

Playing Fair: Fairness Beliefs and Health Policy Preferences in the United States

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Abstract Conventional wisdom suggests that the best way to persuade Americans to support changes in health care policy is to appeal to their self-interest—particularly to concerns about their economic and health security. An alternative strategy, framing problems in the health care system to emphasize inequalities, could also, however, mobilize public support for policy change by activating underlying attitudes about the unfairness or injustice of these inequalities. In this article, we draw on original data from a nationally representative survey to describe Americans' beliefs about fairness in the health domain, including their perceptions of the fairness of particular inequalities in health and health care. We then assess the influence of these fairness considerations on opinions about the appropriate role of private actors versus government in providing health insurance. Respondents believe inequalities in access to and quality of health care are more unfair than unequal health outcomes. Even after taking into account self-interest considerations and the other usual suspects driving policy opinions, perceptions of the unfairness of inequalities in health care strongly influence respondents' preferences for government provision of health insurance.

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It is probably no accident that the failed reform efforts of the Clinton administration appealed to middle-class self-interest and to the self-interest of large employers worried about costs, with no appeal to the moral considerations about equality and fairness that lie at the heart of universal coverage.

—Norman Daniels, Bruce Kennedy, and Ichiro Kawachi

With that sense of the battle-scarred history of health care politics, Mr. Obama began a careful campaign to frame the issue more as a pocket-book concern than a moral one. Given that four of five Americans are dissatisfied with health costs, while only 15 percent lack insurance, strategists have argued since the Clinton health care debacle of the 1990s that success would depend on persuading the vast middle of its economic self-interest.

—Kevin Sack

As the health care reform debates of 2009 and 2010 recede into political history, commentators can begin to reflect on the role of public opinion in shaping the political and policy outcomes. Despite structural obstacles to health care system reform (see, e.g., Hacker 2002, Steinmo and Watts 1995, and Quadagno 2005), public norms, beliefs, and opinions are widely believed to influence policy, as well as be influenced by it.¹ This robust relationship between public opinion and policy has been documented both generally (Stimson 2004; Burstein 2003) and in the particular case of health care reform (Cappella and Jamieson 1997; Jacobs and Shapiro 2000). Any successful attempt to change the health care system through public policy will need to account for public preferences. But what shapes public opinion toward health policy? Are policy preferences informed for the most part by citizens' self-interest? Or do the considerations about fairness cited by Daniels, Kennedy, and Kawachi (2000: 93) in the first epigraph also play an important role in public opinion?

Scholars of the failed Clinton health care reform attempt have argued that public opinion of a particular kind—that is, opinion driven by self-interest—critically undermined the administration's efforts. Political elites successfully shifted public opinion against the health reform proposal Clinton introduced in 1993, the story goes, by making middle-class Americans anxious about losing their current health benefits (Goldstein et al. 2001; Jacobs 2001). Lessons taken from the mid-1990s seemed to shape the Obama administration's early efforts to persuade the public. In

1. "Policy feedback" effects of health policy on public opinion, while potentially substantial (see, e.g., Jacobs and Shapiro 2000, Barabas 2009, and Campbell and Morgan 2009), are not the focus of this article.

policy speeches, President Obama took pains to emphasize that health care reform would enhance the economic security of middle-class Americans and spent only limited time encouraging Americans to connect health care reform with their considerations based on morals or values.

In this article, we use data from a nationally representative survey of Americans to explore the relative importance of self-interest and fairness considerations, among other factors, for opinions about health insurance policy. Because little is known about ordinary Americans' beliefs about fairness, our study has the following three aims: first, we describe how Americans define fairness in general and explore differences between their attitudes about health as compared with other social goods; second, we describe Americans' beliefs about the fairness of various group differences in health and health care; and third, we assess the influence of fairness beliefs on attitudes toward government-provided health insurance. We find that while individual-level characteristics that reflect potential for personal benefit (e.g., uninsurance and ill health status) do influence their preferences, what Americans believe about the fairness of health care inequalities often more strongly predicts support for an enhanced government role in providing health insurance, even net of political predispositions and values. Our results suggest that fairness considerations could have a particularly important influence on public opinions about health insurance policy in a context in which policy debates emphasize the existence of inequalities in access to health care and health care quality.

Background

What Drives Public Opinion on Health Policy?

Before assessing Americans' beliefs about fairness, we review the major determinants of Americans' opinions about policy matters. The standard view is that several key "ingredients" at the individual level—self-interest, ideology, racial or social group identity, and fundamental social values—contribute to the public's beliefs and preferences (Kinder and Sanders 1996). The self-interest perspective, which enjoys widespread currency in economics, political science, and psychology, suggests that Americans will support those policies that will help them maximize their short-term individual goals or interests, such as improved financial or health status (see, e.g., Miller and Ratner 1998; Brook, Preston, and Hall 1998; Cnaan et al. 1993; d'Anjou, Steijn, and van Aarsen 1995). In fact, political campaigns often center on "pocketbook issues," in an attempt to convince vot-

ers that proposed policies will improve (or at least not harm) their material well-being (Chong, Citrin, and Conley 2001).

However, despite such campaigns and the intuitive appeal of self-interest as a motivator, abundant empirical research has shown that characteristics plausibly indicating the extent to which individuals are likely to benefit tangibly from a policy generally have only modest associations with policy opinions (Sears et al. 1980; Chong, Citrin, and Conley 2001; Lau and Heldman 2009). This is partly because survey researchers who seek to identify self-interest effects on policy preferences frequently must make simplifying assumptions about which characteristics identify those respondents whose self-interest would really be served by particular policies. Self-interest has been found to have a significant influence on policy preferences under generally restricted circumstances: when the risks and benefits of a particular policy are abundantly clear to individuals, when the issue has relatively large stakes, and when individuals have been primed to consider their own personal expected benefit before considering their opinions on that policy (Chong, Citrin, and Conley 2001; Green and Gerken 1989).

While self-interest is often a weak predictor of policy preferences, much research shows that people rely heavily on partisan and ideological cues as shortcuts to inform their opinions on complex policy matters (Sniderman 1993). Americans' attitudes toward the social groups to which they belong and their attitudes toward other groups also contribute significantly to their policy opinions (Bobo and Hutchings 1996; Gilens 1999; Kinder and Sanders 1996; Nelson and Kinder 1996). Social values such as egalitarianism and humanitarianism comprise another important framework within which members of the public interpret their opinions across multiple policy issues (Rokeach 1968; Sniderman 1993; Tetlock 1986). More accessible to most Americans than ideological considerations, these values provide an efficient benchmark against which to measure complex policy choices.

