BEYOND THE SENTIMENTAL CLICHE:

HOW LOCAL COMMUNITIES IMPACT RESIDENTS AND SHAPE PUBLIC OPINION

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ABSTRACT:

Previous research on the ways in which communities impact their residents suggest that community-level factors and perceptions of such factors can influence beliefs and behaviors (Baldassare and Katz 1992; Wong 2007). I hypothesized that as individuals' perceived need for reproductive health care services in their community increased, their support for federal reproductive health subsidies would also increase. Through a survey experiment of 865 adults in the US, I tested this hypothesis. The results suggest that there is statistically significant evidence that perceived need for reproductive health services is positively correlated with support for federal reproductive health funding and, while that support decreases when abortion services are linked with accessing reproductive health care, the relationship remains positive. A correlational OLS regression analysis suggests that there is statistically significant evidence that ideology is a stronger predictor of support for federal reproductive health subsidies when abortion services are linked with accessing reproductive health care. Given these results, the role that communities and community-level factors play in influencing public opinion deserves further investigation.

The Title X National Family Planning Program financially supports public health facilities and nonprofit clinics in the US that provide family planning and reproductive healthcare to all who need it with an emphasis on serving low-income individuals. Services covered by Title X funding include a broad range of contraceptive methods, education and counseling, sexually transmitted infection (STI) testing and treatment, HIV testing, breast and cervical cancer screening, and pregnancy diagnosis and counseling. Title X funds cover or subsidize the cost of family planning and related preventative health services for individuals whose family incomes are at or below 250% of the federal poverty line. Over the past decade, these federally subsidized reproductive health services have been disproportionately used by women (92%) and those who live at or below the federal poverty line (69%) (Fowler et al. 2018). In 2017, there were more than 3,800 service sites that offered Title X subsidized family planning and related health services to more than four million clients, 90% of whom qualified for reduced fee or no-fee services (Fowler et al. 2018).

There is evidence that the need for Title X remains high. While the number of unintended pregnancies in the US has decreased in recent years, 45% of pregnancies remain unintended and, in some states, more than 50% of pregnancies are unintended (Guttmacher Institute 2012). Additionally, the record number of STI cases reported in 2016 and 2017 prompted the Centers for Disease Control and Prevention to release information to the public underscoring the danger of these infections to become resistant to current treatments (Centers for Disease Control and Prevention 2018). Furthermore, a significant amount of research has underscored the negative health and social outcomes to individuals that result when they lack access to reproductive health care (Gipson, Koenig, and Hindin 2008; Herd et al. 2016; Wendt et al. 2012)

The health and social costs experienced by individuals impacted by unintended pregnancy and STIs and the economic costs experienced by the state and federal governments can all put a strain on community vitality and resilience (McAslan 2010). Communities that have inadequate resources to provide their residents with knowledge about and access to reproductive health services are less resilient. Residents who experience unintended pregnancy and STIs face diminished physical and mental health and that hinder their ability to contribute to their communities and enhance community resilience. Additionally, as rates of unintended pregnancy, STI prevalence, and other other indicators of diminished reproductive health increase, states and the federal government have to direct funding to programs that respond to these concerns. Because treatment is more costly than prevention (Frost et al. 2014), it could reduce the discretionary funding for grants to local governments that they communities rely on to provide essential services to their residents (Center on Budget and Policy Priorities 2018).

New rules and proposed legislation, however, could make it more difficult for individuals to access prevention and treatment services for reproductive health. National level Republican officials have promoted legislation that would eliminate funding to any reproductive health service providers that offer abortion services (Associated Press 2018; Mali 2018). The Trump administration has issued a rule that will eliminate Title X funding to any providers that offer abortion services or referrals and is scheduled to go into effect in April 2019 (Office of Population Affairs 2019). Although federal funding, including Title X funds, cannot be used to cover the costs of abortion services, supporters of the proposed legislation and rule argue that federal funding is indirectly supporting abortion services because many of the providers that offer these services rely on federal funding and Medicaid reimbursement to cover the costs of the

other services they provide, thereby enabling the clinics to keep their doors open to offer

abortion services (Gordon Earll n.d.).

The effects of cutting federal funding to clinics that also offer abortion services could be

far reaching and have the greatest impact on low-income women's access to family planning and

reproductive health services (Sobel, Rosenzweig, and Salganicoff 2018). Federal reproductive

health subsidies enable lower-income individuals to access contraception, breast and cervical

cancer screenings, and STI preventative, screening, and treatment services that would otherwise

be inaccessible to many of them (Fowler et al. 2018; Frost, Gold, and Bucek 2012; Guttmacher

Institute 2012). One analysis indicated that, if funding were cut from providers who offered

abortion services, the network of Title X providers would be dramatically decreased and the

remaining providers would be unlikely to provide the same variety of timely services to fill the

need created by such a policy (Hasstedt 2017). New providers that do not offer abortion services

may be able to fill the gap over time or perhaps existing providers of abortion services would

reconsider offering those services. It is unclear, however, how long it would take to achieve the

same level of service even with such changes. Planned Parenthood, for example, provided 41%

of the contraception services funded by Title X clients in 2015 (Hasstedt 2017), and they have

pledged to continue offering the same information and services despite the new rule (Planned

Parenthood 2019), which will require them to discontinue operating as a Title X provider.

While there is evidence of a partisan difference on this issue, a large number (49%) of

self-identified Republicans (Princeton Survey Research Associates International 2017), who

typically oppose many types of individual welfare spending (Pew Research Center 2017), do

support federal funding for non-abortion reproductive health services provided by Planned

Parenthood, an organization that has been politicized because of its nationwide presence and provision of abortion services. Although this is a significantly lower rate than support among Democrats (92%) and Independents (69%) (Princeton Survey Research Associates International 2017), it shows a gap between national level Republican rhetoric about providers like Planned Parenthood and the public support for ensuring members of their communities have access to reproductive health services even when that means providing funding to clinics like Planned Parenthood. This evidence indicates that perhaps there are factors beyond cues from political elites that are influencing public opinion on reproductive health and reproductive health care access.

Public opinion on federal funding for reproductive health care has received little to no previous attention from academic researchers. Through an experiment and correlational analysis, I test the hypothesis that community-level factors impact opinion on federal reproductive health subsidies. As the need for reproductive health care access in a community increases, evinced by prevalence of STIs, unintended pregnancy, and poverty rates, individuals in those communities should perceive a greater risk to themselves and those around them, leading to more support for public solutions to address it, like federal funding programs.

Community's Influence

While communities need not be place based (Bhattacharyya 2004), by communities, I mean localities that have defined territories and which foster a sense of solidarity among residents. Being a "New Yorker" is a well-known example of how a locality can foster a sense of identity among the individuals who live there. For some, that solidarity may not have as much resonance for some individuals as other parts of their identities, but localities create senses of

solidarity through even mundane mechanisms, like locality-based tax payers or locality-based commuters facing the same traffic or infrastructure challenges.

Research on contextual effects have often defined community by the geographical space that is administered by governmental units (Baybeck 2006; Dyck and Gimpel 2005; Huckfeldt and Sprague 1995; Pearson‑Merkowitz and Dyck 2017). Others, especially within the context of racial threat, have focused on allowing the individual to define community by themselves (Cho and Baer 2011; Moore and Reeves 2017; Wong et al. 2012). Through pilot survey of 62 participants, Wong et al. (2012) find that participants' perceived community does not fit within the boundaries of communities defined by government units and they suggest that using census information based on those government-defined communities may eliminate information that contributes to the "contextual effect." For example, if an individual perceives their community to be only their neighborhood and their neighborhood is the community unit that most influences their beliefs and behavior, then placing their beliefs and behavior in the aggregate context of their county may yield misleading results. Others who evaluated the individual-defined community versus the government-defined community, however, found that objective measures within the government-defined community boundaries were better predictors of subjective perception of community populations of racial minorities that the objective measures within the individual-defined community (Velez and Wong 2017).

Some of our most meaningful interactions happen at the community level. We spend most of our time in the communities we live and work in, and those communities are crucial to our personal knowledge and experience (McLeroy et al. 1988; Putnam and Feldstein 2003). The community context is related to political behavior. One study among a sample in Tallahassee,

Florida found a positive correlation between the sense of community one feels and likelihood of voting in local elections and engaging in political discussion (Anderson 2009).

