The Influence of Partisan Politics and Values on Chicago-area College Students Concerning Health Care Reform in the 2012 Presidential Election

Alina Perez

SENIOR HONORS THESIS
Submitted In Partial Fulfillment of Requirements of the
College Scholars Program
North Central College

May 13, 2013

Approved: _____________________________________ Date: __________
Thesis Director Signature
Dr. Jonathan Visick

Approved: _____________________________________ Date: __________
Second Reader Signature
Dr. Karl Kelly
# Table of Contents

**Prologue** .................................................................................................................. 3

**Introduction: Analyzing the Current Health Care System** ................................. 5

  * America’s Uninsured ........................................................................................................ 7
  * Existing Government Programs: Medicare and Medicaid ........................................ 9
  * Pharmaceuticals ............................................................................................................. 13
  * Tort Reform .................................................................................................................. 15
  * Defining Health Care .................................................................................................... 17

**The Political Debate** ................................................................................................. 18

  * Voting and Values ........................................................................................................ 18
  * Health Care in the 2012 Election ................................................................................ 20
  * Universal Coverage in Massachusetts ........................................................................ 22
  * Political Positions on Health Care Reform ............................................................... 24

**Materials and Methods** .......................................................................................... 28

  * Participants .................................................................................................................. 28
  * Online Survey .............................................................................................................. 28

**Survey Results** ......................................................................................................... 31

  * Background Information ............................................................................................ 31
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controversial vs. Benign Political Prompts</td>
<td>35</td>
</tr>
<tr>
<td>Scenario Prompts</td>
<td>42</td>
</tr>
<tr>
<td>Leaning Independents</td>
<td>47</td>
</tr>
<tr>
<td>Discussion</td>
<td>50</td>
</tr>
<tr>
<td>Perceptions on Proposed Models for Reform</td>
<td>56</td>
</tr>
<tr>
<td>Canada’s Universal Health Care</td>
<td>56</td>
</tr>
<tr>
<td>American Proposals for Reform</td>
<td>60</td>
</tr>
<tr>
<td>Utilizing Primary Care</td>
<td>63</td>
</tr>
<tr>
<td>References</td>
<td>67</td>
</tr>
<tr>
<td>Appendices</td>
<td>74</td>
</tr>
<tr>
<td>Appendix A</td>
<td>74</td>
</tr>
<tr>
<td>Appendix B</td>
<td>75</td>
</tr>
<tr>
<td>Appendix C</td>
<td>83</td>
</tr>
<tr>
<td>Appendix D</td>
<td>86</td>
</tr>
<tr>
<td>Appendix E</td>
<td>87</td>
</tr>
<tr>
<td>Appendix F</td>
<td>88</td>
</tr>
<tr>
<td>Appendix G</td>
<td>89</td>
</tr>
</tbody>
</table>
Prologue

Over the course of the 2012 presidential campaign, the candidates – Republican Mitt Romney and Democrat incumbent Barrack Obama – have proposed radically different ideas on the role of government in the public’s lives. This is the theme that has stretched over a variety of debates, dividing the country into two deeply entrenched political camps. One of the emerging debates focuses on health care reform and whether the federal government should finance access to health care coverage (Berenson, 2012). Democrats favor government intervention, pointing out the rising costs and decreasing patient satisfaction with the current medical system. Republicans oppose government involvement and point out the expensive and not entirely efficient government-run programs of Medicare and Medicaid. The debate is dramatized in courtrooms – recently the Supreme Court upheld President Obama’s Affordable Care Act – and media outlets; with lobbyists, insurance agents, politicians, and physicians the main characters that all talk circles around each other. Where is the truth? Where does our current medical system really stand in terms of cost effectiveness and care quality? How much would government involvement change the current model? Could the problems with the current health care system actually be fixed?

The answers vary depending on the politician, the motive and the media outlet affiliation. Indeed, it appears impossible to come up with an impartial stance on this complex issue. The best approach is to evaluate where the current medical system stands in relation to other developed countries and if government-run systems such as Medicare and Medicaid are competitive and successful. Next, it is necessary to turn a critical eye on the politics themselves: to fully comprehend what each presidential candidate is proposing and the nature of political sway. Finally, being knowledgeable about some of the proposed health care reforms and understanding
other medical models – such as that implemented in Canada, for example – will turn the American citizen into an educated and interested voter.

This thesis was my own attempt to better analyze the health care debate; I hope it to be a resource for others. Yet when I was doing this research I experienced first-hand just how difficult it is to separate politics from the health care issue. With the presidential campaign running at full speed, it was nearly impossible to not associate certain proposals with certain candidates, to judge their character and make inferences on what the next four years would be like with each man as President. This sparked my interest: do other college students struggle with isolating a debate from the political realm? Exactly how much does party affiliation play on our opinions and feelings? In an attempt to answer this question, I created a survey for my peers to evaluate their political and personal background, how they felt about the health care debate and whether their party identification was the predominant factor in their decisions. This subset of the population has been given the tools necessary to objectively analyze issues; would students use these skills to form their own conclusions on the debate? My goal is that this survey will not only create a better understanding of how college-aged voters analyze political debates but also indicate how influential politics are in the American society and culture.

I do not pretend to have the answers that could fix this problem; but I do appreciate the complexity of the issue at hand. It was difficult to separate my own background, experiences and career goals from this project and there are times when I may have been less than objective. However, I passionately believe that health care reform is too important to be merely a political debate and is worthy of an attempt at an appropriate and educated analysis. Enjoy.
Introduction: Analyzing the Current Health Care System

While there are many socioeconomic challenges facing the United States today, I believe that the state of our current health care system is undoubtedly one of the most prominent and difficult issues requiring reformation. Health care is a growing and profitable business, making up approximately 17.6 percent of the gross domestic profit in 2010 and expected to rise to 19.8 percent by 2020 (Keehan et al., 2011). According to the Organization for Economic Co-operation and Development (OECD) on global health issues, the United States spends more money on any health care than any other country but has the eighth-lowest life expectancy (Sauter and Stockdale, 2012). Other countries are spending significantly less for their public’s health care. Japan, for example, spends approximately $2,878 per person – about $5,000 less than the U.S. – on health care expenses per year and has the highest life expectancy of the 35 OECD members (Sauter and Stockdale, 2012). This disparity has inevitably raised eyebrows, and with a federal deficit that is now exceeding $1 trillion per year, health care reform has become a hot-button issue, especially politically (Matthews, 2013).

The country became especially divided on the issue of health care reform when President Barrack Obama signed into law a health care reform bill – the Affordable Care Act (ACA) – in 2010. According to a survey done in April 2012 by the Kaiser Family Foundation, 42% of people were favorable towards the ACA while 43% were unfavorable (Jacobs and Skocpol, 2012). Indeed, the nation is literally and figuratively split on how to approach the issue of health care reform and this has resulted in an unseemly political stalemate. To me, it appears that both parties claim to seek bipartisanship but then turn around and attempt to thwart the other party’s efforts at progress. For example, several Republican leaders have promised to repeal the ACA if
Massachusetts governor Mitt Romney is elected President (Jones, 2012). The health care debate has political tempers running high and the public at large concerned about the cost of coverage (Jacobs and Skocpol, 2012). Thus it is necessary to take a step back, re-analyze why health care reform is necessary in the first place and identify major obstacles to improvement.

It appears obvious to me – and will be discussed in detail – that for all the good it will bring, the Affordable Care Act has some apparent flaws. So why hasn’t a proposal been made to address all of these issues? The answer is simple yet infinitely complex and represents the root of the real health care problem: cost. As before mentioned, health care is a business that runs on capital. To expand the health care sector to cover millions of additional, previously uninsured Americans will require a substantial amount of money. The sticker price of such reform has polarized the country. Some people argue that the cost is insignificant compared to the issue at large: that $1 trillion dollars to cover America’s uninsured over 10 years is, in fact, a bargain (Attaran et al., 2009). Meanwhile, others caution that a quick fix will not address the issue properly and that hospitals, providers, and health professionals’ education could see turmoil in the future (Fincham, 2009).

The complexity of cost centers around what exactly we want out of health care reform. Should every single American have health care coverage, regardless of the cost? Speaking of cost, can America continue to afford – and expand – programs such as Medicare and Medicaid? How do pharmaceutical companies and tort reform contribute to the cost? What do we even define as health care? These questions are complex and at times even uncomfortable to ask, but it is necessary to inspect these questions and concerns to understand the scope of the cost of health care reform. While I attempt to address these issues, to do so at the appropriate length exceeds
the goal of this project. This evaluation is merely a summary on what I believe to the major issues facing health care prosperity.

To reiterate, the main objective of this project is to understand how soon-to-be college graduates are analyzing the health care debate of the 2012 presidential election. Specifically, I am interested in whether partisan politics of individual moral analysis determines how these students respond to political prompts. Before I could investigate this further, however, I first needed to scrutinize the current health care system and determine what I believed to be the main obstacles to effective and efficient health care. The uninsured American population, insurance companies’ ability to deny sick individuals coverage, the current Medicaid and Medicare system, the misuse of pharmaceutical drugs and tort reform are what I believe to be the predominant sources of inefficiency in our current health care model. However, I believe that reforming only one of these aspects of health care will be insufficient to bring about notable and meaningful change; a major overhaul in the structure of health care is needed.

America’s Uninsured

Indeed, the predominant argument for health care reform is the sheer number of uninsured Americans: approximately one in every six Americans does not have health care insurance (Fuchs and Emanuel, 2005). While alarming, I believe that these statistics are very vague and do not give any demographic information. For example, could these “uninsured” individuals be new immigrants or even illegal immigrants who have not gone through the process of applying for American citizenship? If that were the case, America is not the only country to face problems providing health care to their new immigrants. New immigrants to Canada, for example, have reported difficulty in getting access to health care; some provinces
even require a three-month wait before newly landed immigrants can tap into the universal health care system (Caulford, 2012). Furthermore, it is necessary to identify a prevalent misconception that uninsured Americans do not receive any form of health care. For those people who cannot afford insurance, there is limited access to primary care, immunizations, dental care, prescriptions, eye exams and mental care. However, everyone does have access to emergency care in emergency rooms; though emergency care is costly and could often have been avoided through appropriate primary care (National Association of Community Health Centers, 2012). Yet it is incorrect to assume these uninsured people are kicked to the curb with their medical concerns completely ignored.

The Affordable Care Act seeks to address the issues that face uninsured Americans. There are provisions in place that will eventually expand insurance coverage to an estimated 32 million individuals; however, the Congressional Budget Office estimates that this bill will still leave 23 million people – including some undocumented immigrants – without coverage (Fiscella, 2011). I believe that the Affordable Care is a step in the right direction for America’s uninsured; however, the ACA does nothing to specify the quality and access to care. It is wonderful to say that people can go to a doctor whenever they need to, but if no doctor or clinic is available in the area the effort is null. As will be discussed below, aspects of American culture also contribute to the problems facing health care.

Another battle cry for health care reform is on behalf of the population that is uninsured and very sick. According to the 2005/06 data from the National Health and Nutrition Examination Survey, the U.S. has approximately 4 million uninsured Americans who have been diagnosed with emphysema, diabetes, stroke, cancer, congestive heart failure, angina or a heart attack (Pollack, 2011). Such pre-existing conditions currently limit an individual’s ability to
obtain affordable health insurance under certain circumstances such as self-employment, retirement, or working with an employer that does not offer coverage; these people may be subject to high premiums if they are not outright denied coverage (Collins et al., 2012). Fortunately, the ACA does address the dual challenge of the uninsured and ill. High-risk individuals will receive extensive help and protection in the new system of health insurance exchanges; insurance companies will not be able to discriminate against sick individuals (Pollack, 2011).

Basically, the Affordable Care Act has a three-pronged plan of attack: the bill will expand Medicaid and subsidized coverage for high risk individuals, ban insurance agencies from denying coverage to individuals with a pre-existing condition and open up access to the insurance market through the creation of insurance programs that would specifically cover those with a known health conditions (Collins et al., 2012). However, in order to fully address and care for people with chronic diseases the federal appropriations may end up being significantly higher than either Democrats or Republicans have proposed (Pollack, 2011). Cost is indeed on everyone’s minds as, perhaps, it should be. The government already spends a notable amount of money on health care programs: Medicare only cost the government $452 billion in 2010 (Koba, 2011). Before getting caught up in the estimated cost of health care overhaul, however, it is necessary to analyze America’s current government-sponsored health programs.

Existing Government Programs: Medicare and Medicaid

There are two major government-sponsored health programs in the United States: Medicaid and Medicare. Medicaid specifically is a state and federal-funded health insurance program for low-income individuals (Walter et al., 2002). Today, Medicaid is the largest single
insurer of health care in the U.S. both in terms of the numbers of people covered and the dollars spent: it accounts for 17% of all health care costs (Mann and Westmoreland, 2007). U.S. states are required to cover all those who enroll and who are eligible to Medicaid; to pay for such a large program, however, each state is guaranteed federal funding for a portion of the cost of coverage (Mann and Westmoreland, 2007). This aspect of Medicaid specifically is what allows it the flexibility to expand in response to increased demand: if state enrollment in Medicaid rises, so does federal funding (Mann and Westmoreland, 2007). In all, Medicaid provides coverage to an approximate 41.3 million individuals (Walter et al., 2002). And the program continues to grow: it is projected to cover 80 million beneficiaries by 2020 (Rosenbaum, 2012).

