks about health care reform (Funigiello 2005). Carter's troubled administration came to be known as the most conservative Democratic administration since Grover Cleveland. As such, commentators judged that he had single-handedly built the foundation that was to become the full-fledged conservative architecture under Reagan (Funigiello 2005). Despite constant prodding by Senator Edward Kennedy, a lifelong advocate of universal health care, no progress was made toward health care reform. Reagan's ultra-conservative "Reaganomics" economic policy allowed no further effort toward health care reform. Reagan's efforts were directed toward shrinking, rather than expanding, any public benefits, including welfare and government programs of benefit to the poor which included assistance with housing and food stamps.

Health care reform efforts were dormant through several presidencies, for a period of over 20 years. Several candidates tried to revive reform efforts as a moral issue, especially Jesse Jackson in his unsuccessful bid for the presidency (Funigiello 2005). In the early 1990s, Clinton's health care reform efforts were unsuccessful. Hillary Rodham Clinton spearheaded a task force to produce a proposal for health care reform (Pfiffner 1995; Toner and Kornblut, 2006). The resulting plan was highly complex, founded on a

base of managed competition. The Clinton proposal drew opposition from all sectors including businesses, insurance companies, unions, grassroots organizations, AMA, legislators, and lobbyists for many special interests. There was such disagreement over the Clinton proposal that it was literally gutted and became a victim of incrementalism (Funigiello 2005).

The theory of incrementalism posits that if you cannot defeat the entire legislative package you just tear apart its components, accomplishing the same purpose. There is much evidence that this same plan is being tried today in the Obama health care reform efforts. The failure of the Clinton reform effort demonstrates the power of private interest groups to block reform. Blame must be shared with reformers' failure to inspire grassroots activism in support of health care reform. Ineffective narrative framing by the Clinton administration is thought to be one likely culprit responsible for the failure of the Clinton health care proposal (Howard and Parente 2010). Lessons derived from failure of the Clinton proposal include a clearer understanding that any proposed policy change must be perceived as an expansion of existing benefits. Support will most certainly be withheld if policy changes are perceived to take away any perceived benefit to powerful interest groups (McBeth et al 2007; Pfiffner 1995).

The bedrock of Clinton's plan included an employer mandate to provide health insurance along with federal government assistance through payment of premiums for an HMO for those unemployed or otherwise ineligible for Medicaid. Clinton campaigned extensively concerning the critical need for health care insurance for the 37 million

people in America lacking any form of health insurance coverage (Pfiffner 1995; Toner and Kornblut 2006). Clinton campaigned that these uninsured placed an overwhelming burden on emergency room care and that costs of emergency room care are re-distributed to those insured through higher insurance premiums.

Throughout all these health care reform efforts, the relentless opposition of special interest groups including business, insurance and the AMA prevented implementation of any widespread changes in health care insurance in America. Most proposals for change have tended toward placating powerful interest groups more than winning popular support of the people (Funigiello 2005). Ordinary people have difficulty rallying around complex proposals with a goal of sweeping changes to the status quo. Only the Civil Rights legislation has evoked as much negativism as efforts for health care reform in America (Funigiello 2005; Tuohy 1999). In addition, none of the health care reform efforts were fought at the grassroots level. Rather, reformers put their faith in professional lobbying and experts, with no attempt toward popular activism.

Clinton wanted a single payer plan – universal health care – providing basic coverage for all. The resulting complicated package failed in this respect. In addition, arguments were dominated by advocacy groups and lobbyists. Further, Bill and Hillary Clinton's own personal issues and scandals resulted in a loss of confidence which led to a public hesitant to place trust in reform efforts that were based solely on trust which many felt was unearned. Other reasons why Clinton's effort failed were that Democrats were divided on health care reform. This led to the emboldenment of Republicans in their

opposition to Clinton's ambitious proposal. The role of media pundits increased public access to information that served, in many cases, to further confuse rather than enlighten. The power of corporate media had a powerful effect, then as now, on the formation of public opinion in America (Funigiello 2005; Tesler 2012; West 2013).

The Patient Protection and Affordable Care Act (ACA), also known as Obamacare, is the latest effort toward health care reform. Jacobs and Skocpol (2012) in the second edition of their book *Health Care Reform and American Politics – What Everyone Needs to Know,* are engaged in increasing public awareness of the politics influencing health care reform. They have suggested that the ACA represents a milestone, even though its implementation has taken a rocky course thus far. The U. S. Census Bureau (2012) report 15.7 percent of Americans have no health insurance. Taking into account those underinsured, either having only intermittent coverage or only able to afford the premiums of catastrophic coverage, this figure exceeds 20 percent of the population by many estimates (Magge, Cabral, Kazis, and Sommers 2012). Many ideas resurrected from prior presidencies, both Republican and Democrat, are incorporated within the provisions of the ACA. And, for much the same reasons as Clinton, Obama took "single-payer" off the table. Leaving the option of universal, single-payer, health care on the agenda would virtually guarantee that the Obama administration would garner no support from of business, insurance, AMA, conservative politicians, or other powerful lobbies. (Tesler 2012; West 2013) Even without single-payer, Obama has received only sparse support from these groups.

As we all know, the implementation of the ACA is only one of many issues plaguing the Obama presidency. Upon assuming the Presidency, Obama was faced with the U. S. economic collapse, the Great Recession, which began in late 2007, the effects of which continue to damage the population in many ways. Though Obama has denied this, his race has been a prime issue throughout his entire presidency (Tesler 2012; West 2013). Obama is quoted in an interview by David Gregory on Meet the Press in September of 2009 "What I'm saying is this debate that's taking place [over health care reform] is not about race, it is about people being worried about how our government should operate." The effects of negative black racialization of public opinion have been fueled by the media, whose marching orders, in many instances, come from powerful behind the scenes elite forces bent on maintaining the status quo. Obama has been further hindered by two inherited wars (Iraq and Afghanistan) and an out-of-control debt situation. Former President Jimmy Carter remarked on September 15, 2009 in an interview with NBC Nightly News anchor Brian Williams: "an overwhelming portion of the intensely demonstrated animosity toward Barack Obama is based on his race."

Despite these hindrances, the Affordable Care Act was signed into law in 2010 with gradual implementation immediately thereafter. The ACA, surviving the Supreme Court challenge in 2012, continues the implementation process despite all the hoopla and multiple efforts by conservatives to repeal the law. October 1, 2013 heralded the opening of the health care marketplace where citizens could shop for health care coverage which could then be purchased to become effective on January 1, 2014. It is common

knowledge that computer glitches hampered the roll-out of the insurance marketplace application process much to the apparent delight of conservative opponents who have had a field day with the reasons for this obstacle.

This thesis concerns the effects of negative black racialization of opinion on support for government finance health care. It is arguable that Obama's entire presidency has been plagued with racial issues. This thesis has discerned that underlying race lies the impact of elite cuing of negative black racial stereotypes plus issues of moral formation in determining attitudes toward health care reform (Lakoff 2002). Issues of social justice are intertwined with deservingness of recipients who emanate from groups who are stereotypically depicted as lazy and living off public assistance (Gilens 1999). Without doubt, Obama's presidency has been one of the most difficult in recent American history (Tesler 2012; West 2013). Many would even disavow the legitimacy of the Obama presidency, wishing to just forget this two-term president completely – much as occurred after the scandal-ridden Nixon administration.

MILESTONES IN HEALTH CARE REFORM

Throughout history, effecting change in public attitudes toward reform of any government policy aimed at provision of assistance for those deemed less fortunate or weaker has met with opposition from powerful interest groups (Tuohy, 1999). The Social Security Act of 1935 was well received by the public (Sherman 1989) though knowledge and understanding of the program was limited. Opposition stemmed predominantly from differing perceptions of the shortcomings of the plan rather than

from the principle of government-provided funding of pensions. Some early polls referred to "pension" and the mere usage of this word possibly explained confusion in public attitudes toward social security benefits.

A second monumental milestone toward health care reform is the Medicare/Medicaid Act of 1965, an addendum to the Social Security Act of 1935. Medicare legislation insured health care coverage for the aging population of age 65 and older. Medicaid made provision for health insurance for those younger than 65 years of age who were disabled and unable to be employed and were, thus, unable to obtain access to employer-based health insurance coverage.

ATTITUDES TOWARD GOVERNMENT FINANCING OF HEALTH CARE

An extensive body of literature has analyzed public attitudes toward U.S. health care, past and present (Banks 2013; Blendon and Benson 2001; Blendon and Donelan 1990; Gelman, Lee, and Ghitza 2010; Gollust and Lynch 2011; Grande, Gollust, and Asch 2011; Gross, et al 2012; Harell, Soroka, and Ladner 2012; Hoffman 2003; Jacobs and Mettler 2011; Newport and Jones 2009; Olafsdottir and Pescosolido 2010; West 2013; and Williamson, Skocpol, and Coggin 2011). The most recent analysis has been conducted since the U.S. Supreme Court decision of June 28, 2012, affirming the constitutionality of the Affordable Care Act. The literature suggests an approximately equal division in current public attitudes between support for and opposition to health care reform. Interestingly, Newport and Jones (2009) report that seniors tend to oppose the new health care law. This is surprising since seniors are already covered under

Medicare, another government-funded health care program. These authors conclude that seniors may be wary of a possible dilution of their current Medicare benefits with the proposed expansion of coverage to include more citizens. Seniors are uncertain and uncertainty often leads to opposition.

Jacobs and Mettler (2011) examine the effects of situational framing on the dynamics of public opinion over time. Indeed, Blendon and Benson (1991) report that same phenomenon nearly two decades earlier. Both these studies have determined that the public can, and often does, hold two divergent opinions concurrently, depending on how a situation is framed or worded. Extreme pros and cons mirror the partisan political divide in America today. The impact of self-interest presumes an emotional component in the formation of attitudes, both in opposition to and support for health care reform.

Many players possess an interest in health care reform, including employers, hospitals, medical professionals, ancillary health care industries, pharmaceutical manufacturers, taxpayers, insurance providers, and current Medicare and Medicaid beneficiaries. Of interest in this thesis are attitudes of racial and ethnic minorities toward health care reform efforts. Hispanics, in particular, are generally pro-reform (Sanchez et al 2008) though health care reform is not their most salient concern. They are, however, more likely than whites to believe in the importance of affordable health care programs and less likely to believe that individuals are responsible for assuring coverage for everyone. In addition, Hispanics are more in favor of extending coverage to undocumented immigrants (Sanchez et al 2008). The black population is known to be

predominantly affiliated with the Democratic Party, and therefore are overwhelmingly pro-Obama. Blacks stand to benefit under the Affordable Care Act provisions. Little has been written directly concerning attitudes of other racial and ethnic groups though studies have shown that all minority groups tend toward the more liberal political views (Funigiello 2005; Tuohy 1999; White 2007; and others). Therefore, it may be inferred from this tendency that they would also be in agreement with the implementation of ACA provisions. Since negative black racialization of opinion has its roots in the triggering of unconscious negative black stereotypes it would be useful to understand the effects, if any, of the use of these negative stereotypes on these minority groups.

A Berkeley study by Gellman, Lee, and Ghitza (2010) estimated support for health care reform by age, income, and state. Opposition to reform is concentrated among higher income voters and those 65 years of age and older. The study demonstrates only minimal variation by state. The study poses limitations due to the use of older poll data only through 2004. Nonetheless, the study highlights what can possibly be learned from relative positions of different demographic groups and states despite swings in public opinion.