Previous work demonstrates that all of these basic "ingredients" of policy opinion predict health policy preferences well. Sears and colleagues (1980) find that characteristics representing Americans' personal potential to benefit from the policy (which they define as lacking health insurance, being underinsured, or having a low income) do, in fact, predict support for government-sponsored health insurance. (Note, however, that Sears and colleagues define "self-interest" more narrowly than is commonly the case in contemporary American health politics. As the epigraphs emphasize, persuasive appeals based on self-interest, in the current health policy

context, usually involve trying to convince middle-class and currently insured Americans that they stand to benefit from health reform because of their vulnerability to rising health care costs or loss of health insurance.) Political orientations (i.e., being liberal, or a Democrat, or both) are even more strongly associated with health policy opinions than are these self-interest variables (Sears et al. 1980). Nearly identical patterns—a small but significant role of self-interest, but much larger influence of political predispositions—were found in a recent replication of Sears and colleagues’ now-classic study (Lau and Heldman 2009). Group membership also influences health policy preferences. For example, African Americans were significantly more likely than whites to report that health care was the first or second most important issue contributing to their presidential votes in the 2008 election (Blendon et al. 2008). Confirming the role of social values in influencing health policy preferences among the public, Koch (1998) finds that, adjusting for self-interest, political self-identifications, and sociodemographic factors, egalitarian values strongly predict support for government-sponsored health insurance.

While these individual-level “ingredients” predict opinion fairly well, albeit to varying degrees, across different types of policy issues, public support for policies is also based at least partly on individuals’ judgments of the particular policy context—including whether they perceive the policy mechanisms or outcomes to be fair (Corneo and Gruner 2002; Fong 2001; Hochschild 1981; Kluegel and Smith 1986; Rasinski and Tyler 1988). Previous empirical studies support the notion that beliefs about fairness may also be salient considerations underlying health policy opinions, above and beyond the other considerations already described. For instance, evaluations of fairness frequently emerge in Medicare beneficiaries’ discussions of potential policy changes to Medicare (Bernstein and Stevens 1999), and clashes in norms of fairness between the public and elites explain public antipathy toward managed care and other market-oriented health care reform strategies (Schlesinger 2002; Laugesen 2005).

To fully understand the role of fairness beliefs within health policy preferences, however, we must consider the multiple meanings of fairness and their potential variation across policy contexts. Research suggests that for a plurality of Americans, the idea of fairness in general is most closely linked to the notion of equal opportunity or equal treatment, rather than to equal outcomes (Tocqueville 1963; Lipset 1990; Verba and Orren 1985; Rasinski and Tyler 1988). Americans’ views of the fairness of public policy are also affected by other considerations, particularly beliefs about

the deservingness or merit of the target population that would be helped by the policy (Gilens 1999; Schneider and Ingram 1993) and the causal attributions for the policy issue at hand (Stone 1989).

Applying these ideas to the health policy context, we find some similarities—as well as some reasons to suspect differences—in the contours of fairness beliefs in the health domain relative to other social policy domains. To be sure, concerns about equal opportunity (notably Daniels's [1985] “fair equality of opportunity” account) and fair procedures feature prominently in contemporary thinking about health equity (Jacobs 2005; Ruger 2008), as they do in other domains. Beliefs about merit or deservingness also play an important role in considerations about the fairness of health inequalities (Jacobs 2005; Stone 2006; Schlesinger and Lee 1993). However, empirical research has found striking variation in fairness beliefs in different domains (Hochschild 1981), and Walzer's (1983: 89–90) normative account of justice suggests that indeed fairness beliefs *should* be different in health, at least insofar as medical care is envisioned by society as a “needed good” rather than a luxury. Fairness beliefs in the health domain may be further distanced from normative evaluations of the distribution of other social goods like income, education, or political voice to the extent that members of the public see health, but not, for instance, income, as a fundamental human right—or at least as a good with “special moral importance” (Daniels 2008; Ruger 2006). Finally, as illnesses linked to health behaviors become increasingly prominent contributors to population health, personal responsibility for health has become a central moral value (Leichter 2003), resonating in media coverage of health policy topics (Kim and Willis 2007) and reflected in policy actions (Pearson and Lieber 2009; Schmidt, Voigt, and Wikler 2009; Steinbrook 2006). Attitudes about fairness in health and health care, then, are likely to be especially strongly shaped by individuals' beliefs about whether people are causally responsible for their health and health care outcomes (Wikler 2002; Stone 2006).

Framing Inequalities as a Fairness Issue

While the evidence just reviewed suggests that self-interest, group interest, political identifications, values, and perceptions of fairness might explain much of the variation in Americans' health policy preferences, the relative importance of these specific components in influencing policy opinion can change, and new factors can emerge, depending on how policy debates are framed in public discourse. When the communication environment

emphasizes certain issues over others, thus making certain beliefs more available, accessible, or otherwise influential, we expect to observe corresponding changes in the considerations the public draws from in forming opinions (Chong and Druckman 2007a). This is because politicians and other elites aim to mobilize the public's support for particular policies by "encouraging [the public] to think about these policies along particular lines . . . by highlighting certain features of the policy, such as its likely effects or its relationship to important values" (ibid.: 106). Such framing effects have been observed in studies of health policy opinion in the past (see especially Koch 1998, Jacobs and Shapiro 2000, and Winter 2005, who document the changing influence of values, ideology, and gender-related attitudes on health policy opinion in the 1990s).

The present research does not test the effects of alternative frames on policy preferences. However, if the current information environment were to emphasize the problem of health inequalities in health policy debates, this might activate fairness considerations. There is ample attention to health inequalities, and policy elites have drawn prominent links between health inequalities and concepts of fairness. For example, in the past five years, groups including the Institute of Medicine, the World Health Organization, and the Robert Wood Johnson Foundation have made raising public awareness of health inequalities major policy goals (Smedley et al. 2003; Marmot and Bell 2009; Robert Wood Johnson Foundation Commission to Build a Healthier America 2009). Academic studies document rising scholarly (Kaplan 2004) and media (Taylor-Clark et al. 2007) attention to health inequalities as well. And while there has been no research, to our knowledge, on whether the American public considers health inequalities unfair, rather than simply unfortunate or unavoidable, health policy elites draw strong conceptual linkages between health inequalities and concepts of fairness. The seminal definition of health inequalities for policy elites is differences in health that are "avoidable, *unfair*, and unjust" (emphasis added) (Braveman 2006; see also Whitehead 1992). In the book *Healthy, Wealthy, and Fair* (Morone and Jacobs 2005), health policy experts promote health reform policies predicated partly on the unfairness of the inequalities inherent in the current system. Thus, in an information environment rich with descriptions of unequal access to health care, unequal quality of care, and unequal health outcomes, as well as explicit links with values and beliefs about fairness, we suggest that individuals' perceptions of the fairness of these inequalities are likely to be influential contributors to American public opinion about health policy.

