

# Support for Health Care in the Welfare State: Australia, Britain, Canada, New Zealand and the United States

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## Abstract

Health care is an increasingly important issue for the public in many different countries. This paper examines the level of support for health care spending and government spending over time, in similar countries (in terms of overall spending as a proportion of GDP and levels of state financing). We compare the United Kingdom, Canada, Australia and New Zealand with the United States which both has higher overall spending and less spending by the government. First, we find that the public is increasingly concerned about health care. Second, we analyze the changing level of public support for government activity in and government spending on healthcare. Third, we examine the sources of support within each country. We hypothesize that variations across countries in the relationship between the explanations for support and support for health care funding itself will depend on the structure of the health care system and the levels of government spending. Our results show the importance of distinguishing between support for government intervention and support for government spending; and show surprising differences in the level of support across countries. We find a growing consensus that government should spend more on health care but declining definitive support for government intervention in health care.

*Comments would be greatly appreciated.*

Tables separate.

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## **Introduction**

Following a trend of greater public attention to the issue of health care, scholars in recent years have begun to examine public opinion on health care. The research questions in this expanding area include (1) why some countries have different health care arrangements, and if public opinion explains these differences (Jacobs 1992), (2) the overall level of support for government activity in the health care sector, (3) the level of support for major reform in the United States, (Jacobs and Shapiro 1993, 1996) and satisfaction with health care in other countries (Blendon et. al 1999), and finally, (4) the relative importance of health care as an issue or issue saliency. We focus mainly on question (2) in this paper by examining the level of support for health care spending and government involvement in health care over time, and to a lesser extent (4), the saliency of health care. Using cross national and time series survey data we examine a group of similar countries -- the so-called "liberal welfare states": the United Kingdom, Canada, Australia and New Zealand (Ruggie, 1996; Esping-Andersen 1990) and the United States.<sup>3</sup> We analyze the (1) overall level of support for universal health care 1986-1996, (2) track this support from 1986-1996, and (3) analyze the sources of support within each country.

## **Comparative Public Opinion on Health Care**

Consistent findings and predictions have not completely emerged in the work on public opinion on health care. Research on voter attitudes often combines health care with other social policies. We draw here on studies that have both examined health care and, more generally, the welfare state. Scholars have mostly focused on examining the differences in public opinion on health care. Differences can occur across countries regarding the financing and organization of health care. Differences also exist within countries among different groups. There are three likely explanations for cross-national variations in public opinion.

First, systemic variations as outlined below may explain cross-national variations in opinion. Systemic variables range from delivery arrangements to spending levels and even to processes for incorporating citizens in public debate and decision-making. For example, more generous regimes may produce greater satisfaction and less desire for increased spending. The work in this area shows mixed results. Mossialos (1997) demonstrates a relationship between per capita expenditures and satisfaction

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<sup>3</sup> Ruggie (1996) includes Canadian, British and American welfare states as liberal welfare states. She suggests these three countries lean towards market solutions and emphasize individual rights and freedoms. The United States is both a liberal welfare state and unique among these countries as it has higher overall spending on health care and considerably less spending by the government than the other countries.

with health care and support for reform in the 15 European Union member states. Other authors question the usefulness using a systemic approach. For example, Bean and Papadakis (1998) in a more general analysis of welfare services conclude that the systemic<sup>4</sup> or regime based explanations for support are weak largely because there is little variation across regimes. They conclude that the middle class remains “morally committed to the welfare state” in most countries despite the reports of the demise of its legitimacy (Bean and Papadakis 1998, 232). However, as the discussion on health care below shows there are relatively important differences between countries both in terms of health expenditure and particularly there are important differences in regimes between the United States and other countries examined.

A second group of explanations uses social group membership to explain differences within countries and these social group differences may be generalizable across countries (for an examination of the effect of socio-economic status on health care opinions see Pescosolido, Boyer and Tsui 1985). Some groups will benefit more from government activity and spending. The elderly in every country appear more concerned about health care than other age groups, and groups depending on state income support can naturally be expected to be more supportive of such programs (Bean and Papadakis 1998). The elderly are the group most likely to make use of health services. In addition, women are usually more concerned about access and financing of health care than men are, for example. The demographic explanations seem to be more important in explaining differences both within countries and possibly across them.

A third group of explanations examines the links between partisan attachments, political ideologies and support for government intervention and welfare spending. For many social policies left-right support is a good predictor of support for social policies, health care may show very different patterns of support that vary. Schlesinger and Lee (1993) find that patterns of support for health care in the United States are less constrained by social group membership and are more closely associated with support for equal opportunity than more overtly redistributive policies. In short, people are less tolerant when it comes to public programs for the poor.

Finally, while the groups of explanations outlined above seek to explain *variation* in attitudes, one of the notable observations regarding public support for health care spending and government activity is the consensus on two factors. First, in most countries the public is remarkably supportive of government provision and or financing of health care. Our results confirm this. Second, in the late 1990s the public showed consistent lack of satisfaction with current arrangements, even in very different health care systems. In no country is a majority satisfied with health care (Donelan, Blendon, Schoen, David and Binns 1999; Cutler 1999).

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<sup>4</sup> Bean and Papadakis use the term ‘institutional’ whereas we use ‘systemic’ instead.

## **Comparing the Health Care Systems in the United Kingdom, Canada, Australia, New Zealand and the United States**

We hypothesize that the views of the public across countries will be influenced by the expectations that exist about the respective roles of the government and the private sector in the health care sector which are based on existing systemic arrangements. Therefore, we provide a basic analysis of health care financing in the countries under study.

### Global Reform Trends Over Time

David Cutler (1999) outlines three waves of health care policy reform in the Group of Seven nations. In most countries the first wave of reform as Cutler describes it, was the establishment of health care system where providers were paid on a fee for service or salary basis. This wave lasted until the late 1970s, although was largely completed in 50s and 60s (Cutler 1999). In most countries, under these arrangements little or no cost sharing existed and fee for service payment developed. In our country sample, the dates of adoption of national health insurance vary widely. In New Zealand, the first democratic country to provide national health insurance established health care in 1938, and in the United Kingdom, national health insurance is a well-established right of citizenship, even if recent reforms have challenged the level of government provision that citizens will expect. In Canada and Australia, by contrast, national health insurance came much later. National health insurance was established in 1984 in Australia after a series of attempts by various governments over decades. In Canada's case national health insurance<sup>5</sup> was established through complex negotiations between federal and state levels in the 1960s. In the United States national health insurance has never developed but health insurance programs for the poor and over 65 group have provided coverage for these groups since the 1960s.