Hoffman (2003) emphasizes the importance of grassroots social movements, otherwise described as change from below, that have occurred occasionally in the history of U.S. social reform efforts. The relationship between social movements and demand for universal health care coverage is, therefore, critical. Most 20th century reforms were initiated and run by elites who were more concerned with defending against attacks from

interest groups than with popular mobilization (Funigiello 2005; Tuohy 1999). Any changes, even those initiated by grassroots movements, have only succeeded in bringing about relatively incremental and short-term changes rather than long-term changes to the health care system as a whole. Also common during various reform attempts has been that after plans were proposed, opposition groups entered the debate with arguments ranging from new programs being worse than existing ones, to the extreme fear-mongering regarding health care reform leading us down the path toward rampant socialism, or worse (Funigiello 2005). Such extreme opposition preys on public emotions. With time, opponents' arguments take a toll upon public opinion, thereby producing an increasingly negative public view of health care reform (Funigiello 2005).

Many factors impact public attitudes toward the broad issue of health care reform in general and government financing of health care in particular. Beliefs about the role of government in society, basic human values, and the overarching American market-driven agenda all impact the formation of attitudes toward health care reform. Attitudes are often manipulated by media pundits who reside on both sides of the partisan divide, many of whom are, intentionally or unintentionally, providing misleading information, which keeps the public confused as to benefits proposed in health care reform. In addition, morally and racially charged metaphors can be potent triggers affecting polling results.

Overall, the public holds conflicting views on health policy issues. General views are coupled with citizens' opinions in support or opposition to government regulation of the private sector (Blendon and Benson 2001). Correlates of public opinion are mixed at

best regarding health care reform (Grande et al 2011; Grande, Gollust, and Asch 2011). Public support for health care reform depends on how the issue is framed by elites, or elite cuing (Tesler 2012). Conflicting views on health care and distrust of government are predominant arguments (Blendon and Benson 2001). Americans, according to Pew (2010) and Gallup (2011), are increasingly critical of the public/private health care system and of private health insurance/managed care industries. A majority of Americans indicate in various polls, general support for a national health insurance plan (Blendon and Benson 2001).

Starr (1991) reported the cyclical nature of attitudes toward health care reform. During times of economic expansion, attitudes toward health care reform are less of an issue. In 1945, post-World War II America for example, Harry Truman proposed health care insurance reform (Funigiello 2005; Tuohy 1999). Pivotal in Truman's proposal was his statement that only 4 percent of national income was devoted to medical costs. Truman surmised from this that Americans could afford to pay more for health care. His statement was intended to sweeten his plan for universal health care coverage efforts by promising increased earnings for doctors and hospitals, thereby garnering support for health care reform. This attitude is certainly no longer held with today's skyrocketing costs of health care.

To further complicate the landscape of public attitudes, polls report somewhat contradictory public satisfaction with their current medical arrangements (Olafsdottir and Pescosolido 2010), which hints that other factors may be influencing poll results. Future

research efforts may well be directed to determining the presence of another dynamic in the ongoing health care debate. The severe economic recession of late 2007 through 2009 contributed to "widespread readjustment of citizens' priorities" (Grusky et al 2011:162). Therefore, as history has demonstrated, no matter the era, efforts toward health care reform are contingent upon greater societal forces. The GFK Custom Research Poll (2011) data demonstrates that employers continue to be skeptical of reform efforts. At the same time few propose dropping coverage for their employees. Employers' lack of support correlates to recent increases in insurance premiums. Finally, Grande, Gollust, and Asch (2011) found that public support for reform was broader than previously reported, depending significantly upon the framing of proposals. It is clear that over time opinions wax and wane regarding health care reform and for a multiplicity of reasons. Employers providing health insurance blame consumer lifestyles for the ever-increasing premiums. Physicians blame patients for the excess use of health care resources. The consumer blames fraud and high costs of care on the skyrocketing costs of health care. Depending on one's point of view, "the others" are always at fault in the conundrum in which we find ourselves regarding government financing of health care in America today (Miller, Goodman, and Norbeck 2010).

Appearing frequently in the literature is a discussion of fundamental value systems (Lakoff 2002). Moral values are generally imparted through parents. Generally, a Strict Father Model or Nurturant Parent Model, or some combination of these two basic ideas, dictates how an individual processes life choices (Lakoff 2002). Lakoff (2002)

noted that there exist at least a dozen models for evaluating fairness, including equality of distribution, equality of opportunity, needs-based distribution, scalar distribution, and others. Two main foci are the Strict Father and the opposing Nurturant Parent models. According to Lakoff, the Strict Father model stresses discipline, authority, order, boundaries, homogeneity, purity, and self-interest. On the other hand, the Nurturant Parent model emphasizes empathy, nurturance, social ties, fairness, and happiness. These moral models underlie much of the partisan outrage on health care reform as witnessed in 2009-2010. Rich, in an op-ed for *The New York Times* (2010:2) contends "it was only the Civil Rights bill that came near in comparison to the current outrage. The reason is that both events invoked enormous change to the moral identity of the country, not just its governance." Any perceived threat to an in-group causes a rallying of in-group members. Often such rallying results in decisions that run counter to actual benefits that could be derived from programs defined by out-groups. It would be impossible to do justice to the topic of negative black racialization and its effects on attitudes toward government financing of health care without giving priority to the underlying issues of morality that guide us all in our every action, thought, and word.

Supporters of health care reform often declare that health care is a basic human need or right. This implies that everyone deserves it. The United Nations (1948) declared that health care is a basic human right worldwide. Conservative opponents to health care reform value the moral principles of self-discipline and earned rewards, implying the scalar model of fairness (the harder you work, the more you deserve).

Liberal metaphors provide rationale for expansions in social programs including health care reform. Narratives serve to simplify complex realities by giving priority to one set of evaluative criteria over all others. In this way, narratives are always political because their framing reflects their narrator's ideology, values and beliefs (Cobb and Rifkin 199l; Jones and McBeth 2010; Rifkin, Millen, and Cobb 1991).

RACIALIZATION AND RACIAL CUES

Race plays a significant role in our current health care debate. This has been seen especially since the presidency of Barack Obama which provides a distinctly racial tone to all presidential efforts (Tesler 2012; Watkins-Hayes 2009; Wear 2011; West 2013). Racialized and moralized trigger words shape public opinion concerning government financing of health care (Domke 1998; Tesler 2012; Watts, Domke, Shah, & Tan 1999). As previously explained, reference to Cadillac health care coverage evokes racial stereotypes by triggering subconscious thoughts of blacks as undeserving, wasteful, and exploiting the government while living an extravagant lifestyle (West 2013). Senator John McCain began using the term Cadillac health care during his presidential run in 2008 and this term has stuck in U. S. health care reform dialogue since that time. In a 2013 editorial in *The Morning Call*, McCain is quoted "Those who support the health care law were led to believe everyone would have Cadillac health care plans at a Chevrolet price, with no out-of-pocket expenses. Bottom line: Those who pay nothing for their health care plans (those receiving entitlements) will still have their Cadillac plans and pay nothing; those covered under employer-sponsored health plans will pay

more in premiums, deductibles, taxes, and co-pays." McCain's frequent references to community organizing efforts (Barack Obama's previous endeavor prior to the presidency) are aimed at evoking negative black racial stereotypes. Community organizing has been linked with race since the era of civil rights. Much literature exists concerning welfare, the welfare state, welfare reform, inner city, urban centers, affirmative action – all racially charged trigger words. One example is the work of Jill Quadragno (1994) which discusses at length the use of such trigger words to evoke negative racial connotations. Yet another example comes from Barack Obama himself in an interview with David Remnick of the *New Yorker Magazine* where he refers to the triggering effects of comments regarding community organization and inner city and urban planning as counterproductive to the Affordable Care Act provisions. Perhaps the most insidious use of triggering devices comes from visual representations of references to health care reform with a backdrop of images of black individuals as subtle references of the linkage of health care reform to race. Conservative media have been particularly adept at the usage of such visual triggering devices (see Fox News Archives).

Elites often capitalize on pre-existing linkages between issues and social groups to alter the criteria citizens use to make political decisions, as suggested by Valentino, Hutchings, and White (2002). Many contemporary researchers have pointed to this same triggering of stereotypes as being influential in attitudes toward crime (see Blumer 1958), welfare (Schram, Soss & Fording, eds. 2006; Ward 2008; and Watkins-Hayes 2009). Furthermore, inequities in health care practice in America have been discussed by

Williams and Rucker (2000) and Braveman (2011). Studies indicate that news media continue to be highly influential in the propagation of stereotypes (Gilens 1999). There have been various studies on the effects of stereotypical triggers (Harell, Soroka, and Ladner 2012; Tesler 2012; Valentino, Hutchings, and White 2002; White 2007). Recent studies have called attention to the racialization of opinions specifically related to U.S. health care reform (Tesler 2012; West 2013).

Yet another example of the spillover of racialization into health care attitudes is seen in Tesler's (2012) study. He draws on "theories of elite cues and mass cue-taking to show that Barack Obama's strong association with health care reform has racialized white American's opinions about this issue." The United States is far from unique with regards to holding prejudicial attitudes. A Canadian study by Harell, Soroka, and Ladner (2012), using Canadian Election data, examines the ways in which racial cues influence attitudes toward redistributive policy. They found that public support for welfare may deteriorate if and when it is framed in a way that promotes Aboriginals' use of such benefits.

A study by White (2007) explains how racial cues influence opinions of black Americans on the issue of health care reform. Contrary to accounts that would support racial group identification is the consistent central organizing principle of black political opinion. The results suggest that attachment of blacks' racial predispositions to non-racial issues is malleable, and that racialized context can play a role in defining the racial implications of politics for black Americans. Additionally, the results suggest that both

implicit and explicit racial messages and cues play differing roles in activating black racial group identification and whites' racial group resentment. Although racial cues are effective in activating whites' racial attitudes on non-racial issues only when they are implicit through subliminal cues, the same is not true for blacks. Explicit racial cues successfully activate black in-group identification while implicit cues do not activate racial thoughts among blacks. These findings are highly suggestive of the depth of the negative nature of racial resentment and stereotyping directed against blacks. Among both blacks and whites there exists a degree of ambivalence to racially coded political communications. For whites, tension arises when they have to negotiate between attitudes of egalitarianism and those of racial conservatism. The root of black ambivalence, on the other hand, centers on tension in the definition of whose interests belong on the black agenda. Connecting blacks' in-group attitudes and their positions on public policies hinges on a tension between belief in a common racial group interest and negative representations of some sub-sets of the group. Thus, when an issue is linked, through elite cuing and negative black stereotyping, to a perceived marginalized sub-set of the in-group of blacks, the role of black group identification in determining support for that issue is lessened. Despite the implications of its racial meaning, it is treated as "beyond boundaries of blackness" (White 2007).

EMPLOYER-BASED HEALTH INSURANCE COVERAGE

The latest estimate provided by the Centers for Medicare and Medicaid Services (2009) is that approximately 50 percent of current health insurance is provided through

employer-based health insurance plans. Though provided as part of an employee compensation package, this coverage is indirectly subsidized by the federal government through tax subsidies which allow these benefits to be tax free. This produces loss of tax revenue for the federal government (Blendon and Benson 2009). The ACA provision slated to begin in 2018 to tax the high dollar, luxury insurance plans (Cadillac plans) provided by employers is an effort to recoup some of the lost tax revenue due to these tax subsidies. In addition, small business owners receive tax credits as incentives for them to provide health care coverage for their employees. This produces an additional drain on potential tax revenues for the federal government.

