

What Moves Public Opinion on Health Care? Individual Experiences, System Performance, and Media Framing

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Abstract Although Canadians generally support their health care “model,” dissatisfaction with health care policy and demands for fundamental changes in the system often surface in public opinion surveys. We seek to explain variations in levels of dissatisfaction and demands for health care reform with a series of micro- and macro-level analyses that account for a combination of individual experiences with health care delivery, broader measures of system performance, and media framing. Empirical analyses are guided by a model of opinion on policy that distinguishes between personal and collective, and prospective and retrospective assessments. This view helps make sense of the fact that those who use the system can have generally positive experiences even as there is decreasing confidence in the system’s ability to meet future needs, and increasing demand for reform. What drives these divergent perceptions? We suggest that system performance plays a role in driving the long-term trend, but media content may also be an important driver as well, particularly for collective attitudes.

Although Canadians generally support their health care “model,” dissatisfaction with health care policy and demands for fundamental changes to the system often surface in public opinion surveys. Indeed, surveys reveal an interesting paradox in Canadians’ attitudes toward their health care system. On the one hand, people tend to be satisfied with the level of care they receive, and Canadians remain supportive of the principles of public health insurance—so much so that the system is often hailed as a constitutive part of the country’s identity. On the other hand, growing concerns about the escalating costs of health care and about the system’s ability to answer ever-increasing demands have led many Canadians to question the viability of their system and to call for major changes.

Levels of satisfaction with health policy and demands for reform show some underlying stability, but also considerable variance across individuals and over time. How can we explain this variance? What would such an explanation tell us about the policy process and about the role citizens play in it? A growing body of work makes clear that public policy reacts, at least partly, to public preferences. Understanding the nature and sources of public opinion is important not just for the sake of better health care policy development—it is also a critical part of assessing the nature and quality (indeed, the viability) of representative democracy. This article takes a first step toward exploring shifting public attitudes in a complex policy environment that meshes three interrelated dimensions: individual health care experiences, overall system performance, and media framing of health care issues.

We first provide some context on the role of public opinion in the policy process, discuss a theory of the structure of public attitudes about health care, and outline the characteristics of the Canadian health care system. Our empirical analyses then proceed in several steps. The first analysis outlines and illustrates a model of opinion formation at the individual level. Drawing on a new survey tapping into four different types of evaluations of the health care system, we investigate (1) whether discontent and the resulting calls for major reform are driven by people's concerns for themselves and their families, or by more "societal" concerns (personal vs. collective), and (2) whether discontent and calls for reform are driven by assessments of past or current performance of the system, or expectations about the system's future capacity to deliver on its promises (retrospective vs. prospective). We find that retrospective evaluations, or evaluations of the system's current ability to meet health care needs, are most strongly associated with demands for reform. Prospective evaluations matter as well, however, particularly prospective system-wide evaluations. This is an important finding, since collective evaluations, whether prospective or retrospective, may be particularly susceptible to influence through exposure to mass media.

This observation then leads to several related questions about changes in collective opinion over time. Do prospective evaluations show a different trend over time than retrospective evaluations? What are the relationships between (1) trends in the various personal/collective and retrospective/prospective evaluations and (2) trends in media content, and/or measures of system performance? These questions are explored, albeit tentatively, in subsequent sections. As is the case for economic policy (and many other fields of government activity), we suggest that individuals may obtain a fair amount of information on the state of the system from their own experience and that of those close to them, but they also must rely on the media to form

opinions on policy matters that are beyond the scope of their own experience. This matters to overall system support, as we show. In a concluding section, results are discussed as they pertain to not just health care policy in Canada but health care policy—in fact, public policy more generally—elsewhere, including the United States.

Public Opinion and Health Care Policy

Health Care and the Opinion-Policy Nexus

Although social scientists debate the impact of public opinion on policy, a growing body of work suggests that public opinion on policy issues matters. For example, surveys on social policy issues reveal actual “preferences” rather than “nonattitudes” among the public (see, e.g., Zaller 1992). At the same time, research increasingly shows that the public, in the aggregate, moves in ways that suggest a good deal of rationality. Public attitudes shift over time, in response to real-world factors, as well as to shifts in policy (see, e.g., Page and Shapiro 1992; Erikson, MacKuen, and Stimson 2002; Soroka and Wlezien 2010).

The relationship between opinion and policy is not the same over time, across countries, or across policy domains. The way in which preferences affect policy will depend on a number of factors. In policy areas such as health care, institutions (such as federalism or parliamentary governance) are crucial in translating or channeling public voice through the political system (Maioni 1998). The historical development and institutionalization of existing policies may create their own parameters that can constrain policy makers’ responses, narrowing the range of feasible choices and the extent of change (Tuohy 1999; Hacker 1998). It has been argued that modern welfare states are durable partly because of the expectations raised and popular support enjoyed by universal, or “middle-class,” benefits such as health insurance. As such, politicians may be loath to pay the political price—in opinion polls and at the voting booth—associated with dismantling popular social programs (Pierson 1994).

At the same time, recent work shows a correspondence between public preferences for policy and budgetary policy in the health care domain, in Canada, in the United Kingdom, and in the United States (see, e.g., Soroka and Lim 2003; Wlezien 2004; Soroka and Wlezien 2010). The connection between opinion and policy is not homogeneously powerful, but it does exist—and not just in the year-to-year relationships between preferences and budgetary policy but in the electoral connection as well. Governments can, and often do, win and lose elections based on policy decisions,

including decisions on health care. Through the 1990s and early 2000s, for example, health care was identified as a salient electoral issue—mainly to the benefit of the centrist Liberal Party of Canada—while support for the Canadian model remained strong (Blais et al. 2002). The kinds of dissatisfaction with specific elements of the health care system—funding shortages and waiting times, for example (see Mendelsohn 2002)—did have an impact on the choices the federal government made in health care funding. More recently, health care has remained a top issue for voters even though health reform per se has been less visible as a policy premise (see Soroka 2011 and Soroka and Maioni 2011).

The impact of public opinion on health policy is a well-developed area of study in the American case, in particular with reference to the last two rounds of major reform attempts under the Clinton and Obama administrations. Jacobs and Shapiro (2000), for example, question the notion of public opinion as a guide to policy choices and instead consider how the Clinton administration's overreliance on "crafting" messages about policy choices to sway public opinion backfired as it pushed too far beyond what Americans—and their legislative representatives—were willing to support. Recent analyses of the Obama administration's efforts also reveal that the framing of specific parts of the reform package was crucial in harnessing public opinion (Grande, Gollust, and Asch 2011; Brodie et al. 2010). Also, the work of Blendon and his collaborators on public opinion and US elections—presidential and congressional—shows the two arrows in the picture: how health reform as a policy issue affects public movement in elections and how the electoral results influence the direction and content of health reform (see, e.g., Blendon et al. 2008; Blendon and Benson 2010).