The structure of health care in most countries began to change in the 1970s, when health costs increased. By the 1980s, the second wave of reform of supply side cost containment began. Supply side reforms attempted to put pressure on provider fees (hospitals and physicians for example) as a way to reduce or contain costs. Cutler suggests these reforms worked for a period while physicians eliminated marginal care first. However, because demand was unlimited while supply was limited, the era of supply side rationing could not last.

The third wave of reform in the 1990s saw a new emphasis on market forces in medical care and increased cost-sharing (Cutler 1999). In some countries governments have attempted to introduce bold reform plans. However, in many countries reform has been stalled or blocked, partly because of the

reaction against cost sharing and market incentives. For example, in New Zealand, the National government was forced to abandon many health care reforms between 1991 and 1996 due to a lack of popular support. The public directly blamed the Government for health care reform failures and the government had to change some of its reform plans (Laugesen, 2000). A divergence between public opinion and political considerations has also led to incremental health care reform in Australia (Hall 1999). Below we examine the characteristics of the health care systems five countries.

### The Systems Compared: Financing and Expenditure

Four countries in our sample have national health insurance and all systems have tax financed health care. Within the four countries, Canadian and Australian health care systems are most alike, and New Zealand the United Kingdom are comparable in many ways. In Canada, provinces have a large degree of autonomy, but are constrained by the Health Act (Ruggie, 1996). Australia also contains some mix of provincial and federal responsibilities but there are less state variations than in Canada. New Zealand is relatively centralized along similar lines to the United Kingdom. Both these latter countries have made efforts in the 1990s to encourage efficiency in the health services through market incentives.

The United States is unique compared to the other four countries in many ways. The United States has a largely privately financed health care system (approximately 50%) that is comprised of private insurance companies that contract with providers and are funded by employer and employee contributions. Publicly financed health care exists for the over 65 and poorer members of the population. The federal Medicare program is financed by payroll taxes that are deducted from all employees' wages and salaries. This program provides coverage for the over 65 population but concerns exist over the financial sustainability of the program. Medicaid, which finances health care for welfare recipients and disabled individuals is operated by the states, and conditions vary between states.

### *Health Expenditure Levels and Trends*

Comparisons of health expenditure across the five countries reveal important differences. As Table 2 shows, the United States spends most resources by a wide margin with 14 percent of GDP allocated to health care in 1995. The United Kingdom and New Zealand spend about half as much of their national income on health care as the United States (6.9 percent and 7.1 percent respectively) and are amongst the lower spenders in the OECD sample as a whole. Australia spends slightly more than the United Kingdom or New Zealand, with 8.6 percent of GDP, while Canada spends 9.7 percent of GDP.

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<sup>5</sup> Hospital funding was allocated after the Second World War by the federal government to provinces (Tuohy 1999).

Canada's expenditure is close to the mean expenditure of Group of Seven countries. Among Group of Seven countries health care costs have been increasing steadily between 1985-1995 from a G7 average of 8.1 percent in 1985 to 9.4 percent in 1995. In recent years, managed care and other recent initiatives have slowed spending in the United States (Anderson 1997).

The United Kingdom has the highest percentage of public spending of health care at 84 percent of total health expenditure (see Table 1). New Zealand follows with 77 percent of expenditure allocated by the Government in 1997. In Australia and Canada the public level of expenditure is lower but both countries are roughly comparable with 66 and 69 percent respectively. The public share of funding in Canada, Australia, and the United States increased considerably since 1960, partly a reflection of these three countries' delayed role in developing national health insurance (see Table 1). However, in the last fifteen years private sources of finance are growing in Canada while shrinking in the United States. In all countries except for the United States, between 1985 and 1995 public expenditure on health as a percentage of total spending declined. Declines are seen of almost 7 percent in Australia, 6 percent in Canada, 2 percent in the United Kingdom. In contrast, public expenditure as a percentage of the total amount spent grew in the United States by 13 percent (OECD Health Data 98).

An important factor in understanding different health care systems beyond the role of government that is frequently overlooked is the extent to which households pay for their health care. As Table 3 shows, individual or household out of pocket payments are the highest in the United States when comparing it to the United Kingdom and Canada (Ruggie, 1996), but New Zealand also has high out of pocket expenditures (OECD Health Data 1999). Comparable data across the years in our sample is limited but the following observations are made. Analysis of expenditure in New Zealand, the United Kingdom and the United States between 1984 and 1995 shows that (inflation adjusted) per capita out of pocket expenditure increased 142 percent in New Zealand, a staggering rate of increase, compared to a 12 percent increase in the United Kingdom and a 16 percent increase in the United States (OECD Health Data 1998). In the United Kingdom the largest growth in out of pocket expenditures appears to have occurred under Thatcher's leadership when per person, real out of pocket expenditures increased 111 percent by 1989. Although the years are not comparable for Australia and Canada, both show growth in out of pocket expenditures. Canadian data shows a growth rate for the years 1988-1993 of 12 percent<sup>6</sup> (OECD Health Data 98).

As the above summary of the five countries shows, government and personal financing levels, and total national expenditure vary considerably. In the next section, the cross national differences in finance are tested against the level of support for government intervention and support for government

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<sup>6</sup> Canadian data is for households.

spending. We also analyze the level of saliency in health care by summarizing data on the relative importance of health care in each country.

## **Results: Saliency, Government Spending and Government Activity**

### Data Sources:

We use data from various sources to examine the saliency of health care over time. To examine the sources of support for government spending and activity we use the International Social Survey Program's Role of Government Survey from 1985, 1990 and 1996-1997. Data across time is absent for Canada and New Zealand, and so results are only reported for 1996 for these countries. These surveys use standard questions in all countries and the question wording is stable over time.

The importance of health care as an issue is compiled from various sources and requires some explanation. The most complete data of this nature are from the U.S. and Britain. The trend for the United States in terms of issue is based on responses to Gallup's question regarding the most important problem. British data on the most important problem are from MORI. However, rather than showing the percentage who think health is the *most* important problem, the data from Britain shows the proportion of respondents who named health as the most important problem or offered it when prompted for other important issues. Therefore, the percentages will be greater than in the U.S, although comparable across time within Britain. Australian and Canadian data are from published poll results starting in 1992 and 1988 respectively. Similar to the British data, Australians were asked to name the top three problems so the percentages shown reflect the number who mentioned health as one of three problems. In Canada the percentage reported is the number who responded health when asked to what issue leaders should be paying attention. Most important issue data for New Zealand come from pre-election polls conducted in 1996 and 1999 and is the percentages who identified health care as the most important problem.