The issue of health care coverage becomes critical when an individual loses his job. When employment is ended uncertainty arises due to becoming uninsured when between jobs. Lapses in insurance coverage frequently occur, unless an individual can afford COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) insurance premiums that are notoriously extremely high and out of reach for many of the unemployed. It should be mentioned that employer-based coverage often results in uneven coverage since those who earn higher salaries are often eligible for better coverage. In addition, not all jobs provide insurance, therefore even full time workers may not be covered by health insurance, depending on the size of the company for whom the individual is employed. Finally, it should be said that employers often have a financial incentive to provide as little coverage as they can since it dips into their bottom line profits (Thomasson 2002).

PROBLEMS WITH THE CURRENT HEALTH CARE SYSTEM AND MOTIVATIONS FOR REFORM

Efforts to reform the health care system in the United States have taken varied forms under both Republican and Democratic administrations over the last fifty years (Blendon and Benson 2001; Olafsdottir and Pescosolido 2010). The Affordable Care Act of 2010 has been designed to address many of the problems with the current health care system. Of primary significance is the high cost of health care in America coupled with the costs of caring for the uninsured, which drives up the costs for the insured (Blendon and Benson 2001). Despite the high costs of American health care, health outcomes are very poor compared with many areas of the developed world (Olafsdottir and Pescosolido 2010; Quadagno 2004).

The ACA allows children under the age of 26 to be included in parents' health insurance. Large companies now are required to provide health insurance to employees. No longer can insurance companies deny coverage or charge exorbitant premiums for those with pre-existing conditions. There can no longer be limits to lifetime coverage that have resulted in many suffering with severe, often chronic illness being dropped from coverage while undergoing their treatments or rehabilitation services. Insurance companies may not cancel coverage as long as individuals remain in compliance with rules of coverage. There are measures in place to gradually close the "doughnut hole" for seniors' prescription drug coverage. The "doughnut hole" is a metaphor that refers to the situation that arises when a patient's prescription drug costs reach a certain peak after

which full costs are to be paid by the seniors themselves. Under Medicare Part D, the prescription drug plan available for seniors, an individual pays a $250 deductible at the beginning of each year. Thereafter, the patient pays 25 percent of the costs of all pharmaceuticals used up to $2,000. Once the total of $2,250 has been reached there is no coverage for prescriptions – the doughnut hole – until drug costs are at least $5,100, at which time Medicare drug coverage resumes. This situation has caused much distress for individuals with prescription costs that maybe exceedingly high due to chronic illnesses which frequently require expensive therapeutic drugs, including chemotherapy drugs. In addition, the Act allows for an expansion of Medicaid coverage for low income individuals (Gross, et al 2012), subject to the individual states option to receive the monies provided by the federal government (ACA 2010).

Another benefit of the ACA is preventive health care for all, a particularly important factor that will promote a decrease in health care expenditures over the long term. For the first time, the ACA provides a stipulation that all insurers must provide a uniform explanation of insurance coverage coupled with standardized definitions. There can be no discrimination in health care coverage based on an individual's salary. The ACA aims to ensure quality health care for all with eventual decrease in the costs of coverage. Efforts to rein in the explosive rise in health care costs of nursing home care, pharmaceuticals, and medical devices are further included in the Act (ACA 2010).

As an alternative to expensive long term nursing home care there is proposed the institution of a community option which will allow those who may have previously

required institutionalized care to remain in their homes if possible, supported by community assistance programs. There is an appeals process provided. Through the Act, early retirees, before Medicare age (65), will have a way to obtain coverage through the marketplace, without penalty or disruption of health insurance. Premium tax credits are to be implemented for all participants to assure affordability of the ACA. The ACA will provide credits aimed at assisting with the costs involved in the process of adoptions (ACA 2010).

The provision of grants for funding free-standing health clinics and nurse-managed health centers will improve medical access for citizens in rural areas who may currently travel great distances to have access to health care. Increased medical workforce needs are to be addressed with provision for tuition reimbursement and loan repayment plans to ease the costs of training new health care providers, including physicians, nurses, dentists, physician assistants (PA) as well as mental health professionals. This will improve availability of care for the increased numbers of insured. Special emphasis will be made toward encouraging medical or ancillary practitioners to work in family medicine with both adults and children. There are grants to expand and enhance public health centers. Last, but certainly not least, is the provision for cost controls and measures designed to eliminate fraud and abuse that is rampant in the current system of health care (ACA 2010).

The intent of the ACA is for all citizens to have access to health care insurance, either through employers, Medicare/Medicaid, privately purchased insurance, or by

participation in the health care marketplace. Generating much fear is the much publicized penalty to be imposed on individuals failing to obtain health insurance coverage. Indeed, there will be a penalty imposed for failure to participate. The plan is, after all, designed with the intent that all citizens, both well and sick, be insured. When all citizens are covered, over time it is thought that the costs of coverage premiums will decrease for all Americans. All insurance plans currently use the same risk-sharing factors to compute premium costs; therefore, the ACA is not inventing new policy. Exemptions to the requirement to obtain coverage are provided for religious reasons such as the Amish and Quaker communities who have never participated in any form of insurance plan, opting instead to pay cash for medical care services.

As for the progressively severe penalties for failure to obtain coverage, it must be stated that if an individual simply cannot afford to purchase coverage there will be no penalty imposed. The rationale for funding the states' expansion of Medicaid roles is to remedy this occurrence. Some states have chosen to accept these federal funds while others have opted not to expand Medicaid for the benefit of their citizens. Those individuals who can afford to purchase insurance coverage, but choose not to do so, opting instead to roll the dice hoping to remain healthy forever, are those to whom penalties will be directed. Even so, a provision in the ACA directs the Internal Revenue Service (IRS) not to attempt harsh collection measures such as garnishment or bankruptcy to collect these penalties. Rather, penalties will be paid by adjustments to the income tax returns of these individuals each year. In 2014, the start-up year, the penalty

is to be $95 per individual. In succeeding years penalties are to be substantially increased to hopefully assure all individuals are covered with health insurance in America over time (ACA 2010).

THEORETICAL FRAMEWORK

Drawing on the work of Tesler (2012), elite cues and mass cuing including narrative framing, constitutes the major theoretical thrust of this thesis. Extensive literature suggests that elite cuing and narrative framing are similar in scope and function. Their purpose is the achievement of the triggering of negative black stereotypes. Since both terms are used interchangeably, it is impossible to separate the effects of one from the other. Of particular importance is the role of narrative framing of topics by media outlets and political pundits with their subsequent influence on public attitudes toward government financing of health care. Narrative framing (Jones and McBeth 2010; London 1993), frequently referenced in the analysis of the health care reform debate, refers to the shaping of a particular interpretation and resulting evaluation of events by emphasizing certain elements of the debate while downplaying, even omitting, other elements that may be less in line with a group's values. Framing enables individuals to carve meaning from the never-ending complexity of health care reform by sharpening focus on certain elements while blurring others. Elite cues, more subtle in nature, are described as words that may be interjected in a dialogue, survey, or interview, that, once heard, subliminally trigger negative stereotypes toward black people. The use of metaphorical trigger words provides strong, subconscious motivation for decisions either

in support of or in opposition to health care reform. The formulation of survey questions may possibly be subject to this bias, whether intentional or unintentional. Therefore, both elite cues and mass-cuing are inseparable from the broader narrative framing often employed by powerful interests to maintain their control of issues.

HYPOTHESES

The following hypotheses will be addressed in this thesis.

1. Controlling for other factors, respondents who score higher on racial resentment are more likely to view health care as best left up to individuals than those who score lower on racial resentment.

Hypothesis One is derived from the work of Tesler (2012) which tests the spillover of racialization into attitudes toward health care opinions. Tesler hypothesizes that the salience of Obama's race in public perceptions of him should spill over into public opinions about his visible policy positions. More specifically, source cues that connect racialized public figures to specific issues are expected to activate racial considerations in mass opinion much the way that code words and other subtle race cues have linked African-Americans with public policies in prior research.

2. Controlling for other factors, there is a significant relationship between conservative ideology and support for government financing of health care.

Hypothesis Two is also derived from Tesler (2012) who found that signals provided to ordinary Americans by a presidential issue are especially adept at activating both partisan attitudes and ideological leanings in public opinion.

3. Controlling for other factors, there is a significant relationship between negative black stereotypes and support for government financing of health care.

Hypothesis Three is further derived from Tesler (2012) who found measurement of white Americans' racial attitudes to be one of the most contentious issues in public opinion research.

4. Controlling for other factors, there is a significant relationship between negative white stereotypes and support for government financing of health care.

Hypothesis Four, also derived from Tesler (2012) addresses comparisons in perceptions of blacks and whites regarding symbolic racism as generators of racial resentment. Factors such as these have become focal constructs for explaining the role of racial attitudes in contemporary American politics.

CHAPTER III

DATA AND METHODS

This chapter discusses the data to be employed and a description of the sample and variables used in the analysis. Statistical methods are discussed and limitations of the study are introduced.

DATA

The dataset used for this study is the 2012 American National Election Time Study (ANES). The ANES is a nationally representative sample of U. S. non-institutionalized adults, ages 18 and older, both English and Spanish-speaking respondents (Adams, Dow, and Merrill 2006). The ANES Time Study has only recently incorporated the bilingual feature to their surveys in response to concerns of the Latino community that their voices were not being represented in official surveys which were considered by them as Anglo Studies (Adams, Dow, and Merrill 2006). The strength of the ANES Time Study is based on its continuous use since 1948. It provides a longitudinal trend of opinions and attitudes over time. It is conducted in election years. The 2012 ANES Time Study is the 29th survey conducted. This study uses only the 2012 data; therefore it is limited in that no trends can be established as could be obtained from a longitudinal study of a span of years. One advantage of the ANES is the convenience of having all the data readily available for the research project. An additional advantage of using the 2012 ANES data is that it is very recent. Therefore, few researchers have

had an opportunity to use these data. The data are collected in two ways. The first sampling is collected two months prior to the election and the second is obtained two months after the election. The purpose of the ANES is to describe the electorate and to test hypotheses regarding voting behavior and public opinion.

Weaknesses of the ANES data include that it doesn't cover all social issues with equal depth. For example, the researcher has no control over the wording and placement of questions. The response rate is 38 percent for the face-to-face interviews and 2 percent for the online portion of the survey. The ANES has a very large sample size of 5,916 respondents. The use of bilingual data makes the ANES especially significant for discerning effects of racial cuing on attitudes of Hispanic/Latino minorities toward government financing of health care. Data are weighted to take into account the selection of one adult per household. Weighting allows findings to be generalized to adults living in U. S. households (Knoke, Borrnstedt, and Mee. 2002.) The ANES Time Study has been used widely by researchers, therefore it is considered reliable and valid, sufficient to be used in these research efforts (Adams, Dow, and Merrill 2006).

SAMPLE

The analysis, with its dual mode of face-to-face and internet data collection produced a total response of 5,914 respondents with valid responses to the dependent variable of support for government financing of health care. The sample consists of 2,845 male and 3,069 female respondents.

VARIABLES

Dependent Variable

The ANES data does not refer specifically to the Affordable Care Act (ACA) since its provisions had not, as of the timing of this survey, actually been made into law. Therefore, the question asked of respondents concerns only whether or not they favor government financing of health care. The dependent variable (D/V) is ordinal, consisting of a 7-point scale of attitudes toward government financing of health care. The scale ranges from a low of 1 indicating that health care should be left up to individuals to a high of 7 indicating that government should provide all the financing for health care.

Independent Variables

Previous research (Tesler 2012; West 2013) includes measures of racial resentment which are used to determine their influence upon attitudes toward government financing of health care. There are four indicators of black racial resentment. The first indicator examines respondents' opinions on whether they perceive blacks as having gotten less than they deserve. The second indicator measures respondents' perceptions of current levels of black discrimination in American society today. The third indicator examines respondents' views that blacks should work their way up in society as other marginalized groups have done historically in America. A final racial resentment indicator examines the notion that blacks are just not trying hard enough to get ahead in society without assistance from the government. Together, these four measures of racial resentment point to negative attitudes of blacks as undeserving, lazy, wasteful, and

looking for a free-ride while others, whites implied, pay their way without their earning the privilege (Tesler, 2012; West, 2013).

