Race and the Politics of Welfare Reform
Sanford F. Schram, Joe Soss, and Richard C. Fording, Editors
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CHAPTER 11

Race/Ethnicity and Referenda on Redistributive Health Care Policy

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As the preceding chapters have shown, racial and ethnic diversity has played a significant role in shaping welfare policy outcomes. Despite the importance of this research, the existing literature is limited in two important ways. First, past research on race and welfare policy has focused almost exclusively on a cash assistance program—Aid to Families with Dependent Children (now Temporary Assistance for Needy Families). Based on the individual-level evidence (Gilens 1999; Peffley and Hurwitz 1998), we might expect whites to view the targets of any redistributive policy—not just cash assistance—as less deserving if they are minority (black or Latino). Thus, we are left to ask if the significance of race in explaining welfare policy outcomes extends to in-kind as well as cash assistance programs.

A second limitation concerns the fact that most of the literature on welfare reform and welfare retrenchment focuses on legislative action or bureaucratic disentitlement. Over the last two decades, however, direct democracy elections (ballot initiatives and referenda) have become increasingly important for social welfare outcomes in the states—especially outcomes that have direct effects on racial and ethnic minorities. To better understand the politics of welfare reform, and possibly what to anticipate in the future in some states, we therefore need to pay attention

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to how citizens have behaved when presented with opportunities to exercise direct control over social policy.

In this chapter, we address both of these questions. As is well known, there are vast disparities in access to health care in the United States. In addition, access to health care is distributed unequally among rich and poor, and among racial and ethnic groups. Insofar as the beneficiaries of health policy might be perceived as disproportionately minority, we might expect whites to be less supportive of policies that extend health care coverage to the poor. To investigate this question, we examine racial voting patterns on Proposition 186 in California, which would have expanded health care access for the poor by establishing a universal health care system. Section 1 discusses the increasing importance of direct democracy in state policy-making, and their relationship to race/ethnicity and social policy. Section 2 documents the growing trend of placing questions of health care policy and financing on statewide election ballots, describes current inequities in access to health care in the United States, and provides an overview of the arguments for and against a California citizen initiative (Proposition 186, 1994) that would have created a universal health care system for the state. Section 3 provides an empirical analysis of racial voting patterns on the ballot proposition.

Direct Democracy in the States

Twenty-four states provide for the initiative process, allowing groups outside of the legislature to petition to place policy on the statewide election ballot for a popular vote. If adopted by a majority of voters in the election, the initiative changes either statutory or constitutional law (Magleby 1984). In the referenda (popular or legislative), in contrast, voters can only respond to policy formulated by the state legislature. The appendix lists the initiative states by type.

The initiative process, or the threat of a pending or circulating initiative, is often necessary to translate citizen preferences into policy when state legislatures or bureaucratic agencies are unwilling or unable to act. The process has been used to adopt policies resisted by elected officials, corporate or economic interests, and established political parties, but supported by a majority of the public. Thus, it is not surprising that state legislatures under direct legislation threats have been found to be more likely to adopt the proposed legislation (Gerber 1996, 1999).

California historically has been a leader in the use of the initiative

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process and was the first state in the nation to adopt many new policies at the ballot box. Since California adopted the process in 1911, it ranks second only to Oregon in the number of initiatives placed on the ballot over the past century (Tolbert, Lowenstein, and Donovan 1998). Since 1978, the year California voters adopted tax limitation Proposition 13, use of direct democracy has increased dramatically. More than any other state, California has shifted in favor of direct democracy over other forms of governance. Some of the state's most important decisions—on taxes, education, social policy, immigration, affirmative action, campaign finance reform, environmental protection—have been the subject of statewide referenda votes (Schrag 1998). The expanding role of the initiative process in California is also reflected in initiative spending, which climbed from $9 million in 1976 to $127 million in 1988 to $140 million in 1996 (Gerber 1998).

Most state provisions for the initiative process were adopted during the Progressive Era (Schmidt 1989). Progressive Era policies adopted in some states by initiatives and referenda included the eight-hour workday for women, child labor laws, prohibition, mothers' pensions, women's suffrage, environmental legislation, and regulation of the railroads (Schmidt 1989). In the late twentieth century, the process has been used to adopt progressive policies such as major conservation measures, protection of open space, campaign finance reforms, and the legalization of marijuana for medical purposes, as well as conservative policies such as ending government affirmative action, curtailing reproductive rights, limiting taxation, and enacting term limits. The use of ballot initiatives for health care reform at the turn of the twenty-first century is consistent with early usage of the process during the Progressive Era.