### Increasing Saliency of Health Care:

Overall the data suggests increasing saliency of health care in the 1990s. Table 4 shows the change in the proportion of respondents who think health is an important issue. In the United States, the saliency of health care peaked in 1994 during the Clinton administration's attempt at health care reform and has fallen in the late 1990s. In Britain, the saliency of health has steadily increased over time, but the surge in support happens in the late 1980s about 6 years earlier than in the United States. In Canada,

health care was of comparatively low saliency before 1995 but since 1994 the percentage of people saying health was the most important problem jumped from 3 percent to 55 percent in 2000. The proportion of Australians saying health was the most important issue in the last 12 months almost quadrupled between the 1993 and 1996 elections. While we have no earlier data, health care was the most important issue in the 1996 and 1999 elections in New Zealand. Although we have only limited data on issue saliency for Canada, scholars have remarked that politicians believed it was risky to tamper with the health care system in the 1980s (Tuohy 1999).

The increased saliency of health care could be explained by a number of factors. It is beyond the scope of this paper to analyze why health care became a significantly more important issue in the 1990s than previously, but some tentative answers are considered. First, the public may be responding to actual changes in the level of health care financing or provision. Increased private expenditures and decreased public expenditures are pushing the public to be more aware of health care as an issue. Out of pocket payments and government expenditure levels changed. Out of pocket payments had increased in most countries and fairly dramatically in New Zealand, the United States and earlier in the 1980s in the United Kingdom. This corresponds to the upswing in saliency in most countries. For example, in the United Kingdom the surge in saliency was preceded by comparatively large increases in out of pocket expenditures in Britain and a small decline in the government's share of health expenditure (see Table 1) after 1984. The largest declines in government spending occurred in 1990, 1992 and 1993 in New Zealand, however, the number of respondents saying it was the most important issue dropped after 1996. The United States and Australia show increased concern but also increasing or relatively stable patterns of public expenditure respectively. The rise in concern in the United States in 1994 was preceded by increases in the government's share of expenditure.

Second, the public may be reacting to the increased government attention (signaled by reforms actual or proposed around the world discussed above) to health care policy issues. Major reforms were considered in the United Kingdom in 1989-1990 and implemented in the following years. New Zealand proposed reforms in 1991 that would have dramatically changed the organization and financing of health care to a social insurance model. Not all of these reforms were implemented, but the public anxiety surrounding health care increased markedly in the 1990s. In the United States, President Clinton's reform efforts raised the profile of health care and the problems of the uninsured and partly resulted in a private sector response of increased use of managed care to restrain costs.

What is striking about the data from different countries is the reactive nature of public opinion. Whereas we might assume politicians react to public opinion, the sequence in health care appears to often follow a pattern of threatened or actual reform followed by increased saliency. With the exception of the United States, where reforms aimed to increase government regulation and involvement, there appears to

be a relationship between perceived threats to the role of government and rising issue saliency, and possible increasing support for expenditure. The public considers health care more important when they perceive possible privatization, as was the case in Britain after 1989 when the Thatcher Government announced widespread reforms. In all countries except Britain, significant reforms were not announced until the early or mid 1990s. In Canada, widespread satisfaction was noted in the late 1980s and national health insurance even became a symbol of national identity, leading to reduced incentives to reform (Tuohy 1992:102). However, by the late 1990s, Tuohy reports that growing levels of anxiety regarding health care were evident in Canada (Tuohy 1999:106). In Australia, health policy was rated as the most important issue of the four main issues in the 1993 election after the conservative Liberal-National parties proposed a greater private sector role (Gray, 1996). Similarly in New Zealand, rising concern from 1990-1999 reflects reforms instituted in 1991 that signaled declining public investment in health care. The increased saliency may explain why politicians seem frequently surprised by the reaction to health care reform.

#### Expenditure and Government Intervention:

We next turn to an examination of changes in support for government activity and spending. Our results show that there is a consensus in the late 1990s about a need for increased public spending on health care. In most countries, public financing of health care has decreased and the public's desire for increased spending appears to be a reaction to this decline and the rising private costs of health care. Only a small minority of respondents in each country believes the Government should spend less on health care. In most countries the support for more spending has increased. However, despite majority support for increased spending, variation does exist between countries. As Table 5 suggests, in 1996 Canada shows the lowest level of support for increased spending.<sup>7</sup> Canada is followed by the United States (67.5 percent). The highest levels of support for greater spending in the United Kingdom (91.5 percent) and New Zealand (87.6 percent) followed by Australia (79.9 percent).

Interestingly, in 1996 comparison across countries in Table 5 shows a relationship between support for increased expenditure and two of our systemic variables, the level of expenditure by Government as a percentage of the total, and the overall expenditure as a proportion of GDP. In other words, the less a country is spending in the aggregate and the larger the share of Government expenditure,

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<sup>7</sup> Other data has shown different results however. Data from the Canadian Election Studies in 1993 and 1998 shows a more recent increase in the number of respondents wanting no cuts in health care spending from 71 percent to 81 percent Canadian Election Studies 1993 and 1997. The question asked in the CES differs from those reported from the ISSP in that it asks respondents to indicate whether they want cuts in spending on services rather than whether the level of spending should be increased or decreased.

the stronger the support for increased government spending. Support for increased levels of government expenditure occur in countries with both the highest levels of government spending (New Zealand and the United Kingdom) which are also the countries with the lowest expenditure as a proportion of GDP.

### Support for Government Responsibility for Health Care

In contrast, while there is support for increased spending on health care, and a high degree of consensus for government responsibility for health care, *definitive support* for government responsibility for health care, though still high, is declining somewhat (the exception being the United States). The ISSP survey data used here asks “whether the Government should provide health care for the sick.” We analyze the support according to the choices expressed by respondents over time, which gives respondents the option of either choosing “definitely should” or “probably should” be “the responsibility of the Government to provide health care for the sick.” We aggregate the two categories as well as reporting the percentages of respondents answering definitively (definitely should).