This is all good news, since, after all, representative democracy is supposed to produce a correspondence between public preferences and policy. But knowing that an opinion-policy relationship exists, it seems important to understand the sources of those public preferences. We begin to consider the possibilities, using the Canadian case, below.

The Sources of Public Attitudes on Health Care

There have been relatively few inquiries into the structure of preference formation on health care policy. There are some notable exceptions: Koch (1998), for instance, focuses on elite impact on opinion; he argues that the ideas and arguments of political elites—such as the media, interest groups, and political leaders—can have a great deal of influence in shaping public opinion on issues such as health care, partly because these issues elicit

conflicting responses (e.g., citizens may want access to quality services, but balk at paying higher taxes). In this situation, individuals may be particularly susceptible to elites who seek to shape their opinion in one way or another.

Schlesinger and Lee (1993) focus on the structure of public attitudes on health care in the United States. They argue that health care is different from other social policies because of its more universal implications. Also, because nearly all citizens experience directly the workings of the system, they are more likely to form coherent opinions. As is the case in many other policy areas, Schlesinger and Lee find that ideology and general beliefs about government's role in society are at the core of health policy opinion formation. In the more recent divisive debate on the Obama administration's health care reform agenda, Gelman, Lee, and Ghitza (2010) also find ideology to be a core determinant of opinion formation, with a few policy-specific measures also playing a less prominent role.

There are several existing studies in the Canadian context as well, but opinion formation on health care in Canada, at least nationally, has not been characterized by the same level of partisan and ideological polarization as in the US case. Analyses of the 2008 presidential election and the 2010 midterms in the United States lend support to the existence of a crucial partisan divide—at both the level of legislative positions and mass public opinion (Henderson and Hillygus 2011). In the Canadian case, therefore, in the absence of such clearly delineated polarization, it is possible to observe more directly the impact of policy-specific developments, rather than partisan alignments, on demand for reform or change. Maioni and Martin's (2004) preliminary exploration of Canadians' attitudes toward their health care system suggests that declining confidence in the system is partly a function of a kind of crisis frame in media coverage. Blidook (2008: 358) examines the various sources of public preferences for health care policy, including a combination of "personal experience," "pre-formed opinions," and "information." His work makes clear that opinions on health care have multiple sources. It also shows a significant relationship between media use and negative perceptions of the state of the Canadian health care system.

A Model of Public Opinion on Health Care

The analysis of public attitudes about health care would benefit from distinctions often made in the literature on public opinion on the economy, namely, (1) the distinction between personal and collective attitudes, and (2) the distinction between retrospective and prospective attitudes. (Richardson and Konisky make a similar argument in this issue.)

Collective versus Personal Attitudes

The first follows from the observation that attitudes about a health care system in general are necessarily affected by factors other than one's own personal experience. A question about someone's own interactions with his or her doctor solicits an answer based on personal experience. A question about the system in general solicits an answer based on quite a different set of considerations, almost necessarily not based solely on personal experience. Our thinking here draws partly on a distinction in the political communications literature between what Zucker (1978) calls "obtrusive" and "unobtrusive" issues. In short, the more directly a person experiences an issue, the less open he or she is to media influence on that issue. (See also Ball-Rokeach and DeFleur's [1976] work on media dependency theory.) But we draw more directly on a body of work on "impersonal influence" (Mutz 1992a, 1998): influence on individuals' attitudes that are a consequence of their perceptions of the beliefs or experiences of others.

The concern that people may adjust their own opinions based on information they receive about the opinions of unknown "others" has a long lineage (e.g., Riesman, Glazer, and Denney 1953). Recent work in the field focuses on the capacity of mass media to increase the potential for this kind of "impersonal influence," particularly through the reporting of opinion polls. Media may report on public opinion polls, for instance, and individuals may use the results to help form their own opinions. This is exactly the kind of effect that commentators are concerned about when they discuss a "bandwagon effect" in the context of election campaigns. The dynamic is by no means exclusive to either the campaign context or poll reporting, however. Mutz (1992b) finds, for instance, that media coverage both affects and primes individuals' views of collective perceptions of—rather than personal concerns about—the economy.

We can have both collective (society-level) and personal (individual) perspectives on a number of issues. The economy is a classic example—we have views of both the national economy and our own personal economic situation. (In the economic literature it is typical to use "egotropic" and "sociotropic" to refer to what we call personal and collective attitudes.) But there are also other issues, and policy domains, for which both collective and personal views are both possible and likely. Health care is one example. We can (and do) have views of the health care system generally and of our own personal experience with that system. Existing work on issue obtrusiveness, media dependency, and impersonal influence suggests that media may well affect our view of the system, largely independent of (though certainly alongside) our own personal experiences.

This may be precisely what has been observed in (aggregate) public attitudes about the Canadian health care system. It may be that, even as many individuals have largely positive personal experiences with the health care system, other information—most likely coming from media—suggests to these same individuals that the larger system is in peril. We explore this possibility below.

Retrospective versus Prospective Attitudes

The distinction between retrospective and prospective attitudes may be useful. People have attitudes about the past and the future, and distinguishing between the two may be critical to understanding recent trends in attitudes toward health care. Indeed, this distinction has featured in recent work on health care in Canada, which argues that it is not at all inconsistent for Canadians to be pleased with current levels of care, but concerned about the future viability of the system (Soroka 2011). Prospective and retrospective attitudes can differ; they likely also have somewhat different sources.

Consider a two-by-two matrix in which we might have four different types of attitudes on health care: personal retrospective, personal prospective, collective retrospective, and collective prospective. This fourfold distinction is common in work on economic attitudes (and particularly in work on economic voting; for a survey, see Lewis-Beck and Stegmaier 2000); it has scarcely been considered in other policy domains, however. And what we find most valuable in this fourfold distinction is as follows. Personal retrospective views of health care are likely to be driven almost entirely by personal experience; personal prospective views, however, are likely to include at least a component of systemwide prediction—prediction based on something other than personal experience. In a public system, since individuals cannot know in advance exactly what type or amount of health care services they may require in the future, their perception of the evolution of the system as a whole (or at least in their town or region) is what allows them to judge whether appropriate services will be available to them if needed in the future. Thus prospective attitudes, ego-centric or collective, are likely to be driven almost entirely by external sources, particularly media content, while collective retrospective attitudes likely include a component of personal experience. In short, the past is mostly (but not entirely) about internal experience; the future is mostly (but not entirely) about external information.