Research Goals and Study Design

The present research draws on original survey data to advance three specific goals: (1) to better understand the concepts and definitions Americans associate with fairness in the domain of health, (2) to evaluate how Americans perceive the fairness of inequalities in health and health care, and (3) to assess whether these fairness considerations influence Americans' opinions about government health insurance expansions, above and beyond other determinants of public opinion like self-interest and political ideologies and identifications.

The What's Fair in Health Care survey (Lynch 2007), from which we draw our data, is a nationally representative, Internet-based survey that uses embedded vignettes to elicit Americans' attitudes and opinions about inequalities, fairness, and health policy. Respondents were asked to read a series of vignettes related to inequalities in health status, health care access, and health care quality. They were then asked to evaluate the fairness of the inequalities, to state their opinions on health care reform proposals, and to identify a definition of fairness that most closely matches their own opinions. (We describe the key measures in more detail below, with the complete text of the questions and vignettes appearing in the appendix.)

The survey exposed all respondents to information about health inequalities, making these inequalities more salient or accessible to respondents than they would otherwise be within the current information environment.² If we are correct in hypothesizing that considerations of fairness are activated by content about inequalities, the information about inequalities contained in the survey will have primed respondents to consider their beliefs about fairness when articulating their health policy preferences (Iyengar and Kinder 1987). Thus we expect the survey data to illuminate the impact of fairness considerations on policy opinions in a way analogous to what we would observe if health policy makers framed the problem of health reform in terms that emphasize inequalities. We interpret and discuss our results with this overarching framing effect in mind.

Sample

The Knowledge Networks survey firm recruited a nationally representative sample of individuals who took the *What's Fair in Health Care* sur-

2. All surveys, of course, "frame" their topics for respondents by highlighting the salience of the topic at hand.

vey between August 22 and September 13, 2007 (over two waves of data collection). The completion rate for this survey was 72.6 percent in wave 1 and 79.7 percent in wave 2, considerably higher than the average completion rate of 65 percent in Knowledge Networks surveys.

All results in the analyses (except where otherwise indicated) use the survey weights calculated by Knowledge Networks to adjust the sample to be representative, in demographic terms, of the national U.S. population. The sample appears also to be representative of the national population in other respects that may be relevant to their health policy preferences, such as health insurance status or health status. We observe that 15.3 percent of the Knowledge Networks respondents under age sixty-five were without health insurance (unweighted), which is comparable to the 16.5 percent of the U.S. population without insurance as reported in the 2007 National Health Interview Survey (NHIS 2007). The Knowledge Networks sample appears to be in poorer health than the national population, with 17.5 percent reporting poor or fair health, as opposed to 10 percent in the 2007 NHIS. However, other recent surveys of health policy opinions find rates of fair and poor self-assessed health that are similar to the Knowledge Networks sample (20 percent in 2006 and 16 percent in 2007) (McInturff et al. 2008). We are therefore confident in generalizing the results of this study to the U.S. population as a whole.

Measures

The main variable of interest for this study is a measure of public opinion about the fairness of inequalities. All respondents were exposed to three vignettes about inequalities in health outcomes (life expectancy), inequalities in health care access (health insurance), and inequalities in the health care quality received. Respondents were randomly assigned to vignettes that varied the particular social groups said to be affected by the inequality: men versus women, African Americans versus whites, high school–educated versus college-educated Americans, or low-income versus higher-income groups. After reading the vignettes, all respondents were asked to what extent they perceived the difference (in life expectancy, in access to health insurance, and in receipt of high-quality medical care) to be fair or unfair, measured on a Likert scale where 1 = very fair, 2 = somewhat fair, 3 = neither fair nor unfair, 4 = somewhat unfair, and 5 = very unfair. See the appendix for the text of all vignettes.

Since fairness in general is a multidimensional concept that is likely to be difficult to measure in a survey context, and since there is little

empirical research into the public's conceptions of fairness in health and health care,³ we also asked respondents several additional questions to clarify what they perceive fairness to mean. One item asked respondents to endorse one of six definitions of fairness *in general* (not specifically in the health domain). The response options were derived from the literature on fairness and on preliminary in-depth interview research conducted by one author. In another question, designed to distinguish Americans' perceptions of health care from other social goods, respondents were asked whether they perceive access to a good-quality education, access to a well-paying job, or access to affordable health care as most important to a "good life." Then, they were asked to rank whether their chosen good was important because it ensures that everyone has an "equal chance to get ahead" (anchored as 1 on a scale) or ensures "that everyone has a right to [the outcome of that social good]" (anchored as 10 on a scale). The full text is reported in the appendix.

The main dependent variable in the analyses presented here is support for a government-sponsored universal health insurance plan. A major limitation of this variable is that it does not capture the government's many roles in a changing health care system, such as individual or employer mandates, regulation of the insurance industry, expansions of existing public programs—indeed, all of the various policy tools that emerged out of the health care reform legislation of 2010. However, we use this particular policy question because it matches a question asked regularly in the American National Election Studies and has been used in previous research as a general measure for Americans' support for the government's responsibility in health insurance (Koch 1998; Sears et al. 1980). The question reads: "Some people feel there should be a government insurance plan that would cover all medical and hospital expenses for everyone. Others feel that medical expenses should be paid by individuals, and through private insurance plans. Where would you place yourself on this scale?" The response scale ranged from 1 = "individuals and private insurance" to 7 = "government insurance plan." This item was asked at the end of the survey. The mean was 4.56 (95 percent confidence interval = 4.43–4.68).