Direct Democracy, Racial and Ethnic Diversity, and Social Policy

Direct democracy elections provide an ideal context for measuring citizen policy preference, as well as racial and ethnic voting. In California, the policy preferences of the dominant white electorate are sometimes at odds with the state's growing racial and ethnic groups. Over the past two decades, initiatives and referenda have shaped California's social policies and governmental structures, some with direct and others with indirect consequences for the state's ethnic populations (Schrag 1998). In 1986, California voters adopted an initiative declaring English as the state's official language. In 1994 California voters adopted Proposition 187, which denied social services, including welfare benefits, to illegal immi-

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grants (primarily Latinos and Asians) and their children. Two years later, voters adopted Proposition 209, which prohibits race- or gender-based affirmative action in public employment, contracting, and education. In 1998, voters adopted Proposition 227, which eliminated bilingual education in public schools. Surveys indicate that a majority of whites supported each policy, while a majority of racial and ethnic minorities opposed them (Tolbert and Hero 2001).

Other California ballot measures overturning the state's fair housing laws that prohibited discrimination by race in rental housing (Proposition 14, 1964), restricting new public housing projects (Proposition 15, 1974), prohibiting school busing on the basis or race/ethnicity (1972), or curbing welfare benefits (Proposition 165, 1992) have direct effects on racial and ethnic minorities, as do initiatives increasing penalties for repeat criminal offenders (Proposition 184, 1994) or gang-related activities (Proposition 21, 2000).

Clearly, direct democracy elections have important policy implications for minority groups. A number of recent studies attempt to estimate the effects of initiatives and referendums on the rights of racial and ethnic minorities. Some scholars (Gamble 1997; Cain 1992) suggest that minorities fare poorly in direct democracy elections, as voters have effectively used the process to undo protections and social policy benefits for minorities passed by state legislatures. Others (Donovan and Bowler 1998; Frey and Goette 1998) conclude that the detrimental effects on minorities are more limited, and that civil rights and policy benefits are more vulnerable in local referenda elections than statewide elections where the scope of conflict is broader.

A whole range of policy issues that are not obviously oriented toward racial and ethnic minorities—including education policy, fiscal policy, criminal justice policy, and of course social welfare policy—nonetheless have important implications for them. California's famous property tax limitation initiative (Proposition 13, 1979) may have had the greatest effect on the well-being of racial and ethnic minorities by dramatically lowering the ability of local jurisdictions to provide a variety of public services (Schrag 1998). Of the six million children in California public schools in 2000, barely two million (35 percent) are white, making education policy a priority for racial and ethnic groups (Baldassare 2000). California ballot initiatives in the 1990s have proposed statewide school vouchers, reductions in class sizes for primary schools, and increased spending for public schools.

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Racial cleavages may occur even when ostensibly "race neutral" policies, such as health care, education, and fiscal policy, are at issue. A recent study provides evidence of a racial and ethnic divide concerning a range of public policies decided via ballot propositions in California over the period 1980 through 1998 (Hajnal, Gerber, and Louch 2002). Unlike previous studies examining voting patterns on one or a few highly controversial ballot contests, the research examines outcomes across the entire array of issues addressed through direct democracy (47 propositions) in California since 1980 using 15 different *Los Angeles Times* polls. Hajnal, Gerber, and Louch (2002) explore the probability that racial and ethnic minorities will be on the winning side in initiative and referenda elections. Their analysis provides evidence that Latinos, blacks, and Asian Americans are more likely than whites to be on the losing side on minority-targeted initiatives, but not in initiative elections overall. Latinos, however, are more likely to be on the losing side, even when the subject of ballot propositions cover issues that are most important to them, and even when they vote cohesively.

We have good reason to be interested in how voters respond to health reform ballot initiatives, even those that fail. Recent research suggests voters are capable of making rational decisions in direct democracy elections, even with limited information (Bowler and Donovan 1998). Voters can make decisions consistent with their policy preferences in initiative and referenda elections by relying on simple voter cues—political party, interest group, and media endorsements or opposition (Lupia 1994). Voter pamphlets distributed by the secretary of state providing arguments for and against each ballot measure are the most often cited sources of information. Analyzing voting in referenda elections on real policy questions also avoids many of the limitations of survey data to study racial attitudes (Sniderman and Carmines 1997).