The cost of Medicaid is driven by its high enrollment, not exorbitant per capita spending (Rosenbaum, 2012). Because of this, there’s little money that could be saved from Medicaid without reforming its structure in such a way that would reduce basic coverage (Rosenbaum, 2012). Indeed, it would appear that cutting back on Medicaid is not a realistic or worthwhile option at the moment. However, expanding Medicaid poses its own problems: since Medicaid’s physician payments are notably lower than payments from commercial insurers, some health care providers limit Medicaid participation (Rosenbaum, 2012). Yet pumping more money into Medicaid will not fully address the issues at play, either. Those individuals who cannot afford health care insurance may find it difficult to stay in treatment because of their need of childcare or transportation; additionally, some individuals may have certain clinical or communicational problems (Walter et al., 2002). Furthermore, there are unfortunate numbers of Medicaid recipients with substance abuse problems: compared to an age and sex-matched group of non-Medicaid patients, the Medicaid patients were found to have higher severity problems with drug use, mental health problems, legal issues and unemployment (Walter et al., 2002).
These contributions make it difficult for some individuals to maintain their health, even when there is access to health care. A study identified two important factors related to successful chemical dependency treatment: the rate of initiating treatment and retention in a treatment program (Walter et al., 2002). For those patients returning for at least one follow-up after the initial treatment, the Medicaid group remained in treatment for a shorter period of time compared with people that had private coverage (Walter et al., 2002).

Thus, health care reform for this part of the population needs to work closely in correlation with community outreach programs to address these issues and develop a systematic and continuous form of care. And time is of the essence. Several commercial HMOs have decided to pull out of the Medicaid market altogether, explaining that the high risk and low reimbursement rates for these members is not worth the time (Walter et al, 2002). Yet concurrently the Affordable Care Act seeks to expand Medicaid to an additional 15 million beneficiaries (Rosenbaum, 2011). The lack of cooperation between the state and federal government on this issue is contributing to the problem of quality and coverage.

The other aspect of government-run health care, Medicare, is a federally run program that provides insurance benefits for individuals who are 65 or older and certain young people with disabilities (Grabowski, 2007). Currently, there are several different Medicare plans to cover different aspects of this large group: Medicare Part A, for example, provides hospital insurance while Part B covers physicians’ services (Grabowski, 2007). Most recently in early 2006, Medicare Part D was implemented and offered better access to prescription drug insurance (Polinski et al., 2010). However, this aspect of Medicare is already facing problems: while many pharmacies participate in the program, the trend of a relatively low reimbursement rate along with delays in payments for services provided, have significantly challenged participating
pharmacies (Fincham, 2009). Additionally, a study found that regions that spend less per beneficiary on Medicare provide higher-quality care and achieve equal or better health outcomes, patient satisfaction and physician-reported quality on average (Fisher et al., 2009). It appears to be that there is a disparity in health care between private-insurance holders and Medicare-covered individuals.

These gaps in the quality of care are becoming larger as the population ages and lives longer. Currently, Medicare consumes 3.3 percent of the U.S. GDP and some experts have estimated that the Medicare Hospital Insurance Fund – those payroll taxes paid by employers and employees – will be depleted by 2019 (Fuchs and Emanuel, 2005). Yet the Centers for Disease Control and Prevention project the percentage of the population aged 65 and older will increase by 104.2% by 2030; an relatively big increase due to the eminent retirement of the baby-boomer generation (Kemp, 2012). These trends will translate into fewer wage earners paying taxes to fund programs such as Medicare compared to the rapidly increasing number of retirees (Kemp, 2012).

This data begs the question: can we continue to fund – and expand – Medicare and Medicaid? The answer is no… not as it is. Government-sponsored insurance requires the time and cost to determine eligibility, imposes high marginal tax rates as subsidies fluctuate, and generates inconsistency in coverage (Fuchs and Emanuel, 2005). Indeed, the proposals to reform government-sponsored programs are many and varied but one thing is shockingly clear: this country cannot continue to implement these programs as it has in the past. Ignoring these obvious issues for the sake of political clout or electoral votes will continue to promote dissatisfaction with the health care system and with the government itself.
Pharmaceuticals

The problems with health care go beyond government-sponsored programs. The cost of pharmaceuticals is another contributing factor and aspect of the health care debate. After all, why are drugs so expensive? One study that analyzed the high cost of antibiotics zeroed-in on errors due to both the patient and the physician. For example, there is a degree of ambiguity in diagnosing a bacterial infection. Because many diagnoses depend on patients’ self-reported symptoms, there is evidence to suggest that up to 50% of cases are not identified by health care professionals (Simeons, 2011). Since the problem is not adequately addressed, the underlying infection does not go away. Combined with an increasing trend of antibiotic resistance and variations in patient compliance, the cost of antibiotics overall has steadily risen.

Improper use of medication is another contributing factor; narcotic dependence and illegal sales funnel medical drugs away from those who truly need them. Some research suggests that the U.S. consumes approximately 80% of the world’s opioid pain medication and 99% of the world’s hydrocodone (Volkow, 2011). It is also suggested an estimated 52 million people have used prescription drugs for nonmedical reasons at least once in their lifetime (Kloth, 2011). Such shocking remedial use and overuse has resulted in Americans consuming more opioids to get similar pain-relief: the dosage per person of prescription opioids in the United States has increased 402% between 1997 and 2007 (Volkow, 2011).

Misusing these drugs represents only half the problem. First, these individuals need to obtain the drugs, commonly by presenting to the emergency department complaining of severe, debilitating pain. Such complaints are difficult for physicians to ignore, as they cannot determine who is actually experiencing discomfort and who may be lying (Rosen et al., 2012). In the 19th
century, pain remedies were less frequently used: pain was thought to be a sign of physical vitality and necessary to the healing process (Lembke, 2012). Within the past 100 years, however, there has been such a significant shift in health care such that treating pain is now every doctor’s authorized responsibility (Lembke, 2012). The emergence – and now prevalence – of “pain management” courses for physicians and the astonishing number of new pain medications has changed the American culture on pain (Lembke, 2012). So, depending on the complaint, physicians may run a series of expensive and time-consuming tests followed by the administration of additional expensive drugs. If the patient was seeking care solely to fuel their dependencies then he or she is taking up valuable emergency-room space. Perhaps this is pessimistic, but my own experience shadowing physicians in the emergency room has taught me that such scenarios occur more frequently than the public is aware.

The final problem with drug costs revolves around the controversy of patents. In developed countries like the U.S., research suggests that patents actually increase the cost of medicines (Gold et al., 2010). The premise behind the patent system is that it would encourage pharmaceutical companies to invest in researching and developing a compound through clinical trials and into practice; the prospect of “owning” such patents may encourage manufacturers to introduce new medicines (Gold et al., 2010). Why is such motivation necessary? Medical research is costly, lengthy and high-risk; since not all developing drugs reach the market, pharmaceutical companies use patent exclusivity to generate revenue from sales and make up for the momentous cost of developing other unsuccessful drugs (Gold et al., 2010). It is unclear just how much patents contribute to the cost of drugs and health care, but it is undoubtedly a contributing factor that deserves a second look.
Physicians are the key in connecting pharmaceutical companies to patients: they are the ones prescribing the medications. However, the obstacles facing physicians and current health providers are less frequently discussed in the media. One example of the difficulties health care providers face is tort litigation. This is a difficult issue to discuss, as there are unfortunate cases of incompetent doctors providing substandard care; however, tort litigation contributes to the cost of health care and thus is worth exploring. For example, according to the Congressional Budget Office premiums for all physicians rose by 15% from 2000 to 2002: this was at twice the rate of total health care spending per person (Nelson et al., 2007). Depending on the specialty, some premiums rose at an even higher rate: obstetrics, for example, increased 22% (Nelson et al., 2007). These costs are passed on to consumers – patients – in a way that is consistent with most general economical models.

Those in favor of limiting liability argue that the financial cost of defensive medicine – prescribing unnecessary procedures to avoid a potential lawsuit – is decreasing physician supply in certain specialties and geographical locations (Rothstein, 2010). Those in support of tort reform believe the excessive court awards and attorney and expert witness fees contribute to the cost of health care (Rothstein, 2010). Those against tort reform argue that liability is necessary to promote civil justice, prevent substandard care, punish incompetent physicians and promote systemic health quality improvement (Rothstein, 2010). The controversy of tort reform identifies the center of the health care debate: where is the balance between cost and quality?

Perhaps tort reform is not a topic commonly covered by the TV news because it identifies the complexity of health care reform and the far-reaching consequences reform will have. Yet
ignoring physician well being is naïve and could potentially result in additional health care turmoil. For example, when the Affordable Care Act has been fully implemented, there will be approximately 32 million more individuals eligible for health care coverage than today, leading to many more patient-physician encounters each year (Rothstein, 2011). Based on this dramatic increase and assuming that the rate of medical malpractice remains constant, we can assume that the number of medical malpractice claims will increase (Rothstein, 2011). Furthermore, with a work force of approximately the same size, physicians will have to see more patients in less time which could also increase the likelihood of medical errors leading to malpractice claims (Rothstein, 2011).

There are arguments against this claim. Some suggest that health care reform might reduce malpractice claims due to superior care, physician support, and patient satisfaction (Rothstein, 2010). Yet it is important to remember that the repercussions of health care reform are merely predictions; it is impossible to determine whether malpractice claims will increase or decrease. However, malpractice reform is desirable since some American physicians will not wholeheartedly support health care reform – and the potential cost containment – without it (Brody and Hermer, 2011).

Defensive medicine deviates from professionalism: it does not benefit the patient but is for the benefit of the physician (Brody and Hermer, 2011). Indeed, the goal is not to eliminate malpractice claims completely but to distinguish between deserving and frivolous suits (Brody and Hermer, 2011). I believe that if the right balance can be struck between protecting health care providers and patients, both parties will benefit. Furthermore, with the wholehearted support of the majority of physicians – many who practice individually and directly cover the costs of malpractice insurance – I believe that health care reform is more likely to succeed.
Defining Health Care

The last obstacle to be covered in this paper addresses the very definition of health care reform. One commonly accepted definition of “public health” has been given by Dr. C.E.A. Winslow (Kemp, 2012):

[Public health] is the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing service for the early diagnosis and preventive treatment of disease, and the development of the social machinery which will ensure to each individual in the community a standard of living adequate for the maintenance of health.

I personally believe this to be a relatively comprehensive explanation of health care as it emphasizes the responsibility of health care providers, the community and the individual. Despite being expansive, however, this definition does not cover everything. For example, what is the boundary of “prolonging life?” Who decides what the appropriate “standard of living adequate for the maintenance of life” entails? What is health care? Where is the line drawn? Are physicians accountable… or is the patient responsible for his or her own wellbeing? These are difficult social and cultural issues to address and are often uncomfortable to bring up. Yet without proper acknowledgement, health care reform will always be a doomed enterprise; instead of making lasting change the United States will simply be scraping the surface of an issue that is too important to minimize.
The Political Debate

Voting and Values

As we have seen above, the obstacles facing health care reform are many and diverse. The proposals for reform, however, can be just as controversial as the issues themselves. America’s two-party political system can be deeply divided; not just on issues, but on certain moral values as well. Values can be a rather abstract term: in the case of politics, we will define values as the cognitive representation of abstract and desirable goals that serve as guiding principles in people’s lives, including their political entity via voting power (Caprara et al., 2006). These values are necessary in shaping the political demeanor of the public for they are deeply rooted, “driving force” beliefs; such convictions are a normatively acceptable way for individuals to make judgments (Doherty, 2008). Theoretically, values that have been built up over a lifetime should have a significant influence on political decisions since a voting choice is an intentional and thought-provoking process. (Caprara et al., 2006). Indeed, values are important to the voter, and politicians appear to have recognized this. As a result, there is a growing trend in politics of personalizing candidates. This personification is interesting, as the personalities of candidates become the focus of voters’ attention; such attention puts emphasis on the individual voter’s personality instead of his or her political interests (Caprara et al., 2006).

I personally believe that this shift of the spotlight is a result of the increasing complexity of political issues. Rather than clearly and plainly laying out their positions on a potentially controversial policy, a political candidate can use his or her personality as a shield of ambiguity. Then the average individual can make an electoral judgment based on their perceptions of “what candidates are like” instead of evaluating the candidates’ policy positions (Doherty, 2008).
Naturally, one way to convey what “candidates are like” is through the use of value cues that have become associated with their respective political parties. Put another way, perceptions of party-associated values can lead individuals to connect those values with the candidates (Doherty, 2008). For example, after George W. Bush won the 2004 presidential election, some political experts argued that the Democratic Party lost the election because it could not frame its policies in terms of values (Doherty, 2008).