We also assess various sets of independent variables as predictors of opinions about government health insurance provision. These include self-interest-related variables, which we define as self-rated health (a five-point scale ranging from excellent to poor), recent history of uninsurance (being

3. Most of the extant empirical survey research on fairness beliefs is in the domain of earnings inequality or, particularly in the U.S. context, affirmative action. See, e.g., Kinder and Sanders 1996, Kluegel and Smith 1986, and Osberg and Smeeding 2006.

without any form of health coverage for one month or longer at any time in the past three years), respondent or a close family member having a serious medical condition, being economically insecure (defined as the respondent or main income earner having been unemployed during the past three years or having earnings at 200 to 300 percent of the federal poverty level, adjusted for household size), or being in poverty (an indicator variable representing size-adjusted household income at or below 200 percent of the federal poverty level). In contrast with earlier work on self-interest influences on health insurance policy opinion (Sears et al. 1980; Lau and Heldman 2009), we define self-interest more expansively to encompass the potentially vulnerable middle or working class, those often alluded to in political appeals. We expect that sick, uninsured, unemployed, or otherwise economically insecure respondents will support government payment of medical expenses for self-interested reasons.

Other independent variables in the analyses include group interest or symbolic politics variables, which we define following Sears et al. 1980 and Sniderman 1993 as encompassing political group identities and membership in a group affected by inequalities in health and health care. These variables include political party identification (a seven-point variable ranging from 1 = strong Democrat to 7 = strong Republican) and ideological identification (a seven-point variable ranging from 1 = very liberal to 7 = very conservative). We also construct a variable that indicates whether the respondent is a member of the disadvantaged group described in the inequality scenario to which he or she was exposed in the survey vignette (having below a high school education, being at or below 200 percent of the poverty level by household size, or being nonwhite).

Finally, we include measures of egalitarian and humanitarian values. These measures have been shown to influence public preferences on social policy matters (Feldman and Steenbergen 2001) and may be important correlates of fairness judgments (Rasinski 1987). The egalitarianism variable is constructed as the mean response to the six-item egalitarianism battery from the American National Election Study, scaled 1–5 with higher values indicating more egalitarian views. In this sample, the scale has a Cronbach's alpha of 0.80. The mean level of egalitarianism is 3.29 (standard deviation [SD] = 0.82). The humanitarianism scale is constructed from four items from Feldman and Steenbergen 2001. Mean humanitarianism is 3.76 (SD = 0.67), and the scale has a Cronbach's alpha in this sample of 0.72.⁴ See the appendix for the text of these items.

4. Respondents missing values on any one of the egalitarianism- or humanitarianism-scale items (3 percent of the sample) were dropped in constructing these variables.

Analysis

In addition to calculating descriptive statistics, we conduct multivariate ordinary least squares (OLS) regression analysis using the survey functions in Stata 10.1, regressing opinions about private versus governmental health insurance on various covariates, with judgments of the fairness of inequalities as the key independent variable. We then simulate predicted levels of policy opinion under alternative scenarios of fairness judgments. To do so, we first calculate the predicted value (\hat{y}) of support for governmental provision of health insurance using the actual sample distribution of fairness evaluations. Then we estimate predicted support under a counterfactual condition. We begin by shifting everyone in the sample who actually evaluated health care inequalities as fair to evaluating these inequalities as neutral (neither fair nor unfair), holding all other respondents' fairness judgments and all other variables in the model constant. We repeat this procedure for shifts from each level of fairness judgments in the model (fair to neutral, neutral to somewhat unfair, somewhat unfair to very unfair). Finally, using the Clarify program for Stata 10.1 (Tomz, Wittenberg, and King 2003), we calculate the predicted value of policy support if all individuals were to evaluate health care inequalities as very unfair.

Results

What Does Fairness Mean?

Because of the difficulties inherent in measuring a concept as multidimensional as fairness, we begin with a validation check. Answers to an item asking respondents to endorse one of six potential definitions of fairness in general (*not* specifically in health or health care) provide confirmation that respondents in this survey understand fairness in terms consistent with previous research. The distribution of responses shown in table 1 reveals plurality support for the notion of fairness as equal opportunity (everyone has equal chances, 38.4 percent), with the next most popular responses divided between defining fairness as everyone treated equally (18.5 percent) and everyone having a decent standard of living (18 percent).

However, this question elicited beliefs about fairness *in general*, and not in the domain of health in particular. Since equal opportunity is such an important component of many Americans' definitions of fairness in other domains and has also been hypothesized to play a central role in theoretical conceptions of justice in health (see, e.g., Daniels 2008), we examine

Table 1 Frequency of Endorsed Definitions of Fairness ($N = 1,322$)

Definition of Fairness	%
Everyone has an <i>equal chance</i> to begin with	38.4
Everyone is <i>treated equally</i> , no matter what	18.5
Everyone ends up with <i>equal amounts</i> (e.g., same health, same income, same amount of learning)	6.8
Everything is happening according to a <i>divine plan</i>	8.0
Everyone has a <i>decent standard of living</i>	18.0
Everyone gets to <i>keep what they have earned</i>	10.3

Note: Frequencies sum to 100 percent; respondents could choose only one definition.

whether the relative importance accorded to opportunity versus outcomes is the same in the domain of health as it is in other policy areas.

Respondents who identified health care as most important to a good life ($n = 339$) had a mean score on the 1–10 opportunity-outcomes scale of 7.97 (95 percent confidence interval = 7.69–8.24), revealing that the importance they accorded to health care arises mainly out of concern about equal outcomes (“everyone has a right to be in decent health”). This contrasts with the stronger appeal to opportunity (“it assures equal chance to get ahead”) as a justification among those who identified education as most important ($n = 567$, mean = 4.98, CI 4.67–5.29) and among those who identified access to well-paying jobs as most important ($n = 423$, mean = 5.76, CI 5.48–6.03). These differences in the mean opportunity-outcome score between the three groups were robust to controls for socio-demographic, health status, and political and ideological characteristics associated with choosing health care, education, or income as the highest priority domain (results not shown). Those who placed a high priority on health care indicated that health care is not important mainly because it provides opportunities to get ahead in life, but because the outcome it affords—“to be in decent health”—is a right in itself.