Direct democracy elections thus provide an ideal forum for studying instrumental or self-interested voting among white and nonwhite racial and ethnic groups in the area of redistributive policy. Redistributive policies involve efforts by the government to shift the allocation of wealth, income, property, or rights among broad classes or groups of the population, often involving economic groups such as the haves and have-nots (Lowi 1964). Policies with a redistributive influence include the graduated income tax, health care programs, and welfare programs. High levels of conflict characterize these policies. They confer benefits to narrowly defined groups, with dispersed costs to society (taxes paid by the general

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population). When redistributive health care policy is the subject of statewide referenda, we might expect cohesive racial and ethnic voting, if the minority is likely to be winner and the majority the loser.

Health Reform Ballot Initiatives

President Clinton's 1994 failed effort at health care reform suggested to some commentators that the public was apathetic on the issue. Nonetheless, 46 million uninsured Americans, widespread discontent with managed care, and the ongoing problems of funding and delivering care under Medicaid and Medicare continue to keep health care reform on the political agenda. A recent CBS poll, for example, found a majority of those surveyed said the "problem of the uninsured" is the "biggest health care problem" facing the nation (Guiden 1999). A *Washington Post* poll in 2000 reported that 72 percent of those surveyed believed the "federal government should work to increase the number of Americans covered by health insurance" (Roper Center Online Poll 2000, Accession number: 0374367, Question number: 045). Indeed the political landscape itself may be changing. Once a chief opponent of national health insurance, seven prestigious physicians' groups, including the American Medical Association, promoted a grassroots campaign to make universal health care coverage a priority in the 2000 presidential elections.

Since health is important to every individual, we might expect a high level of citizen involvement. Ironically, health care policy decision making in this county is more often than not characterized by very little direct citizen participation. The process is quasi corporatist (Leichter 1996) in form, involving information negotiations among key health care stakeholders, such as the insurance industry and physicians groups, and the elected officials dependent on the campaign contributions of these same stakeholders. There are signs, however, that things may be changing. Citizens and professional organizations (health care providers) in several states are using ballot initiatives as a vehicle for placing health care reform on the political agenda. Although largely unsuccessful to date, these initiatives hold the promise of granting the public a larger voice in determining health care policy.

In the 1990s questions of health policy and financing were placed before voters in California, Washington, and Oregon. Although the initiatives involving changes in health care financing were for the most part

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unsuccessful, some of the other health policy initiatives succeeded, California voters, for example, defeated two citizen initiatives, Proposition 166 in 1992 and Proposition 186 in 1994 (the subject of this chapter), that, had they been adopted, would have created a universal health care system for the state. Then again, in 1999 voters in one hundred communities in Illinois overwhelmingly approved an advisory referendum requiring the state to provide health coverage to all residents. As a result, a state constitutional amendment is pending that would require the state to enact a plan for universal coverage.

High-profile constitutional amendments on the ballot in Oregon in 1996 and 1998 legalized physician-assisted suicide. Ballot measures legalizing the medical use of marijuana have been adopted in a dozen states since California voters first approved of this policy in 1996. Failed ballot propositions in Oregon and Washington (1998) would have allowed individuals direct access not only to medical doctors but also to osteopathic doctors, chiropractors, naturopaths, and nurse practitioners. An Oregon measure (1998) would have mandated comprehensive reform of managed care companies. Two 1996 California propositions sponsored by organized labor and the California Nurses Association would have regulated health maintenance organizations (HMOs). Both propositions were eventually defeated. However, under the threat of these initiatives, the California legislature introduced twenty-seven bills (which were later defeated) regulating HMOs (cf. Gerber 1996). In 2000, Arizona voters approved an initiative to allocate tobacco litigation settlement proceeds to finance specified health care benefits for the poor and elderly. Also in the 2000 elections, Massachusetts voters narrowly—by three percentage points—defeated a citizen initiative, Question 5, that would have created a universal health care system for the state (Tolbert and Steuernagel 2001).

Race, Ethnicity, and Health Care Access

In addition to institutional mechanisms for direct democracy, racial and ethnic context has been shown to be important in shaping public policy at the state level, particularly in the areas of health, education, and welfare (Hero 1998). Empirical analysis based on fifty-state data suggests racial minorities tend to fare poorly in terms of social policy outcomes in bifurcated and homogeneous racial/ethnic contexts, relative to minorities living in heterogeneous contexts, with large white ethnic populations (Hero 1998).