Two negative black stereotype variables are examined. The first variable measures respondents' opinions of blacks as being either lazy or hardworking compared with whites. The second black stereotype variable measures respondents' attitudes on whether blacks are intelligent or unintelligent compared with whites. For comparison, white stereotype variables are examined to measure differences between responses for black stereotypes.

Control and Interaction Variables

Dummy variables are artificial variables created to represent an attribute with two or more distinct categories. Dummy variables are useful in regression analysis which treats all independent variables as numerical entities which are directly comparable (Knoke, Borrnstedt, and Mee. 2002.) Analyzed in this thesis are dummy variables for male gender, South region, black race, Hispanic ethnicity, marital status, and average/working class. Other variables examined include ideology and partisanship. Ideology is measured on a seven-point self-placement scale with 1 being extremely liberal to 7 as extremely conservative. Partisanship is measured on a recoded scale of 1 for Democrat, 2 for Republican, and 3 for Independent. The interaction variables of married x male, male x black and male x Hispanic are used to test for the presence of non-linear effects.

DATA COLLECTION

For the first time in ANES Time Series history, face-to-face interviewing is supplemented with data collection via Internet. Data collection was conducted independently in the two modes, using separate samples. For the face-to-face mode, all respondents sampled were interviewed in person using Computer-Assisted Personal Interviewing (CAPI), which also incorporates an interview segment in each wave that is self-administered (CASI). For the Internet mode, all study participants were members of the KnowledgePanel, a panel of regular survey participants administered by GfK (formerly Knowledge Networks). Knowledge Network (GfK) introduced national address-based sampling in 2009 to recruit KnowledgePanel members to address the diminished efficiency of random-digit dialing (RDD) landline telephone recruiting. The purpose was to deliver a panel membership of previously hard to recruit groups since RDD is increasingly delivering fewer young adults, minorities, and low-education and low-income households. Neither does RDD reach the nearly one out of four U. S. households that gave up their landline telephones to now be classified as cell phone only (ANES Codebook). Address-based sampling is designed to resolve these shortcomings and has done so successfully for KnowledgePanel recruitment (ANES Codebook).

DATA ANALYSIS

Data analysis consists of both descriptive and inferential statistics. Descriptive statistics is used to examine patterns of responses. As generally known of descriptive statistics, it provides both numbers and percentages of the dependent variable provide an

initial view of the characteristics of the sample. A correlation matrix is used to examine relationships between variables. Bivariate OLS regression tests effects of all predictor variables on the dependent variable. Ordinary Least Squares Regression (OLS) is a method for obtaining estimates of regression equation coefficients that minimizes the error sum of squares. OLS regression is the most applicable method for dependent variables (Knoke, Borrnstedt, and Mee, 2002). This method is employed because the dependent variable is an ordinal variable with more than 5 categories. Prior to performing the OLS regression, possible violations of regression assumptions are tested, including normality, homoscedasticity, independence, and linearity using a scatterplot. Multicollinearity is tested by performing bivariate correlations. An assumption that a regression model is specified correctly is tested by comparing coefficients of determination (R^2) and performing special F tests as needed. Testing of nested regression models based on previous findings looks for the strength of certain types of relationships.

Multiple linear regressions using unstandardized regression estimates of attitudes toward government financing of health care are tested with interaction variables. Multiple regressions are both linear and additive and assume a linear relationship between independent variables (I/V) and the dependent (D/V) variable (Knoke, Borrnstedt, and Mee. 2002). It is further assumed that the effect of one I/V on the D/V is the same for all values of the other I/Vs in the same model. If the effect of one I/V depends on another I/V, as in the case of interaction variables, then multiple regression does not capture the effect. Using interaction variables, tests for the significance of

merged variables against the D/V, determines the best-fit of several created interactions. Dummy variables are formed by coding a variable as 1 to indicate the presence of an attribute and 0 to indicate its absence. This method is useful for the comparison of the presence of one particular category such as male gender, compared with female gender. Dummy variables are especially useful for estimating and testing interaction effects which reflect differences in the relationship between two variables within categories of a third variable (Knoke, Borrnstedt, and Mee, 2002).

LIMITATIONS

It is generally known that secondary data sources such as the ANES 2012 do not allow the researcher to include certain variables that could potentially influence attitudes toward government financing of health care. Different racial and ethnic groups may also be influenced by racial resentment measures that are specifically focused on blacks and may be difficult to tease out using this dataset. Another limitation is the lack of detail in interval-ratio variables such as age, income, and education which could be useful in examination of non-linear effects. Since respondents of the ANES are representative of the general population, there may be differences in perceptions of black racial resentment and black stereotypes based on different race/ethnic groups. Finally, since the ANES is a cross-sectional analysis, it cannot test change in attitudes toward government financing of health care over time.

CHAPTER IV

RESULTS

This chapter presents the results of the data analysis. The descriptive analysis is presented in the first section. This is followed by a discussion of the results bearing on each of the hypotheses presented herein.

DESCRIPTIVE STATISTICS

Table 1 indicates that opinions concerning government financing of health care are quite divided. Results are evenly distributed between strong opposition, neutrality, and strong favorability, with approximately 22 percent of respondents in each category. In terms of opinions about blacks, the results in this table indicate the persistence of widely divergent positions. About one in five respondents (19.9%) agree that blacks have gotten less than they deserve. Just over half (50.2%) agree that blacks have received less than they deserve. A second indicator, that of respondents' perceptions of whether blacks are currently being discriminated against, reveals that over two-thirds (68.3%) of respondents agree that blacks are currently the objects of discrimination in America. About three-quarters (75.9%) of respondents agree that blacks are currently receiving discriminatory treatment. While a majority of respondents agree that discriminatory practices continue today, it is curious that these same respondents are fairly evenly divided in their opinions on government financing of health care. A third item taps into beliefs that blacks should overcome prejudice in the same manner as other

groups before them and work their way up. Nearly sixty percent (58.3%) agree with this statement. This attitude is in keeping with traditional American ideologies of success and individual responsibility.

A final indicator of racial resentment is the notion that blacks must try harder if they wish to be successful. Almost half (46.1%) of respondents feel blacks must try harder to succeed. The remainder disagree (30.3%) or are uncertain whether blacks should just try harder. Broadly speaking, these findings are consistent with an individualistic ideology that holds persons primarily responsible for their successes and failures.

In terms of respondent characteristics, Southerners comprised the largest single percentage of respondents (39%) while all other regions combined total 61 percent. Males represent 48 percent of respondents. Black and Hispanic groups each compose 17 percent of the total survey respondents, with the remaining respondents (66%) being white or from other ethnic groups. Just under half of the respondents (48%) are married. The largest majority (75%) of respondents described themselves as middle or working class. Most respondents (30%) describe themselves as moderate with significantly smaller percentages at either end of the spectrum from extreme liberal (2.8 %) to extreme conservative (3.2%). Finally, nearly forty percent (39.9%) of respondents self-identify as Democrat. Nearly one-quarter (23.5%) identify themselves as Republican. Of the remainder, thirty percent (31.2%) declare themselves as Independent and the remainder of (5.4%) gave no response.

BIVARIATE CORRELATIONS

Table 2 reveals a moderate negative relationship between the belief that blacks are getting less than they deserve and support for government financing of health care (r=-.385, p<.01). This finding suggests that respondents who think blacks get less than they deserve are less likely to support government financing of health care. Additionally, there is a weak negative relationship between the notion that black people continue to be the object of discrimination (r=-.090, p <.01) and support for government financing of healthcare. This is an indicator that respondents who think that blacks are currently being discriminated against are slightly less likely to support government financing of health care. This weak and somewhat anomalous finding is deserving of future exploration. A moderate, negative relationship (r=-.361, p <.01) exists between the notion that blacks should work their way up as other minority groups have done historically in America, and support for government financing of health care. This finding correlates with less support for government financing of health care since it is suggestive that something is being given that is unearned. Finally, the notion that blacks are not trying hard enough has a moderate, negative relationship (r=-.306, p<.01) with support for government financing of healthcare. Except for the weak negative correlation between respondents' perceptions of blacks as being currently discriminated against leading to less support of government financing of health care, the other three relationships are consistent with the notion that there is a negative relationship between these indicators of racial resentment and support for government financing of healthcare.

The findings in Table 2 further indicate a weak negative relationship between conservative ideology (r=-.188, p<.01) and support for government financing of health care. This is an indicator that respondents who are more conservative in their views are less likely to support government financing of health care. There is a significant negative relationship (r=-.401, p<.01) between partisanship and support for government financing of health care. In other words, as partisanship leans toward Republican, the level of support for government financing of health care decreases. This is consistent with other research such as Tesler (2012). Interestingly, marital status has a weak, negative relationship (r=-.128, p<.01) with support for government financing of health care. One possible explanation is that there may be a deep-seated traditional belief among males that once married they must assume responsibility for all aspects of home and family, including the provision of health care coverage. Additionally, Hispanic ethnicity has a weak, positive relationship (r=.072, p<.01) with support for government financing of health care, an indication that Hispanics lean toward support of government financing of health care.

There is a modest positive relationship between being African-American (r=.289, p<.01), and support for government financing of health care. The weakness of these correlations suggests that indicators of race and ethnicity alone do not have a strong impact on support for government financing of healthcare.

There is a further suggestion in this finding that there may be other more important influences on respondents' views concerning healthcare financing. Male

gender shows a weak negative (r=-.057, p<.01) relationship with support for government financing of healthcare. In keeping with the possible traditional attitudes of married males regarding responsibility for home and family, it is not surprising that they may have less support for government assistance which may be perceived as government usurping the role of the male in society. Surprisingly, there is no significant relationship between average/working class and support for government financing of health care (.007). Being from the Southern region of the U. S. has only a weak positive relationship (r=.028, p < .05) with support for government financing of health care. This finding is an indicator of the level of political conservatism in the Southern United States as indicated by their strong preference to vote for the Republican Party.

HYPOTHESES

Hypothesis One

Hypothesis one states that controlling for other factors, respondents who score higher on racial resentment are more likely to view health care as best left up to individuals than those who score lower on racial resentment. Three regression models are estimated to address this hypothesis. The results are in Table 3. Reported B values reflect an increase or decrease in the amount of change in the dependent variable, support for government financing of health care, for each one unit increase in the independent variable. Changes can be either positive or negative.

Model 2 regresses the four black racial resentment variables plus control variables of dummy South region, dummy male gender, dummy Black race, Dummy Hispanic

ethnicity, marital status, dummy variable for middle/working class, and ideological self-placement. Model 2 ($F=177.787$, $p < .001$) is the best fitting model with an R^2 (.269) accounting for (26.9%) of the variance in support for government financing of health care. This indicates that there is a greater proportion of variation in the dependent variable explained by the independent variables when including control variables than there is by the racial resentment indicators alone. Addition of these control variables results in a weaker, though still statistically significant effect of the racial resentment variables. For instance, the belief that blacks should work their way up (B=-.293, < .001) in this instance shows a weak to moderate negative relationship with support for government financing of health care. The result is less than that found in Model 1. The racial resentment variable that blacks should just try harder (B=-.158, < .001) indicates respondents' conservative sentiments placing value on striving for moving up in the world without assistance from the government. It is in keeping with the conservative view that any outside assistance serves to decrease personal initiative.