Evaluations of the Fairness of Health and Health Care Inequalities

After reading vignettes about inequalities in life expectancy, access to health insurance, and receipt of quality health care, respondents ranked the fairness of these inequalities, on a scale of 1 (very fair) to 5 (very unfair). Table 2 summarizes the evaluations of fairness across the three types of inequalities. Overall, respondents judged inequalities in life

Table 2 Perceived Fairness of Inequalities in Health and Health Care

	Inequalities in Life Expectancy	Inequalities in Quality of Care	Inequalities in Access to Health Care
Perception (by %)			
Very fair (1)	2.8	2.8	2.8
Somewhat fair (2)	5.3	3.1	2.2
Neither fair nor unfair (3)	60.7	22.5	23.7
Somewhat unfair (4)	17.6	30.3	33.2
Very unfair (5)	13.6	41.3	38.1
Mean evaluation on 5-point scale	3.34	4.04	4.01
(95% CI)	(3.28–3.40)	(3.97–4.11)	(3.94–4.08)

Notes: There were significant ($p < 0.05$) differences in the perceived fairness of inequalities in life expectancy, depending on which vignette inequality (gender, race, income, or education) the respondent viewed. See table 3. There were no significant ($p < 0.05$) differences in the perceived fairness of health care inequalities (quality or access) depending on the vignette.

expectancy to be less unfair than they judged inequalities in health care quality or access to be. The majority of study respondents (over 70 percent) perceived health care inequalities to be unfair, while only 31 percent perceived health status inequalities to be unfair. We suspect that the magnitude of this gap may be at least partially due to a priming effect, as respondents were asked to consider causal responsibility in advance of the fairness evaluation in the life expectancy vignette but not in the health care vignettes. Considerations of blame and fault were thus likely to enter more strongly into judgments about the fairness of inequalities in life expectancy.

Recall also that respondents were assigned to different treatment groups for these vignettes, receiving prompts describing inequalities in health and health care defined by gender, race, income, or educational attainment. While the perceived fairness of health care inequalities did not vary across the vignette treatment groups, evaluations of the fairness of inequalities in life expectancy differed significantly across the vignette treatment groups. Respondents rated inequalities in life expectancy across groups defined by income as the most unfair (mean unfairness = 3.51 on the five-point scale), compared with gender differences (3.16), racial group differences (3.34), or educational group differences (3.36). Respondents rated the racial, income, and educational group differences in life expectancy as significantly more unfair than gender group differences (see table 3, model 1). Respondents' rating of the unfairness of racial group differences

Table 3 Causal Attributions Explain Differences in Perceived Fairness of Inequalities in Life Expectancy across Social Groups Affected by Inequality

	Perceived Fairness of Inequalities in Life Expectancy (higher values = more unfair)	
	Model 1	Model 2
Racial group difference (ref = gender)	0.18 (0.09)*	-0.02 (0.07)
Income group difference (ref = gender)	0.35 (0.08)***	0.02 (0.08)
Educational group difference (ref = gender)	0.20 (0.09)*	0.03 (0.09)
Cause = behaviors (ref = bad luck)		-0.15 (0.10)
Cause = prejudice (ref = bad luck)		0.58 (0.22)**
Cause = genetics (ref = bad luck)		0.06 (0.11)
Cause = health system (ref = bad luck)		0.73 (0.12)***
Cause = economic system (ref = bad luck)		0.85 (0.14)***
Constant	3.16 (0.06)***	3.09 (0.11)***
<i>N</i>	1317	1317
<i>R</i> ²	0.02	0.22

Notes: Table entries are unstandardized ordinary least squares regression coefficients, with linearized standard errors in parentheses. ref = reference.

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

was also significantly different from that for income group differences ($t = -2.02$, $p = 0.04$ from two-tailed test). Model 2 of table 3 shows that the causes respondents adduced to explain inequalities (whether they perceived these inequalities to result from individuals' behaviors, prejudice, failure of the health care system, failure of the economic system, biology, or bad luck) explain the differences in fairness evaluations we observe across treatment groups. These results also show that respondents who believe inequalities result from structural factors (prejudice, health system failure, and economic system failure) find these inequalities, regardless of the group affected, to be significantly more unfair.

Perceptions of Fairness Strongly Influence Policy Preferences

How do these perceptions of fairness influence the public's preferences about health insurance? The conventional wisdom outlined in the introduction to this article holds that self-interest is an important driver of the public's opinions on government health insurance expansion. However,

given the importance of other justice-related values like egalitarianism for policy opinions, and given the prominence of inequalities as an issue within health policy discourse in general and in the context of this survey in particular, we expect respondents' beliefs about the fairness of particular health inequalities also to affect their support for a government role in health insurance.

To explain variation in public opinion about government provision of health insurance, we begin by regressing the policy opinion outcome on "self-interest" variables (see table 3, model 1). Each self-interest variable is coded so that higher values indicate having more self-interested reasons to support government health insurance, such as being sicker, economically insecure, or uninsured. All independent variables are rescaled (where necessary) to run from 0 to 1.

All models also include dummy variables for the specific version of the inequalities vignette that the respondent viewed (i.e., gender, race, income, or education), to control for any differences in opinions that might result from being exposed to content about inequalities among a particular social group. In addition, to control for the standard associations between demographic variables and policy opinions, we include variables for age, gender, educational attainment, income, and a single dummy variable indicating respondents of minority (black, Latino, or Asian) racial-ethnic background.

Table 4, model 1, shows that self-interest variables plus demographic controls explain just 10 percent of the variation in respondent preferences vis-à-vis government health insurance provision. Respondents in poorer health and those with a recent history of uninsurance or unemployment were significantly more likely to support government-provided health insurance. These findings buttress the claims of commentators who argue that support for health reform will come from those who are economically insecure (at least in terms of employment and insurance stability) and concerned about their health. We find no evidence that the working class often evoked in policy discussions (i.e., those with income levels in the range of 200 to 300 percent of the federal poverty level) are more supportive of government health insurance, above and beyond the effects of recent uninsurance or unemployment.⁵ However, these findings do support the intuition that emphasizing in political discourse Americans' perceptions of their own vulnerability could enhance these self-interest effects, as prior theory predicts (Chong, Citrin, and Conley 2001).