Interestingly, it appears that Republicans or Democrats have claimed certain values. The Democratic Party, for example, is generally associated with egalitarianism; this can be a problem for Republicans, who often struggle to convince the public that they, too, support egalitarian values (Doherty, 2008). If a voter attributes a personality or certain values to a candidate, that association could create or strengthen the bond between said voter and the candidate (Caprara et al., 2006). Furthermore, as individuals come to support a candidate during an election campaign, their values become more compatible with that of the chosen candidate (Caprara et al., 2006). Democrats place emphasis on the collective well being, education, and tolerance for diversity, making this party more attractive to “friendly” and “open” voters; to better express and affirm their own personality; such individuals identify with and vote for the center-left (Caprara et al., 2006). In contrast, Republicans emphasize individual entrepreneurship and market freedom that appeal to energetic, assertive and “dominant” people; again identifying with this party is a form of self-expression (Caprara et al., 2006). The association of desirable values with a given party creates a bond that goes beyond simply agreeing with political issues. As a result, party identification is one of the most consistent factors that affect voting behavior (Campbell et al., 2011).
I believe that values do play a significant role in party identification, but the extent of influence may vary based on demographics. Some research suggests that values influence political choice more for first-time rather than for veteran voters (Caprara et al., 2006). In a way, this makes sense: with little experience in the political realm young adults might have little to base their opinions on outside of their own experiences and values. However, there are other theories for the establishment of political preference. The “Bread and Peace model” holds that presidential elections may be interpreted as a series of mandates based on the economic record of the party currently in the White House: the incumbent party is punished for poor economic performance but rewarded for good fiscal achievements (Hibbs, 2008).

Health Care in the 2012 Election

Of course, monetary policy takes center stage in voting decisions when the economy is struggling: “pocketbook” issues are often the predominant voter concerns (Maioni, 2009). And health care is a pocketbook issue. Since the 2008-2009 recession, the baby-boomer generation has become increasingly concerned about the future of health care costs (Maioni, 2009). As a result, health care has become an increasingly important topic in presidential elections. In the 2008 presidential campaign, Democrats favored reform that would expand subsidized coverage by the government and employers while Republicans favored free-market, consumer-based approaches (Maioni, 2009). The Democratic Party swept Washington D.C. in 2008, but it was not clear in 2012 whether they would be able to gain the support of the American public a second time?

There is more at stake than the White House, however. The Affordable Care Act was implemented during President Barack Obama’s first presidential term and the 2012 election had
significant implications for its future and success: the next President will decide how and whether to continue implementing the ACA which is the most extensive health care bill ever passed in the U.S. (Blumenthal, 2012). In order for the United States to afford the proposals in the ACA, President Obama essentially cut a deal with health care companies. In return for the expanded pool of insurance subscribers, insurance companies agreed to neither deny coverage to those with preexisting conditions nor impose higher rates on them (Friedman, 2012).

This substantial gain for the Democratic Party did not come without its own cost, however. To compromise, the Obama administration created what would become known as the “individual mandate:” Americans would be required to either purchase health insurance or pay a set amount to the U.S. Treasury (Friedman, 2012). Whenever the government extends itself to an aspect of the American public’s lives that was previously intervention-free, controversy ensues. As a result of the mandate, within weeks of the bill’s passage Republican attorney generals in 26 states had launched a series of legal challenges (Friedman, 2012). Lawsuits continued all the way to the Supreme Court. Finally on June 28, 2012, there was a surprising outcome: Chief Justice Roberts – typically conservative in his jurisprudence – “had crossed partisan lines, writing the lead opinion upholding the individual mandate by a five-to-four vote” (Friedman, 2012).

Initially, Chief Justice Roberts had agreed with conservatives that the individual mandate exceeded the power of Congress in regulating commerce. But then Roberts appeared to change his mind, joining with the Court’s four liberals in upholding the mandate. Clarification was needed, however: the mandate was characterized by the Court not as a penalty, but as a tax and was therefore within Congress’ broad power to tax for the general welfare. (Friedman, 2012). This unique set of wording would come back to haunt the Democratic Party in future debates; Republican presidential nominee and Massachusetts Governor Mitt Romney frequently used this
decision to point out that Democrats were in favor of increasing “taxes.” Regardless, with the ACA now legal it became clear that the new President would have significant influence on the success of this sweeping bill.

*Universal Coverage in Massachusetts*

Another dramatic change in the landscape of politics and health care was the passing of universal coverage in Massachusetts, the home state of the Republican presidential nominee. Due to cooperation between the Governor Mitt Romney and Democratic senator Edward Kennedy, who obtained the support of insurance companies, academics, businesses, hospitals, and even advocates for the poor and religious readers, a form of universal coverage was created (Charatan, 2006). The bipartisan compromise was not without obstacle, however. Some conservatives argued that inappropriate emergency care leads to uncompensated medical bills that raise premiums for those with insurance (Doonan and Tull, 2010). Meanwhile some liberals and center-left organizations argued it was not fair to require people in poverty to spend a lot of money on health care (Doonan and Tull, 2010). Yet the biggest obstacle to Massachusetts’s health care reform was defining affordability. Finally it was determined that people who earned less than $16,000 – the federal poverty threshold – would be able to get free or subsidized policies that had no premiums (Charatan, 2006).

After implementation, it became clear that Massachusetts was an ideal place for experimental health care reform as it had a unique set of circumstances: a relatively high percentage of the population was already covered and the Republican governor and Democratic legislature were willing to work constructively together (Doonan and Tull, 2010). Overall, the reform bill would cover approximately 515,000 uninsured people within three years, or 95% of
the uninsured population, by building on its already sound system: expanding Medicaid, creating new subsidy programs, initiating insurance market reform and requiring employers who did not offer insurance to contribute “a modest amount of money to help finance [such] government subsidiaries (Charatan, 2006; Doonan and Tull, 2010).

Indeed, employers would end up paying significantly to cover this bill: the “modest amount” could be up to $295 per employee per year; employers could avoid this penalty if they paid at least 33% of their employees’ health insurance premiums and at least 25% of employees had to enroll in employer-sponsored coverage (Doonan and Tull, 2010). For employers already covering their employees, things would largely stay the same. But for those employers who did not offer insurance, the cost would be an estimated $750 million a year in new costs (Doonan and Tull, 2010).

Obviously, the price tag is substantial. In Massachusetts, the estimated cost was $316 million in the first year and more than $1 billion by the third year of implementation (Charatan, 2006). However, these costs would cover a substantial part of health care such as preventative and emergency services, ambulance services, mental health care and prescription drug coverage (Doonan and Tull, 2010). Here is my take away on the Massachusetts health care reform: it is a tremendous breakthrough in health care. And through this process we have learned some valuable lessons: that affordability decisions have significant impact on the availability and price of insurance and that no single methodology can provide such an affordability schedule; furthermore, that it is difficult to account for uncertainty so it is necessary to have a system of exemptions and waivers in place (Doonan and Tull, 2010).
Political Positions on Health Care Reform

With so much at stake and the sheer enormity of the cost, the health care debate took center stage in the presidential campaigns. In Massachusetts, Republicans and Democrats had proved they could work together on a statewide scale. Could this compromise be enacted on a national scale as well? The answer, at least during the debates leading up to the 2012 presidential election, appeared to be a resounding no. Republicans and Democrats alike stuck to their traditional principles and criticized the others’ strategy; it appeared that each candidate took an extreme stance on the issue.

While Republicans did acknowledge the flaws in the current health system – costs rising at three times the inflation rate, a large percentage of the population uninsured and the high price of malpractice insurance forcing doctors to close their doors – they seemed unable to fully embrace the ACA (Grassley, 2009). Instead, Republican officials argued the Affordable Care Act would drive private insurers out of business, forcing an eventual government takeover of the health care system (Grassley, 2009). Furthermore, the ACA was only guaranteeing U.S. taxpayers a substantial burden for generations to come, all the while failing to solve the fundamental problems facing health care (Grassley, 2009). For example, Republicans pointed out that while the bill took steps to solve these issues, there was no serious procedure in place that would reduce health care costs (Grassley, 2009).

Republicans had acknowledged one of America’s deepest fears: spending tremendous amounts of money without making any real progress. Presidential nominee Mitt Romney promised to repeal the ACA – dubbed Obamacare in the press – and replace it with patient-centered reforms that were “better suited” to the challenges Americans face (Romney, 2012).
President Obama’s 2700-page federal takeover does not solve [Americans’] problems. His $1 trillion in tax increases hits the middle class hard and drives medical innovation overseas. His $700 billion in Medicare cuts ‘will not be viable’ according to the program’s trustees… Millions of other Americans who were told they could keep their coverage will lose it… After all this, [Obama’s] plan still fails to control costs or to provide long-term solution to the nation’s entitlement crisis… (Romney, 2012).

For those voters who identified with the Republican Party, the thought of private enterprise being taken over by an expensive, potentially inefficient government program was a worst-case scenario. Conservatives began to rally around the repeal of the ACA.

On the other end of the spectrum, Democrats argued that they had at least made progress in the enormity of the health care issue: the Affordable Care Act was pertinent to the issues that faced everyday Americans. President Obama countered that the Romney-Paul Ryan health care plan would recast Medicare as a voucher program; if the vouchers value failed to keep pace with rising health-care costs, seniors would be forced to pay more than ever to buy private insurance (Emanuel et al., 2012). Instead, in the Democrats’ view, the Democratic plan was the only one that would incentivize and assist physicians and hospitals alike to keep patients healthy and out of the hospital: that, Democrats argued, was the only surefire way of reducing health care costs. Indeed, where it has been used, competitive bidding between insurance companies has reduced Medicare spending by 42% (Emanuel et al., 2012) President Obama himself contributed to the debate: “Supporters and detractors alike refer to the [Affordable Care Act] as Obamacare. I don’t mind, because I do care. And because of Obamacare we’re moving forward toward a health care system that broadly provides health security” (Obama, 2012). Furthermore, President Obama chastised Mitt Romney for running a campaign that contradicted his past as one of the architects of health care reform in Massachusetts (Obama, 2012).
I believe this to have been the turning point of the closely run 2012 presidential election. Health care was the prime topic, with both parties bringing legitimate and very-applicable concerns to the attention of the public. Undoubtedly, Mitt Romney’s stance on health care appeared hypocritical to many. With the election on the line, President Obama made some promises of his own:

If I am elected for a second term, I will follow through on the work we have started together to implement the Affordable Care Act. I have also been clear that additional steps are needed. We need a permanent fix to Medicare’s flawed payment formula that threatens physicians’ reimbursement… I support medical malpractice reform to prevent needless lawsuits… and [to] ensure that our regulatory system bring new treatments and tools to pharmacies, doctors’ offices, and hospitals across the country. (Obama, 2012).

In contrast to the Republicans, the Democratic Party was rallying to continue the ACA. The perfect political storm was brewing.

Throughout the duration of the presidential campaign, it appeared that every component of the candidates’ lives was picked apart; truly it was the candidates themselves on the ballot and not just their respective parties. I believe that young voters especially could relate to President Obama’s genuine plea for universal coverage and perhaps saw in the reform-initiating, barrier-breaking candidate a glimpse of their own potential glory. Yet I also recognize the tug of independence, self-sufficiency and the individual distinction of Mitt Romney that drew some young voters to the Republican camp. Additionally, the lines of value-association are blurred. For example, there is a mixture of Republican and Democratic voters who are Catholic, even though the Catholic doctrine has established itself as against abortion and gay marriage (Stonecash, 2010). Value-association can be a tricky thing, especially when values are so unique to each individual.
This brought up an intriguing question. For young voters what component would be more important to their decision in the 2012 presidential election: their own values or their association with their chosen political party? The college-aged generation has grown up in the media maelstrom of political coverage. Every issue, false claim and attack advertisement is at their fingertips. Detangling debates is a difficult feat on the World Wide Web, with editorials having as much weight as objective coverage. And yet the issue of health care and its reform is too big to choose blindly. America’s health in the medical and economical sense is at stake in this election. Would college students follow the herd, think for themselves, or follow their party’s claims, however biased? I decided to study these students, specifically graduating seniors of the class of 2013, in the greater Chicago area. My hope is that surveying this particular subset of the population regarding their values, party association and political views in regard to health care will reveal whether partisan politics or moral values have more weight in their decisions on this issue. Furthermore, I hoped that my results would be reflected in the outcome of the election, revealing what mechanisms were really leading young Americans to vote as they did in early November.
Materials and Methods

Participants

This survey was specifically designed for college seniors planning to graduate during the winter of 2012 to spring of 2013 and who attend school in the northwestern region of Illinois. The survey was approved by the North Central Research and Ethics Committee (Appendix A) and given to all seniors by collegiate e-mail. Every student registered to graduate winter term of 2012 to spring term of 2013 was e-mailed the link to this survey in order to try and obtain as representative a sample as possible. Additionally, the link for this survey was put on Facebook© in the hope that seniors graduating at other northwestern Illinois schools would take the survey and provide a more comprehensive sample.

Overall, 234 participants took the online survey. However, after selecting for students who qualified based on their graduation year and geographical location, 151 eligible participant responses remained. Not all participants answered each question; percentages were adjusted accordingly.

Online Survey

The survey was created via SurveyMonkey.com© and was open from October 2012 until November 2012. Voluntary participants were briefed on the survey’s material, signed an electronic agreement affidavit and were asked a series of short questions about their personal, political, educational and financial background (Appendix B).

The participants were then asked to respond to a series of 22 political prompts but were not told which prompt was associated with which political party. Half of the prompts came from
the Republican presidential campaign or official Republican sources; the other half came from
the Democratic presidential campaign or official Democratic sources. Participants were asked to
respond on a Likert scale in response to each issue: either strongly agree, agree, neutral, disagree
or strongly disagree. Additionally, there were 3 scenario prompts that addressed a political issue
in an applicable situation. These scenarios asked a question and were answered based on the
same sliding scale. For the sake of analysis, strongly agree and agree as well as strongly disagree
and disagree were numerically combined. All raw data is shown in Appendix C.