Social norms and pressure experienced at the community level can also influence political participation and voting. Communities made up of individuals who value political participation and establish it as a community norm can motivate whether and which types of political actions one takes (Anoll 2018). One study indicated that social pressure to vote can increase turnout (Murray and Matland 2014).

Through objective community-level measures, communities can also provide space for experiences that influence the issues and social problems one is aware of. Residents of British Columbia, for example, were more likely to engage in individual and group level political action on environmental issues when they lived in areas with more extractive industries, like mining and forestry (Blake 2001). Demographic changes at the community level can spur shifts in public opinion when issues are framed in relation to the social groups at the root of the change; destabilizing increases in immigrant populations is a prime example (Hopkins 2010).

Another mechanism through which objective community measures can influence political opinion is outlined in the context-cue interaction approach. According to this theory, policy opinion is largely based on lived experiences of social interactions for those who are not involved in politics or have strong political identities, like party identity or ideological identity (Dyck and Pearson-Merkowitz 2014). For those that do have a defined political identity, however, cues from political elites moderate the effect of personal contact (Dyck and Pearson-Merkowitz 2014). Researchers who applied this concept to the issue of gun control found that this theory was substantiated among a sample of 1,000 Americans weighted to

achieve a representative sample (Pearson‑Merkowitz and Dyck 2017). The gun control study used ordered logit models with an interaction term of rates of violent crime per capita and party identification to measure the context-cue relationship between these factors. Their results showed that among strong Republicans, leaning Republicans and strong Democrats level of support for gun control measures were not influenced by the rates of violent crime in their counties, but these crime rates did positively influence Independents' and leaning Democrats' level of support (Pearson‑Merkowitz and Dyck 2017).

While these mechanisms, like social pressure and the context-cue approach, are ways in which communities can influence the beliefs and behaviors of their residents, for the issue of support for federal funding for reproductive health services, I suggest that self-interest provides a strong mechanism through which communities influence policy opinions on this issue.

Self-Interest

Some scholars argue that self-interest has a diminutive impact on political opinion and behavior. Some assert that self-interest is important when a policy impacts individuals in a large and very clear way (Huddy, Sears, and Levy 2013). Others find that self-interest is not an important predictor of policy preference when it is defined in terms of short-term gain and that symbolic predispositions, like party and ideology are stronger predictors of political opinion (Lau and Heldman 2009). The authors of *The American Voter Revisited* go so far as to say that there is a scholarly consensus on the fact that "a personal stake in the outcome of a controversy over policy has little, if any, impact on a person's issue preferences" (Lewis-Beck et al. 2008, 197).

An analysis of longitudinal, cross-sectional data, however, suggested both economic driven self-interest and ideological beliefs are important predictors of economic policy opinion (Jæger 2006). A cross-national survey of 21 European countries suggests that ideological beliefs and self-interest can interact to influence political beliefs about government responsiveness (Rosset, Giger, and Bernauer 2017). Using the basic human values models, Goren et al. (2016) link self-interest and ideology as strong correlates; in their analysis the "transcending self-interest" value is correlated to liberalism and the "conservation" value is correlated to conservatism.

> The more importance people attach to transcending self-interest on behalf of others, the stronger their preferences for the liberal label, a generous welfare state, ameliorative racial policies, cultural progressivism, political tolerance, and dovish foreign policy... The more individuals prioritize respect for tradition, deference to convention, and social order, the stronger their preferences for the conservative label, smaller government, racial self-help, culturally conservative policies, political intolerance, military power, and foreign policy unilateralism (Goren et al. 2016, 995).

While this model labels the value associated with liberalism as "transcending self-interest," the correlated policy positions they cite for both the transcending self-interest value and the conservation value could, in fact, be associated with self-interest more broadly defined by other scholars.

Evolutionary psychologists, like Weeden and Kurzban (2014), argue that when self-interest is viewed beyond short-term economic interests, it can exert an important influence on political attitudes. Self-interest should include "various kinds of material and nonmaterial

gains, over shorter-term and longer-term horizons" (Weeden and Kurzban 2014, 40). This self-interest approach accepts that while party identification and ideology can be important factors that contribute to opinion, self-interest can also have an important influence on attitudes towards certain issues (Weeden and Kurzban 2014; 2017). The issues that should be influenced by self-interest include those that have broadly desired societal goals, tangible implications for the individual, and competitive social significance (Weeden and Kurzban 2017).

Reproductive health has these characteristics that suggest that self-interest is an influencer. Society widely shares the goal of being healthy and values individuals who are healthy (Office of Disease Prevention and Health Promotion 2019a) and reproductive health is an important part of an overall healthy life (Office of Disease Prevention and Health Promotion 2019b). Reproductive health has very tangible impacts on individuals. Reproductive health related infections or illness and pregnancy can have major impacts on the lives of the people experiencing them (Centers for Disease Control and Prevention 2018b; Newton and McCabe 2008). There is also societal competition attached to reproductive health outcomes. Those living with incurable STIs and those who experience nonmarital pregnancy may be stigmatized by others (Mollborn 2009; Morris et al. 2014). While self-interest at the individual level is likely a factor influencing public opinion on reproductive health care and public funding for it, self-interest can come from the social network level (Weeden and Kurzban 2014).

Community-level self-interest is an outgrowth of individual level self-interest (Weeden and Kurzban 2017). Humans have evolved to live in social groups and, as illustrated by realistic group conflict theory (Sherif 1961; Turner, Brown, and Tajfel 1979) and social identity theory (Brewer 1999; 2007), interactions between groups are often marked by competition for resources

or prestige. The social tools humans use to build strong connections among their social networks enable them to act towards common goals and accomplish more together (Weeden and Kurzban 2014, 39). This important human characteristic means that not only is individual self-interest important but group-level interest must also be considered as a factor influencing public opinion. Group-level interest or "inclusive interests" are those in which one's family or broader social network experience tangible and intangible benefits in the short and long term regardless of if the individual directly benefits (Weeden and Kurzban 2014, 40).

If we apply those same characteristic requirements that indicate that an issue would be influenced by self-interest to the inclusive interest level, reproductive health fits because, as a community-level issue, it has widely shared goals, tangible implications, and competitive social implications. Individuals would be motivated to support efforts to reduce indicators of poor reproductive health in their communities to reduce the threat posed to them and their families through the health threat of STI contraction and the greater need for supportive social services for families who experience unintended pregnancy (Power to Decide 2019b). Reducing indicators of poor reproductive health happens on a broad level. There are national initiatives aimed at reducing rates of unintended pregnancy (Power to Decide 2019a) and STI prevalence (National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention 2014). Given the stigma and negative outcomes listed above associated with STI prevalence and unintended pregnancy, communities have a stake in reducing rates of these indicators in order to avoid the notoriety of being published on lists like "Top 20 U.S. Cities with the Most STDS" (BlackDoctor.org Staff 2018).

The need for reproductive health care also has very tangible impacts on communities and has larger social ramifications. Community health resilience is the concept that health in a community is a primary component of building a community's ability to successfully "withstand, adapt to, and recover from adversity" (US Department of Health and Human Services 2015). Communities with a high prevalence of reproductive health indicators reduce the health and fiscal well-being of a community and increase vulnerability in the face of emergencies and disasters (McAslan 2010). Resilient communities, those with healthy residents and strong social infrastructure, have a competitive advantage in attracting economic opportunity and earning prestige (U.S. Economic Development Administration n.d.).

Although community-level factors can shape self-interest and inclusive interest, individuals who are unaware of the risk posed by or the benefits that could result from those factors may inaccurately assess their self and inclusive interests in various policy opinions. Additionally, because public opinion is one factor that drives public policy and expenditures (Caughey and Warshaw 2018), the ways in which individuals perceive their communities, then, could be a more important factor than the realities of their communities.

Perceptions

Our perceptions of ourselves, our communities, and of other communities or regions are not always aligned with objective measures of reality. Using data from the Midlife Development in the US study, Glei, Goldman, and Weinstein (2018) found that individual's perception of their economic circumstances and prospects, especially among working class non-Latinx whites, was sometimes more dire than their objective measures indicated. Newman, Shah, and Lauterbach's (2018) analysis of the 2016 Cooperative Congressional Election Study responses, on the other

hand, found that perceptions of local income inequality were aligned with objective measures and that those with the lowest incomes had perceptions most aligned with the objective reality.