5. These SES findings are robust to removing the control for household income.

Table 4 Predictors of Support for Government Provision of Health Insurance

	Model 1: Self- Interest	Model 2: Symbolic Politics	Model 3: Values	Model 4: Fairness
Self-interest variables				
Self-rated health (scaled 0–1, where 1 = poor)	1.06*** (0.29)	0.82** (0.24)	0.63** (0.23)	0.43* (0.21)
Uninsured in last 3 years	0.39* (0.15)	0.30* (0.14)	0.33* (0.14)	0.24 (0.13)
Serious medical condition	0.23 (0.14)	0.20 (0.12)	0.17 (0.11)	0.10 (0.10)
Unemployed in last 3 years	0.45** (0.16)	0.25 (0.14)	0.26 (0.14)	0.24 (0.12)
Income 2–3x federal poverty level (working class)	0.02 (0.21)	0.08 (0.18)	0.07 (0.17)	0.01 (0.15)
Income ≤ 2x federal poverty level (poor)	0.00 (0.24)	0.06 (0.21)	–0.04 (0.20)	0.02 (0.19)
Group interest variables				
Member of disadvantaged group viewed in vignette		0.30† (0.16)	0.31* (0.15)	0.20 (0.14)
Party ID (scaled 0–1, where 1 = strong Republican)		–1.43*** (0.18)	–0.98*** (0.17)	–0.81*** (0.16)
Ideological ID (scaled 0–1, where 1 = very conservative)		–2.06*** (0.26)	–1.48*** (0.26)	–1.17*** (0.25)
Values				
Egalitarian (scaled 0–1, where 1 = most egalitarian)			2.68*** (0.34)	1.64*** (0.36)
Humanitarian (scaled 0–1, where 1 = most humanitarian)			0.26 (0.36)	–0.25 (0.35)
Fairness of inequalities				
Life expectancy inequalities are fair (ref = neither fair nor unfair)				–0.03 (0.22)
Life expectancy inequalities are somewhat unfair (ref = neither fair nor unfair)				–0.04 (0.12)
Life expectancy inequalities are very unfair (ref = neither fair nor unfair)				0.20 (0.17)
Health care inequalities are fair (ref = neither fair nor unfair)				0.01 (0.27)

(continued)

Table 4 Predictors of Support for Government Provision of Health Insurance (*Continued*)

	Model 1: Self- Interest	Model 2: Symbolic Politics	Model 3: Values	Model 4: Fairness
Health care inequalities are somewhat unfair (ref = neither fair nor unfair)				0.63*** (0.15)
Health care inequalities are very unfair (ref = neither fair nor unfair)				1.43*** (0.17)
Control variables				
Age (continuous)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)	0.00 (0.00)
Female	0.21 (0.13)	0.14 (0.11)	0.08 (0.10)	0.01 (0.09)
Income (19-point scale)	-0.03 (0.03)	-0.01 (0.02)	0.00 (0.02)	-0.01 (0.02)
Educational attainment (9-point scale)	-0.08 (0.04)	-0.12** (0.04)	-0.14*** (0.04)	-0.10** (0.03)
Minority (black, Asian, or Latino, compared with white)	0.38** (0.14)	-0.16 (0.13)	-0.37** (0.13)	-0.23 (0.12)
Vignette treatment				
Race (ref = neutral/gender)	-0.18 (0.17)	-0.18 (0.16)	-0.16 (0.16)	-0.18 (0.14)
Income (ref = neutral/gender)	-0.12 (0.18)	-0.31 (0.17)	-0.28 (0.16)	-0.26 (0.15)
Education (ref = neutral/gender)	-0.16 (0.18)	-0.21 (0.16)	-0.18 (0.16)	-0.12 (0.15)
Constant	4.53*** (0.54)	6.41*** (0.49)	4.37*** (0.52)	4.42*** (0.49)
R^2	0.101	0.308	0.378	0.450
N	1,250	1,250	1,250	1,250

Note: Table entries are unstandardized ordinary least squares coefficients and linearized standard errors in parentheses. ref = reference.

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

Next, in table 4, model 2, we add group interest variables or “symbolic politics” variables (political party identification, ideological identification, and disadvantaged group membership) to the model of health policy opinions (Sears et al. 1980). Adding these group variables to the model explains an additional 20 percent of the variation in policy preferences. Republicans and conservatives, as expected, are significantly more likely to prefer that individuals obtain insurance from the private market.

Next, we add a set of values variables (egalitarianism and humanitarianism) to the model (table 4, model 3). The addition of humanitarianism and egalitarianism explains a significant increment of the variation in policy preferences. After adjusting for all the covariates identified above, respondents with strong egalitarian values are significantly more likely to support government provision of health insurance. Compared with respondents with the lowest levels of egalitarian values, respondents with the highest level of egalitarian values were more supportive of government provision of health insurance by nearly 2.7 units on the seven-point policy opinion measure, holding all else constant.

Lastly, we ask whether respondents’ perceptions of the fairness of health and health care inequalities influence their opinions toward government health insurance, net of other considerations (see table 4, model 4). Given the high correlation between the separate fairness evaluations for the health care quality and health care access vignettes ($r = 0.65$), visible in their similar distributions in table 2, we construct a single variable for health care fairness evaluations by taking the average of both items. (The correlation between this new health care fairness variable and the life expectancy fairness variable is 0.47.) We introduce a series of indicator variables representing fairness beliefs (separately for evaluations of health inequalities and health care inequalities) into the model above. These dummy variables indicate whether respondents labeled these inequalities “fair,” “somewhat unfair,” or “very unfair,” with “neither fair nor unfair” serving as the reference category.

Perceptions of fairness contribute significantly to preferences about the government’s role in health insurance provision, increasing the variation explained to 45 percent. Compared with those who perceive inequalities in health care as *neither fair nor unfair*, respondents who perceive health care inequalities as *somewhat unfair* were more supportive of government provision of health insurance by 0.63 units on the seven-point policy scale, while those who perceive health care inequalities as *very unfair* were more supportive of government provision of health insurance by 1.43 units—even after controlling for other sources of policy opinions.

In contrast, beliefs about the fairness of inequalities in life expectancy were not significantly associated with policy opinions after controlling for health care fairness beliefs (perhaps because the policy outcome under consideration concerned health care, and not a policy strategy directly related to increasing longevity). The effect on public health policy preferences of believing health care inequalities are very unfair (relative to neither fair nor unfair) was significantly larger in magnitude ($p < 0.05$, from Wald tests of parameters) than the individual effects of lacking health insurance or having a history of unemployment. In sum, even after controlling for other important predictors, we find that fairness beliefs have a statistically significant and substantively large effect on health policy preferences.⁶ Moreover, the additional variation in health policy preferences explained by fairness evaluations suggests that considerations of the fairness of specific health care inequalities have effects on policy opinions that are distinct from the effects of more stable characteristics of individuals such as their values or political orientations.⁷

Finally, we assess what the potential influence on policy opinions might be if people were to change their existing beliefs about the fairness of inequalities in health care. To do this, we estimated models simulating support for governmental provision of health insurance under alternative scenarios in the sample's distribution of fairness beliefs. Of course, we cannot assess the likelihood that such changes would actually occur, and we recognize that large shifts in fairness beliefs without accompanying changes in, for example, egalitarian values or partisan identification are unlikely. Nevertheless, the exercise is useful for gaining a sense of the magnitude of the effect of fairness beliefs on policy opinions. Figure 1 illustrates the increases in support for governmental provision of health insurance, relative to the current distribution of fairness beliefs, that would result from shifting respondents from one level of fairness evaluation to another, holding all other variables constant. These simulations indicate the aggregate level of support for governmental provision of health insurance that would be predicted, if, for instance (shown in the second bar), all people who had judged health care inequalities fair were to come to judge them as neither fair nor unfair, with no other changes in those individuals'

6. We also estimated models in which fairness evaluations were interacted with the group treatment and found no evidence that the group treatment affected the impact of fairness evaluations on policy opinions.