What can this model of attitudes do for us in analyses of public attitudes about health care? As we argue below, it offers a way to understand observed differences in survey responses on health care in Canada. It explains why

personal views tend to be driven significantly, but not entirely, by experience, and why collective views tend to be driven significantly but not entirely by media content. It also helps account for the gap between what we have experienced and what we expect to experience. In doing so, it helps us understand the structure of attitudes on health care policy generally, and current calls for health care reform in Canada in particular.

Changes in the Canadian Health Care Model: Reality and Perceptions

Before turning to the structure of public attitudes in Canada, we need to understand the state of health care policy in Canada. The last two or three decades have seen considerable changes both in the Canadian health care system itself and in attitudes about that system. The Canadian health care model has long represented a marriage of convenience—or, for optimists, a successful partnership—between public funding and private delivery of health care services. Provincial governments and their agencies represent the “single-payer” or “single-tap” through which public money flows into the system. Public revenues are used to pay for the operating costs of hospitals and diagnostic testing as well as the reimbursement of physicians, but services are for the most part provided on an individual, “fee-for-service” basis, in which health professionals have a large degree of autonomy. There also exists a parallel range of “supplemental” services not covered by provincial funds—such as dental care and most outpatient drugs—that now account for 30 percent of total spending.

The model can also be seen as a partnership between levels of government. Health care is considered a provincial jurisdiction in terms of the division of powers in Canadian federalism, but the federal government has carved out an important political space within the health sector: initially, through cost-sharing arrangements that offered financial incentives to provincial governments to set up publicly funded hospital and medical care insurance plans; and later, through the passage of the Canada Health Act (1984), which spelled out the “standards” that provinces were to uphold (namely, that provincial health care systems were to be publicly administered, universal and comprehensive in coverage, portable across provinces, and were to guarantee equal access to services on a needs-based criteria) in order to qualify for federal funding.

This model has long been under pressure for at least two different—albeit related—reasons. The first is the unavoidable reality of rising costs in the health care sector, which challenges governments to control spending

in every possible way. The second is the pressure, from interest groups and ideological forces, to consider private and market-based alternatives, inspired partly by the powerful example of Canada's neighbor to the south. In addition, the Canadian health care model has repeatedly been subjected to a barrage of criticism for its inability to contain costs and the lacunae in speedy access to certain services, even as provincial governments had to face the additional constraint of reductions in federal transfers. In the 1990s this situation led most provincial governments to make unpopular decisions, including hospital closures. It also prompted groups in the health care sector to feed a growing perception of crisis and to push relentlessly for solutions or alternative models in line with their interests. Since 2003, health transfers have significantly increased, as has provincial investment in health reform, but the erosion in confidence of Canadians seems to have persisted. In this context, it is not surprising that a substantial proportion of Canadians calls for major reform in the health care system. The question addressed in the next sections is: who calls for major reform and why?

Explaining Individual Dissatisfaction and Calls for Fundamental Change

Among publicly available indicators of dissatisfaction with the health care system and calls for reform, one of the most useful is a question repeated in the Commonwealth Fund's international health surveys on several occasions since 1988 and in several countries. Table 1 shows responses to the following survey question:

- Which of the following statements comes closest to expressing your overall view of the health care system in this country?
 - On the whole the system works pretty well, and only minor changes are necessary
 - There are some good things in our health care system, but fundamental changes are needed
 - Our health system has so much wrong with it that we need to completely rebuild it

Columns show the percentage of respondents giving each response, by year. The summary measure is calculated by weighing responses as 1 for "works well," 0.5 for "some good things," and 0 for "in crisis." The measure thus ranges from 0 (everyone says "in crisis") to 1 (everyone says "works well").

This comparative assessment suggests that Canadians' opinion of their health care system has not quite reached the level of discontent observed

Table 1 Citizens' Views of Their Health Care System (in Percentages of Respondents) in Canada and the United States, 1988–2012

	1988	1998	2001	2007	2010	2012
Canada						
Works well	56	20	21	26	38	29
Some good things	38	56	59	60	51	62
In crisis	5	23	18	12	10	9
<i>Summary Measure</i>	0.75	0.48	0.51	0.56	0.64	0.60
United States						
Works well	10	17	18	16	29	
Some good things	60	46	51	48	41	
In crisis	29	33	28	34	27	
<i>Summary Measure</i>	0.40	0.40	0.44	0.40	0.50	

Question: Which of the following statements comes closest to expressing your overall view of the health-care system in this country?

- On the whole the system works pretty well, and only minor changes are necessary.
- There are some good things in our health care system, but fundamental changes are needed.
- Our health system has so much wrong with it that we need to completely rebuild it.

Sources: Commonwealth Fund n.d.; Innovative Research Group 2012

in the United States. Attitudes about the Canadian situation deteriorated in the 1990s, however, albeit with some recovery in the 2000s. The situation, broadly speaking, is one in which Canadians express fragile and shifting support for their country's health care system. What accounts for these movements?

We take a first step toward answering this question here, by testing a model of opinion formation that includes dispositions (largely embedded in sociodemographic characteristics), retrospective considerations, and prospective considerations. Our dependent variable is the one described above. Because Commonwealth Fund surveys do not include a full account of the four dimensions of opinion formation discussed above, we instead rely on a more recent survey (2012 data in table 1 are drawn from this survey). The survey was fielded as part of the Innovative Research Group's (IRG) Canada 20/20 panel.¹ This more up-to-date survey includes the exact same question used in Commonwealth Fund surveys shown in table 1, alongside questions capturing each of our four types of health care evaluations.

1. IRG is a national survey firm conducting regular surveys both online and through RDD telephone interviews. It has been involved in a series of academic survey projects, including the 2003 Ontario Election Study. Information on the Canada 20/20 panel, a nationally representative online panel, is available at www.innovativeresearch.ca/; and detailed tables on the representativeness of the sample used in this analysis in particular are available upon request from the authors.