In the realm of health, individuals in Appalachia were likely to perceived themselves to be healthy even when objective measures indicated that they were in poor health (Griffith et al. 2011). Research on Ohio health care worker's perception of the health and environmental realities in Appalachian Ohio versus non-Appalachian Ohio, for example, indicated that even those workers whose work is most aligned with these topics had misperceptions of some of the actual negative environmental indicators that impact the health of residents in Appalachian Ohio (Morrone, Kruse, and Chadwick 2014).

Research on perception of the threat from local environmental factors found that perception of threat was the strongest predictor of engagement in environmentally friendly practices, like recycling, water conservation, and reducing driving (Baldassare and Katz 1992). Another study found that perception of the size of the racial and ethnic minority populations in one's local community distorts beliefs about the size of minority populations nationwide; in regression analysis of responses to the 2000 General Social Survey, perception of the local minority population was a stronger predictor of overestimating the number of minorities in the US than the objective percent of the minority populations in the local community (Wong 2007).

Several studies have assessed the disparities between objective measures of crime rates and perceived levels of crime. In a correlational study of perceived crime rates and personal victimization of crime, researchers found that, in Australia, there is a gap between perceived crime rates and actual crime rates with perceived rates being higher; additionally, perceived crime rates in one's locality was a negative predictor of life satisfaction even when controlling

for personal victimization from crime (Ambrey, Fleming, and Manning 2014). Perceptions may also impact policy opinions on criminal punishment. Findings from a correlational study in the England suggest that perceptions not only of higher local criminal activity but also perceptions of a negative economic outlook had a positive influence of on support for more punitive criminal justice policies (King and Maruna 2009).

Ultimately, objective measures of community can influence political behavior and beliefs, as outlined in the section above, but perceptions of community can also play an important role in policy opinion. Self-interest and inclusive interest are defined by what individuals believe will lead to material and non-material gains for themselves and those close to them, so their perceptions should be considered important factors, especially since those perceptions may not be based on objective measures of reality.

Experimental Design

Through an online survey experiment conducted in February 2019, I assess how subjects' perceived community need for reproductive health care, using rates of unintended pregnancy and STIs as indicators, influences their support for federal funding for a reproductive health clinic. Because the national debate about the Title X program has become linked to Planned Parenthood and abortion services (Associated Press 2018; Mali 2018), I also assess how perceived community need impacts support for federal funding for a clinic that offers only non-abortion reproductive health services and a clinic that offers privately paid for abortion services in addition to the other reproductive health services.

I collected data through the Qualtrics survey platform to test these hypotheses.[1] The Qualtrics algorithm randomly assigned subjects to one of two treatment groups in the survey. subjects received the following prompt:

> Imagine that you lived in a community that might establish a new health clinic that would offer only nonabortion reproductive health services such as birth control and prevention and treatment of sexually transmitted diseases. The community has very [low/high] rates of unplanned pregnancy and sexually transmitted diseases.[2]

All subjects were then asked three questions. The first post-treatment item asked "How much do you think your hypothetical community would need this new clinic?" They could select from the following options: no need, low level of need, moderate level of need, high level of need, and very high level of need. This was a dependent variable in my analysis, and I constructed a five-level variable based on this five-point scale. Based on this question,

The second post-treatment item asked "How much would you oppose or support this clinic receiving federal funds?" They were given the following options: oppose strongly, oppose moderately, oppose slightly, neither oppose nor support, support slightly, support moderately, and support strongly. This was also a dependent variable in my analysis, and I constructed a seven-level variable based on this seven-point scale.

The third post-treatment item asked "How much would you oppose or support this clinic receiving federal funds if the clinic offered abortion services paid for by private funds?" They were given the same seven options from oppose strongly to support strongly. This was also a

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[1] The Illinois State University Institutional Review Board approved this survey design under study number IRB-2018-634.

[2] See full text of survey along with the survey flow in Appendix A.

dependent variable in my analysis, and I constructed a seven-level variable based on this seven-point scale.

Based on these three post-treatment items, I anticipate the following:

- Hypothesis 1: Subjects' perceived level of need for the hypothetical health clinic will have a positive relationship with their support for federal funding for the hypothetical clinic.

- Hypothesis 2: Compared to subjects asked to imagine that their community has very low rates of unplanned pregnancy and sexually transmitted diseases, subjects who are asked to imagine that their community has very high rates of unplanned pregnancy and sexually transmitted diseases will indicate greater support for federal funding for a new health clinic that would offer only non-abortion reproductive health services such as birth control and prevention and treatment of sexually transmitted diseases.

- Hypothesis 3: Support for federal funding for the hypothetical clinic will be lower if the hypothetical clinic offered abortion services that would be paid for with private funds.

Two attention check questions followed the post-treatment questions. The first attention check assessed whether the subjects had paid attention to the manipulation in the initial vignette and could remember it by asking them to indicate what the passage stated about rates of unplanned pregnancy and sexually transmitted diseases. In order to hinder any bias introduced by those not paying attention and simply selecting the top answer, there were two different orders for the answer options for this question with the second order being a reverse of the first order,

and subjects were randomly shown one of the two options. 90% of subjects passed this attention check. The second attention check simply checked if the subjects were reading the prompts. It asked them to select pregnancy test from a list of five options the order of which was randomized. 99.5% of subjects passed this attention check. 89% of subjects passed both attention checks.

Demographics of the Sample

There were 865 test subjects who were recruited through the Prolific survey platform.[3] Power calculations indicated that I could achieve 80% power to detect a 0.20-standard deviation difference between the two treatment groups with 865 subjects. The responses from those that failures the attention checks, therefore, should not have an influence on the results large enough to cause concern. While I used the Prolific platform to recruit and compensate subjects, the survey was implemented on the Qualtrics platform. Along with responses to the survey items, Qualtrics also recorded subjects' IP addresses, location latitudes, and location longitudes in order to check for duplicate or non-independent responses.

After dropping the nine responses that did not accept the informed consent and the one response that timed out after only accepting the informed consent, I generated the variables indicating responses that had non-unique Prolific IDs, IP addresses, and latitude and longitude combinations. There were 4 responses that had non-unique Prolific IDs. This means that two pairs of responses were non-unique based on Prolific ID. Prolific IDs are unique to each user so there should be no duplicates unless the same user completed the survey twice. I dropped the

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[3] Prolific connects researchers willing to provide compensation for survey completion with survey participants around the world. Participants create a profile on Prolific that includes information that enables Prolific to match participants with surveys for which they qualify. Prolific participants may have received notice of their participation eligibility through a Prolific recruitment email or they may have simply seen the survey listed on their available studies page on the Prolific platform.

response for each pair that started the survey at the later time as recorded by Qualtrics. After dropping these two responses, I had 865 observations and all Prolific IDs and all IP addresses were unique in the dataset. There were 129 responses, 15% of the total responses, that had a non-unique latitude and longitude combination. I kept all of these duplicate location responses because duplicate location coordinates could occur when subjects use public computers that another subject has used to complete the survey.

All subjects were prescreened by Prolific on the following items: 18 years old or over, residing in the US, had completed 10 or more Prolific surveys, and had a 97% or higher acceptance rate for their previous Prolific survey completions. Prolific recruited these subjects by sending out email invitations to eligible subjects and listing the study as available to eligible subjects on their Prolific dashboards. subjects were offered $0.49 in compensation for participating in the study.[4] The median completion time was two minutes and twenty-five seconds. The rate of compensation for the median completion time was $12.17 per hour. The sample was skewed liberal and Democrat. Democrats made up 60% of the sample while only 18% think of themselves as Republicans and 22% think of themselves as Independent, unaffiliated, or "other." Additionally, 65% think of themselves as liberal; 19% think of themselves as conservative; and 16% think of themselves as moderate or middle of the road.[5]

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[4] Subjects had the right to refuse compensation but no subject who accepted the informed consent refused payment. The individuals who rejected the informed consent and who timed-out did not request compensation.
[5] See Appendix B for more sample characteristics.

Results

I conducted the statistical analyses using Stata 14 software (StataCorp 2015), and I used R to produce the graphs (R Core Team 2018). All p-values in the results are from two-tailed tests, and all variables were either dichotomous or coded on a 0-to-1 scale.[6]

Efficacy of Treatment

The results of the experiment in Figure 3.1 indicate that the manipulation of the treatment successfully influenced subjects' perceived need for the hypothetical health clinic; the mean level of perceived need in the low rates condition 0.461 with a standard deviation of 0.221 and was 0.827 with a standard deviation of 0.212 in the high rates condition ($p<0.001$).