7. Multicollinearity does not appear to be a problem in the model. Variance inflation factors for the full model shown in table 3, column 4, range from 1.0 to 3.78, offering no evidence that fairness evaluations are collinear with any other predictors in the model.

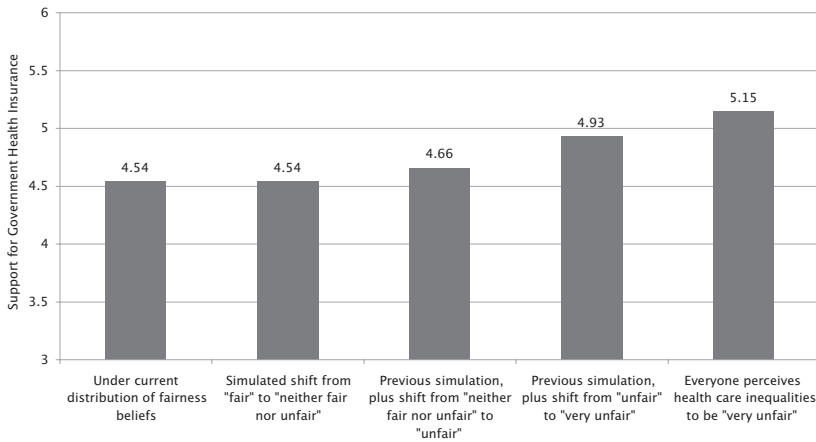


Figure 1 Changes in the Distribution of Fairness Beliefs Increase Aggregate Support for Government Provision of Health Insurance

Note: Predicted support is generated by estimating predicted values from the model in table 4, column 4, simulating incremental changes in the sample distribution of fairness beliefs.

characteristics or any changes in any others' fairness beliefs. The last bar of figure 1 shows the predicted level of support for governmental provision of health insurance if everyone were to perceive these inequalities as *very unfair*. Our results indicate that if all Americans were to perceive health care inequalities as one increment more unfair than they currently do, aggregate support for government provision of health insurance would increase from 4.54 to 4.93 on the seven-point scale, an increase of 8.6 percent over current levels, *ceteris paribus*. If all people were to consider health care inequalities as "very unfair," that change in fairness evaluations would produce a 13.4 percent increase in support for government health insurance (equivalent to a move from 4.54 to 5.15 on the scale of support for government involvement in health insurance).

Discussion

Using unique survey data representative of all Americans, we assess how Americans understand fairness in the context of health and health care. We find that a plurality of Americans endorse a definition of fairness *in general* that evokes equal opportunities, consistent with the intuition of other commentators (e.g., Jacobs 2005). However, Americans who value

health care highly perceive it as an important social good because they believe that everyone has a right to decent health, not just because health confers equal opportunities (the more common justification for equity in education and income). This empirical finding, consistent with Ruger's (2006) theory, suggests that political appeals for health care equity may not rely primarily on norms of equal opportunity, as some authors have suggested (Daniels, Light, and Caplan 1996; Daniels 2008). It also signals that beliefs about fairness in the domain of health are likely to be somewhat distinct from beliefs about inequality in other domains.

We also find that Americans, like policy elites, believe that certain types of inequalities are unfair. More than 70 percent of Americans think inequalities in quality of care or access to health care are fundamentally unfair, regardless of the social group affected by these inequalities. This finding is strikingly consistent with other recent survey evidence: a similar proportion (68 percent) of Americans believes that the current distribution of income and wealth in the United States is unfair (Page and Jacobs 2009: 41). However, in contrast to the attention provided by scholars and policy elites to the unfairness of health status inequalities, we find that far fewer Americans (31 percent) perceive inequalities in life expectancy to be unfair. These findings offer strong support for Stone's (2006) argument that health care quality disparities are likely to be a more compelling frame for motivating policy action than health status disparities, because the latter's complex determinants are often reduced to a personal responsibility narrative that seems to obviate the need for government action (*ibid.*: 131). Indeed, in other work (Gollust and Lynch 2010), we demonstrate that attributions of causal responsibility for illness to the sick individual have important consequences for beliefs about how much of a role government should have in paying for health care. Inequities in the quality of health care, in contrast, invoke a civil rights injustice narrative and provide a clear focus for remediation in the form of health care providers who "discriminate" (Stone 2006: 134).

Furthermore, we find that these perceptions of the unfairness of health care (quality and access) inequalities strongly influence opinions about whether the government or the private market should be providing health insurance—even after controlling for the effects of "the usual suspects" that predict policy opinions, including self-interest considerations and political orientations. Beliefs about the fairness of inequalities, thus, are not merely a proxy for a liberal, egalitarian, or Democratic worldview; beliefs about fairness exert an independent influence on Americans' preferences for the government's role in providing health insurance. Nor are

these beliefs motivated purely by self-interest in the policy question at hand. To be sure, Americans without health insurance and Americans who are ill represent important elements of any coalition in support of insurance expansions. Moreover, Americans with a history of unemployment, even adjusting for a history of lacking health insurance, tend to be more supportive of government-provided health insurance. Thus emphasizing the way these individuals stand to gain (as is common in political discourse) could yield greater support for government health insurance, as the promise of self-interest appeals suggests. Yet, in contrast to the conventional wisdom posing economic self-interest as the *most critical* single lever on which to push to generate support for reform, we find that considerations of fairness also shape Americans' health policy preferences to a surprisingly strong degree.

These results suggest that Americans' predisposing attitudes about fairness, and not just their self-interest or group identifications, could be harnessed in a political effort to mobilize support for expanding government health insurance provision. This finding supports Gamson's (1992) contention that emphasizing injustice in the framing of social problems is an important precondition for popular mobilization around policy change. Fairness beliefs may be particularly important when the policies in question require sacrificing individual self-interest to achieve either a more equitable distribution of resources or a long-term goal like addressing climate change (see, e.g., McCormick 2010, Ruger 2007).