Findings are negatively correlated with support for government financing of health care, though results are weakened somewhat by the addition of the control variables. This regression reveals a strong relationship between race, ethnicity, and support for government financing of healthcare. More specifically, both black race (B=.793, <.001) and Hispanic ethnicity (B=.584, < .001) are strongly related to support for government financing of healthcare. Not surprisingly, ideology (B=-.178, < .001) shows a weak, negative relation to support for government financing of health care.

Those respondents having more conservative ideological views tend to be less supportive of government interference in any way in their lives. Support for government financing of health care will, necessarily, be withheld by those holding such conservative views.

The indicator of black deservingness (B=-.267, p <.001) shows a weak, negative correlation between respondents' sentiments that blacks have gotten less than they deserve and support for government financing of health care. This is highly suggestive that notions of blacks being undeserving may serve as an underlying trigger for attitudes toward government financing of health care. The racial resentment indicator of opinions concerning current levels of discrimination toward blacks (B=-.122, < .001) shows a weak, negative correlation. In other words, there is a negative correlation between current perceptions of black discrimination and levels of support for government financing of health care. The dummy variable male (B=-.130, < .05) shows a weak, negative correlation with support for government financing of health care. This finding could be an indicator that males view their role as caretaker for their family to include providing health care coverage, therefore, are less likely to support government financing of health care since it might be construed as the government taking away a traditional male responsibility. Control variables of region, marital status, and dummy variable for middle/working class are not significant.

In summary, the results of this regression analysis support the hypothesis that indicators of black racial resentment have a significant effect on attitudes toward government financing of health care.

Table 1. Variables Used in the Analysis of Opinions on Government Financing of Health Care, U.S. Adults, 2012 (ANES)

Variable		N	%
Dependent Variable			
Opinions on Govt. Fin. Health Care			
	1-Strong Opposed	1310	22.2
	2-Moderately Opposed	552	9.3
	3-Somewhat Opposed	136	2.3
	4-Neutral	1302	22.0
	5-Favor Somewhat	235	4.0
	6-Moderately Favor	1067	18.0
	7-Strongly Favor	1239	21.0
		5914	100.0%
Independent Variables of Racial Resentment			
Agreement with notion that black people have gotten less than they deserve			
	1- Agree Strongly	394	6.7
	2- Agree Somewhat	781	13.2
	3- Neither	1351	22.8
	4- Disagree Somewhat	1459	24.7
	5- Disagree Strongly	1484	25.1
	No Response	445	7.5
		5914	100.0%
Agreement that black people are currently being discriminated against in the U.S.			
	1- A great deal	675	11.4
	2- A lot	1284	21.7
	3- A moderate amount	2080	35.2
	4- A little	1232	20.8
	5- None at all	196	3.3
	No Response	447	7.6
		5914	100.0%
Agreement that black people should overcome prejudice like other groups before them and work their way up			
	1- Disagree Strongly	375	6.3
	2- Disagree Somewhat	689	11.7
	3- Neither	973	16.5
	4- Agree Somewhat	1612	27.3
	5- Agree Strongly	1836	31.0
	No Response	429	7.3
		5914	100.0%

(Continued)

Notion that it is a matter of not trying hard enough. Agreement that black people should just try harder			
	1- Disagree Strongly	578	9.8
	2- Disagree Somewhat	978	16.5
	3- Neither	1201	20.3
	4- Agree Somewhat	1576	26.6
	5- Agree Strongly	1151	19.5
	No Response	430	7.3
		5914	100.0%
Control Variables			
Region			
	South	2283	38.6
	Non-South	3631	61.4
		5914	100.0%
Gender			
	Male	2845	48.1
	Female	3069	51.9
		5914	100.0%
Race/Ethnicity			
	Black	1016	17.2
	Other Races	4869	82.3
	No Response	29	.5
		5914	100.0%
	Hispanic	1005	17.0
	Other Races	4880	82.5
	No Response	29	.5
		5914	100.0%
Marital Status			
	Married	2832	47.9
	Other Marital Status	2963	50.1
	No Response	119	2.0
		5914	100.0%
Social Class Self-Placement			
	Average (Middle/Working) Class	4404	74.5
	All other classes	1510	25.5
		5914	100.0%

(Continued)

Liberal-Conservative Self-Placement			
	1-Extremely Liberal	166	2.8
	2-Liberal	646	10.9
	3-Slightly Liberal	639	10.8
	4-Moderate	1756	29.7
	5-Slightly Conservative	671	11.3
	6-Conservative	975	16.5
	7-Extremely Conservative	188	3.2
		5914	100.0%
Partisanship			
	1-Democrat	2361	39.9
	2. Republican	1389	23.5
	3. Independent	1845	31.2
	4. No Response	319	5.4
		5914	100.0%

Table 2. Correlation Matrix for Variables Used in the Analysis, ANES 2012 (N=5914)

	Support Health Law	Resent Deserve	Black Discrim.	Resent Work Way	Resent Try Harder	Region	Male	Black	Hispanic	Married	Avg/ Work. Class	Ideol- ogy	Part- isan- ship
Support Health Law	1.00												
Resent Deserve	-.385***	1.00											
Black Discrim.	-.090**	.323**	1.00										
Resent Work Way	-.361**	.459**	.204**	1.00									
Resent Try Harder	-.306**	.431**	.200**	.593**	1.00								
Region	.028*	-.030*	-.035**	.014	.031*	1.00							
Male	-.057**	.048**	.061**	.011	.060**	-.015	1.00						
Black	.289**	-.392**	-.113**	.238**	-.204**	.203**	-.049**	1.00					
Hispanic	.072**	.008	-.044**	.028*	.096**	.002	.002	-.207**	1.00				
Married	-.128**	.141**	.028*	.092**	.052**	-.030*	.067**	-.190**	-.010	1.00			
Avg/Work- ing Class	.007	.003	.033*	.050**	.035**	-.006	-.004	.066**	.021	-.068**	1.00		
Ideology	-.188**	.258**	.698**	.196**	.148**	.001	.071**	-.111**	-.087**	.108**	.032*	1.00	
Partisan- ship	-.401**	.264**	.098**	.249**	.153**	-.065**	.082**	-.262**	-.053**	.133**	-.040*	.167**	1.00

* p < .05, ** p < .01, *** p < .001 (1-tailed test)

Table 3. Unstandardized Regression Estimates Predicting Support for Government Financing of Health Care, U.S. Adults, ANES, 2012 (standard errors in parentheses)

Predictor	Model 1	Model 2	Model 3
Constant	7.876***	7.486***	7.559***
	(.103)	(.128)	(.132)
Black Racial Resentment			
Black Deservingness	-.424***	-.267***	-.268***
	(.027)	(.028)	(.028)
Discrim. Blacks	-.195***	-.122***	-.122***
	(.021)	(.021)	(.021)
ResentWorkway	-.350***	-.293***	-.292***
	(.029)	(.028)	(.028)
Resent	-.130***	-.158***	-.156***
Try Harder	(.028)	(.027)	(.027)
Control Variables			
Region		.032	.029
		(.057)	(.057)
Male		-.130*	-.284***
		(.054)	(.089)
Race (Ref=White)			
Black		.793***	.646***
		(.084)	(.107)
Hispanic		.584***	.567***
		(.075)	(.104)
Married		-.080	-.184**
		(.056)	(.078)

(Continued)

Middle/Working Class		.018 (.063)	.020 (.063)
Ideology		-.178*** (.012)	-.179*** (.012)
Interactions			
Male x Black			.312* (.149)
Male x Hispanic			.030 (.148)
Male x Married			.198 (.110)
R^2	.208	.269	.270
F	358.077***	177.787***	140.248***
N	5,449	5,319	5,319

*p < .05, **p< .01, ***p < .001 (1-tailed test)

Hypothesis Two

Hypothesis two states that controlling for other factors, there is a significant relationship between conservative ideology and support for government financing of health care. Results are presented in Table 3. Regression Model 2 in Table 3, the best fitting model as stipulated in Hypothesis 1, indicates (B=-.178, p<.001) a weak, negative relationship between conservative ideology, as measured by respondents' self-placement on a seven-point scale from extremely liberal to extremely conservative and support for government financing of health care. This indicates that the more conservative a

respondent may be the less support might be given to government financing of health care. Though the effects of the racial resentment variables are weaker in this model, the overall finding is consistent with Tesler's (2012) previous research illustrating the role of ideology in affecting opinions on support for government financing of health care. Tesler (2012) found a much weaker impact of ideology (B =-.044, p<.01) on support for government financing of health care. He obtained those results in September of 2009, less than two years into the Obama Presidency. The more negative B (-.178) reported here appears to illustrate an increasing ideological divide in American society today. This finding may also reflect the tendency of individuals to be more conservative during periods of economic stress and job losses (Brooks and Manza, 2013).

Media impact upon public attitudes is a significant factor in changing public perceptions of Obama's health care law. In fact, the media impact has been significant in the overall ideological shift toward conservatism in all political matters as indicated by the actions, or inactions, of the Congress (Funigiello, 2005; Tesler, 2012; and West, 2013). During the current administration there has been an increasing shift in levels of partisanship, ideology, and taxation preferences, greater than at any time since the Great Depression of the 1930s according to Brooks and Manza (2013). Lakoff (2002), in his discussion of issues of social justice and moral formation with their effects on attitudes toward public policy, has indicated that deservingness of recipients of intended proposals is intertwined with stereotypes of race, particularly those of blacks depicted as lazy and living on public assistance. Racial stereotypes such as these are deeply embedded in

American culture and are frequently employed to promote a conservative political agenda. Consistent with results obtained both in this study as well as that of Tesler, it appears that opinions toward health care reform efforts have become somewhat more racialized during Obama's presidency.

Hypothesis Three

Hypothesis 3 states that, controlling for other factors, there is a significant relationship between negative black stereotypes and support for government financing of health care. The findings are reported in Table 4. Two models are estimated. Model 2, incorporating control variables, is significant (F=80.421, < p .001). With an R^2 (.144) this model is the best fit since it accounts for a little over fourteen percent (14.4%) of the variance in support for government financing of health care. Model 1 accounts for less than 1 percent of the variance. The weak, negative statistical relationship (B=-.124, p < .001) in the Model 1 measurement of perceptions of blacks as either lazy or hardworking becomes insignificant with incorporation of control variables in Model 2. The indicator measuring perceptions of intelligence of blacks compared with whites is weak and positive (B=.091, p < .001) in Model 1, and gains strength in Model 2 (B=-.137, p < .001) with the addition of the control variables. This suggests that respondents who see blacks as less intelligent than whites are slightly more likely to support government financing of health care. The perception that blacks have less intellectual capacity stems from a Darwinian perspective, may influence respondents' views of blacks. This could possibly cause whites to feel pity for a supposed diminished capacity, thereby causing whites to be

more compassionate and therefore supportive of the health care law as a means to redress such an imbalance. Not surprisingly, using black race as a dummy variable reveals a highly significant ($B=1.562$, $p < .001$) result. The same effect ($B=.577$, $p < .001$) can be seen using a dummy variable for Hispanic ethnicity. There is a weak, negative relationship ($B=-.160$, $p < .001$) between ideology and support for government financing of health care. For instance, respondents who hold a conservative ideology may hold the belief that blacks are lazy or less intelligent compared with whites and may therefore be less in support of government financing of health care. This would correlate with the conservative view that hard work and personal effort are the best way to get ahead and that those who are less industrious should not be rewarded for their lack of a good work ethic. This view would lead to less support for government financing of health care since it might be perceived as an unearned benefit for those less deserving. Tesler's findings are slightly less negative than the current findings; however Tesler's data were obtained at the end of 2009, early in the Obama presidency.