SurveyMonkey© provided an Excel© document based on the survey results. As
mentioned previously, participant responses had to be modified so that only eligible participant
responses remained. This modified data was analyzed using SPSS© software.

For the 22 political prompts and 3 scenario prompts, a numerical value of 1 was assigned
to Strongly Agree, 2 to Agree, 3 to Neutral, 4 to Disagree and 5 to Strongly Disagree to produce
a mean score. These means had been to be analyzed separately for Democratic and Republican-
associated political prompts (Appendix D-E). For example, the prompt “I believe in expanding
coverage and cutting health care costs” came from a Democratic source. In this case, a low mean
score would indicate that most participants agree with this statement and are therefore
Democratically-leaning for this prompt.

To determine if there was a significant difference between Republican, Democrat and No
Affiliation responses, I performed an ANOVA analysis on each prompt (Appendix D-E). The
prompts that produced a p-value of less than 0.05 indicated that there was a significant difference
in group response. To determine the source of this difference, a post-hoc student’s t-test was
performed. The student’s t-test was performed for Democrat and Republican responses (Appendix F) as well as for Republican and No Affiliation responses (Appendix G).
Survey Results

The health care political platform has become increasing popular – and important – to the American public. I believe that this issue was especially important to a particular niche of the population poised to enter the working world: with substantial college loans that need to be repaid, the college graduates of 2012-13 are concerned about the prospect of paying for their own expensive health care insurance (Baum and O’Malley, 2003). Theoretically, this educated portion of the population should be savvy enough to analyze the health care debate for its pros and cons. The survey results presented here seek to determine whether they would do so or whether these young twenty-somethings would follow “the party faithful?”

Background Information

Of the 151 eligible participant responses, approximately 98% attended North Central College in Naperville, Illinois. 2% of participants identified as students of DePaul University in Chicago, Illinois.

Approximately 22% of participants identified as Republican, 38% as Democratic, 2% as Other (i.e. Green Party, Libertarian, etc.) and 39% claimed No Affiliation (Figure 1).
I had expected most of the participants to identify with one of the two predominant political parties; the large number of participants who did not identify as Republicans or Democrats was a surprising twist to the analysis. Furthermore, the large number of students choosing not to identify politically strengthens my confidence in my general hypothesis that for this part of the population, partisan politics should not have a tremendous influence.

In total, approximately 67% of eligible participants answered that they were planning on voting in the 2012 presidential election. Post-election it was found that young voters aged 18-29 accounted for 19% of the total voting population – an increase in 1% from 2008 – suggesting that voter turnout is evidence of engagement and electoral influence (Lipka, 2012). Nationally, an estimated half of eligible voters in this age range had cast their ballots (Lipka, 2012). Clearly, political matters are of concern to these students. Yet 52% of participants in my survey believed themselves to be only “somewhat informed” on the political health care debate; 30% thought themselves to be “well informed” and 9% each identified as “very informed” and “not informed.”
As many of the participants attended a relatively expensive private college, it was expected that most of the survey participants would be covered under their parents’ health care insurance or have their own adequate coverage. As expected, 94% had health care insurance with 50% reporting being “satisfied” with their coverage (Figure 2).

However, this assessment may not be an accurate reflection of the attitudes these individuals might have towards the same health care coverage in a few years. Very few young people find the need to use their health care insurance; statistically this percentage of the population is healthy. They are likely to lack experience in dealing with their insurance carrier and indeed may not even be informed about exactly what coverage they have and how much it costs. Thus, they might tend to overestimate their satisfaction.

**Figure 2.** Participants’ satisfaction with current health care insurance based on calculated percentages.

Because family income influences the extent of health care coverage, the participants were also asked to estimate their financial status. The majority of participants identified as
middle class (53%), followed by upper middle class (34%), working poor (6%), wealthy (4%) and poor (3%). No one identified as extremely wealthy (Figure 3).

![Pie chart](image)

**Figure 3.** Participants’ financial identification based on calculated percentages.

This demographic background information was necessary in order to draw inferences from the survey data. To summarize, the participants are mostly middle-class, educated and insured individuals. Approximately half of participants identify with one of the two dominant political parties while the other half has no party affiliation. The participants are generally satisfied with their insurance, though they likely have had little experience in using it. Most planned to vote in the presidential election; this statistic is slightly above the national average for American college students and suggests that this particular population is more actively involved in politics (Lipka, 2012). Finally, the 52% of participants identified as being only “somewhat informed” on the candidates’ health care platforms.

Based on the age and financial status of these participants, I can hypothesize that few of the participants have had to purchase or pay individually for their coverage and have most likely
never had to use it to a great extent. As a result, I cannot call these participants a representative sample of the American public overall. However, this fraction of the populace should not be ignored due to its impact on the American economy. For example, federal loans make up approximately 45% of student financial aid: at approximately $18,500 per student, the country is heavily invested in education (Baum and O’Malley, 2003). To pay back these loans, students need to be able to find secure jobs after graduation. Otherwise, without sufficient income some necessities like health insurance can be temporarily ignored.

With little experience, I believe that recent college graduates are the first to suffer from a bleak economic forecast: I believe they will be the ones who will struggle to find jobs or lose their jobs more quickly compared to the general working population. As a result of this hypothesis, I believe that this aspect of the population deserves special attention to its political concerns.

**Controversial vs. Benign Political Prompts**

I hypothesized that some of the more controversial political prompts – those that focused on publicized, moral-related issues and used strong language – would show a significant difference between Democrat responses and Republican responses. In other words, I hypothesized that there would be a significant difference between the mean Republican and mean Democrat response. These controversies are typically tied to ethical dilemmas that are associated with a specific party but not unique to it: for example, an anti-abortion stance is linked to the predominantly conservative, Christian views of the Republican Party. Thus, for these “controversial” political prompts I hypothesized that party identification between Republicans and Democrats would be significant.
In contrast, I hypothesized that for some of the more benign political prompts – those that used neutral language and were not easily associable with a political party – there would not be a significant difference between Republican and Democrat responses. In other words, that there would not be a significant difference between the mean Republican and mean Democrat response. These were prompts that I believed could generally be agreed or disagreed upon for both Democrats and Republicans. Due to the neutral language, I hypothesized that party identification would not be significant for these political issues.

As expected, some of the more controversial and partisan-identifiable prompts did show significant differences between Republican and Democratic responses. For example, for the political statement “I believe abortion is a legitimate medical procedure under some circumstances,” approximately 80% of participants agreed with the statement, 8% were neutral and 12% disagreed (Appendix C). The ANOVA p-value was 0.000, which indicated that among the Republicans, Democrats and those that claimed no Affiliation there was a significant difference (Appendix D). To determine whether this significant difference was specific to Republicans and Democrats, a post-hoc student’s t-test was performed: it was shown that there was a significant difference between Democrat and Republican responses (Appendix F, Figure 4 and Table 1).

The debate over abortion has been relatively polarized in politics due to religious beliefs: Republicans are largely anti-abortion while Democrats mainly advocate the right of female choice. While not often directly identified, voters may infer traits or beliefs from a candidate’s religious association and these inferences could potentially influence voter decision (Campbell et al., 2010). Thus it is not surprising that this controversial and politically associated issue resulted in a significant difference between how Democrats and Republicans responded.
Similarly, the view that “…job-given health insurances should cover the cost of contraceptives, regardless of religion” had an ANOVA p-value of 0.009 (Appendix D). Approximately 72% of participants agreed, 16% were neutral and 13% disagreed (Appendix C). The post-hoc student’s t-test determined that there was a significant difference between Republicans’ and Democrats’ mean response (Appendix F, Figure 4 and Table 1). Like the topic of abortion, contraceptives are controversial; the significant difference in how Democrats and Republicans responded is not surprising.

However, there were prompts I believed to less controversial and yet still had a significant difference between Republican and Democrat responses. For example, the view “I believe in expanding coverage and cutting health care costs” I believed to be relatively benign due to its neutral language and general positivity. Indeed, 77% of participants agreed with this statement, 16% were neutral and 7% disagreed (Appendix C). However, this view had an ANOVA p-value of 0.022 (Appendix D) and a significant difference between Republican and Democrat responses (Appendix F, Figure 4 and Table 1).
Figure 4. Mean Republican and Democrat responses for the political statements “I believe in expanding coverage and cutting health care costs,” “I believe that job-given health insurances should cover the cost of contraceptives, regardless of religion” and “I believe that abortion is a legitimate medical procedure for certain circumstances.”

Table 1. Mean Republican and Democrat responses for specific political issues that had a significant difference.

<table>
<thead>
<tr>
<th>Prompt</th>
<th>Mean Republican Response</th>
<th>Mean Democrat Response</th>
<th>Observed t-test value</th>
<th>Observed ANOVA p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expand coverage and cut costs.</td>
<td>2.31</td>
<td>1.85</td>
<td>0.015</td>
<td>0.022</td>
</tr>
<tr>
<td>Employers should cover contraceptives.</td>
<td>2.53</td>
<td>1.73</td>
<td>0.001</td>
<td>0.009</td>
</tr>
<tr>
<td>Abortion can be acceptable.</td>
<td>2.57</td>
<td>1.48</td>
<td>0.000</td>
<td>0.000</td>
</tr>
</tbody>
</table>

While controversial political claims were often the ones who had more significant differences between Democrat and Republican responses, this was not always the case. However, as eight of the ten “controversial” political issues identified had a significant
difference between the response of Republicans and Democrats, my hypothesis was largely supported (Figure 5, Table 2).

![Image of a graph showing mean Republican and Democratic responses for controversial political prompts.]

**Figure 5.** Mean Republican and Democratic responses for controversial political prompts.

**Table 2.** Mean Republican and Democrat responses for controversial political issues that had a significant difference.

<table>
<thead>
<tr>
<th>Prompt</th>
<th>Mean Republican Response</th>
<th>Mean Democrat Response</th>
<th>Observed t-test Value</th>
<th>Observed ANOVA p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion can be acceptable</td>
<td>2.57</td>
<td>1.48</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>Rights of states</td>
<td>2.34</td>
<td>3.04</td>
<td>0.006</td>
<td>0.031</td>
</tr>
<tr>
<td>Aspire to Canada's health care</td>
<td>3.83</td>
<td>2.35</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>Against assisted suicide</td>
<td>2.77</td>
<td>3.47</td>
<td>0.009</td>
<td>0.004</td>
</tr>
<tr>
<td>Government-run health care is inefficient</td>
<td>1.55</td>
<td>2.62</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>Against stem cell research</td>
<td>3.34</td>
<td>4.10</td>
<td>0.006</td>
<td>0.009</td>
</tr>
<tr>
<td>Employers should cover contraceptives</td>
<td>2.53</td>
<td>1.73</td>
<td>0.001</td>
<td>0.009</td>
</tr>
<tr>
<td>Repeal Obamacare</td>
<td>1.52</td>
<td>3.47</td>
<td>0.000</td>
<td>0.000</td>
</tr>
</tbody>
</table>
Also as expected, the majority of relatively benign political prompts had no significant difference between group response for Democrat and Republican participants. The view “I believe in changing Medicare so that seniors have more choice and flexibility” had an ANOVA p-value of 0.808, suggesting that there was no statistical difference between how Republicans, Democrats and those who claimed No Affiliation responded (Appendix D). Approximately 66% of all participants agreed with this view, 29% were neutral and 5% disagreed (Appendix C). This view does not suggest how to change Medicare; it simply puts forth a positive statement that I believed almost everyone – regardless of party identification – could agree upon. Similarly, the view “I believe individuals should be able to customize their insurance so they don’t pay for benefits they don’t need” had approximately 83% of participants agree, 11% were neutral and only 6% disagreed (Appendix C). This view had an ANOVA p-value of 0.342 (Appendix D). Again, there were exceptions to this general pattern. The view “I believe in the ABC approach for AIDS: Abstinence, Be faithful, Change behavior” had approximately 37% agree, 30% were neutral and 33% disagree (Appendix C). This prompt had an ANOVA p-value of 0.002 (Appendix E). When a student’s t-test was performed it was shown that there was a significant difference between Democrat and Republican participants’ responses (Appendix F, Figure 6 and Table 3). Personally, I believed this issue to be less controversial since this method of HIV protection has been advocated generally and not just by one specific political party. However, this data suggests that the participants saw this prompt as a political issue.
Figure 6. Mean Republican and Democrat responses for the political statements “I believe in changing Medicare so that seniors will have more choice and flexibility,” “I believe that individuals should be able to customize their insurance so they don’t pay for benefits they don’t need” and “I believe in the ABC approach to AIDS: Abstinence, Be faithful and Change behavior.”

Table 3. Mean Republican and Democrat responses for specific political issues that had a significant difference.

<table>
<thead>
<tr>
<th>Prompt</th>
<th>Mean Republican Response</th>
<th>Mean Democrat Response</th>
<th>Observed t-test value</th>
<th>Observed ANOVA p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC Approach to AIDS</td>
<td>2.43</td>
<td>3.27</td>
<td>0.002</td>
<td>0.000</td>
</tr>
</tbody>
</table>

I believe my hypothesis that relatively benign political prompts would not have a significant difference between the mean Republican and Democrat response was largely
supported. Two of the twelve “benign” political prompts had a statistically significant difference (Figure 7 and Table 4).