### *Role of Government*

We first analyze the respondents who either said they probably or definitely considered the government had a responsibility to provide health care for the sick. As Table 5 shows, there is a high degree of public consensus outside of the United States that the Government should be responsible for providing health care for the sick. The United Kingdom leads in the overall support for Government providing health care for the sick; with close to 99 percent either suggesting the Government “probably should” or “definitely should” should provide health care both in 1990 and in 1996, closely followed by New Zealand with 97 percent. Thus, in Canada, Australia, New Zealand and the United Kingdom over 90 percent of the respondents suggest government should be responsible for providing health care to the sick. Even in the United States, support for the role of Government is very high. In 1985, 83 percent of the public supported government activity, 89 percent in 1990 and 85 percent in 1996. Comparing the United States and Canada shows some interesting data. Canadians are not as supportive as Americans are on increasing government expenditure in 1996. Americans want more spending on health care but are not as supportive of Government’s role in health care as Canadians. In other words, Canadians are very supportive of the role of government in health care, but are less enthusiastic about increasing government expenditure.

### *'Definitive' support for role of Government*

The percentage of respondents who consider that health care should “definitely” be provided by the government for the sick shows much more variation. As Table 5 shows, in 1996, 82 percent of British respondents, 71 percent of New Zealanders, 61 percent of Canadians and 42 percent of Australians considered Government definitely should provide health care for the sick. Data from the United States for 1996 shows that 39 percent considered government should “definitely” be responsible for providing health care for the sick. In this question a weaker relationship is seen between financing levels and support for government activity.

In terms of unqualified support over time however, the trends suggest a slight loss of certainty that the Government should be responsible for health care in the countries for which we have cross time data (Australia, United States, and the United Kingdom). The biggest decline in unqualified support for government activity occurred in Australia where national health insurance was introduced in 1984. The percentage of respondents saying the Government should “definitely” provide health care for the sick decreased from 60 percent in 1985-6, to 38 percent in 1990 then increased to 42 percent in 1996. At the same time however, the total number of respondents in Australia who either said “definitely” or “probably” has been relatively stable at around 93-94 percent in the same period, suggesting a constant degree of support but perhaps a less definitive basis than in the United Kingdom. A small decrease is evident in the percentage suggesting Government should “definitely” provide health care for the sick in the United Kingdom, from 85 percent in 1985-6 to 81 percent in 1996.

### *American Exceptionalism*

On average almost 85 percent of the public support government activity in health care in the United States.<sup>8</sup> Jacobs has suggested that Americans are simultaneously supportive of significant reform and uneasy about expanding the government's role. Using public opinion data gathered through the early 1990s, Jacobs, Shapiro and Schulman (1993) show that the U.S. public was dissatisfied with the current system and supportive of government intervention. In 1991, close to 70 percent said there was too little government spending on health care, between 60 and 68 percent of the public would be willing to pay higher taxes for adequate health care and a majority favored national health insurance (Jacobs, Shapiro and Schulman 1993). Lack of public support is not to blame for the failure to introduce universal health care in the early 1990s (Jacobs and Shapiro 1995). In 2000, there is still majority support for government

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<sup>8</sup> We are aggregating the totals here (definitely + probably).

activity; 59 per cent of respondents in a recent survey said that it is the responsibility of the federal government to “make sure all Americans have health coverage.”<sup>9</sup>

In sum, there is not as clear a consensus for government activity as there is for increased government spending on health care. In most countries the number of respondents offering unqualified support for Government’s role has dropped, suggesting some changes have occurred in definitive support.

### Social Bases of Support for Government Spending and Activity

We next look at the base of support for government activity and spending in health care. We expect that the groups who we would expect to benefit most from government activity and spending to have the highest levels of support. In other words, these are groups who cannot afford health care or those who are least likely to have health insurance provided by an employer.<sup>10</sup> For example, women who are less likely to be active in the labor force would be expected to have higher levels of support. We would also expect the eldest and the youngest age groups to have higher levels of support. The young are more likely to face uncertainty in employment and the elderly are more likely to be retired, possibly less affluent, sicker, and will rely more heavily on social services including pensions. Likewise, these groups would most likely be the most adversely affect by cutbacks in health spending. Therefore, we expect support for increased spending and activity to grow more significantly in these groups.

We would also expect the relationship between social group membership or socio-demographic characteristics and support for health care spending and government intervention to vary by type of health care system. For example, in the United Kingdom and New Zealand where there is a long history of a universal health care and higher levels of government involvement, there should be less variation between social groups than in a country such as the United States which does not have universal coverage where certain groups would stand to benefit considerably from greater government involvement. Additionally, as previously discussed, in some countries there is a strong consensus regarding spending and activity and, naturally, we would expect less social group variation in the United Kingdom and New Zealand where the strongest consensus exists.

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<sup>9</sup> “Gallup Social and Economic Indicators” January 13-16, 2000. Gallup Organization. [www.gallup.org](http://www.gallup.org)

<sup>10</sup> The category of employer supplied insurance applies mainly for the United States. The category of affordability would apply to both the United States and the other countries, all of whom have some form of cost sharing for most health care services, to varying degrees.

### *Support for increased spending*

We first look at variation in support for increased spending by different categories of socio-demographic variables in Table 6. There are fairly consistent variations in the effects of each variable. Women, those with lower incomes, self-described lower or working class individuals and the unemployed are more likely to support increased spending. Income (including even self-defined class status) and political attachments show the largest variations within each country. The difference between categories of socio-demographic and political factors is largest in Canada. Looking at Table 6, the difference between first and fourth income quartiles in Canada in 1996 is over 24 percent. This difference is twice as large as in any other country (see also class differences which are substantial in Canada). This challenges assumptions long held about the consensus that exists in Canada across all income groups on the support for increased health spending. Interestingly, the relationship between income and support for increased spending is not linear in the United Kingdom. The greatest support is among those in the first income quartile while the lowest support is among those in the second quartile with the third and fourth quartiles in between.

Overall, the largest *political* differences occur in the United States and the smallest social group variations occur in New Zealand. In the United Kingdom, as well, smaller social group variations exist lending some support to the hypothesis that small variations will occur in countries that have longer experiences with national health care. Social and political group variations do occur across countries in largely hypothesized directions but the extent of the differences does vary. Therefore, the conclusion drawn by Bean and Papadakis (1998) that a moral consensus on the welfare state exists in advanced Western democracies may be an overstatement.

The data on support among the various social and political groups over time as shown in Table 8, suggests that increases in support are fairly consistent across categories. There is little support for the hypothesis that there would be a greater change in those groups most disadvantaged by cuts in health spending. The exceptions are age, income and, in Australia, political attachments. In the United States, the greatest increase in support is among the oldest age group while in the United Kingdom the greatest increase is among the young. In Australia, the greatest increase in support is among the 39-44 age group. Surprisingly, in the United States the greatest change in support for increases in spending is among the highest income quartile. In the United Kingdom, the second quartile actually had a decrease in support and in Australia the middle income categories had the highest increases.