Figure 3.1 Difference of Means Test by Treatment Group on Perception of Need for Hypothetical Health Clinic
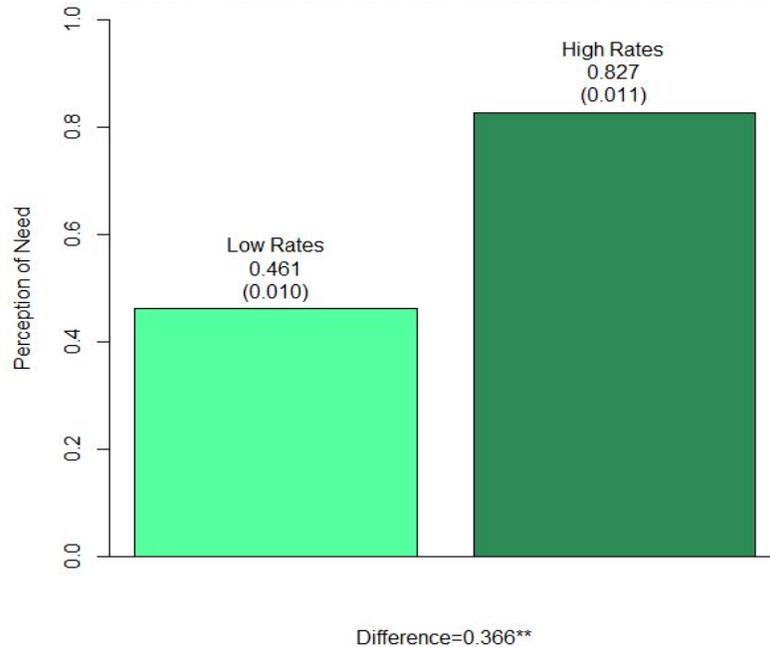
Note: Column values are treatment group means with standard errors in parentheses. DV has five levels and is coded as support for federal funding for reproductive health services where 0 is no need and 1 very high need. +: $p<0.10$; *: $p<0.05$; **: $p<0.01$. I used R to construct this graph (R Core Team 2018).

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[6] See Appendix C for selected descriptive statistics.

Hypothesis Tests

As indicated in Hypothesis 1, I anticipated that subjects' perceived level of need for the

hypothetical health clinic would predict their level of support for federal funding for the

hypothetical health clinic and that the relationship would be positive. To test this correlational

hypothesis, I ran an ordinary least squares linear regression on all responses. I chose a linear

regression because the dependent variables, support for federal funding for the clinic that did not

offer abortion services and for the clinic that did offer abortion services, were measured on

7-point Likert-type scales. While the values on the scales are a categorical representation of the

amount an individual opposes or supports federal funding for the hypothetical clinic, the

underlying concept is continuous.[7] To reduce the effect of the treatment on these correlational

results, I also conducted separate analyses for each treatment group to test this hypothesis. The

dependent variable in this regression was the variable representing support for federal funding

for the hypothetical health clinic offering non-abortion reproductive health services. The

independent variable was the perceived need variable. I included all demographic variables as

control variables in this analysis.[8]

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[7] The results of the models shown in Table 3.1 were consistently significant and positive for the relationship between the perception variable (IV) and the support for federal reproductive health funding variable (DV) when reported analyses were re-estimated using ordinal logistic regression.

[8] I also ran this analysis with the exclusion of party identification and ideology because the relationship between party identification and the dependent variable and between ideology and the dependent variable is less certain. An individual, for example, might be more supportive of federal funding for reproductive health access because they identify with the Democratic Party or consider themselves a liberal. Another individual may identify with the Democratic Party or consider themselves a liberal because they support federal funding for reproductive health care access and they see the Democratic Party or liberals as more aligned with their own policy position. The significance and direction of the relationship between perceived need (IV) and support for federal funding for the clinic (DV) remained in the regressions that excluded party identification and ideology.

Table 3.1
Predicting Support for Federal Funding for Hypothetical Clinic

	All No Abortion Offered	Low Rates Treatment No Abortion Offered	High Rates Treatment No Abortion Offered	All Abortion Offered	Low Rates Treatment Abortion Offered	High Rates Treatment Abortion Offered
Perceived Need for Reproductive Health Services	0.418**	0.551**	0.510**	0.156**	0.192**	0.146*
	(0.028)	(0.046)	(0.061)	(0.031)	(0.053)	(0.063)
Subject is Female	0.029	0.050*	0.004	0.029	0.017	0.042+
	(0.015)	(0.023)	(0.020)	(0.017)	(0.024)	(0.025)
Subject Identifies as Latinx	0.028	0.079	-0.009	0.039	0.078+	0.008
	(0.030)	(0.048)	(0.037)	(0.035)	(0.045)	(0.052)
Subject is Living in the US only Temporarily	0.014	0.001	-0.012	-0.075	-0.117	-0.034
	(0.049)	(0.077)	(0.058)	(0.067)	(0.095)	(0.108)
Subject Has Insurance Coverage	-	-	-	-	-	-
Subject Does Not Have Insurance Coverage	-0.020	-0.033	-0.014	0.038	0.086*	-0.029
	(0.024)	(0.032)	(0.036)	(0.026)	(0.034)	(0.037)
Subject's Insurance Coverage (Refused)	-0.036	0.005	-0.280**	0.322*	0.268	0.407**
	(0.100)	(0.042)	(0.033)	(0.126)	(0.177)	(0.054)
Subject is a Democrat	-	-	-	-	-	-
Subject is a Republican	-0.034	-0.010	-0.042	-0.130**	-0.132*	-0.121+
	(0.032)	(0.048)	(0.039)	(0.043)	(0.058)	(0.063)
Subject is an Independent	0.008	0.028	-0.022	-0.052*	-0.069+	-0.035
	(0.020)	(0.029)	(0.026)	(0.026)	(0.039)	(0.034)
Subject's Ideology Very Liberal to Very Conservative	-0.183**	-0.282**	-0.066	-0.548**	-0.538**	-0.572**
	(0.042)	(0.063)	(0.050)	(0.052)	(0.074)	(0.072)
Subject's Age	0.014	0.008	0.017	-0.078	-0.117+	-0.040
	(0.046)	(0.066)	(0.060)	(0.047)	(0.066)	(0.066)
Subject Identifies as White	-	-	-	-	-	-
Subject Identifies as Black	0.021	-0.001	0.053+	-0.098**	-0.196**	0.009
	(0.026)	(0.043)	(0.031)	(0.037)	(0.057)	(0.044)
Subject Identifies as Asian	-0.034	-0.035	-0.044	-0.042	-0.052	-0.019
	(0.029)	(0.038)	(0.043)	(0.030)	(0.032)	(0.055)
Subject's Race (Other/Multiple Races/Refused)	-0.043	-0.113*	0.016	-0.048	-0.102*	-0.005
	(0.033)	(0.054)	(0.037)	(0.037)	(0.051)	(0.054)
Subject Did Not Complete High School	-0.062	-0.025	-0.037	0.029	-0.148**	0.145*
	(0.048)	(0.080)	(0.055)	(0.072)	(0.044)	(0.066)
Subject Has a High School Degree	0.009	-0.014	0.041	-0.035	-0.066	-0.011
	(0.026)	(0.038)	(0.032)	(0.034)	(0.050)	(0.047)
Subject Has Some College Education	0.005	-0.040	0.054*	0.023	0.042	-0.003
	(0.020)	(0.029)	(0.026)	(0.022)	(0.029)	(0.034)
Subject Has a 2-Year Degree	-0.001	0.000	0.021	0.013	0.029	0.000
	(0.028)	(0.041)	(0.036)	(0.030)	(0.045)	(0.040)
Subject Has a 4-Year Degree	-	-	-	-	-	-
Subject Has Graduate Degree	0.043*	-0.002	0.076**	0.047	0.029	0.064+
	(0.021)	(0.030)	(0.027)	(0.025)	(0.035)	(0.036)
Constant	0.553**	0.562**	0.404**	0.844**	0.850**	0.834**
	(0.029)	(0.038)	(0.058)	(0.031)	(0.042)	(0.059)
R^2	0.30	0.35	0.29	0.42	0.46	0.41
N	864	458	406	864	458	406

Note: This table represents the results of a correlational analysis of my survey sample. Cell values are OLS coefficients with robust standard errors in parentheses. DV has seven levels and is coded as support for federal funding for reproductive health services where 0 is oppose strongly and 1 support strongly. +: $p<0.10$; *: $p<0.05$; **: $p<0.01$.