![Figure 7](image)

**Figure 7.** Mean Republican and Democrat responses to benign political prompts.

<table>
<thead>
<tr>
<th>Prompt</th>
<th>Mean Republican Response</th>
<th>Mean Democrat Response</th>
<th>Observed t-test value</th>
<th>Observed ANOVA p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC Approach to AIDS</td>
<td>2.43</td>
<td>3.27</td>
<td>0.002</td>
<td>0.000</td>
</tr>
<tr>
<td>Universal access</td>
<td>1.97</td>
<td>1.37</td>
<td>0.000</td>
<td>0.002</td>
</tr>
</tbody>
</table>

**Scenario Prompts**

Political prompt statements are only one of the ways the American public is exposed to the presidential candidates’ stance on health care. Scenarios – such as those that arise in debates
or play out across political advertisements – are another powerful political representation. In the context of this survey, these scenarios are more difficult to analyze than a simple one-sentence issue and emphasize life’s shades of gray. I hypothesized that in the scenario portion of the survey, party identification would be relatively less important. Thus, I would expect that there would be fewer instances of significant differences between the mean Republican and Democratic response for these three scenario prompts.

The first scenario addressed the controversial topic of abortion: a young couple is expecting their first child. Three-months pregnant, the mother goes in to have a routine doctor’s appointment. An abnormal result leads to a series of tests which determines that the fetus has Tay-Sachs disease, a fatal recessive genetic disorder that is characterized by decreased muscle tone, delayed mental and social skills, seizures and slow growth. The couple is presented with two choices: having the child knowing their baby will suffer this disease and die young or to have an abortion. If they choose to try and conceive again, there is a 75% chance they will have an otherwise healthy baby. The couple decides to have an abortion; the question, however, was whether government-sponsored health care should cover the cost of this procedure.

53% of participant agreed with the view that the government’s health care programs should cover abortion in this scenario, 12% disagreed and 35% disagreed (Appendix C, Figure 8 and Table 5). According to the ANOVA p-value of 0.001 (Appendix D) there was a significant difference between group responses for this view, indicating that politics did affect how this situation was analyzed. When a post-hoc student’s t-test was done, it was determined that there was a significant difference between Republicans’ and Democrats’ responses (Appendix F).
These results were particularly interesting when compared to the political prompt “I believe that abortion is a legitimate medical procedure for certain circumstances” in which the majority of participants agreed with the prompt (Appendix C). The catch may be the distinction between legalizing abortion and the government paying for abortion. However, I hypothesize that many people recognize the complexity of this issue in different situations.

The second scenario addressed the issue of tort reform. In the political statement section of the survey, three prompts addressed tort reform (Appendix D-E) and all three had insignificant differences between the mean Republican and Democrat response. I was curious to see whether this trend would also be seen in an applicable situation: a patient presents to the emergency room claiming chest pain and shortness of breath. After a series of tests, admittance to the hospital and 24-hour observation and care, the patient feels better and is discharged. The following day, the patient dies from a rare heart defect; the survival rate for this condition upon treatment is less than 25%. The family is devastated, sues the physician, and is awarded approximately $1.5 million. The question asked whether the government should restrict the condition under which patients can sue hospitals and physicians.

Approximately 49% of participants agreed with the view that the government should restrict physician litigation, 23% were neutral and 28% disagreed (Appendix C, Figure 8). These results differed with the political view “I believe in tort reform” in which approximately 58% of participants disagreed with the statement (Appendix C). The difference between Republicans’ response and Democrats’ response was insignificant, with a p-value of 0.495 (Appendix E). It appears that opinions on the topic of tort reform – like abortion – are influenced by the presentation of the specific issue: a simple statement provoked a different response from a scenario.
The final scenario also addressed an uncomfortable topic: limiting the number of Medicare and Medicaid patients due to lack in payment consistency from the federal government. A CEO of a hospital is balancing the budget and needs to make the decision of whether or not to fund the latest surgery technology. This technology could help minimize surgery risk and is especially useful for cancer treatment. However, in order to afford the technology the hospital would have to cut back on the accepted number of Medicare and Medicaid patients accepted; this would help the hospital better guarantee payment for their services. After consideration, the CEO decides to purchase the technology and restrict Medicare and Medicaid admittance. I asked whether hospitals should be allowed to limit the amount of Medicare/Medicaid patients.

Again, the analyses of participants’ responses were split across the Likert scale: 24% agreed, 25% were neutral and 51% disagreed (Appendix C, Figure 8). The ANOVA p-value for this view was 0.075, suggesting that there was no significant difference between the mean Republican and Democrat response (Appendix E).
Overall, I am unable to say with certainty whether my hypotheses that these scenarios would have fewer significant differences between the mean Republican and Democrat response was supported or rejected. However, based on comparison with previously analyzed political prompts, it does appear that framing a political issue in a specific situation does not rely as much on political party identification.
Leaning Independents

Results from a Millennial Values Survey (2012) suggested that students who identified as independent tended to lean a certain way. For example, 58% of independents leant toward the Democratic Party while 39% leaned Republican; only 3% were completely impartial (Millennial Values Survey, 2012). In this circumstance, it appears that “No Affiliation” and “Independent” are used interchangeably; if we make this assumption, I hypothesized that some of the students who claimed No Affiliation actually leant towards the Democratic Party.

If these participants who claimed No Affiliation were non-identified Democrats, then I hypothesized that there would be a significant difference between the mean response of Republicans and No Affiliation. Since I had already performed the ANOVA analysis to determine a significant difference between Democrat, Republican and No Affiliation responses (Appendix D-E), I performed a post-hoc student’s t-test between the mean Republican and No Affiliation response (Appendix G). Of the twelve prompts that had a significant ANOVA p-value, eight of them produced a significant t-test value (Figure 9 and Table 6).
Figure 9. Mean participant responses of Republican and No Affiliation participants for the political prompts that had an observed t-test value less than 0.05.

Table 6. Mean Republican and No Affiliation responses for specific political issues that had a significant difference.

<table>
<thead>
<tr>
<th>Prompt</th>
<th>Mean Republican Response</th>
<th>Mean No Affiliation Response</th>
<th>Observed t-test Value</th>
<th>Observed ANOVA p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion can be acceptable</td>
<td>2.57</td>
<td>2.04</td>
<td>0.036</td>
<td>0.000</td>
</tr>
<tr>
<td>Aspire to Canada's health care</td>
<td>3.83</td>
<td>2.68</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>Government-run health care is</td>
<td>1.55</td>
<td>2.40</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>inefficient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Against stem cell research</td>
<td>3.34</td>
<td>3.91</td>
<td>0.021</td>
<td>0.009</td>
</tr>
<tr>
<td>ABC approach for AIDS</td>
<td>2.43</td>
<td>3.03</td>
<td>0.001</td>
<td>0.000</td>
</tr>
<tr>
<td>Repeal Obamacare</td>
<td>1.52</td>
<td>3.03</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>Universal access</td>
<td>1.97</td>
<td>1.50</td>
<td>0.006</td>
<td>0.002</td>
</tr>
<tr>
<td>Abortion Scenario</td>
<td>3.57</td>
<td>2.69</td>
<td>0.003</td>
<td>0.001</td>
</tr>
</tbody>
</table>
Interestingly, the prompts that Republican and No Affiliation participants appear to agree upon were some of the more controversial prompts used in this survey. For example, the view “I support the right of states to make their own decisions concerning health care as each state is different” had an observed t-test value of 0.089 between the mean Republican and No Affiliation response (Appendix G), indicating that the different responses between these groups is not significant. However, for the same prompt the t-test value was 0.006 between Republican and Democratic participants (Appendix F), suggesting that this difference is significant.

Similarly, the view “I believe that job-given health insurances should cover the cost of contraceptives, regardless of religion” showed an insignificant difference between the mean Republican and No Affiliation response: the t-test value was 0.082 (Appendix G). In contrast, the t-test value between the mean Republican and Democrat response was 0.001 (Appendix F).

My hypothesis that the participants who claimed No Affiliation may lean Democrat appears to be supported; at the very least these participants do not agree with the Republican mean on certain issues. While claiming No Affiliation, it does appear that these participants are actually influenced by partisan politics.
Discussion

The observed significant difference between the mean Republican and Democrat response for some of the relatively benign political statements – and contrarily the lack of significant difference for some of the controversial statements – may be due to the polarized and publicized nature of the health care debate. When issues are high on the political agenda, there is an increase in news media coverage: as coverage increases, so does the time citizens spend thinking about that specific issue (Dancey and Goren, 2010). Furthermore, news organizations recognize the opportunity to emphasize conflict between the competing political sides by focusing on certain “hot-button” issues which also increase public awareness about what issues divide the political parties and where each party stands on that matter (Dancey and Goren, 2010). While the view “I believe in expanding coverage and cutting health care costs” may be seemingly benign, it may be that the participants recognized this as a much-publicized aspect of the health care debate and were able to identify how their respective political party would respond to such a claim.

My own hypothesis is that those relatively benign political prompts that provoked a split-party response are, perhaps, more important to this aspect of the population than to the general American public. After all, politics are a brief concern relative to our more personal interests; it stands to reason that individuals would focus their attention only one those specific issues which apply to them (Price et al., 2006). While surprising, those exceptions to the general pattern give important insight into the mind of millennial students. Thus, based on my results I propose the hypothesis that political views widely covered in the media will be more closely correlated to
I hypothesized that statements in which partisan politics were not significant would be indicative of situations where values were more important than politics. Overall, it appears that party identification and personal values or opinions are equally important for these soon-to-be college graduates when they are analyzing debates about health care reform. Generally, more controversial topics concerning moral-associated issues such as abortion rely heavily on party identification. Meanwhile, less controversial topics that appear to strive toward a common goal can generally be agreed upon, suggesting that these values are compatible when the origin of the statement is unknown. There were exceptions to the pattern, however. The issue of tort reform, which is most commonly associated with the Republican Party, had no significant difference between mean Republican and Democrat response when put into an applicable situation. Values and politics are balanced by these participants, and perhaps rightly so. It is very difficult to separate values from political issues because I believe that oftentimes the two parties have taken extreme stance on certain moral dilemmas. That being said, this survey exclusively focused on the party identification of these participants. To fully support this hypothesis, additional research based on value association is needed.

College-graduating seniors, members of the millennial generation, are facing a variety of complex and interwoven political issues. This is, perhaps, why so many participants claimed No Affiliation rather than association with one of the major political parties (Figure 1). I was surprised by this statistic: I believed that social identification through political parties would appeal to young adults (Greene, 2004). Yet I also believe that the accessibility and instantaneousness of knowledge and ideas over the Internet has blurred the traditional party lines.
For example, one could identify as a “fiscal” conservative but a “social” liberal: in that circumstance, identifying with only one political party can be difficult. Finally, it is also becoming more socially and politically acceptable to identify as “independent;” in several states individuals can register as “independent” just as they would a Republican or Democrat (Greene, 2004). However, there are very few “pure” independents: the majority of Americans still have some clear partisan preferences (Greene, 2004).

In a survey conducted jointly by the Public Religion Research Institute and Georgetown University’s Berkley Center for World Affairs, 2,000 students aged 18-24 were asked a series of questions about political, religious and moral issues. Results suggest that the majority of these young millennials identify as independent (45%) which is consistent with my own obtained results if we assume that “No Affiliation” is a synonym for “independent” (Millennial Values Survey, 2012). Similarly, more students identified as Democrat than Republican; 33% and 23%, respectively (Millennial values Survey, 2012). It is unknown exactly why more American college students identify as Democrat over Republican, but I believe value association to be a significant factor (Doherty, 2008). These values translate into stereotypes, which – from experience – I know to be an active part of collegiate life. It is therefore unsurprising that stereotypes translate into the realm of politics for these young adults. For example, it is a common stereotype that conservatives have little to no moral compassion, especially for underprivileged groups; furthermore, that conservatives actually enjoy seeing the rich get richer while the “innocents” suffer (Graham et al., 2012). This is an exaggerated stereotype, of course, but research has suggested that liberals exaggerate these partisan stereotypes the most (Graham et al., 2012). Whether these stereotypes are actually responsible for the majority of college students identifying themselves as Democrats – or as No Affiliation but actually leaning
Democratic – is inconclusive. However, it is worth noting that these stereotypes exist and have been shown to be applicable to college students; especially as the results of this survey support outside research (Graham et al., 2012).

Indeed, data collected from this sample of the population is consistent with surveys results from other millennial samples. For example, the majority of millennials – at approximately 30% - agree that abortion should be legal in most cases. The political statement in my survey that “I believe that abortion is a legitimate medical procedure for certain circumstances” generated an approximate 80% response of either “strongly agree” or “agree.” Such a trend is not limited to college-graduating seniors, either. A national Gallup poll suggests that 52% of the general American public support abortion under certain circumstances (Gallup Politics, 2013). Abortion is typically a controversial topic, yet the uniformity of support among my participants, other millennials and the national average suggest that this issue is gaining widespread favorability under specific circumstances.