### *Support for Government Intervention*

While support for government spending is increasing, support for government intervention is steady or declining in the countries under study except for the United States (see Table 5). There is more variation between social groups on the question of government responsibility to provide health care than on government spending. Certainly, the question about government responsibility is more likely to tap long held beliefs about the role of government rather than a more short term response to current spending levels. In Canada and New Zealand it is the oldest age group that is more likely to say it is the responsibility of government to provide health care while in the United States it is the youngest who are more likely to say this. Political attachments also play a large role in differentiating those who prefer government activity. In Canada, New Zealand and Great Britain there is tremendous support among the left but the differences between the left and right are largest in Canada possibly reflecting that national health care is a more recent phenomenon in Canada than Great Britain or New Zealand. In other words, a consensus has not developed among the different ends of the political spectrum on the provision of health care.

The largest over time changes in opinion on government activity occur in Australia. Most likely, this is in response to the introduction of a national health insurance system. Particularly among the high income and those without degrees, there has been a significant decline in the number of Australians who feel it is the responsibility of the government to provide health care. As Table 7 shows, the decline has not been steady over time. The 1990 survey shows the lowest level of support among all groups in Australia (except non-union members).

### *Regression Analysis*

In order to test the statistical significance of social groups and political attachments, we have regressed support for increased spending and government activity on the independent variables in Tables 8 and 9. High values for the dependent variable indicate more spending and government responsibility for health care. We have performed a separate regression for each country in 1996. The results confirm that political attachments and socio-economic well being (measured both by income and subjective social class) are consistent predictors of both preference for government activity and spending on health care across countries. Women are also significantly more likely to support increased spending and government activity in all countries (except in Great Britain and in the United States on spending). These results confirm that those most likely to use health services or who would benefit from increased government

activity are more supportive. However, even after controlling for social group membership, political attachments still play a significant role.

### Health compared to other social policies

We compare health care support for other areas of social policy. Table 10 compares support for government activity and increased spending in health care to other policy areas. Old age and unemployment benefits are more re-distributive in nature than health care and education. Two points are of interest. First, there seems to be a consensus in the late 1990s about a need for increased public spending on health care and education especially when compared to unemployment and retirement benefits.

In addition, health care does seem to be different from other more re-distributive social services. When compared to other social services, the decline in support for government activity is greater for the other social services and not health care (the exception being Australia). Support for spending is increasing and support for government activity is declining less dramatically than for other social services.

### **Conclusion**

Health care is an increasingly important issue for the public in many countries. The rising saliency of health issues may reflect widespread reforms to health care systems. Reforms around the world have made efforts to contain costs by increasing patient fees and charges and by limiting health budgets. The response to much of these changes has been a reaction against reform, and high levels of support for government spending increases in countries with low levels of government support for health care.

Our analysis of comparative public opinion data on the saliency of health care and public support for health care has examined the extent to which a cross-national consensus exists on health care and has tested explanations for variations when they exist. Cross national and cross-time comparison of views on health care reveal important differences spatially and over time. Our results suggest that citizens have become more concerned about health care in the 1990s, regardless of the type of financing and the system of organization. The increase of saliency across countries may reflect changes by financiers of health care – either public or private – to restrict or dampen demand for health care in an era of reforms of the 1990s.

Saliency of health care is evidently influenced by reforms proposed or implemented and appears to be reactive rather than anticipatory of reform.

Generally, we see a large degree of consensus on the need for increased spending on health care. Again, it appears that public opinion is reactive, in the sense that the desire for increased spending is a reaction to reductions in spending. Perhaps the most interesting aspect of comparison is that support for increased expenditure is strongly related to present levels of expenditure by government (and these countries also have the lowest health expenditure as a proportion of GDP).

Most people in all countries believe the Government should have a role in providing health care to the sick. In all countries only a small minority considers Government should not provide health care for the sick. Whether government should “definitely” have a role shows much sharper differences over time and across country. There is a slight loss of certainty on the role of government in the most recent survey.

One of the most interesting results is that there is steady support for spending and government intervention in countries that have long traditions of a national health service despite reform attempts. In New Zealand and the United Kingdom support for government activity and spending is high. In the United States, a country with no universal national health system, we see movement in the direction of support for greater government activity. The largest shifts in opinion seem to occur in Australia, which had a history of private insurance until a national health insurance system was introduced in 1984. While health policy changes have been incremental since then public opinion has changed more dramatically than in any other country under study. This suggests that the nature of the health care system may influence variation among countries, changes in opinion respond the specific reforms.

Analysis of social bases of support for spending and involvement suggests that the relationship between income and support for government intervention varies across different countries rather than being a linear relationship in all countries. For example, the percentage of respondents in the highest income group supporting increased government health spending has grown in the United States. Systemic variations matter to the extent that there are less social differences in support in countries with longer experiences. On the other hand, generally political attachments and socio-economic well-being show a consistent relationship to preferences on government activity and spending. Opinions on the role of government show that political attachments are good predictors of levels of support.

Our results show some interesting patterns of change in public opinion on health care and reflect to some extent the global reform trends discussed earlier and demonstrate a relationship between levels of government expenditure and the desire for greater expenditure. One possibility is that among systems where the financing is historically more mixed, for example in Australia and the United States, there is more willingness to blame the main existing financier. Perhaps the blame for disruption or changes to health services is born by the main provider, public or private. In the United States, where the private

sector has been the main provider except for the elderly and the poor, the desire for government activity is on the rise suggesting people are looking to government when dissatisfied with the current provisions by the private sector.

This research raises a number of questions, which we hope to investigate further. Further analysis of the systemic variations in health care systems and the relationship to public opinion is needed. Analysis may also be promising in terms of relationships between dissatisfaction and saliency. Differences in support across health and other social policies should also be examined.