Table 2 Descriptives: Four Questions on Health Care

Retrospective Personal		%
We are interested in how you feel about the health care you receive. Thinking about the last five years, would you say that the health care that you and your family have received has been . . . (average: 3.9/5)	Very good	28.5
	Good	42.5
	Fair	21.6
	Poor	4.8
	Very poor	2.6
Prospective Personal		%
And now think about when you and your family might need health care in the future, meaning a few years from now or more. Do you expect that the health care you receive then will be . . . (average: 2.8/5)	Much better	2.1
	Somewhat better	12.2
	About the same	55.5
	Somewhat worse	23.9
	Much worse	6.4
Retrospective Collective		%
Now we'd like to ask about our health care system in general. Thinking about the last five years, would you say that the health care that Canadians in general receive has been . . . (average: 3.5/5)	Very good	10.2
	Good	45.3
	Fair	33.8
	Poor	7.6
	Very poor	3.1
Prospective Collective		%
And what about a few years from now or more? Do you expect that the health care Canadians receive in the future will be . . . (average: 2.8/5)	Much better	2.2
	Somewhat better	14.1
	About the same	49.4
	Somewhat worse	27.3
	Much worse	7.0

Source: Innovative Research Group 2012

Those four questions are listed alongside their respective distributions in table 2. The models we used to elaborate these questions are their economic-conditions equivalents in the University of Michigan Consumer Sentiment Index (MCSI), though there are a few notable differences. One important change is the time horizon in each question. We do not ask about the past or future twelve months, just the past five years or the future, broadly defined. Our objective here is to define periods more likely to include actual use of the system. But there is one critical similarity with the MCSI questions as well: the questions ask very directly about both personal and systemwide assessments, both in the past and looking toward the future.

There are some important differences in the resulting distributions. First, retrospective personal evaluations—those most clearly based on actual

Table 3 Pairwise Correlations between Four Assessments on Health Care

	Retrospective Personal	Prospective Personal	Retrospective Collective
Prospective Personal	0.35		
Retrospective Collective	0.69	0.44	
Prospective Collective	0.31	0.83	0.45

Source: Innovative Research Group 2012

Note: All correlations are significant at $p < 0.001$; $N = 1599$.

experience—are the most positive. Indeed, a vast majority (71 percent) of Canadians believe that the care they have received is either very good or good. Second, prospective evaluations are worse than retrospective evaluations, not just for personal but for collective assessments as well. So while just 7 percent of Canadians believe their own recent care is poor or very poor, 29 percent express some or a great deal of pessimism when considering their future care. And while 11 percent express a negative opinion of the health care Canadians in general have received, 34 percent believe that the care Canadians will receive in the future will deteriorate. In short, Canadians are more likely to express pessimistic views about the future of the health care system than they are to perceive it negatively in retrospect.

Table 3 shows simple bivariate correlations between the four measures. Results make clear that there are relationships between the various health care assessments, to be sure. The two prospective measures show a correlation coefficient of 0.83, and the two retrospective measures show a correlation of 0.69. There are some important differences as well, however, particularly across prospective versus retrospective measures. The relatively weak correlations are striking, we believe, particularly considering the questions were fielded as a single battery, one after the other. The critical point for our purposes below is that these questions do not simply capture the same opinion repeatedly. Like their economic equivalents, these questions appear to capture different assessments of the health care system.²

How do these different assessments matter to demands for reform? Table 4 presents the critical test—a model of the Commonwealth Fund question,

2. Note that (similar to their economic equivalents) our retrospective questions are asked in terms of the quality of care, while prospective questions are asked in terms of expected changes in quality. The different formulation will tend to reduce the correlation between the two sets of measures; but it may also produce a negative correlation between the two, since better health care in the recent past reduces the likelihood of improvement in the future. We do not quite see that negative correlation here. But this is almost certainly part of the reason that we see weak correlations between the retrospective and prospective measures.

Table 4 Ordered Logit Regression Analysis of Dissatisfaction with the Canadian Health Care System

	Model 1	Model 2	Model 3	Model 4
Retrospective Personal (1–5)	.669**** (.053)	.664**** (.055)	.670**** (.056)	.624**** (.051)
Prospective Personal (1–5)	.880 (.106)	.863 (.106)	.882 (.109)	1.494**** (.169)
Retrospective Collective (1–5)	.361**** (.034)	.365**** (.035)	.357**** (.034)	1.113 (.158)
Prospective Collective (1–5)	.780** (.090)	.758** (.089)	.743** (.088)	1.169 (.180)
Retrospective (1–5)				.945 (.068)
Prospective (1–5)				1.153 (.139)
Female (binary)				1.387 (.234)
Age (35–55) (binary)				1.072 (.207)
Age (55+) (binary)				1.039 (.230)
Health status (1–5)				2.810**** (.451)
Private insurance (binary)				.863 (.186)
Region: BC (binary)				1.536**** (.226)
Region: Alberta (binary)				1.007 (.171)
Region: Prairies (binary)				.786 (.120)
Region: Quebec (binary)				.208
Region: Atlantic (binary)				1599
Party: Conservative				
Party: Liberal				
Party: New Democratic Party				
Pseudo R ²	.188	.208	.214	.208
N	1599	1599	1599	1599

Source: Innovative Research Group 2012

Notes: Cells contain odds ratios from an ordered logit model with standard errors in parentheses. Note that odds ratios show the change in the relative odds of the dependent variable being one step higher on the three-point scale; they are read as a ratio of X:1, so that values greater than one reflect a positive effect, and values less than one reflect a negative effect. The residual categories for polytomous variables are as follows: for ages 34 and under; for Ontario; and for Bloc Québécois/Green/other parties.

* $p < 0.10$; ** $p < 0.05$; *** $p < 0.01$; **** $p < 0.001$

as fielded in the IRG survey, as a function of all four assessments alongside some demographic controls. We proceed in a stepwise fashion. A first model includes just the four assessments. A second model adds each of the following: (1) gender, captured using a binary variable equal to one for female; (2) age, captured using dummy variables for those aged thirty-five to fifty-four and fifty-five and over, with under thirty-five as the residual category; and (3) region, captured using a set of binary variables with Ontario as the residual category. Note that we exclude both income and education. In sharp contrast with the situation in the United States, income level has no measurable effect on our dependent variable, in any permutation of the model. It was omitted in the tests presented here, alongside education, which also contributed nothing to the model, and which because of data limitations reduced the available sample by 20 percent. We do include both health status, scaled from 1 to 5, and a binary variable capturing whether respondents are covered by supplementary private insurance.³

A third model adds current partisanship. A good argument can be made that preexisting ideological beliefs will structure attitudes about health care. Partisanship is one relatively simple way to capture those beliefs. (It may also capture the “political” portion of health care system assessments, i.e., the extent to which assessments, both retrospective and prospective, are a product of attitudes about the current government. But note that our objective here is not to assess the contents of partisanship but to include partisanship as a control as we examine the impact of retrospective and prospective assessments.) Finally, in a fourth model we revise the assessments variables—we combine the two prospective measures and the two retrospective measures. (We sum the measures and then divide by two so that the index has the same range.) The prospective measures in particular are highly correlated, as we have seen (table 3). Combining them may reduce collinearity in the regression models and may consequently reveal more robust effects.