Similarly, those young adults attending a private or public college or university have been shown to be more likely to support the availability of birth control (Millennial Values Survey, 2012). The survey prompt of “I believe that job-given health insurances should cover the cost of contraceptives, regardless of religion” received a 72% response of “strongly agree” or “agree.” A national poll reaffirms this observation by suggesting that approximately 89% of the American populace feels that birth control is morally acceptable (Newport, 2012). It appears to me that as birth control shifts from a controversial topic to a generally and publicly supported one, the debate is becoming less and less political.
For both observations, my own results were above the average both for the Berkley survey and national polls. However, it is necessary to consider the political demographics of the state of Illinois: typically a blue state in presidential elections (Glanton, 2012). Yet North Central College, located in DuPage County, is considered part of a “collar county:” a densely-populated suburban county that is generally well educated and wealthy (Cohen, 2012). Since the hometowns of these survey participants are unknown, it is difficult to speculate to what extent geographical – and thus, potentially, political – origin affects this survey data. Additional research that was specifically limited to college graduating seniors from the northwestern Illinois region – not just attending school there – is necessary.

The participants of this survey attended North Central College or DePaul University, which are esteemed private institutions that are relatively expensive; this despite both institutions’ generous grants and scholarships. The attendance at such a school may impact the opinions of these survey participants. Indeed, education and family income has been shown to be strong predictors for political activity (Greene, 2004). I believe this was observed in my survey as a more participants stated that they would vote in the presidential election than the national average for American college students. While this sample population is very specific, there are aspects of this project that have projected into national trends. This suggests that Chicago-area, college-graduating seniors are in tune with the political atmosphere of the general public. Additional support is observed in the outcome of the presidential election: incumbent Democratic President Barrack Obama won a second term at the White House. It would be seemingly impossible to identify the core issue for this outcome, but I postulate that health care did play its important role throughout the course of the presidential campaign.
I believe that based on the results of this survey there are certain aspects of health care reform that both Republicans and Democrats can agree on. Hopefully all aspects of the government in Washington D.C. can recognize this unanimity and make the necessary changes to the current health care system.
Perceptions on Proposed Models for Reform

Whether influenced by values or politics, most survey participants did support some aspect of health care reform; for example, 80% of participants either agreed or strongly agreed with the prompt that “I believe insurance companies should not be allowed to discriminate patients based on pre-existing conditions.” With health care costs becoming an increasing burden for middle class families, some form of health care reform seems inevitable (Komisar, 2013). Fortunately, there are several examples of health care reform that can serve as examples to the United States; if politicians can systematically analyze the pros, cons and lessons of these models, perhaps successful health care reform is possible. However, such careful consideration is extremely time-consuming due to the number of proposals and models of reform available. To better understand the health care debate, it is necessary to investigate some of these models and proposals. I have selected a few of such examples – one from abroad and several domestic propositions – to emphasize the variety of lessons that could be learned. Finally, I will give my own opinion on how health care reform should be approached.

Canada’s Universal Health Care

One model that is particularly close to home is that of our friendly northern neighbor: Canada. Due to its close proximity and the drastically different approach to health care, Canada is used both as an example and a warning to the American public (Robinson, 2008). Unfortunately, many Americans are misinformed and not knowledgeable about how Canada’s health care system works; one such myth is that Canadians don’t get to choose their own doctor (Robinson, 2008). A closer look is therefore critical; lessons can be learned from Canada’s triumphs and pitfalls.
To begin, perhaps it is best to identify how Canadians feel about their health care. According to the Canadian Health care Website, Canada’s system is a group of publicly-funded socialized health insurance plans which provide coverage to all citizens; while this system has guidelines that are set by the federal government, health care is administered on a provincial or territorial basis (“ Provincial Health Insurance,” 2007). Indeed, Canada’s single-payer system is what truly distinguishes it from the American health care market.

I was personally surprised that government funds are administered through the provinces and territories. The survey prompt “I support the right of states to make their own decisions concerning health care as each state is different” was almost equally split between agree (32%) and disagree (28%). Yet this methodology has worked apparently well for Canada: health care was allowed to evolve within these individual provinces in increment with support from the national government through a series of cost-sharing programs (Deber, 2003). Indeed, the federal government acts more as a regulator than an implementer. This is an interesting and important caveat of the Canadian health care system that is overlooked by the American media; but perhaps this is because the most popular health care reforms proposals have the American federal government – and not the states – controlling the financing and administration. While the Canadian federal government may attempt to influence health care policy by providing money or suggesting guidelines, the national government does not hold all the power (Deber, 2003). Furthermore, by allowing individual provinces to develop their own systems, Canada ensured that each province was able to efficiently and effectively address the health care issues most pertinent to its citizens.

As a result, the Canadian health care system is efficient, especially compared to the United States. The administrative costs for the Canadian national health plan was 1.5% in 1999,
compared to 3.6% for the American government-run Medicare program (Kemble, 2010). By setting physicians’ fees and hospital budgets, Canada can ensure that insured services are free: “no premiums, deductibles, or co-payments are imposed” (O’Neill and O’Neill, 2008). Patients being treated in a hospital have full access to necessities such as nurses, physiotherapy and pharmaceuticals (Deber, 2003). However, public funds do not continue to pay for services such as medicines after a patient is discharged (Deber, 2003).

In truth, Canadian citizens often have independent insurance or pay out of pocket for things such as pharmaceuticals and dental care (Deber, 2003). However, the problem with unlimited access – and what may have many American policymakers skeptical – is a simple economic model: when demand is unrestrained, things become expensive. Canada is already experiencing some of this market trouble through shortages and explicit rationing (O’Neill and O’Neill, 2008). As a result, there has been a slight decline in Canada’s long-standing approval of their health care system leading up to the new millennium: a nation-wide survey suggested that two-thirds of Canadian citizens felt that waiting times for procedures such as surgery had grown over the previous 12 months (Sanmartin et al., 2000). Furthermore, survey participants felt that access to specialists had become more difficult (Sanmartin et al., 2000).

At least in the American media, waiting times are a sticking point for the Canadian health care model. Some statistics claim that Canadian patients wait twice as long as American patients – sometimes for more than a year – in order to see a specialist for an elective surgery such as a hip replacement (Atlas, 2009). These claims can be misleading, however, depending on the source and the data; furthermore, the “waiting lists” have been shown to be “non-standardized, capriciously organized [and] poorly monitored” (Chua, 2006). A more objective analysis of waiting times came from Canada’s own provincial note-keeping of surgery times: the median
wait time for vascular surgery was 2.7 weeks, for gallbladder surgery 5.1 weeks, for cataract surgery 9.4 weeks, for hip replacement 21.8 weeks and knee replacement 28.3 weeks (Chua, 2006).

Obviously, waiting lists will be influenced by the demand for a certain procedure, the amount of physicians doing the procedure and the availability of appropriate health care facilities (Chua, 2006). Variability is expected, but how much do these wait times affect the public’s perception of health care? In a national survey, 40% of sick Americans said it was difficult to see a specialist compared to 53% in Canada (Chua, 2006). Of those 40% U.S. respondents, 40% cited long waiting times as the primary difficult; in contrast, of the 53% of Canadian respondents 86% cited long waiting times as the major deterrent (Chua, 2006). This data suggests that waiting times may be a more prevalent problem in Canada, yet this issue is not limited to north of the border: some Americans experience this problem as well (Chua, 2006). What is important to take away is that Canada’s universal coverage isn’t ideal and has some disadvantages.

Another better-known flaw of Canada’s single-payer system is that coverage does not include prescription drugs. Yet perhaps Canada is smart to be reluctant to take on this aspect of health care: no province has successfully been able to control the costs of publicly funded drugs (Lewis et al., 2001). The history lesson is indeed apparent, with annual percentage increases that are routinely double-digits (Lewis et al., 2001). This conjures up the image of vulnerable elderly Canadians crossing the American border to get their life-saving drugs. However, this is actually far from the truth: the provinces have reimbursement plans for qualified prescription drugs. Furthermore, even though a patient with congestive heart failure may pay $1,283 out-of-pocket for prescriptions, this is significantly less than the total medical burden of care that has resulted in many Americans filing bankruptcy (Demers et al., 2008).
Canada’s health care system is complex, so it is not surprising that some Americans have misunderstood the true implications of Canada’s universal coverage. Those Americans who are for and against such universal coverage should learn carefully from Canada’s example. Indeed, ignorance could be detrimental to health care reform in the United States if such admonitions are not carefully considered.

*American Proposals for Reform*

I know America to be a country known for its innovators. Therefore it is unsurprising that some Americans have proposed their own health care reform provisions instead of just following a previously implemented model. These proposals largely focus on the individual’s perception of the dominant issue facing health care reform. For many analysts, the prevailing issue with America’s multi-payer system is the inefficiency of the health care sector. For example, the basic economic model is that of supply and demand. Fluctuations in the price of seeing a doctor are signals used to make production and consumption decisions. Based on an economic supply and demand graph, with a high demand and fixed supply, prices should rise until enough people get forced out of the market; this new lower level of demand will produce a new equilibrium price (Deber, 2003). However, health care markets appear to defy these economic principles due, in part, to the ethical dilemma of “pricing out” patients who cannot afford their care. Beyond these economic-defying logistics is the problem of the insurance market. The whole concept of insurance is “risk pooling;” distributing the cost of those few sick over a large, dominantly healthy population (Kemble, 2010). The problem with health care insurance is that many people know of their pre-existing conditions or risk factors and are thus highly motivated to purchase insurance. For example, a smoker is highly motivated to purchase health insurance due to their
increased chances of lung cancer. In contrast, healthy individuals sometimes decide that they would rather take their chances not purchase the insurance. As a result, there is a sicker-than-average pool of subscribers who drive the cost of insurance up; this undermines the benefits of risk pooling (Kemble, 2010).

Indeed, behavioral psychology is just as important as market theory when it comes to analyzing health care insurance. “Behavioral hazard” has blurred the lines of market efficiency (Baicker et al., 2012). For example, Baicker and her colleagues explain that moral hazard results in cases of “people overusing expensive care that provides few health benefits” and not utilizing inexpensive care that could provide substantial health benefits. A classic example of diabetic medicine: glucose-lowering drugs can increase a patient’s life span, reduce the risk of limb loss or blindness and improve the quality of life (Baicker et al., 2012). Yet despite these obvious benefits, many benefits take these drugs sporadically, with roughly 65% adherence (Baicker et al., 2012). The psychological reasons for not taking these effective medicines are characterized as behavioral hazards, as they result in misbehavior.

So what are the models Americans have proposed? One particular proposition that intrigued me was the Balanced Choice proposal. This model strives for the universal coverage seen in Canada while still imploring some market forces. Balanced Choice proposes a single-payer system with a minimal co-payment; such co-pay could easily be waived in certain circumstances of financial hardship (Kemble, 2010). However, each health care provider would have the option of charging a higher fee for expanded services such as prime appointment times (Kemble, 2010). Put another way, everyone will have access to quality care, but those who can afford to pay a higher share for their health care will additional perks.
What interested me about this particular proposition was that it addressed the reluctance of U.S. physicians in supporting a government-run health care program. Many doctors have experienced frustration at incompetent administration, provider services and fees from the Medicare program (Kemble, 2010). I believe acknowledging physicians’ concerns are important for reform. However, this model fails to acknowledge the inequality in service that is present in health care. Those who can afford it will continue to receive adequate care; the remaining population will get the “leftovers” of the health care system. Despite the pluses and minuses, this American model emphasizes the issues American analysts are deeming important; politicians should carefully consider these suggestions when drafting their own proposal.

Similarly, it is important to consider how physicians are addressing the issue of health care reform. They are – pun intended – the heart of the health care system. However, reform is largely focused on patient satisfaction and patient needs: equitable health care means creating patient-centered systems of care that foster healing and caring relationships which focus on patients’ needs and wishes (Fiscella, 2011). While ideal, this model undermines how much health care is already focused on patient satisfaction. For example, Press Ganey is an organization that collects and analyzes patient experience reports and returns data to advisors suggesting improvements in “clinical, operational, financial and experimental outcomes” (Press Ganey, 2013). Press Ganey surveys are then commonly used by state and federal governments to rank hospitals and administer additional funding. The Mayo Clinic is another example of patient-centered care: the core tenant of the hospital is “The need of the patient first” (Mintzberg, 2012). Doctors, nurses and even janitors meet almost weekly to brainstorm ideas on how make the service and care for patients better; also, physicians are on a set salary and aren’t rewarded for seeing extra patients (Mintzberg, 2012).
Indeed, the perception that patients have no say in the current health care system is largely a myth; at least it is not the physicians that are ignoring the cries of the public. However, the costs are only continuing to rise. For example, it is projected that if health care costs continue to grow at the current rate, health care could consume 38% of the U.S. GDP by 2075 (Chernew et al., 2003). Some causes of the rising health care costs include defensive medicine prompted by malpractice litigation, the moral dilemma of using medical services for end-of-life care that is often fruitless, unhealthy life styles that warrant medical care and unreasonable administration costs (Boncheck, 2012). This claim may be harsh, but it does bring to light the tendency of Americans to overspend on health care. Again, smoking is an example of a voluntary behavior that can lead to expensive medical treatment. Based on these issues, one could hypothesize that reform is simply a Band-Aid on a larger problem: that even with the implementation of the Affordable Care Act, reform could not succeed without controlling the escalating cost of U.S. health care (Chernew et al., 2003). The claims that systems which reward payment for health care value rather than volume would produce better alignment between patients and health care resources sound wonderful, but undermine how much of our current health care system is centered around patient needs (Fiscella, 2011).