The results, shown in the first and fourth results columns of Table 3.1, support this hypothesis. A subject's perceived need in the hypothetical community for a reproductive health clinic was positively correlated to how much they supported federal funding going to the hypothetical health clinic regardless of whether the hypothetical health clinic offered abortion services or not (no abortion offered $p<0.001$; abortion offered $p<0.001$). As a subject's perception of need in the hypothetical community for the clinic increased, their level of support for federal funding for the clinic also increased. Subjects' perceived need for the clinic had a greater point estimate of correlation to their support for federal funding for the clinic that offered non-abortion reproductive health services than any other variable in the analysis. In the case of the clinic that offered abortion services, there was statistically significant evidence both that subjects' perceived need for the clinic was positive but that subjects' ideology exerted a greater point estimate of effect on their support for federal funding for the clinic than their perceived need for the clinic. The ideology scale was a based on a seven-level variable with zero being very liberal and one being very conservative. As subjects' reported ideology increased on the scale, i.e. became more conservative, their support for federal funding for the clinic decreased.

Figure 3.2 Clarify Predicted Values for OLS Regression Predicting Support for Hypothetical Clinic that Does Not Offer Abortion Services
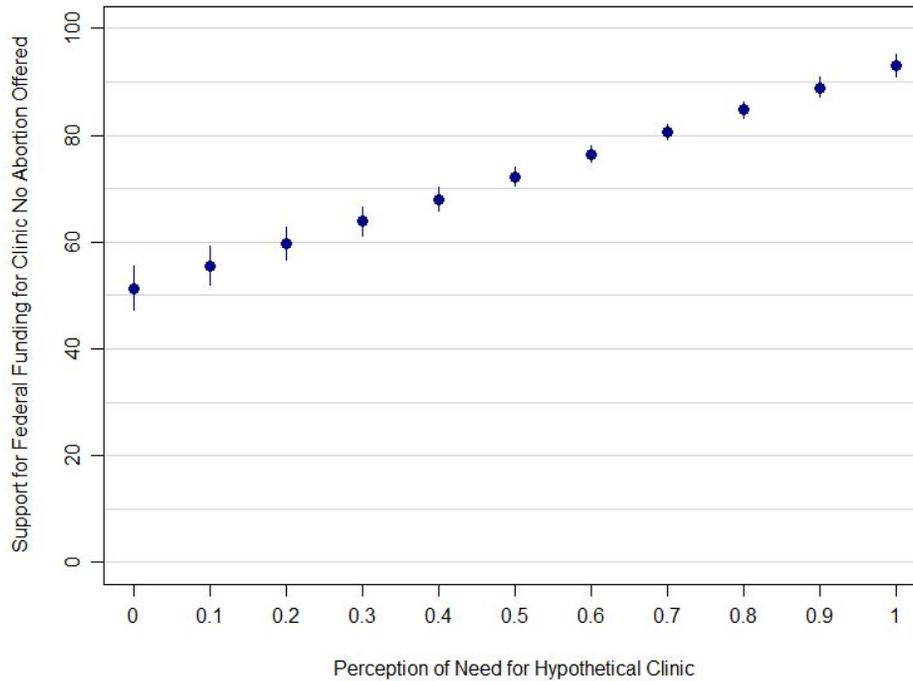
Note: This figure represents the results of a correlational analysis of all subjects in my survey sample. Points represent Clarify predicted values and bars represent 95% confidence intervals (King, Tomz, and Wittenberg 2000; Tomz, Wittenburg, and King 2003). I used R to construct this graph (R Core Team 2018).

Figure 3.2 and Figure 3.3 show a graphic representation of Clarify predicted values indicating the correlation sizes of perceived need on support for federal funding for the hypothetical clinics among all subjects (Tomz, Wittenburg, and King 2003). One can see that as subjects' perception of need for the clinic increases, their support for federal funding for the clinic providing non-abortion reproductive health services increases more dramatically than the their support for the clinic that offers abortion services. The results of a test of seemingly unrelated estimation on these two means indicated that there was evidence of a statistically significant difference between the two means ($p < 0.0001$), which means that the relationship between perception of need for the clinic and support for federal funding for the clinic varied by whether the clinic offered abortion services.

Figure 3.3 Clarify Predicted Values for OLS Regression Predicting Support for Hypothetical Clinic that Offers Abortion Services
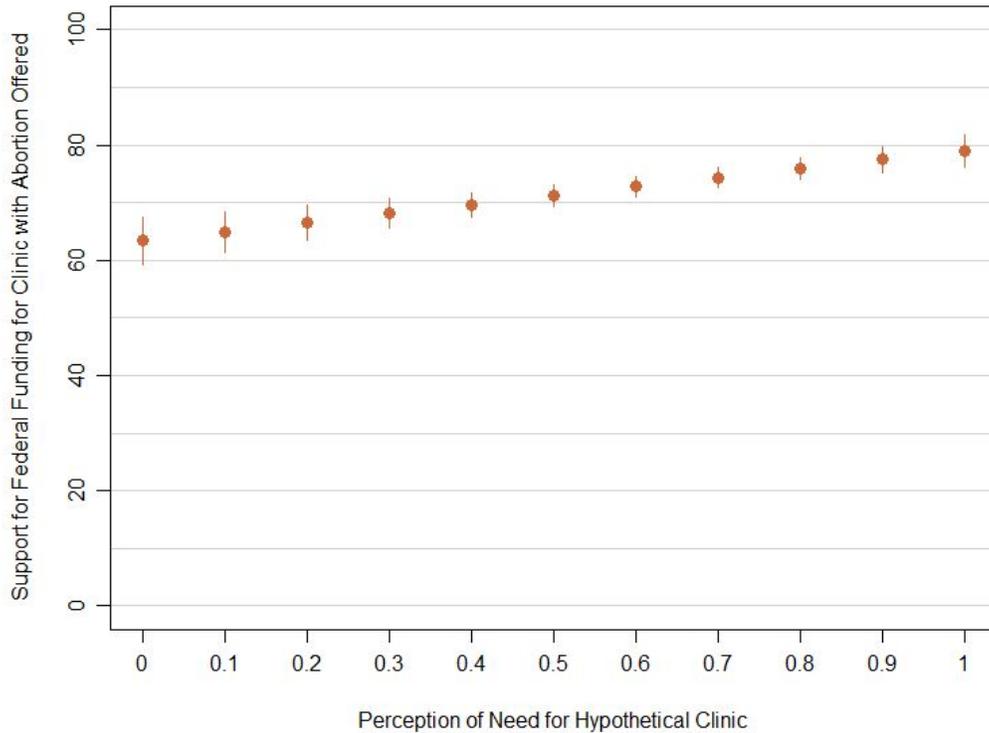

Note: This figure represents the results of a correlational analysis of my survey sample. Points represent Clarify predicted values and bars represent 95% confidence intervals (King, Tomz, and Wittenberg 2000; Tomz, Wittenburg, and King 2003). I used R to construct this graph (R Core Team 2018).