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California has been characterized as having a bifurcated social structure with a large minority (primarily Latino) population and a large white (nonethnic) population (Tolbert and Hero 1996). As the nation's most ethnically diverse state, growing racial and ethnic diversity is a defining feature of California politics. In 2000 California become the first 'majority-minority" state, in which racial and ethnic minority groups now outnumber non-Hispanic whites (Baldassare 2000). Projections by the U.S. Census Bureau indicate that by the year 2025 whites will comprise just 30 percent of the state's population (Johnson 1999).

California politics is also characterized by a mismatch between the composition of the voting electorate and the population. While racial and ethnic minorities comprise roughly half of California's population, the electorate is still largely white. In 1996 whites represented only 53 percent of the population but accounted for 88 percent of registered voters. In contrast, the nonwhite registered voters were 11 percent Latino, 5 percent black, and 4 percent Asian (Chavez 1998). In 2000, whites represented less than 50 percent of the state's population, but comprised 68 percent of the electorate, while Latinos represented only 19 percent, and blacks and Asian Americans followed with 6 and 7 percent respectively (Baldassare 2000). The electorate exaggerates the power of white voters, and thus elections (especially initiative elections) may be a critical mechanism for white voters to exert their policy preferences over minority groups in a number of policy areas, including health care (Tolbert and Hero 2001).

Given existing disparities in access to health care, we would expect racial and ethnic minorities to be more supportive of expanded government health care provisions than whites. There are vast disparities in access to health care in the United States by race and ethnicity. Among whites in 1999, 11 percent lacked health insurance, compared to 21 percent of African Americans, 21 percent of Asians, and 33 percent of Hispanics (U.S. Department of Health and Human Services 2000). This translates directly into higher infant mortality, lower life expectancy, and lower immunization rates. The health status outcomes or disease statistics by race/ethnicity in the United States are highly correlated with uninsured rates (U.S. Department of Health and Human Services 2000). In no state are the disparities in access to health care more evident than in California. In 1994–95, 15.5 percent of nonelderly Americans in the United States, or over 40 million people, were without health insurance (Liska, Brennan, and Bruen 1998). In California, a staggering 19.7 percent of the population is uninsured. Overall 5.56 million of California's 28 million

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people are without health insurance (Liska, Brennan, and Bruen 1998, 111).

There is also a dramatic gap in the health insurance coverage (of nonelderly) by economic class. Of the 84.96 million families in United States living below 200 percent of the poverty line, 26.7 percent, or 23 million, are without health insurance. In contrast, of the 72.62 million U.S. families earning at least 400 percent of the poverty line, only 5 percent, or 3.63 million, are without health insurance. In California, this division is more dramatic. Of the 12 million families living below 200 percent of the poverty line, 29 percent were without health insurance in 1994–95. Of the 9.3 million families earning at least 400 percent of the poverty line, only 7 percent were uninsured (Liska, Brennan, and Bruen 1998, 76–81). Racial and ethnic minorities comprise a disproportionate percent of those living below the poverty line. Given these disparities in access to health care, we would anticipate that racial and ethnic minorities would be more supportive than whites of attempts to create a universal health care system.

California's Universal Health Plan Initiative (Proposition 186)

Proposition 186, the "single-payer initiative" of 1994, provides an important test case of a referendum on universal health insurance. A costly statewide campaign battle provided extensive information to voters, and a number of diverse constituencies were involved.

Proposition 186 would have replaced the current system of private health insurance with a Canadian-style government-run health care system. It would have guaranteed health insurance coverage to all legal residents of the state, including the estimated six million Californians uninsured at the time.[1] It would have given all the state's residents complete health care coverage, including full mental health benefits, full long-term care benefits, prescription drug coverage, and some dental benefits. Citizens would have been permitted to choose their physicians, and physicians, in turn, would have had responsibility for all medical decisions, although the health care system was to be run by an elected health commissioner.

Proposition 186 was a redistributive policy requiring new personal income and business taxes along with a one-dollar-a-pack tax on cigarettes. The nonpartisan State Legislative Council projected that the new taxes would raise $40 billion annually, doubling the state budget. Money raised by the tax increases would be used to dispense more than $100 bil-

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lion in health benefits annually to more than 30 million Californians (Morain 1999).