**Utilizing Primary Care**

Physicians continue to suggest one aspect of reform that might make the most difference in price reduction: the utilization of primary care. When individuals actively and consistently meet with the same doctor, health concerns can better be addressed and preventative care can prevent future diseases from becoming detrimental. Studies have found that when primary care physicians are utilized there has been significantly decreased demand for other health care
sources such as emergency department visits (Kravet et al., 2008). Clearly, primary care should be a focus of health care reform and an appropriate link between patients and physicians.

Yet why isn’t primary care being properly utilized now? Seeing a physician regularly requires people to be proactive about their health, and I expect some healthy individuals think they don’t need to take the time or pay the expense of seeing a doctor. Indeed, paying an expense when there is not an immediate health issue is too extravagant for some Americans to pay for out-of-pocket Perhaps the underuse of primary care doctors is why emergency room visits have skyrocketed. Emergency rooms cannot deny anyone access to care – even if they can’t pay – resulting in an influx of patients using these urgent clinics for non-urgent concerns. The Affordable Care Act has reaffirmed this medical privilege and designated emergency care as a right for U.S. citizens (Schmitz and Tull, 2012). Physicians worry that patient volume, wait times, and costs will continue to rise unless this issue is properly addressed (Schmitz and Tull, 2012).

Interestingly, it is not the increase in patient volume that is causing health care prices to rise: a recent study demonstrated that reducing non-urgent emergency room visits will actually result in little to no savings for the health care system (Schmitz and Tull, 2012). The real cost-saving mechanism is in reducing admissions to the hospital (Schmitz and Tull, 2012). The increase in patient admittance correlates back to the general lack of a primary care doctor: without much background on the patients’ health concerns, many physicians err on the side of caution and admit a patient for overnight examination. A survey of physicians indicates that the fear of lawsuits it the predominant cause of excessive testing, which is the barrier to effectively cutting spending in the emergency department (Schmitz and Tull, 2012).
One proposed way to encourage the public’s acceptance and utilization of primary care physicians is education. However, selecting a quality health care provider isn’t the same “as buying a washing machine;” it requires research and the ability to comprehend complex medical information, which the general public typically doesn’t have (Boncheck, 2012). This is a place where government intervention could actually do a lot of use; promoting the expansion of the primary care market could drive costs without an extensive overhaul of the sector. Indeed, if we learn anything from Massachusetts it’s that health care reform may not actually decrease costs unless there is better access to primary care, tort reform is enacted and the emergency department is better utilized (Schmitz and Tull, 2012).

These are only a couple examples of health care reform the United States has to consider. The obstacles are numerous and complex, the outcome uncertain and everyday Americans continue to struggle to pay for their health care. However, I believe that the dominant issue needing to be addressed is the definition of health care. American culture has created a consumer economy where the “customer is always right.” This mannerism has translated into the medical sector. Physicians are no longer highly respected individuals whose word is the law; rather, they are at the mercy of satisfying their patients’ needs, even if the patient has an unrealistic expectation of medicine. For example, a patient may feel that they need an unnecessary medical service; clearing up the misperception is potentially a more effective way to curb costs than many current reforms suggest (Woolf, 2002).

Also, the emergence of online medical databases that “diagnose” patients on a preliminary set of symptoms has shifted the doctor-patient relationship even further out of balance. Patients are walking into clinics and hospitals with a preconceived diagnosis – often a worst-case scenario – and are often met with a much more benign classification from their
doctor. The emotional rollercoaster of stomach cancer to stomach gas has some patient’s misinterpreting the relative good news for doctor insensitivity and arrogance. Additionally, there need to be boundaries between patient responsibility and health care. Should the public at large be responsible for an individual’s drug addiction, unhealthy eating habits or the decision to have unprotected sex? Some analysts are worried that the implementation of universal health care will result in rationing procedures; for example, an individual will not receive full coverage unless they change their lifestyle habits (i.e. quit smoking). This crosses the politically-correct boundary of interfering with personal choice. However, when personal choice affects the financial health – and physical health – of a country, certain provisions should and need to be made.

My relatively cynical outlook is perhaps due to my uncertain future in health care. As someone entering medical school, I’m entering a career that will be drastically different within the next decade. A balance of addressing physicians’ concerns, patient needs and economic theory is the balance that politicians need to aim for. Beyond that, flexibility is the ultimate tool. With President Obama re-elected and in the White House for another four years, I expect that some form of the Affordable Care Act will be implemented. However, the success of this bill depends on the support of the majority of politicians, health care providers and the public. Hopefully, the values of these politicians will allow such flexibility to take American health care into the future. After all, when lives are on the line it is not a time for politics.
References


Chua, K.P. (2006). Waiting Lists in Canada: Reality or Hype? AMSA.


Appendices

Appendix A

TO: Alina Perez
CC: Professor Karl Kelley, Faculty Supervisor
FROM: Professor Jennifer Keys, Chair, NCC Research Ethics Committee
DATE: October 19, 2012

RE: “The Influence of Partisan Politics and Values on Health care Reform” (#2012-42)

The NCC Research Ethics Committee has reviewed and approved your application titled, “The Influence of Partisan Politics and Values on Health care Reform” (#2012-42). The reviewer notes, “It is well-designed and timely. There is no discernible risk to participants and they will likely benefit from reflecting on the issues. They may even become better citizens. Informed consent is adequately addressed and confidentiality is protected.” Thank you for thoughtful consideration of ethical issues.

We wish you the best of luck with your research!

Kindest Regards,
Professor Jennifer Keys, Ph.D.
Appendix B

Application for Research Ethics Committee Review – Human Participants Research

North Central College

Title
The Influence of Partisan Politics and Values on Health care Reform

Investigator
Alina Perez

Faculty Supervisor
Karl Kelley, Ph.D. and Jonathan Visick, Ph.D.

Duration and Location of Research
This research will run from October 2012 to November 2012. The data will be collected by an online survey specifically made for this project.

Description of Research
It is my belief that misinformation and close-mindedness due to party politics are the greatest obstacles that health care reform faces. Partisan beliefs concerning the health care debate have led to misunderstandings about how health care is organized and led to unrealistic expectations of what health care should offer. In the 2012 Presidential Election, the health care debate covers the key topics of how doctors practice medicine, insurance regulations, and government involvement. By surveying the class of 2013 – a group of individuals posed to enter the workforce and thus a new realm of health care – I hope to investigate whether personal values align with party politics. This survey is a component of my College Scholar’s honors thesis.

The survey has been broken down into three essential components: background information, values concerning political talking points, and values concerning specific scenarios. The first component to obtain background information is to ensure a wide and diverse pool of participants. The second component is to investigate whether an individual will support political talking points of their given political party if they do not know which presidential candidate made the statement. Essentially, I am looking to investigate whether values or politics play a bigger role in having an opinion about health care reform. The third component is similar to the second in that
it investigates the relationship between values and political parties; this time in a scenario setting where one presidential candidate would clearly support an outcome the other presidential candidate would not support.

**Participants**

Participants will be from the graduating class of 2013 and will be recruited on a voluntary basis.

**Confidentiality**

The responses provided by the volunteer students will never be used to directly identify any individual. Information will not be disclosed to anyone not associated with the research project.

**Risks and Benefits**

There are no anticipated risks associated with participating in this study. The benefits for this study include being part of a greater and more diverse pool of participants that can be generalized to graduating seniors in the northern Illinois region. Furthermore, this research will directly benefit my participation in the College Scholar program upon completion of my honors thesis. It should be noted that participants will be given the opportunity to obtain a copy of the findings and will access to the completed thesis if they so desire.

**Informed Consent**

Before beginning this study, participants will read and electronically sign an informed consent (see attached).

**Debriefing**

Participants will be provided with an electronic debriefing (see attached).

*I have reviewed the regulations governing the NCC Research Ethics Committee and certify that my proposed research is in compliance with those regulations. I also certify that the information presented above is accurate and complete. I agree that, in the event that conditions and/or procedures of the proposed research undergo substantial change, I am required to submit a new approval form to the Research Ethics Committee before further research activity may proceed.*

_________________________________  ____________________________
Alina Perez
Informed Consent

Purpose of the Research
Thank you for agreeing to participate in this survey. For this project, I will ask you a series of questions in order to discern your political beliefs and values about health care reform. The goal of this project is to determine how graduating seniors’ politically and individually analyze issues concerning the health care debate in the 2012 Presidential Election. This survey will be used in the completion of my honors thesis.

Confidentiality
Your participation in this survey will remain confidential and your identity will not be stored with your data. Your identity will never be brought up in the context of my thesis and will not be shared with anyone who is not associated with this research project.

Participation and Withdrawal
Your participation in this survey is voluntary. If you feel uncomfortable answering any questions during the course of the survey, you may skip them. Also, you may withdraw from the survey at any time without penalty.

Contact
If you have any questions about this survey or project, please contact Alina Perez at amperez@noctrl.edu.

Agreement
The purpose and nature of the research has been sufficiently explained and I agree to participate in this study. I understand I am free to withdraw at any time without incurring any penalty.

I certify that I am 18 years of age or older □

Please type your name as an electronic signature: __________________________________________
Thank you!

Thank you for participating in this study!

This project is being conducted by Alina Perez, a biochemistry major at North Central College for her 2013 honors thesis.

In this study, you completed a survey identifying political and value-based opinions concerning health care reform. Your contribution will give insight into how graduating seniors in the northern Illinois region think about health care reform in the upcoming presidential election.

If you would like to receive a summary of the results at the end of the year upon completion of the thesis, please contact Alina Perez at amperez@noctrl.edu.
Potential Survey Questions

Background Information

Background information questions will largely be multiple-choice with several different options for an answer. Participants are not required to answer any of the questions.

- What is your name? _________________________
- What is the name of the college or university you are currently attending?
- What is your anticipated major? _________________________
- What is the year of your anticipated graduation? _________________________
- What political party do you consider yourself to be a part of?
- Do you plan on voting in the 2012 Presidential Election? _________________________
- How informed are you with the presidential nominees’ stance on health care?
- Do you currently have health care insurance? _________________________
- How satisfied are you with your current health care insurance?
- What is your family’s approximate household income before taxes?

Political ‘Talking Points’ Prompts

Participants will be asked to respond to the prompts on a scale of 1 to 5, with 1 being strongly agree and 5 being strongly disagree.

- I would like the government to initiate market-based reforms that empower states and invidious to reduce health care costs.

  1 Strongly Agree  2 Agree  3 Neither  4 Disagree  5 Strongly Disagree

- I believe in an ABC approach for AIDS: Abstinence, Be faithful, Change behavior.

  1 Strongly Agree  2 Agree  3 Neither  4 Disagree  5 Strongly Disagree

- I do not support stem cell research.

  1 Strongly Agree  2 Agree  3 Neither  4 Disagree  5 Strongly Disagree

- I do not believe assisted suicide should be used under any circumstances.

  1 Strongly Agree  2 Agree  3 Neither  4 Disagree  5 Strongly Disagree

- I believe that government-run universal health care can lead to inefficiencies.
I support the right of states to make their own decisions concerning health care as each state is different.

I believe in changing Medicare so that seniors will have more choice and flexibility.

I believe that individuals should be given tools to manage their own health care.

I believe that individuals should be able to customize their insurance so they don’t pay for benefits they don’t want.

I believe in tort reform (that physicians should not be sued for mistakes).

ObamaCare should be repealed and other health care options should be considered.

I believe that insurance companies should not be allowed to discriminate patients based on pre-existing conditions.

I believe that lowering health care costs will guarantee more choices.

I believe that Medicare is an acceptable and efficient program; Medicare should not be privatized or voucher-ized.

Everyone should have access to affordable health care.

I believe in expanding coverage and cutting health care costs.
I believe that a prescription drug benefit should be added to Medicare.

I believe that job-given health insurances should cover the cost of contraceptives, regardless of religion.

I believe that abortion is a legitimate medical procedure for certain circumstances.

I believe that physicians should be serving and answering to the patient.

I believe that physicians should be accountable financially for their mistakes.

I believe that Canada’s universal health care system is something to aspire to.

Scenario Prompts

Participants will be asked to respond to the prompts on a scale of 1 to 5, with 1 being strongly agree and 5 being strongly disagree.

1. A young couple is expecting their first child. The mother is three months pregnant and is going to a routine doctor’s appointment. During the appointment, some tests procedure abnormal and alarming results. A chorionic villus sampling (CVS) is performed to determine the genetic makeup of the fetus. One week later, results confirm that the fetus has Tay-Sachs disease. This is a recessive genetic disorder that can cause deafness, decreased muscle tone, delayed mental and social skills, loss of motor skills, paralysis, seizures, and slow growth. There is no treatment for Tay-Sachs disease; children with this disease generally die very young. The couple is presented with two choices: to have the child knowing that he/she will most likely die early in childhood or to have an abortion. If the couple decides to get pregnant again there is a 75% chance that they will have an
otherwise healthy baby. After careful consideration, the couple decides to have an abortion.

Should government-sponsored health care insurance cover this type of procedure?

1. 2. 3. 4. 5.
Strongly Agree Agree Neither Disagree Strongly Disagree

2. A patient comes into the emergency room complaining of chest pain and shortness of breath. The patient is immediately placed into a hospital room and several tests are performed, all of which come back normal. Despite a lack of prognosis, the patient is admitted to the hospital for 24-hour observation and care. After 24 hours have passed, the patient feels better and is released from the hospital with instructions to return if the symptoms should return. The next day the patient dies from an unusually rare heart defect. Treatment for this defect is risky and survival is less than 25%. Regardless, the family is devastated that the physicians did not identify the patient’s problem and have decided to sue the doctor and the hospital. The expense for hospital lawyers, possible pay-out and rise in malpractice insurance will cost the hospital $1,500,000. This cost will be passed onto the patients.