Since the dependent variable has three ordered categories, we use an ordered logit regression method to test our model. Table 4 consequently shows odds ratios and their associated standard errors. (An identical model estimated using OLS regression is included in the appendix. The table confirms that our results are robust to change in estimation procedure.) As it turns out, adding demographics and partisanship (from model 1 through

3. Health status is based on the following question: “Compared to others your age, how would you describe your overall state of health these days? Would you say your health is very good, good, fair, poor, or very poor?” Insurance is based on, “In addition to government funded health services, are you currently covered by any supplementary private health insurance that you or a member of your family pays for or that an employer or association provides? Yes/No.”

model 3) makes little difference to the coefficients we are most interested in. We accordingly do not interpret those controls in any detail here. Instead, we focus on one question: which of the various assessments of health care matter to opinions about system reform?

Note that the dependent variable is dissatisfaction, so that scores move upward from “works well” to “in crisis.” Each of our four health care assessment variables is measured using a similar five-point scale (and scaled in these models from 1 to 5), so the resulting odds ratios are fairly easy to compare. As we would expect, positive assessments are negatively related to dissatisfaction. The assessment most closely linked with demand for reform is the retrospective collective one, the odds ratio for which implies that a one-unit increase in retrospective collective assessments is associated with a 65 percent decrease in the likelihood of being one category higher where attitudes about the need for reform are concerned. (Given that the assessments questions are scaled from 1 to 5, this implies a massive shift in system support for a move across the entire range of collective assessments.)

Retrospective personal assessments are also linked to system support, though the impact of a one-unit shift is lower. Here the odds ratio suggests a 30 percent decrease in the likelihood of being one category higher on the dependent variable given a one-unit increase in retrospective personal assessments. The coefficients for prospective assessments are smaller still. Prospective collective evaluations do matter—a one-unit increase is associated with a 22 percent downward shift in the likelihood of being one unit higher on the dissatisfaction variable. The coefficient for prospective personal evaluations is correctly signed, but insignificant in models 1 through 3. Model 4, which combines the (1) prospective and (2) retrospective measures, reveals robust effects for both. The impact of a shift in retrospective evaluations in this case is especially strong (though note that a one-unit shift in this case implies a one-unit drop in each of the two variables, or a two-unit shift in one of them). The impact of a shift in prospective evaluations is highly significant, but roughly half the size. In the end, then, results point toward the particular importance of retrospective and/or collective evaluations.

Our analyses lead to a number of tentative conclusions. First, they point to the importance of the citizen’s own experience in triggering demands for political change. This has particularly interesting implications for the United States: even if there is a strong sense of societal urgency about the need for reform, individual satisfaction with the quality and availability of care may be a powerful obstacle to any reform effort (see, e.g., Blendon et al. 2002; Pauly 2004). Second, collective evaluations, particularly retrospective ones, seem to matter a great deal.

The fact that the collective variable is more strongly related to (dis)satisfaction with the system as a whole (and demands for reform) than is any other measure based on presumed needs (age, health status) or direct experience with the system is, we believe, the key finding from this analysis. A significant part of what drives people to demand reform, or radical reform, of the health care system is based on information about a system that lies beyond the scope of their own experience. This finding quite clearly matters to our understanding of policy attitudes, not just for health care but for other domains as well. In forming these attitudes, citizens invariably rely on various (external) sources of information. We suspect that this is particularly true for prospective collective attitudes, where citizens must not just think about the experience of others but the experience of others in the future. The result is that policy preferences are driven not just by experience with the system but by other things as well, quite likely including media content. We explore this possibility, in a preliminary way, in the following section.

Real-World Indicators, Public Opinion, and Media Content over Time

What is the relationship between public attitudes toward health care, actual health care indicators, and media content? An answer to this question would be a valuable addition to our argument that collective assessments are necessarily driven more by external sources, and particularly media content, than by personal experience. What we really need, then, are either (1) individual-level data with the questions discussed above, alongside detailed information about both the amount and quality of health care system use, and detailed information about media exposure, or (2) long-term aggregate-level trends in both prospective and retrospective, collective and personal, attitudes toward the Canadian health care system, alongside measures of health care system performance and media content.

Unfortunately, most of these data are not currently available. Individual-level data with all the required variables do not exist (at least to our knowledge). And aggregate-level data are not available for each of our four types of assessments, over an extended period of time. While preceding analyses have illustrated the value of distinguishing between the four types of assessments, and while they point toward the possibility that system support is driven as much by “impersonal influence” as by actual experience with the system, we are currently deeply constrained in our ability to examine this possibility over time.

Nevertheless, some useful opinion data do exist, and while the sample size is not large enough to allow for detailed time-series analysis, comparing

trends across graphics is strongly suggestive—suggestive, that is, of the possibility that different types of assessments have quite different sources.

Our focus here is on the difference between trends in retrospective versus prospective evaluations of the system, across both personal and collective dimensions. The data are laid out in figures 1 and 2. There are some weaknesses in these data, to be sure—some questions do not perfectly capture the dimension (personal versus collective, or retrospective versus prospective) to which we wish to attach them here. That said, most come very close, and as we shall show, it is a rather basic difference in the aggregate trends that is the issue here.

Figure 1 shows results from three questions captured over time in Ipsos Reid national health care surveys. Each deals with personal attitudes; two focus on retrospective evaluations, and one on prospective evaluations.⁴ In each case, we subtract the proportion expressing concern or opposition to the existing system from the percentage expressing a favorable or supportive opinion about that system, to get a single index value that summarizes the general trend in responses.