The addition of control variables results in slightly more support for government financing of health care. Holding this negative stereotype may lessen the negative opinions on the health care law. Tesler (2010) found a ($B=-.069$, $p < .05$) in his November, 2009 regression. Tesler's finding is produced early in the Obama presidency. Interestingly, the findings of this thesis, though still weak, are now positive. Therefore, opinions appear to have become slightly more temperate toward the black stereotype of less intelligence as they are exposed to the very intelligent black president.

The more current ANES (2012) results rely on responses obtained in the 2010 mid-term election period, while the economy was still struggling to overcome the effects of the Great Recession. The mood of the country was more somber than during the heightened mood of hopefulness in the nation with Obama's entrance into the White House. Additionally, the trend to become more conservatively focused during times of economic hardship may partially account for this finding as we searched for possible targets of blame for our circumstances. The president is always a prime target when social conditions are on a downward trend.

Table 4. Unstandardized Regression Estimates OF Black Stereotypes and Support for Government Financing of Health Care, U.S. Adults, ANES, 2012 (standard errors in parentheses)

Predictor	Model 1	Model 2
Constant	4.238***	4.210***
	(.042)	(.088)
Black Stereotypes		
Blacks perceived as lazy or hardworking compared with whites	-.124***	-.019
	(.024)	(.024)
Intelligence of blacks as compared with whites	.091***	.137***
	(.025)	(.025)
Control Variables		
Region South		-.138*
		(.059)
Male		-.371***
		(.093)
Race (Ref=White)		
Black		1.562***
		(.106)
Hispanic		.577***
		(.107)
Married		-.309***
		(.080)
Middle/Working Class		-.067
		(.064)
Ideology		-.160***
		(.011)

(Continued)

Interactions		
Male x Black		.484** (.155)
Male x Hispanic		.255 (.152)
Male x Married		.191 (.114)
R^2	.006	.144
F	16.984***	80.421***
N	5,914	5,766

*p < .05, **p< .01, ***p < .001 (1-tailed test)

Hypothesis Four

Hypothesis 4 states that, controlling for other factors, there is a significant relationship between negative white stereotypes and support for government financing of health care. The findings are reported in Table 5. Two models are estimated. Model 2 is the best fitting model, significant (F= 92.554, p < .001). This overall model ($R^{2=}$=.162), accounts for 16.2% of the variance in the amount of change in attitudes toward government financing of health care. The addition of control variables in Model 2 presents more or less the same picture for white stereotypes as that seen in Model 1 in that there is a weak positive relationship (B=.128, p<.001) between perceptions of whites as hardworking and support for government financing of healthcare. A positive response

to this white stereotype lends itself to a more positive attitude in support of government financing of health care since the perception of whites as more hardworking than blacks makes them more deserving of assistance with their health care needs. Second, there is a weak positive relationship (B=.072, p<.01) between the perception that whites are more intelligent than blacks and support for government financing of health care. The reversal of signs between Models 1 and 2, though not a great difference between the two, is certainly deserving of future investigation. This may tap into an ideation of whites as more deserving than blacks due to greater intelligence. The addition of control variables does little to change the values of the white stereotypes. A comparison between the stereotypes of blacks against whites, however, demonstrates marked differences. While stereotypes of blacks are negatively correlated with support for government financing of health care, the same indicators for whites are positively correlated with support for government financing of health care. This attests to the impact of black stereotypes on attitudes toward government financing of health care. Results of this regression analysis lend some support to the hypothesis that indicators of white stereotypes have a significant effect on attitudes toward government financing of health care. Tesler (2010) found a slight positive relationship (B=.062, p< .05) in his November, 2009 regression. It is likely that Tesler's finding was influenced by many social factors including the Great Recession.

Together, the findings suggest that respondents' attitudes toward blacks are sensitive to triggering of racial resentment and negative black stereotypes embedded

within the wording of survey questions. This finding is consistent with previous studies by Howard and Parente (2010) and by West (2013) with their reference to "Cadillac health care plans" that received extensive media coverage and served, intentionally or unintentionally, to shape public opinion through use of negative black stereotypes as referring to blacks' historical affinity for the Cadillac automobile. The findings indicate that the triggering of negative black stereotypes is at least partially responsible for respondents being less supportive of government financing of health care. As noted above, negative black stereotypes tend to have a negative effect on support for healthcare financing while white stereotypes tend to have a positive effect.

These findings are consistent with conclusions reached by Tesler (2010). Tesler's much broader study incorporates a number of additional data sources including a commissioned survey from the Cooperative Campaign Analysis Project's (CCAP), two cross-sectional surveys, and a total of 35 media polls conducted between 1993 and 1994. In addition, 66 similar studies undertaken in 2009 and 2010 are employed by Tesler to estimate racial breakdown in levels of support for both Clinton's and Obama's respective health care proposals.

Results obtained in this current research are consistent with Tesler's argument in support of increasing polarization of public opinion through elite cuing. This study utilizes the more recent 2012 ANES data. This more current data, obtained in 2010, three years into the Obama presidency and during the mid-term election cycle, indicates a slight increase in the levels of racial resentment and negative black stereotyping over that

indicated by Tesler's work. This is similar to Gilens' (1999) proposal that as negative stereotypes come into consciousness, responses to these stereotypes may affect decisions in other widely diverse areas having no apparent relation to the initial stereotypes.

Table 5. Unstandardized Regression Estimates of White Stereotypes and Support for Government Financing of Health Care, U.S. Adults, ANES, 2012 (standard errors in parentheses)

Predictor	Model 1	Model 2
Constant	3.995***	4.173***
	(.039)	(.086)
White Stereotypes		
Whites more hardworking than blacks	.087***	.128***
	(.022)	(.022)
Whites more intelligent than blacks	-.045*	.072**
	(.022)	(.022)
Control Variables		
Region South		-.099
		(.058)
Male		-.350***
		(.092)
Race (Ref=White)		
Black		1.374***
		(.106)
Hispanic		.517***
		(.105)
Married		-.276**
		(.080)
Middle/Working Class		-.053
		(.064)

(Continued)

Ideology – Liberal-Conservative		-.198*** (.011)
Interactions		
Male x Black		.491** (.153)
Male x Hispanic		.240 (.150)
Male x Married		.172 (.113)
R^2	.004	.162
F	12.715***	92.554***
N	5,914	5,766

*p < .05, **p< .01, ***p < .001 (1-tailed test)

CHAPTER V

CONCLUSION

SUMMARY AND DISCUSSION

Funigiello (2005) ;Tesler (2010), West (2013), and others have studied the effects of elite cuing as a tool to change public opinion. Stereotypical triggers have been used successfully by powerful interest groups as a mechanism to sway public opinion in favor of policies that reflect the interests of dominant groups. This study examines racial resentment triggers and negative stereotypes that are used by Tesler (2012) in his examination of black racial resentment and negative black stereotypes and their effect on attitudes toward government financing of health care. In keeping with Tesler's findings, this study reveals that these effects continue and are somewhat stronger than has been demonstrated by Tesler's (2012) data. Four hypotheses are tested and results are supportive of Tesler's findings that those scoring higher on racial resentment indicators and negative black stereotypes are less likely to be supportive of government financing of health care.

Overall, this study indicates that opinions on government financing of health care are fairly evenly distributed between strong opposition, neutrality, and strong favorability, with approximately 22 percent in each category. The weak, negative findings on the racial resentment variables correlate with negative attitudes toward the government financing of health care. Interestingly, the results for the indicator that

blacks should try harder, while still weakly negative, is the weakest indicator of the four racial resentment indicators. This may point to perceptions of lack of initiative among blacks as being less of a triggering mechanism for stereotypes of racial resentment than the other three indicators.

The control variables of male gender, black race, Hispanic ethnicity, and ideology are all statistically significant in the various regressions. Male gender has only a weak negative correlation with support for government financing of health care. On the contrary, being black has a strong, positive correlation with support for government financing of health care. Similarly, Hispanic ethnicity has a moderate, positive correlation with support for government financing of health care. Interestingly, class, specifically the dummy variable middle/working class, has no significant relationship with support for government financing of health care. One's self-perception of class is, however, a relative indicator and may be subject to change based on many factors including region, employment, income, property holdings, and family relations.

There is a weak, negative relationship between conservative ideology and support for government financing of health care. This finding is in keeping with the earlier studies of both Tesler (2012) and West (2013), both pointing to the prominent role of ideology in affecting public opinion. Furthermore, this finding is somewhat more acute in this current study as opposed to Tesler's September 2009 data, which also indicates a weaker, though still significant negative relationship between racial resentment, negative black stereotypes and support for government financing of health care. The slightly

stronger impact of ideology demonstrated in this study may reflect several factors. The influence on public attitudes caused by the election of our first black president plays a significant role in the formation of public attitudes, especially among white Americans (Tesler 2012; West 2013). Media hyper-exposure of political discontent among conservatives has been a significant element responsible in the formation of public opinion (Tesler 2012; West 2013). In addition, the Great Recession of 2007-2009 may be at least partially responsible for the current conservative trend of citizens. Historically, during periods of economic stress and widespread job losses (Brooks and Manza 2013), the trend toward fiscal and ideational conservatism is present.

The ideological shift toward conservatism in all political matters is amply demonstrated in the actions, indeed, inactions of the current Congress (Funigiello 2005; Tesler 2012; and West 2013). The findings in this thesis support the second hypothesis that there is a significant relationship between conservative ideology and support for government financing of health care.

The findings concerning hypothesis three, that of the effect of negative black stereotypes on support for government financing of health care, lends further support to the trends seen above. Respondents' perception that blacks are lazy and less hardworking than whites is statistically significant. This response correlates with less support for government financing of health care. The perception of blacks as being less intelligent than whites has a curious weakly positive correlation, though statistically significant. This finding is in opposition to the indicator of the previous lazy/hardworking measure.

Interestingly, addition of control variables causes this finding to change to weakly negative, though still statistically significant. Possible reasons for this anomalous change are certainly worth exploring. It must be said, however, that the results do not vary significantly from the positive to the negative score and may just be an anomalous finding. One possible answer could be that in current times there has been a great focus within the educational system toward encouraging our youth to not hold racist views. The impact of efforts to reduce racism may have possibly caused suppression of conscious thoughts and attitudes toward racism while leaving untouched subconscious thoughts which may often be triggered subliminally through the use of stereotypical trigger words and racial cuing. Such tactics have been employed successfully by those in positions of power to impose their wishes on unsuspecting citizens (Tesler 2012). Though Tesler (2012) also finds a negative impact caused by the negative stereotype of blacks as being lazy, this thesis shows a slightly stronger effect. Thus, findings are in support of hypothesis three that there is a significant relation between negative black stereotypes and attitudes toward government financing of health care.

Findings concerning hypothesis 4 indicate no apparent effect from use of white stereotypical trigger words on support for government financing of health care. Thus, there is a failure to reject the null hypothesis that there is no relationship between white stereotypes and attitudes toward government financing of health care. A minimally negative result indicates that other factors may be involved which are deserving of further investigation.

The addition of control variables does little to change the finding regarding white stereotypes. A comparison between the stereotypes of blacks against whites, however, demonstrates marked differences. While negative stereotypes of blacks are negatively correlated with support for government financing of health care, the same indicators for whites results in a positive correlation with support for government financing of health care. This attests to the greater significance of the effects of black stereotypical suggestions on attitudes toward government financing of health care. Lakoff (2002) lends credence to issues of social justice and moral formation and their effects on attitudes toward public policy. He has indicated that deservingness of recipients for any proposed government assistance is intertwined with stereotypes of race.