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**Table 1. Public Expenditure on Health as a Percentage of Total Expenditure on Health**

	1960	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Australia	47.6	71.7	71.5	70.6	69.9	68.4	67.9	67.3	66.9	67	67	66.8	67.1	66.5	66.7
Canada	42.7	76.1	75.6	75.1	75	75	74.8	74.6	74.6	74.2	72.8	72.1	71.1	70.3	69.8
New Zealand	80.6	87		86.3	87.2	85.6	85.8	82.4	82.2	79	76.6	77.5	77.2	76.7	77.3
United States	24.8	41.1	40.6	41.2	41.4	40.4	40.4	40.5	41.5	42.2	42.9	44.6	45.8	46.2	46.4
United Kingdom	85.2	86.9	85.8	85.3	84.6	84	84	84.1	83.7	84.5	84.8	84.1	84.4	84.5	84.6

Source: OECD Health Data 99

**Table 2. Health Expenditure as a percentage of GDP, 1986-1995**

	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995
Canada	8.7	8.6	8.5	8.7	9.2	9.9	10.2	10.2	9.9	9.7
UK	5.9	5.9	5.8	5.8	6	6.5	6.9	6.9	6.9	6.9
USA	10.9	11.1	11.5	12	12.7	13.5	14.1	14.3	14.1	14.2
Average G7	8.1	8.2	8.3	8.3	8.5	9	9.4	9.5	9.5	9.4
Australia	8	7.8	7.7	7.8	8.2	8.6	8.6	8.5	8.4	8.6
NZ	5.3	5.9	6.5	6.6	7	7.5	7.6	7.3	7.1	7.1

Source: OECD Health Data 99

**Table 3. Out of pocket payments per person, at \$ exchange rate (unadjusted for inflation)**

(US Dollars)	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Canada					225	249	268	289	285	274	277	287	300	302
%increase over previous year						10.7%	7.6%	7.8%	-1.4%	-3.9%	1.1%	3.6%	4.5%	0.7%
New Zealand	51		64	83	122	119	158	163	185	212	237	275	302	
%increase over previous year			25.5%	29.7%	47.0%	-2.5%	32.8%	3.2%	13.5%	14.6%	11.8%	16.0%	9.8%	
United Kingdom	15	16	19	23	28	30	35	38	40	35	36	35		
%increase over previous year		6.7%	18.8%	21.1%	21.7%	7.1%	16.7%	8.6%	5.3%	-12.5%	2.9%	-2.8%		
United States	384	422	449	478	520	539	578	600	625	634	646	650	671	703
%increase over previous year		9.9%	6.4%	6.5%	8.8%	3.7%	7.2%	3.8%	4.2%	1.4%	1.9%	0.6%	3.2%	4.8%

Source: OECD Health Data 99

**Table 4. Changes in the Saliency of Health Care as and Issue: Most Important Problem**

	Britain	Australia	Canada	New Zealand	U.S.
1974	2.5				
1975	na				
1976	na				
1977	10				
1978	na				
1979	16				
1980	17.5				-
1981	na				-
1982	11				-
1983	13.4				-
1984	11.2				-
1985	14.1				-
1986	16.5				<.5
1987	24.9				1
1988	42.9		-		-
1989	34.1		-		-
1990	26.9		-		-
1991	36.1		-		4.5
1992	31.6	14	-		10.3
1993	32.1		7		23
1994	35.2	24	3		25.2
1995	40.5	24.7	12		9.5
1996	37.2		13	39.8	9.3
1997	47.1		18.8		6.7
1998	41.8	37	23		6
1999	39	42		21.64	7
2000	70*		55		

Source: Britain - Market and Opinion Research International (MORI - [www.mori.com](http://www.mori.com)). Combined per cent who responded "NHS" when asked, "What would you say is the most important issue facing Britain today?" and "What do you see as other important issues?" Per cent reported is averaged over polls conducted that year except 2000 which is only one survey (20-25 January). United States - Gallup Organization. Percent who said health care when asked what was the most important problem. Canada: Angus Reid Poll 1988-2000. Question, "Thinking of the issues presently confronting Canada, which one do you feel should receive the greatest attention from Canada's leaders?" ([www.angusreid.com](http://www.angusreid.com)) Australia: Roy Morgan Research Center ([www.roymorgan.com.au](http://www.roymorgan.com.au)). Question, "the three most important things the Federal Government should be doing something about." (% who mentioned health or hospitals).

- Not mentioned.

**Table 5. Government Responsibility and Spending: Change in Support for Health Care**

	<u>Australia</u>	<u>Great Britain</u>	<u>USA</u>	<u>Canada</u>	<u>New Zealand</u>
<i>Government should provide health care for the sick.*</i>					
1985-86 <i>Definitely</i>	60.3	85.4	35.9		
<i>Definitely + Probably</i>	93.3	91.1	82.9		
1990 <i>Definitely</i>	37.6	85.0	40.3		
<i>Definitely + Probably</i>	93.8	99.9	89.1		
1996 <i>Definitely</i>	42.4	81.7	38.5	61.6	71.4
<i>Definitely + Probably</i>	94.1	98.6	84.6	94.1	97.2
<i>Government should spend more or less on health care.**</i>					
1985-86 <i>More</i>	62.5	88.0	58.0		
<i>Less</i>	5.6	0.8	7.8		
1990 <i>More</i>	87.8	89.9	72.2		82.0***
<i>Less</i>	5.3	0.5	3.0		4.0***
1996 <i>More</i>	79.9	91.5	67.5	55.5	87.6
<i>Less</i>	2.1	0.4	6.7	4.5	1.2

Source: International Social Survey Program: Role of Government I, II and III (ICPSR #'s 2808, 6010, 8909)

\*Percentage of respondents who said definitely should or probably should be the responsibility of the govern

\*\*Percentage who said government should spend more/much more and less/much less.