Note that because question wording and response categories vary considerably, we cannot compare the levels of the “index value” across the three questions. What we wish to highlight here is the difference in trends over time, however. And here we see quite a marked difference. Retrospective evaluations dip ever so slightly in the mid-2000s, but if anything the trend here is a small increase over the ten years. Prospective evaluations move in the opposite direction, from mainly positive to mainly negative evaluations. That is, even as retrospective evaluations are improving, prospective expectations are worsening.

The same is true for collective evaluations, shown in figure 2. Again, three measures are available, this time one for retrospective attitudes (from Strategic Counsel surveys) and two for prospective attitudes (from Ipsos Reid surveys). The retrospective measure shows a similar trend to the retrospective personal measures in figure 1, albeit with somewhat more variance over time. Again, there is a dip in the mid-2000s, but the overall trend over the period is upward. And just as with personal attitudes, the trend in prospective collective attitudes is the opposite. These questions capture the perceived viability of the system more than prospective evaluations of care, admittedly—we regard these as the weakest of our aggregate-level measures, that is, the ones that match most poorly with the

4. Question wording is included in the figures themselves, alongside the coding of the variables. (Note that the first two questions are from a “health care report card” in which respondents give grades of A, B, C, or F.)

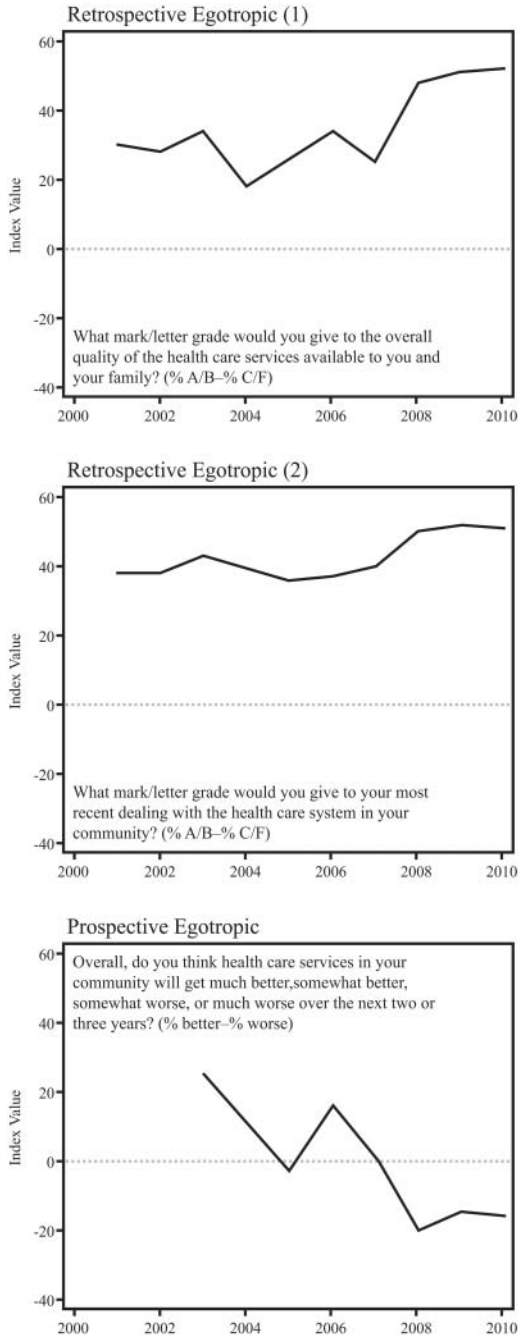


Figure 1 Personal Evaluations over Time

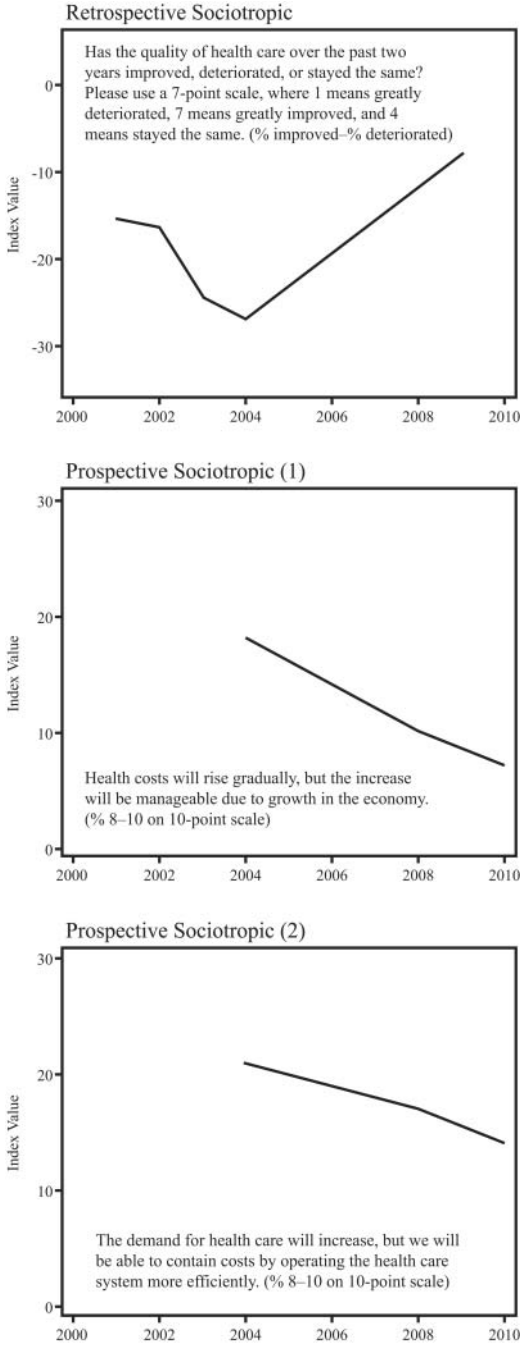


Figure 2 Collective Evaluations over Time

individual-level discussed in the preceding section. Even so, we believe the trend is illustrative of the larger issue we wish to focus on here, namely, the completely different evolution of prospective versus retrospective evaluations of the Canadian health care system.

Individual-level data analyses in the preceding section have already made clear that evaluations vary across each of the four categories examined here. That is, individuals often have prospective/retrospective, personal/collective evaluations that do not match. Aggregate-level data reveal quite different trends in attitudes over time as well, where the central difference seems to be between retrospective evaluations and prospective evaluations.