Proponents argued that California should lead the nation in reforming health care, and that any increase in taxes for a family would be offset by a reduction in out-of-pocket health care expenditures. Opponents objected to what they characterized as a government takeover of health care by the state bureaucracy and the burden additional taxes would place on employers. They also argued that California's personal income tax would almost double, jobs could be driven from the state, and the overall business climate would be impaired. Despite these claims, the initiative was supported by the California Nurses Association, consumer unions, labor unions, the California branch of the American Association of Retired Persons (AARP), and the California League of Women Voters. The grassroots citizen movement relied on ten thousand volunteers to collect over one million signatures to quality the initiative for the ballot (cf. Leichter 1996). It was opposed by the health insurance industry, business groups, taxpayer groups, and medical executives. Eventually, Proposition 186 was defeated by the electorate, garnering only 26.6 percent of the vote.

Opponents of the single-payer initiative far outspent proponents, in a pattern typical of health care reform initiative campaigns (Tolbert and Steuernagel 2001). Led by the insurance and health care industries, opponents spent more than $9 million in an effort to defeat the initiative, while opponents mounted no media campaign. The Health Insurance Association of America alone poured more than $1.5 million in the effort to defeat Proposition 186. Of the four citizen-generated initiatives on the 1994 ballot, Proposition 186 was the second most expensive, after a tobacco tax initiative. Total spending on the five initiatives was 35 million (Morain 1999), far more than total expenditures on all election campaigns for the state legislature. Research suggests that campaign expenditures by proponents does not increase the chance of successful passage, but negative campaign expenditures by opponents significantly increases the probability of defeating an initiative (Gerber 1999).

Data, Methods, and Findings

What is the role of race and ethnicity in shaping support for universal health care in California as it would have been enacted by Proposition 186? To answer this question, we examine survey data from the Voter

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News Service Exit Poll of California voters conducted on November 8, 1994. The dependent variable in our statistical models is a "yes" vote for Proposition 186.

Since minorities represent a disproportionate percent of those without health insurance in the United States, we expect racial and ethnic respondents to be significantly more supportive of Proposition 186 than whites. We measure the race and ethnicity of the respondent (black, Latino, Asian American) with a series of dummy variables, with non-Hispanic whites as the reference group. In addition, women also tend to have higher uninsured rates in terms of private insurance, so gender is also considered.

We also control for personal economic factors, education, political ideology, age, and policy preferences. Personal income is measured as the yearly family income of the respondent. We expect those with lower incomes to have more difficulty paying for needed health care and thus to be more supportive of universal health care. The models also control for changes in personal finances over the past year and perceptions of the state's economy (Bowler and Donovan 1994). Higher values for these variables are associated with negative evaluations of the state economy and personal finances.[2] Conservatives have historically disfavored policies that entail extensive government involvement, while liberals have generally been more favorable of greater government intervention. The variable "liberal" and "conservative" were measured with dummy variables, with moderates as the reference group. The models also control for the number of years of formal education completed and age of the respondent (ordinal level variable with higher values equaling more education).

Descriptive statistics highlight a divide along racial, economic class, and ideological lines in support for health care reform providing universal coverage. While only 30 percent of whites voted for Proposition 186, over 40 percent of all minority groups[3] (blacks, Latinos and Asian Americans) supported the ballot measures (though Asian Americans tend to have a higher socioeconomic status than other minority groups).

Equally interesting is the breakdown of the vote by income. Of those respondents earning under $15,000 annually, almost a majority (45 percent) supported the policy, compared to only 24 percent of those earning $100,000 or above. Of those earning between $15,000 and $29,000, almost 40 percent voted for Proposition 186. This reveals a significant socioeconomic class divide in support for universal health care.

Party affiliation was also a strong predictor of opposition or support

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for the initiative. Of self-reported Republicans, only 15 percent favored the initiative, compared to 47 percent of Democrats. What is notable is that not even a majority of Democrats voted in favor of this health reform proposal. Thirty-five percent of Independents favored the policy, approximately the mean popular vote. It is not surprising then, that 56 percent of self-reported liberals favored the single-payer initiative, compared with only 18 percent of conservative voters. Surprisingly, gender had no impact of support for the initiative. The same percentage of males and females supported the policy. Do these patterns and relationships remain in a multivariate regression model, when controlling for other factors?