\*\*\*Source: New Zealand Values Survey 1989-90

**Table 6. Government Spending on Health Care: 1985, 1990 and 1996**

	<u>Australia</u>			<u>Great Britain</u>			<u>United States</u>				<u>Canada</u>	<u>New Zealand</u>		
	1985	1990	1996	D1996-1985	1985	1990	1996	D1996-1985	1985	1990	1996	D1996-1985	1996	1996
<b>Female</b>	67.0	72.2	83.9	16.9	89.9	91.8	93.2	3.3	63.6	72.6	70.8	7.2	62.5	91.4
<b>Male</b>	58.4	63.5	75.9	17.5	86.6	87.8	88.8	2.2	54.6	71.7	63.6	9.0	45.7	83.6
<b>Age:</b>														
<b>18 thru 29</b>	63.5	67.5	78.5	15.0	90.0	91.8	89.2	-0.8	58.8	69.8	73.5	14.7	56.9	85.3
<b>39 thru 44</b>	59.0	65.5	83.0	24.0	89.4	92.2	92.9	3.5	60.1	73.5	67.7	7.6	50.0	85.3
<b>45 thru 64</b>	62.6	68.1	78.9	16.3	89.3	89.1	91.3	2.0	57.2	72.2	66.4	9.2	50.2	89.1
<b>65+</b>	65.8	73.1	78.5	12.7	81.7	86.1	90.9	9.2	64.7	72.6	60.8	-3.9	64.7	92.3
<b>Income:</b>														
<b>First Quartile</b>	68.8	73.8	82.8	14.0	89.9	91.9	97.4	7.5	67.6	75.0	74.3	6.7	64.4	91.4
<b>Second Quartile</b>	64.0	71.2	82.6	18.6	90.5	93.0	82.5	-8.0	60.1	70.1	68.4	8.3	57.1	91.2
<b>Third Quartile</b>	58.8	65.8	80.8	22.0	88.6	88.8	92.1	3.5	61.8	69.2	66.4	4.6	48.0	85.5
<b>Fourth Quartile</b>	54.5	60.1	71.1	16.6	81.3	87.7	86.2	4.9	47.5	74.4	59.2	11.7	37.0	79.2
<b>Degree</b>	54.3	57.9	75.5	21.2	87.1	86.2	84.6	-2.5	55.5	70.2	58.3	2.8	47.1	81.3
<b>No Degree</b>	63.2	69.5	81.0	17.8	88.5	90.4	92.3	3.8	60.7	72.7	68.3	7.6	63.4	88.6
<b>Unemployed</b>	60.0	73.3	73.3	13.3	90.3	97.7	100.0	9.7	64.7	88.0	74.0	9.3	63.3	90.3
<b>Employed or not looking</b>	62.5	67.7	80.0	17.5	88.2	89.7	91.0	2.8	59.5	71.8	67.5	8.0	53.9	87.4
<b>Lower and working class</b>	68.6	74.1	86.8	18.2	92.5		96.3	3.8	66.1	73.5	71.4	5.3	73.0	91.2
<b>Other class</b>	55.7	63.5	75.0	19.3	84.1		87.4	3.3	53.5	70.9	63.5	10.0	52.1	86.5
<b>Union member</b>	62.3	66.8	82.8	20.5	92.4	94.4	95.5	3.1	67.0	77.4	74.8	7.8	56.7	88.3
<b>Not union member</b>	62.6	68.1	77.9	15.3	86.9	88.8	89.2	2.3	58.4	71.7	65.2	6.8	53.2	87.2
<b>Left Party ID</b>	69.4	73.0	85.0	15.6	95.1	95.8	93.2	-1.9	69.1	77.6	79.0	9.9	55.4	93.4
<b>Center</b>	56.7	67.6	80.6	23.9	91.3	94.1	93.6	2.3	62.5	74.3	69.0	6.5	54.5	87.8
<b>Right Party ID</b>	55.5	61.9	74.7	19.2	78.0	81.1	82.8	4.8	46.0	66.0	51.9	5.9	39.5	82.7

Data are weighted.

**Table 7. Government Responsibility for Health Care: 1985, 1990 and 1996**

Government should definitely be responsible for providing health care for the sick.

	<u>Australia</u>			<u>Great Britain</u>			<u>USA</u>				<u>Canada</u>	<u>New Zealand</u>		
	D1996-			D1996-			D1996-							
	1985	1990	1996	1985	1990	1996	1985	1985	1990	1996	1985	1996	1996	
<b>Female</b>	63.7	39.4	45.0	-18.7	85.6	85.1	82.9	-2.7	40.6	43.6	41.7	1.1	70.4	74.4
<b>Male</b>	57.3	35.8	39.8	-17.5	86.1	84.9	80.6	-5.5	30.6	36.1	34.6	4.0	56.3	68.2
<b>Age:</b>														
<b>18 thru 29</b>	58.0	38.2	46.5	-11.5	82.8	82.5	79.1	-3.7	40.1	39.6	43.0	2.9	60.5	68.6
<b>39 thru 44</b>	55.1	36.3	43.4	-11.7	86.3	86.5	81.1	-5.2	27.7	41.1	39.1	11.4	62.3	69.1
<b>45 thru 64</b>	64.9	37.5	40.9	-24.0	87.8	84.3	84.3	-3.5	38.3	40.0	34.4	-3.9	63.4	70.8
<b>65+</b>	68.5	38.9	41.4	-27.1	86.5	86.1	83.1	-3.4	41.6	40.1	38.5	-3.1	72.2	78.8
<b>Income:</b>														
<b>First Quartile</b>	67.9	42.3	49.8	-18.1	89.3	88.3	89.0	-0.3	51.5	46.9	51.2	-0.3	67.7	78.6
<b>Second Quartile</b>	61.4	44.2	41.8	-19.6	88.7	84.2	81.5	-7.2	41.6	37.9	40.1	-1.5	56.4	75.0
<b>Third Quartile</b>	60.0	31.7	40.3	-19.7	83.9	84.8	79.7	-4.2	24.1	37.2	33.8	9.7	61.7	66.6
<b>Fourth Quartile</b>	44.7	32.0	35.9	-8.8	78.5	83.2	73.9	-4.6	20.4	39.7	24.4	4.0	66.8	60.8
<b>Degree</b>	50.4	33.5	41.6	-8.8	85.4	95.7	75.7	-9.7	23.1	32.5	29.0	5.9	60.2	58.1
<b>No Degree</b>	61.2	38.3	42.6	-18.6	91.3	84.0	82.2	-9.1	39.5	42.5	39.3	-0.2	67.4	73.5
<b>Unemployed</b>	70.6	47.7	56.8	-13.8	88.8	79.1	90.5	1.7	57.9	36.0	48.1	-9.8	61.3	79.7
<b>Employed or not looking</b>	60.1	37.4	42.1	-18.0	85.5	85.2	81.6	-3.9	35.5	40.4	38.3	2.8	63.4	70.8
<b>Lower and working class</b>	68.1	46.6	51.0	-17.1	88.6	na	88.9	0.3	41.8	42.7	44.0	2.2	70.5	76.5
<b>Other class</b>	51.7	31.5	36.4	-15.3	83.0	na	76.5	-6.5	30.8	38.0	32.9	2.1	62.6	69.9
<b>Union member</b>	57.9	40.2	na	-17.7	89.4	88.2	91.1	1.7	44.9	42.7	50.5	5.6	73.5	75.1
<b>Not union member</b>	61.4	36.7	na	-24.7	84.5	83.9	77.3	-7.2	34.8	40.1	34.7	-0.1	59.4	69.4
<b>Left Party ID</b>	69.3	46.8	53.9	-15.4	91.5	90.0	90.3	-1.2	51.9	48.3	50.5	-1.4	73.4	84.3
<b>Center</b>	60.0	36.4	45.0	-15.0	83.8	85.4	80.7	-3.1	35.9	43.7	39.5	3.6	62.8	69.3
<b>Right Party ID</b>	51.0	27.6	31.3	-19.7	79.3	78.8	70.5	-8.8	19.2	30.9	22.9	3.7	35.1	62.4

Data are weighted.