To test Hypothesis 2, I conducted an unpaired difference of means test not assuming equal variances for the variable representing support for federal funding for the hypothetical clinic offering only non-abortion reproductive health services by treatment group to assess whether the treatment affected this variable. To explore whether the treatment also affected support for the hypothetical clinic that offered abortion services, I ran an unpaired difference of means test by treatment group not assuming equal variances for the variable representing this item. Figure 3.4 shows that subjects in the high rates treatment group indicated higher levels of

support for federal funding for the hypothetical clinic regardless of whether the clinic offered

abortion services or not (no abortion offered p<0.0001; abortion offered p=0.0006).[9]

Figure 3.4 Mean Support for Federal Funding for the Hypothetical Clinic, by Treatment Group and by whether the Clinic Offered Abortion Services
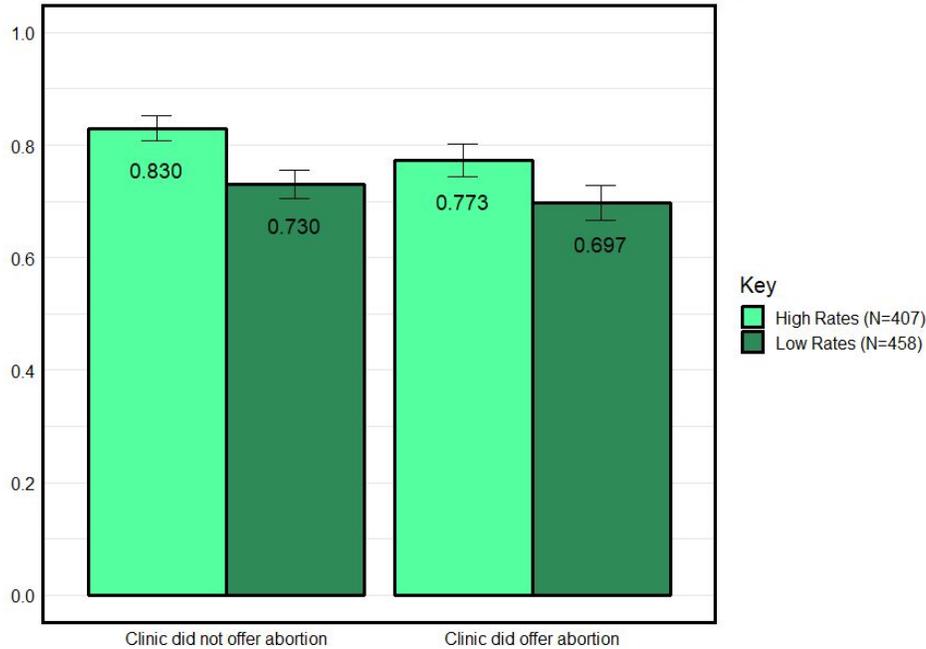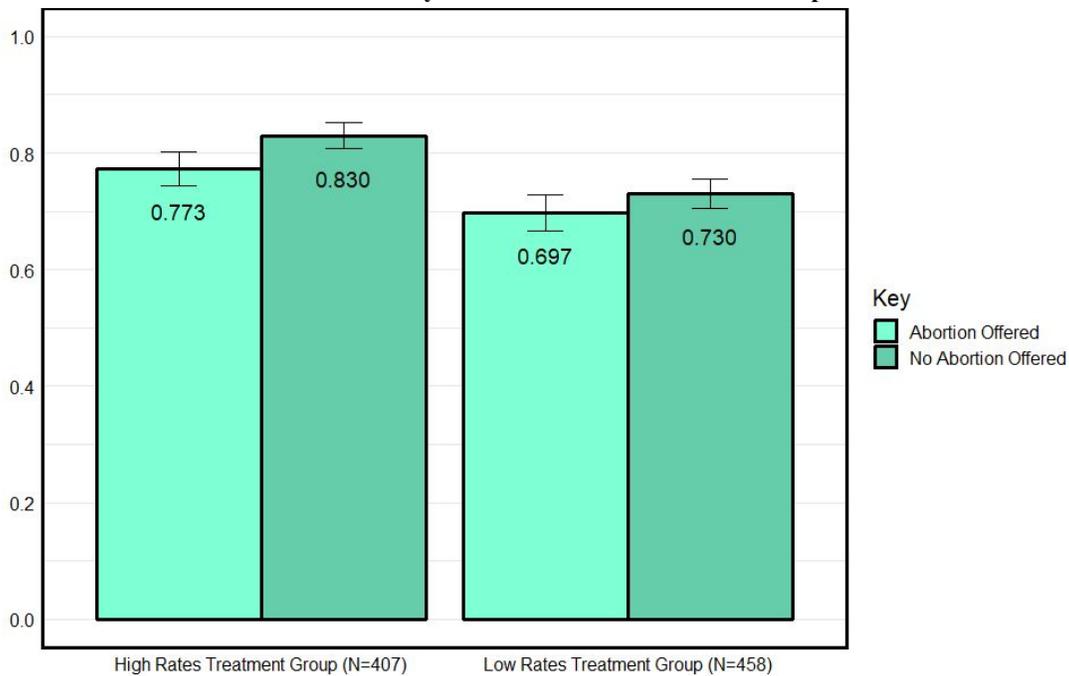

Note: Column values are treatment group means of responses to two items that all subjects were asked. Braces represent the standard errors. DV has five levels and is coded as support for federal funding for reproductive health services where 0 is no need and 1 very high need. For support for the clinic that did not offer abortion services, the difference in support between the high rates treatment group and the low rates treatment group was 0.100 (p<0.0001). For support for the clinic that did offer abortion services, the difference in support between the high rates treatment group and the low rates treatment group was 0.076 (p=0.0006). I used ggplot2 to construct this graph (Wickham 2016).

To test Hypothesis 3 and assess whether subjects' level of support for federal funding for

the hypothetical health clinic was lower if the clinic offered abortion services paid for by private

funds than when the hypothetical clinic did not offer abortion services, I ran paired difference of

means tests for the variables representing support for federal funding for the non-abortion

reproductive health services offering health clinic and support for federal funding for the clinic

_____

[9] I ran a seemingly unrelated estimation test to assess whether the difference between the treatment groups for the "No Abortion Offered" clinic (-0.100) and the difference between the treatment groups for the "Abortion Offered" clinic (-0.076) were different from one another, which would indicate that the effect of the treatment was different for the non-abortion item than it was for the abortion item. The results indicated that the null hypothesis that the two differences were the same could not be rejected (coef=0.024, SE=0.021, p=0.256, CI -0.018-0.066).

that also offered abortion services. In order to alleviate any bias caused by the treatment, I ran

two versions of this test. One limited responses to the low rates treatment group and one limited

responses to the high rates treatment group. The results in Figure 3.5 indicate that in both tests

levels of support for federal funding for the hypothetical clinic were lower if the clinic offered

abortion services than when it did not (low rates difference p=0.0206 and high rates difference

p=0.0003).

Figure 3.5 Paired Difference of Means Test by Clinic Items on Treatment Group

Note: Column values are treatment group means with braces representing the standard error. DV has five levels and is coded as support for federal funding for reproductive health services where 0 is no need and 1 very high need. Among the low needs treatment group, the difference in support between the clinic that did not offer abortion and the clinic that did offer abortion was 0.033 (p=0.0206). Among the high needs treatment group, the difference in support between the clinic that did not offer abortion and the clinic that did offer abortion was 0.058 (p=0.0003). I used ggplot2 to construct this graph (Wickham 2016).

Discussion

The results of this experimental survey provide evidence to support all three hypotheses

posed at the beginning of this chapter and, thereby, supporting my underlying theory. Subjects

who perceived higher need in the hypothetical community for a clinic offering reproductive

health services indicated higher rates of support for federal funding for the clinic supporting hypothesis one. Perception of need for the clinic in the hypothetical community exerted the greatest point estimate of influence on how much subjects supported federal funding for the non-abortion providing clinic than any other variable in the analysis, including party identification and ideology supporting hypothesis two. While perception was also a positive predictor of support for federal funding for the clinic that did offer abortion services, ideology exerted a greater point estimate of influence over support for federal funding for the clinic in this case supporting hypothesis three. Together, there results suggest that access to reproductive health care when individuals perceive a high community need for it is not seen as a politicized issue by the sample. With the addition of abortion services provision by the clinic, however, ideological beliefs become a stronger predictor of support for the clinic receiving federal funds.

Importantly, subjects who read that rates of unintended pregnancy and sexually transmitted infections were very high in their hypothetical community remained more likely to indicate greater levels of support for federal funding for the clinic even if it were to offer abortion services than those who read that the rates of unintended pregnancy and sexually transmitted infections were very low in their hypothetical community. This trend was the same for support for the clinic offering only non-abortion reproductive health services with the low rates treatment group having a lower overall mean of support for federal funding for the clinic than the high rates treatment group. This suggests that manipulating public perception on the local need for reproductive health care access can strongly influence public opinion on federal funding for this issue that would benefit the local community.

Although the reduction in support for federal funding for the clinic that would provide abortion services compared to the one that would not was small among each treatment group, this reduction could possibly be amplified in reality if there was political protest against a clinic that offered abortion services that exerted greater influence than simply reading that abortion services would be offered. When serving a community where subjects perceive the need for reproductive health services is high, though, they are likely to receive more support from the public for federal funding for their services than those serving a community where subjects perceive the need reproductive health services is low.