Under what conditions would we observe declining prospective attitudes but not declining, even improving, retrospective attitudes? One possibility is that individuals' health care experiences are still largely positive, but they see cracks in the system (or, all too often, cracks in the hospital walls, literally), and start to believe that the system is in decline—even despite continuing, largely positive experiences. Another is that retrospective perceptions and prospective perceptions have somewhat different sources. Retrospective attitudes are based more on personal experience; prospective attitudes are not.

Or, at least, prospective attitudes are driven more by something other than personal experience. One likely culprit is media content. The relatively short time-series data illustrated in figures 1 and 2 preclude a serious econometric analysis. Even so, it is possible to compare trends in those figures with some simple content-analysis data. To do so, we draw on an existing database of newspaper content on health care issues in Canada. The data are described in detail in Soroka 2011. Here we use two simple measures.

We begin by focusing just on content in the *Toronto Star*, the daily newspaper in Canada with the largest circulation, one known to be consistently center and center-left in its editorial positions, and the one for which reliable full-text data are available since 1990.⁵ We subtract out all content on fitness-related issues, as well as content on specific diseases (e.g., cancer, mental illness).⁶ Of the remaining 36,975 articles, we capture the number of times the term *wait lists* (and various derivatives) is mentioned in articles, and the number of times *crisis* is mentioned in articles. Figure 3 shows the results—annual averages of the proportion of words in an article that focus on wait lists or on crisis.

5. We also have data for the *Globe and Mail* back to 1990, though there are some gaps in the mid-1990s. For this reason, we focus only on the *Toronto Star* here. But results using the *Globe and Mail*, for the period for which data from both papers are available, are largely consistent with results in the *Star*. Results are available upon request.

6. The method by which this is done is described in Soroka 2011.

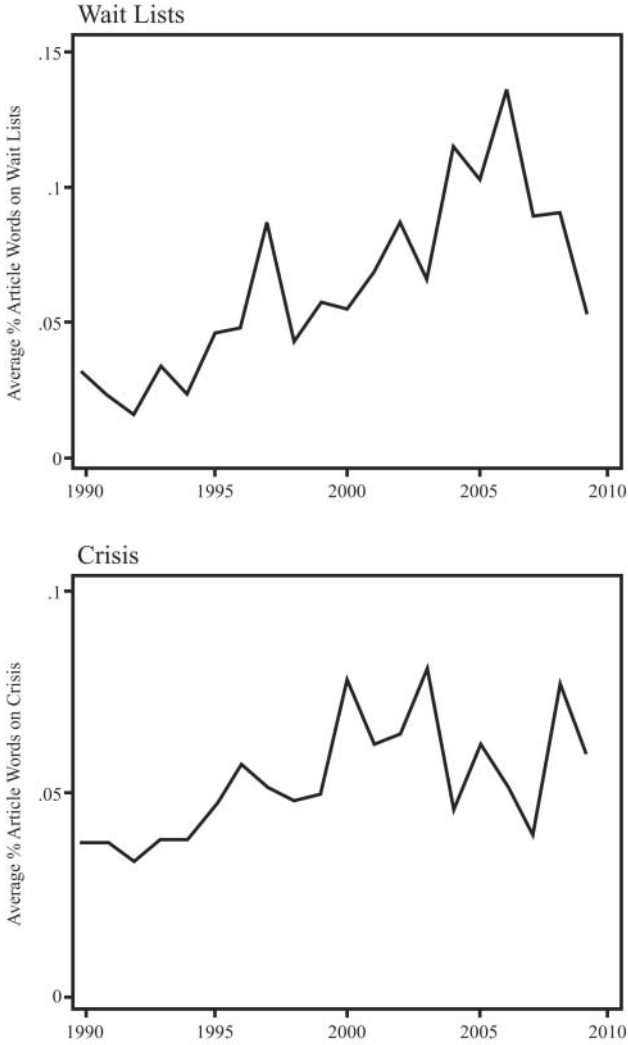


Figure 3 Media Coverage of Health Care

This is a relatively thin content analysis, to be sure, but the results are striking. In short, there is a clear increase in the proportion of content focused on wait lists and crisis. There are some year-to-year fluctuations, but the post-2000 equilibrium is clearly different (worse) than the pre-2000 equilibrium. Like our measures of prospective attitudes, media content worsens over the last fifteen years.

This is, at best, tangential evidence that prospective attitudes are more driven by media content than retrospective attitudes; indeed, there is no statistical demonstration that prospective attitudes are driven by media here at all.⁷ Even so, given differences in retrospective and prospective evaluations, a role for media content in the opinion-policy nexus seems likely. And even if proving the connection between media content and prospective attitudes must wait for a larger body of data, the fact that there are systematic differences both at the individual level cross-sectionally and at the aggregate level over time, between personal/collective and retrospective/prospective evaluations of health care, stands as evidence of the benefits of using this fourfold distinction to better understand public opinion on health care (and likely on other policy domains as well).

Discussion and Conclusions

Declining prospective evaluations of the health care system have important implications for future health care policies. Figure 4 is a case in point—it shows trends in a Strategic Counsel question, “Individuals should be allowed to pay extra to get quicker access to health care services.” Increased interest in for-pay services is very clear here. Declining confidence in the Canadian health care system is, it appears, coincident with increasing support for alternative systems.⁸

It follows that understanding the structure of public attitudes toward health care policy is important—important to our understanding of how (or the extent to which) representative democracy works, and important also to our understanding of future (and past) changes in health care policy.⁹ We have argued here that attitudes about health care policy, and indeed attitudes on a wide range of domestic policies, can be better understood if we distinguish between components that are personal and collective, retrospective and prospective. Recognizing these different components—and the different drivers of each—helps us better understand the apparent

7. In fact, we cannot easily tell if media discussions of crisis focus on measures of performance or on the state of public opinion on health care. There may thus be some endogeneity in the relationship between media and opinion measures—media may be reflecting rather than driving public opinion. Of course, it is likely that they are doing both.

8. This is true at the individual level as well. See, e.g., Soroka 2007; and Soroka and Fournier 2011.

9. This is true not just for the general system-level variables explored in detail above but also for more policy-specific variables such as the one in figure 4—policy change can be driven by a range of attitudes, of course, both general and specific. Indeed, a complete understanding of policy change as a function of public opinion requires in most instances a consideration of other attitudes as well, i.e., confidence in government. Our aim here has not been to fully account for health care attitudes, however, but to make clear the advantages of distinguishing between personal and collective, and retrospective and prospective, assessment.