Explaining the Vote for Universal Health Care (Proposition 186)

Since our dependent variable is a binary variable indicating a vote for or against the health care reform, we use logistic regression. In table 11.1 we see that a number of variables have a statistically significant effect on support for Proposition 186. Race/ethnicity appears to be important. Nonwhite voters, self-identified as black, Asian Americans, or Latino, were significantly more likely than whites to support the ballot measure,

TABLE 11.1. Voter Support for Universal Health Care (Proposition 186)

Explanatory Variables	Unstandardized Coefficient (β)	Standard Error	Probability	Odds-Ratio
Nonwhite	***.340***	***.186***	***.069***	***1.404***
Liberal Ideology	***1.00***	***.192***	***.000***	***2.721***
Conservative Ideology	***–.499***	***.195***	***.011***	***.607***
Personal Finances Worse	–.187	.191	.327	.829
Income	***–.189***	***.063***	***.003***	***.828***
Education	.096	.079	.229	1.100
View State Economy Worse	–.172	.129	.183	.842
Age	.045	.038	.235	1.046
Female	–.048	.163	.770	.954
Constant	–.239	.534	.654	
Log/ratio Chi-square	73.69		.000	
Log likelihood	–469.924			
Pseudo R^2	.07			

Source: Voter News Service Exit Poll and phone survey, November 4, 1994.

Note: $N = 804$. The dependent variable is binary, 1 if voted for Proposition 186 and 0 if voted against it. The coefficients presented are logistic regression coefficients with standard errors in parentheses. Stata logistic regression command code available upon request. Probabilities based on two-tailed test. ***Statistically significant variables in bold italic.***

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even after controlling for ideology, income, perceptions of the economy, personal finances, education, age, and gender. The odds-ratio indicates that liberal ideology was the single most important factor in shaping support or opposition to the ballot measure, followed by the race/ethnicity of the respondent. This suggests racial minorities (blacks, Latinos, and Asian Americans) and the white majority may vote differently even on general social policies, such as health care, that are not explicitly "minority issues," such as welfare policy. These findings highlight an important racial division in health policy preferences.

The nonwhite population in California is not homogeneous, and specific ethnic groups may have diverse policy preferences. Table 11.2 replicates table 11.1 but includes separate variables for black, Latino, and Asian American respondents with white voters as the reference (comparison) group. The coefficients for black and Latino respondents, like minorities in general, are statistically significant and positively related to support for Proposition 186. Blacks and Latinos were clearly more likely than whites to support this policy. Asian Americans, however, were not more supportive of this policy than whites. The higher socioeconomic status of Asian Americans may dampen their support for "redistributive" policy. In both models, political ideology was an important factor in shaping policy preferences.

TABLE 11.2. Voter Support for Universal Health Care (Proposition 186)

Explanatory Variables	Unstandardized Coefficient (β)	Standard Error	Probability	Odds-Ratio
Asian American	.352	.294	.232	1.421
Latino	***.472***	***.189***	***.012***	***1.602***
Black	***.486***	***.203***	***.017***	***1.626***
Liberal Ideology	***1.005***	***.140***	***.000***	***2.734***
Conservative Ideology	***–.653***	***.144***	***.000***	***.521***
Personal Finances Worse	–.213	.138	.121	.808
Income	***–.241***	***.047***	***.000***	***.786***
Education	***.147***	***.059***	***.012***	***1.159***
Age	.046	.028	.100	1.047
Female	.049	.118	.677	1.051
Constant	***–.769***	***.279***	***.006***	
Log/ratio Chi-square	174.82		.000	
Log likelihood	–880.09915			
Pseudo R^2	.09			

Source: Voter News Service Exit Poll and phone survey, November 4, 1994.

Note: N = 1,530. The dependent variable is binary, 1 if voted for Proposition 186 and 0 if voted against it. The coefficients presented are logistic regression coefficients with standard errors in parentheses. Stata logistic regression command code available upon request. Probabilities are based on two-tailed test. ***Statistically significant variables in bold italic.***

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There also appears to be a strong class division in support for universal health care. In both models (tables 11.1 and 11.2) the coefficient for personal income is statistically significant and inversely related to support for Proposition 186. Voters with lower income levels (and more likely to be without health insurance) were more supportive of the policy, even after controlling for other factors. Individuals with higher incomes (and likely to have private health insurance) were more likely to oppose this policy. This is a logical finding that emphasizes again how important redistributive issues are when considering health reform in America. The level of education of the respondent was also clearly important, but only in table 11.2. Voters with higher education were more supportive of universal health care after controlling for other factors. The age or gender of the respondent had no statistical impact when controlling for other factors.