Predominating in this thesis is the effect of ideology on attitudes toward government financing of health care. As has been previously shown by Tesler (2012) and West (2013), ideology may be transmitted by factors such as media outlets, known for their ability to socially construct opinions (Funigiello 2005, Tesler 2012, and West 2013). There is strong support for government financing of health care, not surprisingly, among both blacks and Hispanics.

Importantly, the findings of this study support Tesler's elite cue theory. Previous researchers' findings of the presence of factors leading to black racial resentment and triggering of negative black stereotypes stem, in large part, from the subliminal cuing of black racial stereotypes by elites (Tesler 2012; West 2013). Powerful business entities, the wealthy, politicians, and both liberal and conservative media outlets, use elite cuing

to influence opinions on issues such as welfare, food stamps, affordable housing, affirmative action, and inner city issues. Health care, specifically the current Obama plan of health care, is certainly not exempt from the same subliminal cuing tactics. Literature concurs that the same elite cuing has been effective without regard for the era in which the research has been conducted (Funigiello 2005, Tesler 2012, and West 2013).

IMPLICATIONS

It is important for activists to be aware of the continued presence of black racialization and its influence on attitudes toward government financing of health care. It may help these activists to influence the development of proposed policies. The findings of this study are consistent with the studies of Tesler (2012), West (2013), and others which highlight the continued existence of black racialization with its persistent influence on policymaking in areas such as health care. The question of why people make decisions that are apparently contrary to their own best interests is at least partially answered by this thesis which demonstrates the impact of cuing of negative black racial resentment and black stereotypes by media and other public sources of information. The findings of this study reinforce the continuing presence of negative racialization against blacks and its continuing influence on social policies which direct decisions and continue to have negative outcomes for whites, blacks, and other minorities in American society. As long as attitudes toward race continue to be volatile and easily manipulated, there will be a persistent inability to form public policy that is equitable to all segments of society.

An additional implication of the findings is that the public needs to be more aware so that they may be in a better position to form rational opinions concerning health care needs.

In addition, the findings may be beneficial to policymakers who are in a position to make the concerns of the grassroots Americans known in Congress. For instance, a heightened attention of policymakers to those in need of health care coverage would go a long way to influence their votes. A more aware voter is better able to choose representatives who will act on his or her behalf in Washington. Congressional supporters of health care reform may benefit by knowledge of the persistence of black racialization and its influence on attitudes toward various public policy issues including health care, welfare, and other social concerns.

Scholars such as Tesler (2012) and West (2013) have presented evidence of negative black racialization and its continuing influence on public attitudes. The findings of this study provide additional support for their assertions. Using more recent data than that used by Tesler, the findings of this research suggest that there may be some intensification of black racialization since the onset of Obama's presidency.

FUTURE RESEARCH

While the ANES is a substantial, nationally representative dataset, it is limited in the number of variables that measure attitudes toward government financing of health care. Thus, there is an opportunity to expand and improve upon the data with future efforts. Using qualitative techniques, researchers may gain a greater depth of understanding of racialization and how it is embedded in a cluster of related attitudes

toward race and the role of race. Using a combination of focus groups and probing interviews may tease out deeper connotations of such cuing and stereotyping. By focusing on certain groups such as the elderly, students, or minority groups, researchers may be able to elicit responses that clarify the correlation between racial attitudes, attitudes toward the proper role of the welfare state, and attitudes toward personal efforts to succeed with minimal assistance from the government.

It has long been known that race is a critical factor in attitude formation on a wide range of topics with health care reform being only one example. Understanding this complex issue will add to the body of research on this topic. How black stereotypical triggers affect voters of other ethnic groups may be a possible topic for future research. For instance, little is known of the impact of such triggers on Asians or other minorities other than the black community. In addition, a study might expand on the dependent variable by re-specifying attitudes toward government financing of health care as support for single-payer or universal health care. It is known that terminology is a factor in attitude formation. It would be interesting to examine results obtained by the use of the term "single-payer" versus "universal health care." A prime example is when respondents refer to Obamacare there is a negative reaction while reference to the Affordable Care Act produces a less negative reaction.

Other factors may strongly affect attitudes toward government financing of health care that are not considered in this study. These include, but are not limited to, education, income, age, and having one's own health insurance coverage. In addition, there may be

other effects which surface as the implementation of the Affordable Care Act proceeds. As mentioned above, the anomalous finding relating to respondents' attitudes toward intelligence of blacks compared with whites, is contrary to the finding on attitudes toward blacks as hardworking compared to whites. This finding suggests that other factors may be involved in such a response that is opposite to the other indicators. Yet another curious finding, that of the slightly negative views of whites' intelligence levels, is also deserving of future research. Overall, very few respondents answered questions relating to perceptions of hardworkingness or intelligence among either blacks or whites, therefore this finding is not be representative of the entire population. Other factors might be investigated that may possibly account for these negative perceptions of whites, especially since a majority of those who did respond to this question were white. Due to limitations of the dataset, these and other possible predictors could not be adequately tested. These factors might well be the subject of future work.

Future research using qualitative methods to survey the population may be very enlightening and productive of other significant indicators of racial resentment and negative black stereotyping. Even a mixed methods study could be highly useful to determine further underlying factors that are at work in the formation of attitudes.

REFERENCES

Adams, James, Jay Dow, and Samuel Merrill III, 2006. "The Political Consequences of Alienation-based and indifference-based voter abstention: Applications to Presidential Elections." Springer Science-Business Media, Inc. 2006. Retrieved March 26, 2014 (http://link.springer.com/article/10.1007/s11109-005-9002-1/fulltext.html)

American Medical Association Archives. 1976. "The AMA and Medicare and Medicaid, 1965." Retrieved October 1, 2013 (www.ama-ssn.org/resources/doc/ethics/medicare.pdf).

American National Election (ANES) Time Series Study, 2012. Stanford University and University of Michigan. Retrieved October 10, 2013 (www.electionstudies.org)

Banks, Antoine. 2013. "The Public's Anger: White Racial Attitudes and Opinions Toward Health Care Reform." Original Paper, Department of Government and Politics, University of Maryland.

Banks, Antoine and Melissa Bell. 2013. "Racialized Campaign Ads: The Emotional Content in Implicit Racial Appeals Primes White Racial Attitudes." *Public Opinion Quarterly, 77*(2): 549-560.

Banks, Antoine and Nicholas Valentino. 2012. "Emotional Substrates of White Racial Attitudes." *American Journal of Political Science, 56*(2):286-297.

Blendon, Robert and John Benson. 2001. "Americans' Views on Health Policy: A Fifty-

Year Historical Perspective." *Health Affairs*, 20(2):33-46.

Blendon, Robert and Karen Donelan. 1990. "The Public and the Emerging Debate Over National Health Insurance." *The New England Journal of Medicine*, (323):208-212.

Blumer, Herbert. 1958. "Race Prejudice as a Sense of Group Position." *Pacific Sociological Review*, 1(1):3-7.

Braveman, Paula. 2011. "Health Inequalities by Class and Race in the US: What can we learn from the patterns?" *Social Science & Medicine*, 74:665-667. Retrieved August 8, 2013 (www.elsevier.com/locate/soscimed)

Carter, Jimmy. 2009. NBC Nightly News – Interview with Brian Williams, September 15, 2009.

Centers for Medicare and Medicaid Services. 2011. *National Health Expenditure Projections 2011-2021*. Retrieved August 2, 2013 (http://www.cms.gov/Research...NationalHealth/ExpendData.../Proj2012.pdf).

Cobb, Sara and Janet Rifkin. 1991. "Practice and Paradox: Deconstructing Neutrality in Mediation." *Law & Social Inquiry*, 16(1):35-62.

Conover, C. (2011). "Government Share of Healthcare is Far Bigger than Advertised." Retrieved August 2, 2013 (http://www.american.com).

Domke, David. 1998. "Elite Messages: The Rose of Race as a Source Cue." Retrieved August 2, 2013 (http://www.ebscohost.com).

Funigiello, Philip. 2005. *Chronic Politics: Health Care Security from FDR to George W. Bush*.

Lawrence, Kansas: University of Kansas Press.

Gelman, Andrew, Daniel Lee and Yair Ghitza. 2010. "Public Opinion on Health Care Reform." The Berkeley Electronic Press, Berkeley, California. Unpublished manuscript.

Gilens, Martin. 1999. *Why Americans Hate Welfare: Race, Media, and the Politics of Anti- Poverty Policy*. Chicago, Illinois: The University of Chicago Press.

Gollust, Sarah and Julia Lynch. 2011. "Who Deserves Health Care? The Effects of Causal Attributions and Group Cues on Public Attitudes about Responsibility for Health Care Costs." *Journal of Health Politics, 36*(6):1061-1095.

Goodman, Louis and Timothy Norbeck. 2013. "Who's to Blame for our Rising Healthcare Costs?" Retrieved August 6, 2013 (www.forbes.com/sites/realspin/2013/04/03/whos-to-blame-for-our-rising-healthcare-costs/).

Grande, David, Sarah Gollust and David Asch. 2011. "Polling Analysis: Public Support for Health Reform was Broader than Reported and Depended on How Proposals Were Framed." *Health Affairs, 30*(7):1242-1249.

Gross, Wendy, Tobias Stark, Jon Krosnick, Josh Pasek, Gaurav Sood, Trevor Tomson, Jennifer Agiesta, and Dennis Junius. 2012. "Americans' Attitudes Toward the Affordable Care Act: Would Better Public Understanding Increase or Decrease

Favorability?" Unpublished manuscript. Research conducted with support from the Robert Wood Johnson Foundation, GfK, Stanford University and the Associated Press.

Grusky, David, Bruce Western and Christopher Wimer, eds. 2011. *The Great Recession*. New York: Russell Sage Foundation.

Harell, Allison, Stuart Soroka, and Kiera Ladner. Paper presented at a workshop of the Canadian Political Science Association Annual Meeting, June 15-17, 2012, Edmonton, Alberta, Canada, Retrieved August 3, 2013 (www.cpsa-acsp.ca/papers-2012/Harell-Soroka--Ladner.pdf).

Herman, Bob. 2012. "A Look from Within: Why Are U. S. Healthcare Costs so High?" Retrieved August 2, 2013 (http://www.beckershospitalreview.com/racs-/icd-9-/-icd-10/a-look-from-within-why-are-u.s.-healthcare-costs-so-high).

Hoffman, Beatrix. 2003. "Health Care Reform and Social Movements in the United States." *American Journal of Public Health, 93*(1):75-85.

Howard, Paul and Stephen Parente. 2010. "Toward Real Health Care Reform." Retrieved August 2, 2013 (http://www.NationalAffairs.com).

Iglehart, John. 2010. "Historic Passage – Reform at Last." *New England Journal of Medicine.* Retrieved October 6, 2013. Doi:10.1056/NEJMp1003376 (www.nejm.org).

Internal Revenue Service. 2013. *Small Business Health Care Tax Credit for Small Employers.* Retrieved August 20, 2013 (http://www.irs.gov).

Jacobs, Lawrence and Suzanne Mettler. 2011. "Why Public Opinion Changes: The Implications for Health and Health Policy." *Journal of Health Politics, Policy and Law*, *36*(6):917-933.

Jacobs, Lawrence and Theda Skocpol. Revised ed. 2012. *Health Care Reform and American Politics – What Everyone Needs to Know.* New York: Oxford University Press.

Jones, Michael and Mark McBeth. 2010. "A Narrative Policy Framework: Clear Enough to be Wrong?" *Policy Studies Journal*, *38*(2):329-353.

Kaiser Family Foundation. 2013. "Health Tracking Poll." Retrieved August 20, 2013, (http://www.kff.org/other/state-indicator/total-population/).