**Table 8. Support for Increased Government Spending: Multivariate Models OLS Estimates**

1996 Spending (hi values indicate desire for increased spending)

	<u>Australia</u>		<u>Great Britain</u>		<u>USA</u>		<u>Canada</u>		<u>New Zealand</u>	
	b	se	b	se	b	se	b	se	b	se
Constant	4.52 **	(0.10)	4.45 **	(0.12)	4.52 **	(0.13)	4.31 **	(0.12)	4.13 **	(0.15)
<b>Female</b>	0.15 **	(0.03)	0.06	(0.04)	0.08	(0.05)	0.19 **	(0.04)	0.20 **	(0.05)
<b>Age (in 10s)</b>	-0.03 *	(0.01)	0.02	(0.01)	-0.04 **	(0.02)	0.04 *	(0.01)	0.002	(0.02)
<b>Income</b>	-0.06 **	(0.02)	-0.04	(0.02)	-0.09 **	(0.02)	-0.06 **	(0.02)	-0.13 **	(0.02)
<b>Degree</b>	-0.04	(0.05)	0.01	(0.07)	-0.04	(0.09)	-0.06	(0.06)	-0.09	(0.06)
<b>Unemployed</b>	-0.02	(0.12)	0.16	(0.10)	0.09	(0.17)	0.06	(0.09)	0.09	(0.20)
<b>Lower and working class</b>	0.15 **	(0.04)	0.18 **	(0.05)	0.08	(0.05)	-0.03	(0.05)	0.33 **	(0.09)
<b>Union member</b>			0.07	(0.05)	0.16	(0.09)	0.11 *	(0.06)	0.02	(0.07)
<b>Party ID (hi=right)</b>	-0.14 **	(0.02)	-0.13 **	(0.03)	-0.23 **	(0.03)	-0.12 **	(0.03)	-0.18 **	(0.06)
<b>n</b>	1850		812		1135		1018		871	
<b>adj Rsq</b>	0.08		0.09		0.08		0.07		0.1	

**Table 9. Support for Government Activity: Multivariate Models OLS Estimates**

1996 Government Activity (hi values indicate desire for government responsibility for health care)

	<u>Australia</u>		<u>Great Britain</u>		<u>USA</u>		<u>Canada</u>		<u>New Zealand</u>	
	b	se	b	se	b	se	b	se	b	se
Constant	3.71 **	(0.08)	3.92 **	(0.09)	4.01 **	(0.12)	3.95 **	(0.10)	3.86 **	(0.12)
<b>Female</b>	0.08 **	(0.03)	0.03	(0.03)	0.09 *	(0.05)	0.08 *	(0.03)	0.14 **	(0.04)
<b>Age</b>	-0.01	(0.01)	0.01	(0.01)	-0.04 **	(0.01)	0.01	(0.01)	0.01	(0.01)
<b>Income</b>	-0.05 **	(0.01)	-0.04 *	(0.02)	-0.11 **	(0.02)	-0.04 <sup>a</sup>	(0.02)	0.03	(0.02)
<b>Degree</b>	0.04	(0.04)	-0.01	(0.05)	0.04	(0.09)	-0.12 *	(0.05)	-0.05	(0.04)
<b>Unemployed</b>	0.10	(0.10)	0.09	(0.08)	0.11	(0.15)	0.04	(0.07)	0.33 *	(0.16)
<b>Lower and working class</b>	0.09 **	(0.03)	0.08 *	(0.04)	0.14 **	(0.05)	-0.05	(0.04)	0.14 <sup>a</sup>	(0.07)
<b>Union member</b>			0.07	(0.04)	0.16	(0.08)	0.05	(0.05)	-0.07	(0.05)
<b>Party ID (hi=right)</b>	-0.14 **	(0.01)	-0.08 **	(0.02)	-0.26 **	(0.03)	-0.13 **	(0.02)	-0.23 **	(0.04)
<b>n</b>	1844		815		1103		1012		880	
<b>adj Rsq</b>	0.08		0.06		0.13		0.06		0.05	

\*p < .05; \*\* p < .01; a p=.05

**Table 10: Changing Support for the Welfare State: Government Spending**

Increased Government Spending

	Old Age/Retirement Benefits				Unemployment Benefits				Health Care			Education				
				D1996-				D1996-				D1996-				
	1985	1990	1996	1985	1985	1990	1996	1985	1985	1990	1996	1985	1985	1990	1996	1985
Australia	55.0	54.8	49.8	-5.2	12.6	10.2	12.4	-0.2	62.5	67.7	79.9	17.4	64	69.9	70.4	6.4
Great Britain	75.3	82.1	78.0	2.7	41.2	36.3	35.3	-5.9	88.4	90.1	91.4	3.0	74.8	79.8	84.3	9.5
United States	43.5	48.6	50.8	7.3	25.2	27.4	28.3	3.1	59.6	72.2	67.6	8.0	66	74.3	77.4	11.4
New Zealand			46.3				10.3			82.0	87.6				82.8	
Canada			27.8				15.7				52.4				63.2	

Percent who say government should spend more.

Government Activity

	Old Age/Retirement Benefits				Unemployment Benefits				Health Care			
				D1996-				D1996-				D1996-
	1985	1990	1996	1985	1985	1990	1996	1985	1985	1990	1996	1985
Australia	62.4	37.0	37.4	-25.0	15.1	5.5	8.9	-6.2	60.3	37.6	42.4	-17.9
Great Britain	78.7	77.2	71.0	-7.7	44.7	30.3	28.4	-16.3	85.8	85.0	82.0	-3.8
United States	42.7	37.8	38.4	-4.3	15.8	12.7	12.8	-3.0	36.2	40.3	38.5	2.3
New Zealand			58.5				15.2				71.4	
Canada			49.4				16.6				63.4	

Percent who say government should definitely be responsible.