Ultimately, this study indicates that perception of need in one's own community can play an important role in whether subjects support federal funding for reproductive health care access. People care about whether a clinic offers abortion services and show less support for a clinic that does offer it, but they tend to want people to have access to reproductive health care if they perceive that their community has a high need for it regardless of if that means federal funding going to clinics that offer abortion services.

There are some limitations to the generalizability of the findings in this study though. Democrats, liberals, and white people were oversampled in this study and the sample was not nationally representative. The sample also skewed towards younger subjects with seniors being undersampled. These factors undermine the generalizability of the results.

Future studies should address these weaknesses and could explore to what extent these effects hold when the need for reproductive health care is put in a context beyond the community, like at the county, state, regional, or national levels. Other studies could more deeply investigate the relationship between perceived community need for the service and actual rates of

unintended pregnancy, teen births, sexually transmitted infection prevalence, or other appropriate

measurable indicators of need for reproductive health care. Another focus for future research

could be exploring how personal experience with access to reproductive health care impacts

perception of community need for it. Assessing whether the type of public funding or the level of

government it comes from affects support could offer more important information about this

issue. Conservatives and libertarians tend to oppose federal spending, so future research could

analyze whether support increases when the public funding is from the state or local level.

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IRB-2018-634: Survey Instrument
Survey Flow
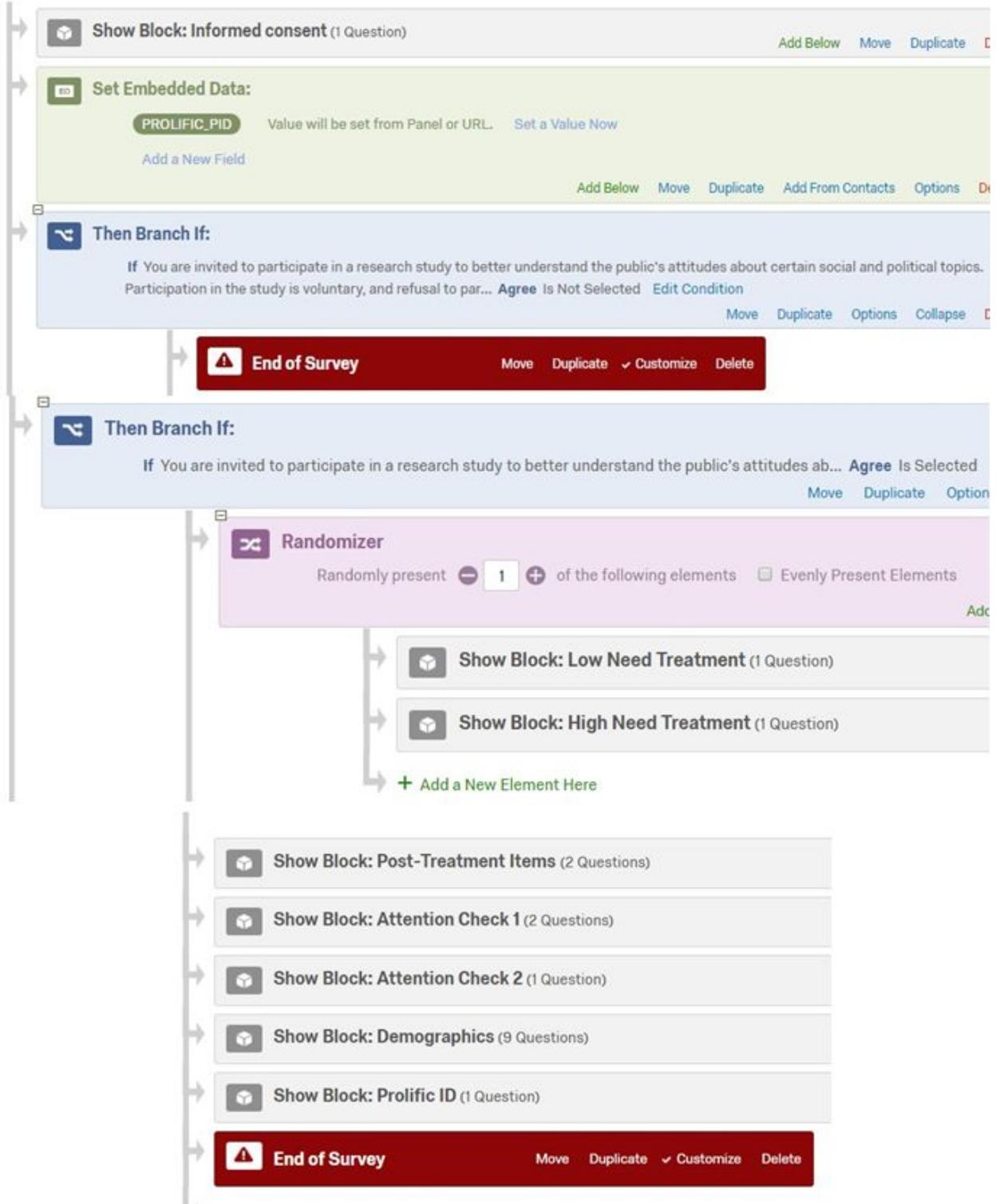
Please note that all bold text in this document is not part of the survey and will not be seen by subjects.

Informed Consent Block

You are invited to participate in a research study to better understand the public's attitudes about certain social and political topics. Participation in the study is voluntary, and refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled.

If you participate, you will be asked to fill out a 4-minute survey. You may skip any items or discontinue participation at any time without penalty. Upon submission of the survey, you will be redirected to Prolific to receive your completion code; we recommend that you keep a copy of this completion code and that you verify your Prolific ID in the survey. Responses for partial survey completions will be recorded and locked 4 hours after you start the survey.

Participating in the study has no foreseeable direct benefits for participants but could contribute to scientific knowledge. Foreseeable risks from participation include feeling discomfort or related feelings while reading or responding to certain items. Moreover, if the participant's responses become known there is a risk that this causes damage to the participant's social standing, financial standing, employability, or reputation.

To help detect non-independent responses, the Qualtrics platform used to collect data for this study will collect participant IP address and location latitude and longitude. While your data will be securely stored, it is remotely possible that a breach of confidentiality could occur and your responses could become known. To minimize this risk, access to the data at the Qualtrics site will be password protected, and participant identifiers will be deleted from any data made public. Data without identifiers might be shared and/or placed online or reported in theses, presentations, academic journals, or other venues.

You will be paid $0.49 for participating. The IRS may consider these payments to be taxable compensation. Recipients of a research participant incentive payment may want to consult with their personal tax advisor for advice regarding the participant's situation. Any participant may choose to participate in the study without accepting the research incentive payment. Moreover, requests for compensation may be rejected if your Prolific ID does not appear in the collected data, if you complete the survey in less than 1 minute, or if you cancel your survey participation on Prolific; multiple submissions from the same Prolific ID may be rejected. After a certain number of rejections, Prolific may limit or remove the participant from the Prolific respondent pool.

Please direct questions about this study (Study IRB-2018-634) to Dr. L.J Zigerell at ljzigerell@ilstu.edu. For questions about research participants' rights and/or a research-related injury or adverse effects, you may contact the Illinois State University Research Ethics & Compliance Office at 309-438-5527 or rec@ilstu.edu. If, during the survey, you feel distress or related feelings, you may call 2-1-1 for a referral to counseling services. We recommend that you save this statement.

Click "Agree" below if you are 18 years of age or older, are not currently within the European Economic Area, reside in the United States, and voluntarily agree to participate. Otherwise, click "Disagree."

Agree
Disagree

Participants' Prolific IDs will be recorded from their URL as part of the Informed Consent page and is later automatically embedded in the survey for them to confirm or change.

If "Agree" is not selected, participants will see the following message.

As you do not wish to participate in this study, please return your submission on Prolific by selecting the 'Stop without completing' button on the Prolific studies page.

If "Agree" is selected, participants will be randomly assigned to either the "Low Rates Treatment" or the "High Rates Treatment."

Low Rates Treatment Block

1a) Imagine that you lived in a community that might establish a new health clinic that would offer only nonabortion reproductive health services such as birth control and prevention and treatment of sexually transmitted diseases. The community has very low rates of unplanned pregnancy and sexually transmitted diseases. How much do you think your hypothetical community would need this new clinic?