Keehan, Sean Paul. 2011. "National Health Spending Projections Through 2020: Economic Recovery and Reform Drive Faster Spending Growth." Retrieved October 1, 2013 (http://content.healthaffairs.org/content/early/2011/07/27/hlthaff.2011.0662.full).

Knoke, David, George Borrnstedt, and Alisa Potter Mee. 2002. *Statistics for Social Data Analysis, Fourth edition.* F. E. Peacock Publishers, Inc. N. Y.

Lakoff, George. 2002. *Moral Politics - How Liberals and Conservatives Think* (2nd ed.). Chicago, Illinois: University of Chicago Press.

Lichtenstein, Marc. 2012 . "Health Insurance – From Invention to Innovation: A History of the Blue Cross and Blue Shield Companies." Retrieved August 8, 2013 (http://www.bcbs.com/blog/health-insurance.html).

London, Scott. 1993. "How the media frames political issues." Retrieved August 3, 2013 (http://www.ebscohost.com).

Magge, Hema, Howard Cabral, Lewis Kazis, and Benjamin Sommers. 2012. "Prevalence and Predictors of Underinsurance among low-income adults." *Journal of General Internal Medicine.* 28(9):1136:42.

McBeth, Mark., Elizabeth Shanahan, Ruth Arnell, and Paul Hathaway. 2007. "The Intersection of Narrative Policy Analysis and Policy Changes Theory." *Policy Studies Journal, 35*(1):87-108.

The Morning Call. (2013, February 22). "Americans have been duped again by Obama. *The Morning Call.* (Allentown, PA). p. A17. Downloaded August 18, 2013 from (http://www.articles.mcall.com/.../mc-obamacare-costs-bomboy-20

Miller, Phillip, Louis Goodman, and Tim Norbeck. 2010. *In Their Own Words: 12,000 Physicians Reveal Their Thoughts on Medical Practice in America*. Garden City, New York: Morgan James Publisher.

Newport, Frank and Jeffrey Jones. 2009. "Seniors Lean Against the New Health Care Law." Retrieved August 18, 2013 (http://www.gallup.com/poll.123164/seniors-lean-against-new-healthcare-law.aspx).

Obama, Barack. 2009. Meet the Press. Interview with David Gregory. September 20, 2009.

Olafsdottir, Sigrun and Bernice Pescosolido. 2010. "Is Health Care Reform Contested in the U.S.? Public Attitudes Toward Government Involvement in Health Care,

1973-2010." Department of Sociology, Boston University, Boston, MA. Unpublished manuscript.

Pew Research Center. 2010. "A Year After Obama's Election: Blacks Upbeat About Black Progress, Prospects." Retrieved September 4, 2013 (www.pewsocialtreands.org/.../blacks- upbeat-about-black-progess-prospe...).

Pfiffner, James. 2009. "President Clinton's Health Care Reform Proposals of 1994." Retrieved August 6, 2013 (http://www.cspresidency.orgpubs/Triumphs_and_Tragedies/President_Clintons_Health_Care_Reform_Proposals.pdf).

Quadragno, Jill. 1994. *The Color of Welfare – How Racism Undermined the War on Poverty*. Oxford University Press. N. Y.

Quadragno, Jill. 2004. "Why the United States Has No Health Insurance." *Journal of Health and Social Behavior*, 45:25-44.

Rich, Frank. 2010. "The Rage is Not About Health Care." *New York Times*, March 28. Retrieved August 2, 2013 (http://www.NYTimes.com/2010/10/03/28/opinions/28rich.html).

Rifkin, Janet, Jonathan Millen, and Sara Cobb. 1991. "Toward a New Discourse for Mediation: A Critique of Neutrality." *Conflict Resolution Quarterly*, *9*(2):151-164.

Sanchez, Gabriel, Amy Goodin, Amelia Rouse, and Richard Santos. 2008. "The Impact of Ethnicity on Attitudes Toward Health Care Reform in New Mexico." Working

Paper, Robert Wood Johnson Foundation, Department of Political Science, University of New Mexico, Albuquerque, NM.

Schram, Sanford, Joe Soss, and Richard Fording, eds. 2006. *Race and the Politics of Welfare Reform*. Ann Arbor, Michigan: The University of Michigan Press.

Sherman, Sally. 1989. *"Public Attitudes Toward Social Security."* Social Security Bulletin, December, 1989 - Office of Research and Statistics - Office of Policy, Social Security Administration, *52*(12):2-16.

Starr, Paul. 1992. "The Logic of Health Care Reform." Retrieved August 2, 2013 (http://www.princeton.edu/~starr/healthrefor/logic92_complete.pdf)

Tesler, Michael. 2012. "The Spillover of Racialization Into Health Care: How President Obama Polarizes Public Opinion by Race and Racial Attitudes." *American Journal of Political Science, 56*(3):690-704.

Thomasson, Melissa. 2012. "From Sickness to Health: The Twentieth Century Development of U. S. Health Insurance." *Explorations in Economic History.* 39:233-253.

Toner, Robin, and Anne Kornblut. 2006. "Wounds Salved - Clinton Returns to Health Care." *New York Times*, June 10. Retrieved August 10, 2013 http://www.NYTimes.com/2006/06/10/Washington/10hillary.html

Tuohy, Carolyn. 1999. *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada*. New York: Oxford University Press.

U.S. Bureau of the Census. 2012. *Population Division Estimates.* Retrieved August 2, 2013, from http://www.census.gov/popest/data/national/asro.php

U. S. Congress. 2010. *"The Patient Protection and Affordable Care Act (Obamacare)."* Washington, DC: U. S. Government Printing Office.

U. S. Supreme Court: National Federation of Independent Business *et al* vs. Sebelius, Secretary of Health and Human Services, No. 11-393, No. 11-398, and No. 11-400 (2012). Decision read June 28, 2012.

Valentino, Nicholas,Vincent Hutchings, and Ismail White. 2002. "Cues That Matter: How Political Ads Prime Racial Attitudes During Campaigns." *American Political Science Review, 96*(1):75-90.

Ward, Deborah. 2008. *The White Welfare State: The Racialization of U.S. Welfare Policy*. Ann Arbor: The University of Michigan Press.

Watkins-Hayes, Celeste. 2009. *The New Welfare Bureaucrats: Entanglements of Race, Class, and Policy Reform*. Chicago and London: The University of Chicago Press.

Watson, Tony. 2008. "Managing Identity: Identity Work, Personal Predicaments, and Structural Circumstances." *Sage Publications, 15*(1):121-143.

Watts, Mark, David Domke, Dhavan Shah, David Fan. 1999. "Elite Cues and Media Bias in Presidential Campaigns: Explaining Public Perceptions of a Liberal Press." *Communications Research, 26*(2):144-175.

Wear, Stephen. 2011. "Sense and Nonsense in the Conservative Critique of Obamacare." *American Journal of Bioethics*, 11(12):17-20.

Weaver, Christopher. 2009. "Obama's Health Care Dilemma Evokes Memories of 1974." Retrieved October 5, 2013 (http://www.kaiserhealthnews.org/Checking-in-With/stuart-altman.asp...)

West, Emily. 2013. "The Racialization of U.S. Health Reform: The Case of the Gold-Plated Cadillac Health Plans." Working Paper, Department of Communications, University of Massachusetts, Amherst, MA.

White, Ismail. 2007. "When Race Matters and When it Doesn't: Group Differences in Response to Racial Cues." *The American Political Science Review, 101*(2):339-354.

Williams, David, and Toni Rucker. 2000. "Understanding and Addressing Racial Disparities in Health Care." *Health Care Financing Review, 21*(4):75-90.

Williamson, Vanessa, Theda Skocpol, and John Coggin. 2011. "The Tea Party and the Remaking of Republican Conservatism." *Perspectives on Politics, 9*(1):25-43.

Winter, Nicholas. 2006. "Beyond Welfare: Framing and the Racialization of White Opinion on Social Security." *American Journal of Political Science, 50*(2):400-420.

Woolley, John and Gerhard Peters. 2009. The American Presidency Project {online}. Santa Barbara, CA: University of California (hosted), Gerhard Peters (database). Available from World Wide Web: (http://www.presidecy.ucsb.edu/ws/?pid=4337.).

APPENDIX

QUESTION SET FROM AMERICAN NATIONAL ELECTION TIME STUDY (ANES) 2012

APPENDIX

QUESTION SET FROM AMERICAN NATIONAL ELECTION TIME STUDY (ANES) 2012

Questions are presented as the original questions before recoding or restriction (ANES 2012).

[VAR health_2010hcr]

Favor or oppose 2010 health care law

1. Favor a great deal
2. Favor moderately
3. Favor a little
4. Neither favor nor oppose
5. Oppose a little
6. Oppose moderately
7. Oppose a great deal

[VAR resent_deserve]

Agree/disagree blacks have gotten less than they deserve

1. Agree strongly
2. Agree somewhat
3. Neither agree nor disagree
4. Disagree somewhat
5. Disagree strongly

[VAR discrim_blacks]

Discrimination in the U. S. against blacks

1. A great deal
2. A lot
3. A moderate amount
4. A little
5. None at all

[VAR resent_workway]

Agree/disagree blacks should work way up without special favors

1. Agree strongly
2. Agree somewhat
3. Neither agree nor disagree
4. Disagree somewhat
5. Disagree strongly

[VAR resent_try]

Agree/disagree blacks must try harder to get ahead

1. Agree strongly
2. Agree somewhat
3. Neither agree nor disagree
4. Disagree somewhat
5. Disagree strongly

[VAR stype_hwkblack]

Stereotype: Blacks hardworking?

1. Hardworking
2. Rather hardworking
3. Somewhat hardworking
4. Neither
5. Somewhat lazy
6. Rather lazy
7. Lazy

[VAR stype_intlblack]

Stereotype: Blacks intelligent?

1. Intelligent
2. Rather intelligent
3. Somewhat intelligent
4. Neither
5. Somewhat unintelligent
6. Rather unintelligent
7. Unintelligent

[VAR stype_hwkwhite]

1. Hardworking

2. Rather hardworking
3. Somewhat hardworking
4. Neither
5. Somewhat lazy
6. Rather lazy
7. Lazy

[VAR stype_intlwhite]

1. Intelligent
2. Rather intelligent
3. Somewhat intelligent
4. Neither
5. Somewhat unintelligent
6. Rather unintelligent
7. Unintelligent

[VAR sample_region]

Sample-Census region

1. Northeast
2. North Central
3. South
4. West

[VAR gender_respondent]

Gender of respondent

1. Male
2. Female

[VAR dem-raceeth]

1. White – non-Hispanic
2. Black – non-Hispanic
3. Hispanic
4. Other – non-Hispanic

[VAR dem_hispanic]

Are you Spanish, Hispanic, or Latino(a)?

1. Yes

2. No

[VAR dem_marital]

1. Married – spouse present
2. Face-to-face only: Married – spouse absent (VOL)
3. Widowed
4. Divorced
5. Separated
6. Never married

[VAR dem_avgclass]

Social class: average or upper working/middle class

0. Lower class or poor (VOL)
1. Average (middle/working) class
2. Upper (middle/working) class
3. Lower (middle/working) class (VOL)
4. Upper class (VOL)
5. Other (specify)

[VAR libcpo_self]

7-point scale liberal-conservative self-placement

1. Extremely liberal
2. Liberal
3. Slightly liberal
4. Moderate; middle of the road
5. Slightly conservative
6. Conservative
7. Extremely conservative

[VAR pid_self]

Does respondent think of self as Democrat, Republican, Independent, or other?

1. Democrat
2. Republican
3. Independent
4. Other