Should the government restrict the conditions people can sue hospitals and physicians?

1. 2. 3. 4. 5.
Strongly Agree Agree Neither Disagree Strongly Disagree

3. Joe is the CEO of a successful Chicago hospital. However, spending needs to be reduced in order to stay within the hospital’s budget. So far there are only two proposals to reduce spending. One proposal is to not buy the latest da Vinci surgery machinery; this robot allows surgery to be minimally invasive and is used on a variety of cancer and medical conditions. Patients recover more quickly and comfortably after da Vinci procedures. Also, having the breakthrough machinery could confirm the hospital’s prestige. The second option is to reduce the number of Medicare/Medicaid patients accepted for procedures outside of the emergency room. Generally the hospital does not receive full compensation from the government for these patients. Reducing the number of Medicare/Medicaid patients could allow the hospital to better guarantee payment for their services and offer a better quality of care. After careful consideration, the CEO decides to reduce the number of Medicare/Medicaid patients the hospital serves.

Should hospitals be allowed to limit the amount of Medicare/Medicaid patients?

1. 2. 3. 4. 5.
Strongly Agree Agree Neither Disagree Strongly Disagree
Appendix C

The political prompt, respective prompt number and raw data of survey results.

<table>
<thead>
<tr>
<th>Prompt Number</th>
<th>Prompt</th>
<th>Number of Participant Responses</th>
<th>Total Participant Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I would like the government to initiate market-based reforms that empower states and individuals to reduce health care costs.</td>
<td>Strongly Agree: 13, Agree: 79, Neutral: 40, Disagree: 11, Strongly Disagree: 1</td>
<td>144</td>
</tr>
<tr>
<td>2</td>
<td>I believe in expanding coverage and cutting health care costs.</td>
<td>Strongly Agree: 33, Agree: 80, Neutral: 24, Disagree: 9, Strongly Disagree: 1</td>
<td>147</td>
</tr>
<tr>
<td>3</td>
<td>I believe that Medicare is an acceptable and efficient program; Medicare should not be privatized or voucher-ized.</td>
<td>Strongly Agree: 12, Agree: 66, Neutral: 45, Disagree: 17, Strongly Disagree: 2</td>
<td>142</td>
</tr>
<tr>
<td>4</td>
<td>I believe that abortion is a legitimate medical procedure for certain circumstances.</td>
<td>Strongly Agree: 59, Agree: 61, Neutral: 12, Disagree: 11, Strongly Disagree: 7</td>
<td>150</td>
</tr>
<tr>
<td>5</td>
<td>I believe that insurance companies should not be allowed to discriminate patients based on pre-existing conditions.</td>
<td>Strongly Agree: 56, Agree: 60, Neutral: 17, Disagree: 9, Strongly Disagree: 6</td>
<td>148</td>
</tr>
<tr>
<td>6</td>
<td>I support the right of states to make their own decisions concerning health care as each state is different.</td>
<td>Strongly Agree: 18, Agree: 52, Neutral: 40, Disagree: 38, Strongly Disagree: 0</td>
<td>148</td>
</tr>
<tr>
<td>7</td>
<td>I believe that individuals should be able to customize their insurance so they</td>
<td>Strongly Agree: 39, Agree: 85, Neutral: 17, Disagree: 7, Strongly Disagree: 2</td>
<td>150</td>
</tr>
<tr>
<td></td>
<td>Statement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>8</td>
<td>I don't pay for benefits they don't need.</td>
<td>18</td>
<td>38</td>
</tr>
<tr>
<td>9</td>
<td>I believe that Canada's universal health care system is something to aspire to.</td>
<td>20</td>
<td>28</td>
</tr>
<tr>
<td>10</td>
<td>I do not believe assisted suicide should be used under any circumstance.</td>
<td>21</td>
<td>93</td>
</tr>
<tr>
<td>11</td>
<td>I believe that individuals should be given tools to manage their own health care.</td>
<td>50</td>
<td>77</td>
</tr>
<tr>
<td>12</td>
<td>I believe that physicians should be serving and answering to the patient.</td>
<td>58</td>
<td>67</td>
</tr>
<tr>
<td>13</td>
<td>I believe in changing Medicare so that seniors will have more choice and flexibility.</td>
<td>17</td>
<td>80</td>
</tr>
<tr>
<td>14</td>
<td>I believe that government-run universal health care can lead to inefficiencies.</td>
<td>24</td>
<td>73</td>
</tr>
<tr>
<td>15</td>
<td>I do not support stem cell research.</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>16</td>
<td>I believe that a prescription drug benefit should be added to Medicare.</td>
<td>23</td>
<td>78</td>
</tr>
<tr>
<td>17</td>
<td>I believe that job-given health insurances should cover the cost of contraceptives, regardless of religion.</td>
<td>50</td>
<td>58</td>
</tr>
<tr>
<td>18</td>
<td>I believe in tort reform (that physicians should not be sued for)</td>
<td>4</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Mistakes</td>
<td>I believe that lowering health care costs will guarantee more choices.</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>----------</td>
<td>---------------------------------------------------------------------</td>
<td>---</td>
</tr>
<tr>
<td>19</td>
<td></td>
<td>5 52 56 32 2 147</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td></td>
<td>I believe in the ABC approach to AIDS: Abstinence, Be faithful, Change behavior.</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td></td>
<td>7 48 45 28 21 149</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td></td>
<td>Obamacare should be repealed and other health care options should be considered.</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td></td>
<td>21 29 58 30 12 150</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td></td>
<td>Everyone should have access to affordable health care.</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td></td>
<td>80 58 8 3 1 150</td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>Real-world Abortion prompt.</td>
<td>27 49 18 32 18 144</td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>Real-world tort reform prompt.</td>
<td>16 54 33 35 5 143</td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Real-world Medicare/Medicaid limitation prompt.</td>
<td>3 32 36 53 20 144</td>
<td></td>
</tr>
</tbody>
</table>
Appendix D

Mean Republican, Democratic and No Affiliation response for Democratically-associated political prompts. A low score represents a higher percentage of participants that “strongly agree” or “agree.” A high score represents a higher percentage of participants that “strongly disagree” or “disagree.” Non-common letter subscripts represent a significant difference.

<table>
<thead>
<tr>
<th>Prompt</th>
<th>Mean Republican Response</th>
<th>Mean Democratic Response</th>
<th>Mean No Affiliation Response</th>
<th>F value</th>
<th>ANOVA p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>2.31a</td>
<td>1.85b</td>
<td>2.15ab</td>
<td>3.298</td>
<td>0.022</td>
</tr>
<tr>
<td>3</td>
<td>2.29</td>
<td>2.33</td>
<td>2.60</td>
<td>2.629</td>
<td>0.052</td>
</tr>
<tr>
<td>4</td>
<td>2.57a</td>
<td>1.48b</td>
<td>2.04b</td>
<td>8.371</td>
<td>0.000</td>
</tr>
<tr>
<td>5</td>
<td>1.97</td>
<td>1.90</td>
<td>1.94</td>
<td>1.853</td>
<td>0.140</td>
</tr>
<tr>
<td>7</td>
<td>1.90</td>
<td>1.96</td>
<td>2.09</td>
<td>1.123</td>
<td>0.342</td>
</tr>
<tr>
<td>8</td>
<td>3.83a</td>
<td>2.35b</td>
<td>2.68b</td>
<td>16.377</td>
<td>0.000</td>
</tr>
<tr>
<td>11</td>
<td>1.86</td>
<td>1.71</td>
<td>1.88</td>
<td>0.568</td>
<td>0.637</td>
</tr>
<tr>
<td>12</td>
<td>2.31</td>
<td>2.10</td>
<td>2.41</td>
<td>1.711</td>
<td>0.167</td>
</tr>
<tr>
<td>16</td>
<td>2.24</td>
<td>2.18</td>
<td>2.21</td>
<td>0.577</td>
<td>0.631</td>
</tr>
<tr>
<td>17</td>
<td>2.53a</td>
<td>1.73b</td>
<td>2.10ab</td>
<td>4.030</td>
<td>0.009</td>
</tr>
<tr>
<td>22</td>
<td>1.97a</td>
<td>1.37b</td>
<td>1.50b</td>
<td>5.266</td>
<td>0.002</td>
</tr>
<tr>
<td>23</td>
<td>3.57a</td>
<td>2.37b</td>
<td>2.69b</td>
<td>5.792</td>
<td>0.001</td>
</tr>
</tbody>
</table>
Appendix E

Mean Republican, Democratic and No Affiliation response for Republican-associated political prompts. A low score represents a higher percentage of participants that “strongly agree” or “agree.” A high score represents a higher percentage of participants that “strongly disagree” or “disagree.” Non-common letter subscripts represent a significant difference.

<table>
<thead>
<tr>
<th>Prompt</th>
<th>Mean Republican Response</th>
<th>Mean Democratic Response</th>
<th>Mean No Affiliation Response</th>
<th>F value</th>
<th>ANOVA p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2.66</td>
<td>2.22</td>
<td>2.37</td>
<td>2.033</td>
<td>0.112</td>
</tr>
<tr>
<td>6</td>
<td>2.34a</td>
<td>3.04b</td>
<td>2.72ab</td>
<td>3.038</td>
<td>0.031</td>
</tr>
<tr>
<td>9</td>
<td>2.77a</td>
<td>3.47b</td>
<td>2.85ab</td>
<td>4.688</td>
<td>0.004</td>
</tr>
<tr>
<td>10</td>
<td>2.07</td>
<td>2.06</td>
<td>2.15</td>
<td>0.215</td>
<td>0.886</td>
</tr>
<tr>
<td>13</td>
<td>2.21</td>
<td>2.28</td>
<td>2.33</td>
<td>0.324</td>
<td>0.808</td>
</tr>
<tr>
<td>14</td>
<td>1.55a</td>
<td>2.62b</td>
<td>2.40b</td>
<td>10.803</td>
<td>0.000</td>
</tr>
<tr>
<td>15</td>
<td>3.34a</td>
<td>4.10b</td>
<td>3.91b</td>
<td>4.024</td>
<td>0.009</td>
</tr>
<tr>
<td>18</td>
<td>3.28</td>
<td>3.55</td>
<td>3.44</td>
<td>0.793</td>
<td>0.500</td>
</tr>
<tr>
<td>19</td>
<td>3.07</td>
<td>2.68</td>
<td>2.82</td>
<td>1.622</td>
<td>0.187</td>
</tr>
<tr>
<td>20</td>
<td>2.43a</td>
<td>3.27b</td>
<td>3.03b</td>
<td>5.096</td>
<td>0.000</td>
</tr>
<tr>
<td>21</td>
<td>1.52a</td>
<td>3.47b</td>
<td>3.03b</td>
<td>30.481</td>
<td>0.000</td>
</tr>
<tr>
<td>24</td>
<td>2.79</td>
<td>2.75</td>
<td>2.56</td>
<td>0.802</td>
<td>0.495</td>
</tr>
<tr>
<td>25</td>
<td>2.96</td>
<td>3.59</td>
<td>3.43</td>
<td>2.350</td>
<td>0.075</td>
</tr>
</tbody>
</table>
Appendix F

Post-hoc student’s t-test performed on prompts which had an ANOVA p-value less than 0.05 based on mean Republican and Democrat response.

<table>
<thead>
<tr>
<th>Prompt</th>
<th>Observed t-test value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>0.015</td>
</tr>
<tr>
<td>4</td>
<td>0.000</td>
</tr>
<tr>
<td>6</td>
<td>0.006</td>
</tr>
<tr>
<td>8</td>
<td>0.000</td>
</tr>
<tr>
<td>9</td>
<td>0.009</td>
</tr>
<tr>
<td>14</td>
<td>0.000</td>
</tr>
<tr>
<td>15</td>
<td>0.006</td>
</tr>
<tr>
<td>17</td>
<td>0.001</td>
</tr>
<tr>
<td>20</td>
<td>0.002</td>
</tr>
<tr>
<td>21</td>
<td>0.000</td>
</tr>
<tr>
<td>22</td>
<td>0.000</td>
</tr>
<tr>
<td>23</td>
<td>0.000</td>
</tr>
</tbody>
</table>
Appendix G

Post-hoc student’s t-test performed on prompts that had an ANOVA p-value less than 0.05 based on mean Republican and No Affiliation response.

<table>
<thead>
<tr>
<th>Prompt</th>
<th>Observed t-test value</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>0.375</td>
</tr>
<tr>
<td>4</td>
<td>0.036</td>
</tr>
<tr>
<td>6</td>
<td>0.089</td>
</tr>
<tr>
<td>8</td>
<td>0.000</td>
</tr>
<tr>
<td>9</td>
<td>0.736</td>
</tr>
<tr>
<td>14</td>
<td>0.000</td>
</tr>
<tr>
<td>15</td>
<td>0.021</td>
</tr>
<tr>
<td>17</td>
<td>0.082</td>
</tr>
<tr>
<td>20</td>
<td>0.001</td>
</tr>
<tr>
<td>21</td>
<td>0.000</td>
</tr>
<tr>
<td>22</td>
<td>0.006</td>
</tr>
<tr>
<td>23</td>
<td>0.003</td>
</tr>
</tbody>
</table>