No need
Low level of need
Moderate level of need
High level of need
Very high level of need

High Rates Treatment Block

1b) Imagine that you lived in a community that might establish a new health clinic that would offer only nonabortion reproductive health services such as birth control and prevention and treatment of sexually transmitted diseases. The community has very high rates of unplanned pregnancy and sexually transmitted diseases. How much do you think your hypothetical community would need this new clinic?

No need
Low level of need
Moderate level of need
High level of need
Very high level of need

After moving through either the Low Rates Treatment Block or the High Rates Treatment Block based on their random assignment, all participants will be shown the "Post-Treatment Item Block."

Post-Treatment Items Block

2) How much would you oppose or support this clinic receiving federal funds?

Oppose strongly
Oppose moderately
Oppose slightly
Neither oppose nor support
Support slightly
Support moderately
Support strongly

3) How much would you oppose or support this clinic receiving federal funds if the clinic offered abortion services paid for by private funds?

Oppose strongly
Oppose moderately
Oppose slightly
Neither oppose nor support
Support slightly
Support moderately
Support strongly

After moving through the "Post-Treatment Block," participants will be randomly presented one of the two questions from the "Attention Check 1 Block."

Attention Check 1 Block

4a) What did the passage about the hypothetical community indicate about the rates of unplanned pregnancy and sexually transmitted diseases in the community?

The rates were very low.
The rates were average.
The rates were very high.
The passage did not mention rates of unplanned pregnancy or sexually transmitted diseases.

4b) What did the passage about the hypothetical community indicate about the rates of unplanned pregnancy and sexually transmitted diseases in the community?

The rates were very high.
The rates were average.
The rates were very low.
The passage did not mention rates of unplanned pregnancy or sexually transmitted diseases.

After moving through the "Attention Check 1 Block" item, all participants will be shown the rest of the survey items.

Attention Check 2 Block

5) Select pregnancy test in the list below.
The order of answers for this item are randomized.

pregnancy test
STD treatment
HPV vaccine
hormone therapy
blood test

Demographics Block

6) What is your sex? The order of "Female" and "Male" for this item are randomized and "Other" is always last.

Female
Male
Other

7) Do you identify as Latinx, Latino, or Hispanic?

Yes
No

8) Select each of the following that describes your race:
The "Other" option is always last but the remaining answers for this item are randomized.

White
Black
Asian
American Indian or Alaska Native
Native Hawaiian or Other Pacific Islander
Other

9) Which is the highest level of formal education that you have completed?

Less than a high school degree
High school degree or equivalent
Some college, no degree
2-year college degree
4-year college degree
More than a 4-year college degree

10) Are you living in the United States only temporarily?

Yes
No

11) Please select the year you were born.
Drop down menu only allows a selection of year 1900 – 2001 or participant can leave it blank.

12) Which of the following is your main source of health insurance coverage?

Plan through your employer or your spouse's
employer Plan you purchased yourself
Medicaid, Medi-CAL, or other plan sponsored by your state
Medicare
Plan through your parent
I do not have health insurance coverage
Other

13) Generally speaking, how do you think of yourself?

Strong Democrat
Moderate Democrat

Slightly Lean Democrat
Independent, None, Don't Lean, Other
Slightly Lean Republican
Moderate Republican
Strong Republican

14) Generally speaking, how do you think of yourself?

Very liberal
Moderately liberal
Slightly liberal
Moderate, Middle of the road
Slightly conservative
Moderately conservative
Strongly conservative

Prolific ID Block

15) Please verify your Prolific ID in order to receive compensation. Your completion code will be displayed on the next page.
Participant's Prolific ID will be embedded in the editable text box for them to verify or change.

After submission, participants will be redirected to Prolific and will see that their submission was successfully submitted and they will see a completion code that is automatically recorded by Prolific.

Table B.1 Survey Experiment Sample Characteristics		
Description	**N**	**%**
Female	427	49.4%
Non-Female	438	50.6%
Latinx/Latino/Hispanic	71	8.2%
White	685	79.3%
Black	61	7.1%
Asian	64	7.4%
Other, 2+ Races, No Race Given	55	6.4%
Less than High School Education	6	0.7%
High School Graduate	87	10.1%
Some College Education	233	26.9%
2-Year College Degree	83	9.6%
4-Year College Degree	307	35.5%
Graduate School Degree	149	17.2%
Living in the US Temporarily	20	2.3%
Has Health Insurance Coverage	736	85.1%
Doesn't Have Health Insurance Coverage	125	14.5%
Republican	154	17.8%
Independent	192	22.2%
Democrat	518	60.0%
Very Conservative	39	4.5%
Moderately Conservative	50	5.8%
Slightly Conservative	74	8.6%
Moderate, Middle of the Road	140	16.2%
Slightly Liberal	101	11.7%
Moderately Liberal	257	29.7%
Very Liberal	203	23.5%

Figure B.1 Survey Experiment Histogram of Sample Age
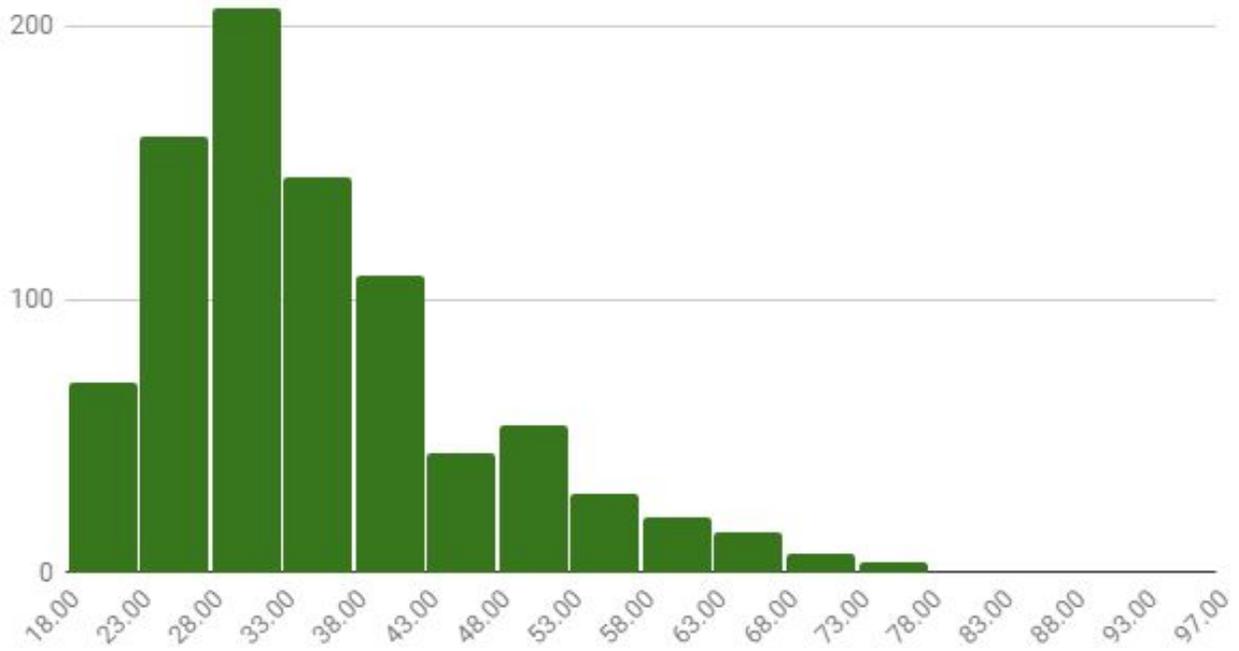
APPENDIX C: DESCRIPTIVE STATISTICS FROM SURVEY EXPERIMENT

	Variable	N	Mean	Standard Deviation	Min	Max
Table C.1 Survey Experiment Selected Descriptive Statistics						
Low Rates Treatment						
	Support Federal Funds for Non-Abortion Clinic	458	0.730	0.282	0	1
	Support Federal Funds for Abortion Clinic	458	0.697	0.337	0	1
	Perception of Need for Clinic	458	0.461	0.221	0	1
High Rates Treatment						
	Support Federal Funds for Non-Abortion Clinic	406	0.830	0.222	0	1
	Support Federal Funds for Abortion Clinic	406	0.773	0.312	0	1
	Perception of Need for Clinic	406	0.827	0.212	0	1
Full Sample						
	Support Federal Funds for Non-Abortion Clinic	865	0.777	0.260	0	1
	Support Federal Funds for Abortion Clinic	865	0.732	0.327	0	1
	Perception of Need for Clinic	865	0.633	0.284	0	1