The Significance of the Statistical Models

To facilitate interpretation of the regression coefficients presented in table 11.2, probability simulations were calculated using Clarify Software (King, Tomz, and Wittenberg 2000). This method allows estimates of the expected probability of a yes vote for the Proposition 186 under various scenarios, by varying the race and ethnicity of the respondent, while holding all other variables constant at their mean value. Because gender (female) is a binary variable, it must be set at either 1 or 0 in the simulations. Because variation in this variable is of substantive interest, even if not an important predictor , separate estimates of support for Proposition 186 are reported for males and females. Table 11.3 shows the expected probability of a "yes" vote and associated standard deviation of support for Proposition 186, by varying race, ethnicity, gender, and economic characteristics of voters. All independent variables (personal finances, income, education, perception of state economy, age) were set to their mean value, except ideology, in which the variable "liberal" was set to 1 and "conservative" set to 0.

Table 11.3 reveals a clear pattern of support for universal health care relative to the race, ethnicity and economic status of the respondent. Row 1 suggests that the overall probability of support for the ballot measure in the survey was 31 percent, slightly higher than the actual popular vote (26 percent). Setting all independent variables at their mean value, but varying the race/ethnicity of the respondent from white to minority (black, Latino, or Asian American), increased the probability of support

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for Proposition 186 by 8 percent for both males and females. Varying the economic status of a respondent from wealthy to poor increased the probability of voting for universal health care by nearly 20 percent for males and females. For example, a minority woman who reported a liberal ideology had a 59 percent chance of supporting the ballot measure, with all other variables set at their mean value. The same woman who was white instead of a racial minority had only a 51 percent chance of voting yes. Similarly, the probability of a minority male supporting the initiative was 60 percent. The probability of a white male voting yes on the initiative was only 52 percent. This is a difference of 8 percent points based on race alone for males and females. Table 11.3 suggests that race/ethnicity and economic class were important determinants of support and opposition to expanded health care, even after controlling for other factors.

TABLE 11.3. Expected Probability of Support for Universal Health Care (Proposition 186)

	Average Vote	Standard Deviation
Overall probability of a yes vote	.31	.02
Minority Women	.59	.06
White Women	.51	.05
difference	8%	
Minority Male	.60	.05
White Male	.52	.04
difference	8%	
Poor White Women	.62	.05
Wealthy White Women	.39	.06
difference	23%	
Poor Minority Women	.69	.06
Wealthy Minority Women	.47	.07
difference	22%	
Poor White Men	.63	.05
Wealthy White Men	.40	.06
difference	23%	

Note: Estimates based on logistic regression model reported in table 11.1. *Minority* = Latino, black, or Asian; *White* = non-Hispanic white respondent. Probabilities calculated using software written by Michael Tomz, Jason Wittenberg, and Gary King (1999): CLARIFY: Software for Interpreting and Presenting Statistical Results, Version 1.2.1 (Cambridge: Harvard University), http://gking.harvard.edu/.

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Conclusion

Proposition 186's defeat came only months after President Clinton's national health reform plan failed in Congress in 1994, highlighting the effectiveness of well-financed media campaigns mounted by the health insurance industry to defeat universal health care proposals proposed via state ballot initiatives or U.S. presidents. Health care reform, however, remains a salient problem in the United States (Hackey 1998; Marmor and Mashaw 1996; Leichter 1997; Rich and White 1996; Skocpol 1997; Steinmo and Watts 1995; Weissert and Weissert 1998). Statewide ballot initiatives proposing health care reform will likely remain on the political agenda in the next decade.

Was the defeat of universal health care at the national level and in California also the result of a racial and ethnic divide, in which white voters perceived that the policy would disproportionately benefit minority (particularly black and Latino) groups, as is currently the case with welfare benefits? Does the recipient of government provided health care have a "black or brown" face in the eyes of the majority white electorate? Clearly, access to health care in this country is uneven, particularly for lower-income and minority groups. This research suggests that voters engage in instrumental voting when health care policy is the subject of statewide referenda, casting votes consistent with their self-interest. To date, most health reforms adopted by state legislatures, such as mandating coverage for particular procedures, have benefited middle-class, primarily white citizens who currently have health insurance. When health policy is the subject of statewide referenda, it may benefit a broader segment of the population.