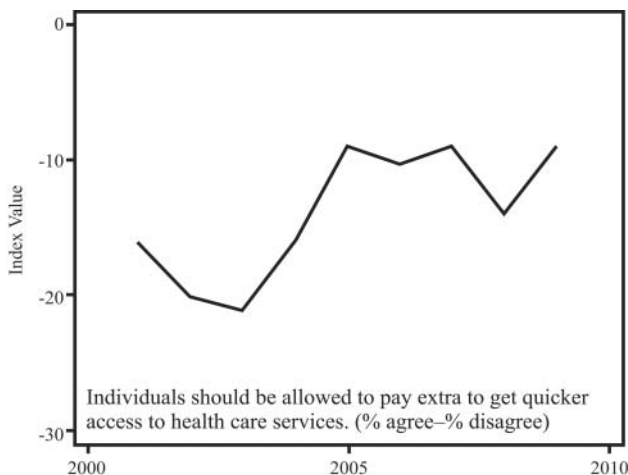


Figure 4 Willingness to Pay for Access over Time

disjuncture between citizens' opinions about their own health care experience and their opinions about the system generally.

Where the Canadian case is concerned, there is no question that persistent concerns about the financial sustainability of public health plans and the perceived shortcomings of access to certain services have left Canadians both anxious and wary about the future of their health care "model." Concerns about access and cost are not particular to the Canadian situation, of course—if anything, they are even more acute in the US context. But in Canada, the drivers of change tend to be different. Here public opinion is being shaped less by past negative experiences or crippling cost concerns on an individual basis than by a larger conversation about what the future holds, and whether alternative delivery or financing arrangements could lead to better system performance (Mendelsohn 2002; Abelson et al. 2004). While federal and provincial governments have increased health spending over the past decade, the economic impact of the recent recession and the way in which health care spending choices are being framed as "crowding out" other social services mean that the political debate about health care reform is far from over.¹⁰

10. For a description of the debate, see Simpson 2012; also see Landon et al. 2006, though note that these authors test and find no evidence for the popular "crowding out" hypothesis. Note as well that this focus on costs in the current debate is somewhat different from the focus of our prospective questions, which deal with the system generally (i.e., not costs in particular). One consequence is that we may actually understate the importance of prospective evaluations. There is in all likelihood an especially strong relationship between prospective views of costs and systemwide evaluations.

We regard media content as one likely driver of the widening gap between retrospective and prospective attitudes, and given that both matter in individual models of system support, that makes mass media a particularly interesting, and potentially powerful, actor in the health care policy process. Whether this is a good or bad thing is unclear, of course. We have talked little above about the actual state of health care in Canada, and most of the existing evidence points toward a system under a great deal of stress. Looking across a range of measures in system quality, from the number of doctors, nurses, and hospital beds per capita to discharge rates and recalled waiting times, suggests that the Canadian health system is in need of some revision.¹¹ That these data have had no discernible effect on (largely static) retrospective evaluations of the system raises some questions about the relevance of the indicators, admittedly. But the possibility exists that what we believe is the impact of media reporting on prospective attitudes is a product of media content that accurately reflects reality. At this point, we cannot make this determination with certainty. We can, however, observe that there is a media impact. Whether this is a good or a bad thing, from the policy point of view, is another question altogether.

There clearly is more work to be done. In particular, we have been constrained by a lack of data capturing each of the four components of health care attitudes over time. New, continuous survey work may be able to capture each of the personal and collective, retrospective and prospective attitudes toward health care policy, however, and that clearly would be a valuable step toward understanding the structure of attitudes on health care, in Canada and elsewhere.

11. Our assessment here is based on an analysis of the following indicators of system quality: (1) per capita number of doctors, (2) per capita number of nurses, (3) per capita total hospital beds, (4) per capita curative acute care beds, (5) per capita discharge rates (all causes), and (6) recalled wait times. The first five measures are available in the OECD Health Data database. The latter is from Fraser Institute waiting list surveys (fraserinstitute.org). The trend in per capita number of doctors in Canada is relatively flat over the past twenty years; all other series have been in a state of steady decline. And while this trend may be a consequence of decreases in spending in the mid-1990s, it is still apparent despite large increases in spending in the early 2000s.

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Appendix Table 1 OLS Regression Analysis of Dissatisfaction with the Canadian Health Care System

	Model 1	Model 2	Model 3	Model 4
Retrospective Personal (1–5)	-.091*** (.018)	-.091*** (.018)	-.088*** (.018)	-.088*** (.018)
Prospective Personal (1–5)	-.037 (.028)	-.039 (.027)	-.035 (.027)	-.035 (.027)
Retrospective Collective (1–5)	-.230*** (.020)	-.219*** (.020)	-.221*** (.020)	-.221*** (.020)
Prospective Collective (1–5)	-.050 (.026)	-.056** (.026)	-.059** (.026)	-.059** (.026)
Retrospective (1–5)				-.299*** (.017)
Prospective (1–5)				-.105*** (.018)
Female (binary)				.089*** (.026)
Age (35–55) (binary)		.074*** (.026)	.083*** (.026)	.083*** (.026)
Age (55+) (binary)		.030 (.032)	.023 (.032)	.025 (.032)
Health status (1–5)		.037 (.035)	.024 (.035)	.032 (.035)
Private insurance (binary)		-.012 (.016)	-.011 (.016)	-.015 (.016)
Region: BC (binary)		.033 (.027)	.025 (.027)	.030 (.027)
Region: Alberta (binary)		.074** (.038)	.075** (.038)	.080** (.038)
Region: Prairies (binary)		.038 (.043)	.019 (.043)	.020 (.044)
Region: Quebec (binary)		.001 (.051)	.013 (.051)	.002 (.051)
Region: Atlantic (binary)		.206*** (.035)	.224*** (.035)	.222*** (.035)
Party: Conservative		-.039 (.050)	-.036 (.050)	-.036 (.050)
Party: Liberal			.095*** (.033)	.094*** (.033)
Party: New Democratic Party			.002 (.039)	.002 (.039)
Constant	3.196*** (.060)	3.069*** (.089)	3.046*** (.090)	3.064*** (.091)
R ²	.279	.303	.311	.304
N	1599	1599	1599	1599

Note: Cells contain coefficients from an OLS regression model with standard errors in parentheses. The residual categories for polytomous variables are as follows: for ages 34 and under; for region, Ontario; for party, BQ/Green/other.
* $p < 0.10$; ** $p < 0.05$; *** $p < 0.01$; **** $p < 0.001$