This research suggests that race and ethnicity are important determinants of voter support for universal health care, even after controlling for other factors, such as socioeconomic conditions. California voters overwhelmingly rejected the ballot measure examined here. Rather than a public good, Proposition 186 (universal health care) was framed as a redistributive policy that would have transferred millions of tax dollars from the middle- and upper-middle-class, primarily white population to the poor, largely black and Latino population without health insurance. There was a clear racial divide in support for Proposition 186. Blacks, Latinos, and those with lower incomes were significantly more likely to support a state-run health care system, whereas wealthier whites were more likely to oppose the policy. We find evidence of the same racial and ethnic division in support for redistributive health care policy, as

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reported by scholars who study referenda on affirmative action and illegal immigration (Tolbert and Hero 1996; Hero 1998) and by scholars who study welfare policy, as reported in other chapters of this volume.

It is clear why people of lower economic classes would support a state-run health care system, as they are generally less able to pay for private health insurance. However, it is less clear why minorities, income notwithstanding, support state-run health care systems. Research suggests Latinos in California have divergent policy preferences than whites. On fiscal issues, such as government taxes and spending, Latinos are more liberal than most Californians. Latinos are more supportive of increased general welfare spending, including health care and education, on the one hand, but morally conservative on the other, showing less support for abortion rights (Baldassare 2000, 187). While most Latinos in California would classify themselves moderate to somewhat conservative, much like whites, what distinguishes Latinos from whites has more to do with their specific policy preferences than their political philosophy (Baldassare 2000, 110–23). Not only are Latinos more likely to vote Democratic, but they have a more positive and less fearful attitude toward government, suggesting their preference for a more active government. Latinos have more liberal attitudes when it comes to taxes and spending on social programs, such as Social Security and health care (58 percent), even if it means higher taxes, than do whites (50 percent) (Baldassare 2000, 122–23). Latinos may want a more active role of government because of their lower socioeconomic status and positive views of government, characteristics often associated with immigrant groups.

Research suggests that a larger and more politically active Latino population in California would swing the state's political pendulum to the left. A major trend is the growth in the Asian and Latino vote. As the new California immigrants have become citizens, they have emerged as the fastest-growing groups of new voters. In the 1990 gubernatorial election, only 4 percent of the electorate were Latino. By the 1998 gubernatorial election, the Latino share had increased to 14 percent based on Voter News Service exit polls (Baldassare 2000, 110–12). It is likely that their participation in elections has been hastened because they have felt threatened by political reaction to their growing presence, as reflected in ballot initiatives directly affecting minority groups (Baldassare 2000). Turnout rates in California elections among Latinos have risen dramatically over the past decade as policies opposed by a majority of Latinos—ending welfare for immigrants, Official English, ending bilingual education, ending affirmative action programs—have been approved in statewide refer-

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enda elections. Over time, demographic diversity may change elections and representation, as California faces the conflicting demands of white, black, Asian, and Latino voters. If Latino and black turnout rates increase in the future, as many predict they will, states like California may adopt general social welfare policies, even provisions for universal health insurance coverage.

As the vote on Proposition 186 demonstrates, referenda on redistributive health policy can be racially and ethnically polarizing. Other states will likely follow California's lead and place health policy, and other forms of social policy, directly on the statewide ballot as a coalition of Massachusetts citizens did in the 2000 general elections. The increasing racial and ethnic diversity of the United States combined with the growing importance of direct democracy elections will likely continue to shape social and welfare policy in the states with important implications for substantive and procedural democracy in the next century.

APPENDIX: TYPES OF INITIATIVES IN THE U.S. STATES

	Direct Constitutional	Indirect Constitutional	Direct Statute	Indirect Statute
Alaska			X	
Arizona	X		X	
Arkansas	X		X	
California	X		X	
Colorado	X		X	
Florida	X			
Idaho			X	
Illinois	X		X	
Maine				X
Massachusetts		X		X
Michigan	X			X
Mississippi		X		
Missouri	X		X	
Montana	X		X	
Nebraska	X		X	
Nevada	X		X	X
North Dakota	X		X	
Ohio	X		X	X
Oklahoma	X		X	
Oregon	X		X	
South Dakota	X		X	
Utah			X	X
Washington			X	X
Wyoming				X

Note: Constitutional initiatives amend the state's constitution. Statutory initiatives amend statutory law.

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NOTES

1. Detailed information on the ballot initiative process in California is available at the website of the Office of the Secretary of State, http://www.ss.ca.gov.

2. The variables for perceptions of the state economy and perceptions of personal finances are coded 5 (worse), 3 (same), and 0 (better).

3. In the survey, average (or mean) support for the initiative was 31 percent, while in the population (or state) it was 26 percent. This is the difference between the survey sample and the true population.