Study Limitations

The results of this study are conditioned by the fact that survey respondents were exposed to more information about health inequalities than they would likely encounter in everyday discourse. The survey, then, was an intensive information environment in which inequalities were framed as salient to respondents—an environment, that is, analogous to the one that they would confront if political actors, other elites, and the media focused sustained attention on health inequalities. Respondents' evaluations of the policy items likely incorporated those fairness considerations that were suggested by the dominant frame to which they were exposed, precisely as the literature on framing and priming effects suggests (see, e.g., Chong and Druckman 2007a, Iyengar and Kinder 1987, and Valentino, Hutchings, and White 2002).

While we assess the differential impact of beliefs about fairness and self-interest on policy opinions, the study was not designed to evaluate

how the public responds in a competitive framing situation (see, e.g., Chong and Druckman 2007b) in which the public is exposed to simultaneous and competing messages about the fairness of inequalities and about protecting individual interests. Within the survey, we observe the results of a one-sided debate, in which inequalities were framed as salient for all respondents, and no respondents received a “nonframed” treatment. Measurement of public opinion over multiple time points during a policy debate would be better suited to evaluating the impact of emergent, competing frames on public opinion. Alternatively, an experimental design that exposes study respondents randomly to either an inequalities frame or an economic frame (i.e., highlighting pocketbook concerns), or both, could detect the influence of frames on public opinion and the interaction of these messages with the public’s predisposing values.

There is potential for an endogeneity bias in our analysis. Respondents’ health care policy opinions might influence their opinions about the fairness of health care inequalities, instead of (or in addition to) the other way around. For example, a respondent’s belief that government should be responsible for providing health care insurance might cause her to conclude that any inequality in access to health insurance would be unfair—whereas holding the opposite belief, that the private sector is responsible for providing care, might cause her to be more permissive of inequalities. We cannot rule out this possibility in a cross-sectional analysis. However, we note that the health policy item appeared at the very end of a long survey, after respondents had already been asked to evaluate the fairness of several different types of inequalities. Moreover, given the timing of this survey (late summer 2007), before the 2008 presidential race had begun in earnest and health care reform was not yet a major issue on the public agenda, it is unlikely, although certainly possible, that respondents were considering their opinions about health care policy changes when they responded to items about the fairness of inequalities. Health care policy opinions and fairness beliefs might also be correlated if they are both related to an unmeasured variable. We believe we have controlled for the most important potential sources of omitted variable bias.

Finally, our main dependent variable presents the government and private markets/individuals as two poles of a continuum of who should provide health insurance. This simplified view of health policy options, while a common measure in public opinion literature (see, e.g., Koch 1998), does not capture the range of roles the government currently plays in health care or will play with the implementation of the 2010 health reform legislation (e.g., regulating the insurance industry, setting up exchanges, etc.).

Implications for Politics

In a dynamic information environment, policy elites and advocates constantly introduce new and competing concepts into public discourse. These novel frames influence members of the public differently, depending on, inter alia, the strength of the frames and the public's predisposing attitudes, prior values commitments, and political awareness (Chong and Druckman 2007a). A comprehensive empirical assessment of how the Obama administration and advocates of health reform framed the public debate during 2009 and 2010 is beyond the scope of this analysis. However, a few relevant points are worth noting. Consistent with the epigraph from the *New York Times* article by Kevin Sack (2008), political commentators generally noted that Obama's and his allies' early efforts to win public support for health care reform tended to invoke self-interest—particularly the threat of loss of health insurance and escalating health care costs—and emphasize policy details far more than moral considerations (see, e.g., Lakoff 2009). In his watershed September 9, 2009, speech to Congress, Obama did present the moral case for health care reform: in describing his perspective on the late Senator Ted Kennedy's view, Obama (2009) said: “[Kennedy] repeated the truth that health care is decisive for our future prosperity, but he also reminded me that ‘it concerns more than material things.’ ‘What we face,’ he wrote, ‘is above all a moral issue; at stake are not just the details of policy, but fundamental principles of social justice and the character of our country.’” Even in this speech, however, Kennedy's views were situated within a sea of appeals to individual self-interest (e.g., offering “affordable choices” and “a good deal for consumers” that would “make the insurance you have work better for you”) and economic security (e.g., reforms to “protect you against financial ruin”). By casting the current system as “an unsustainable burden on taxpayers” that imposes “a hidden and growing tax,” Obama sought to further reinforce the self-interested case for reform. To date, then, an emphasis on health reform as a means to greater equity and fairness has not been central to mainstream politicians' appeals.

What would be the likely political effect of increasing public attention to health or health care inequalities? Our results suggest that if the nascent inequalities frame were to become more dominant in health policy discourse, and in particular if it were to focus on inequalities that most people think are unfair, beliefs about fairness could become increasingly important determinants of health policy opinion and support for a larger government presence in providing health insurance could increase. Major

advocacy and research organizations in the United States (e.g., the Robert Wood Johnson Foundation, the Kaiser Family Foundation, Families USA, the Institute of Medicine, the U.S. Centers for Disease Control's Office of Minority Health and Health Disparities) have devoted considerable resources to educating both the public and policy makers about health inequalities. If these efforts are successful, they could well lead to public mobilization in support of an expanded governmental role in health insurance. Page and Jacobs (2009) reach similar conclusions in their comprehensive analysis of public opinion about economic inequality. They note that a large majority of Americans across the political spectrum are both aware of and bothered by economic inequality in the United States, and would pragmatically favor certain government programs that moderate economic inequality by promoting opportunities, including expanding federal government health insurance programs.

However, despite the apparent promise of drawing attention to inequalities to increase Americans' support for government health insurance programs, we note several caveats that suggest policy advocates should proceed with caution. First, highlighting health inequalities may not lead to a change in beliefs about fairness; even if it does, a heightened emphasis on fairness may prove more demobilizing than activating. While our simulation models suggest that changing beliefs about the unfairness of health care inequalities would modify public preferences, it is unclear, in practice, whether such fairness beliefs among the public can really be changed. Can people be persuaded to believe certain inequalities are unfair, if they are predisposed to resist such a view? A more promising strategy, as described above, might be to frame health policy problems in terms of inequality to activate underlying beliefs among those who already believe inequalities are unfair—thus making these beliefs newly salient determinants of opinion. Nevertheless, research on emotional responses to injustice and inequality, while still in its infancy (Goodwin and Jasper 2006), suggests that exposure to unfair situations may sometimes depress, rather than mobilize, social action.

Second, our results suggest that an explicit strategy of highlighting inequalities, particularly inequalities that disfavor groups that are viewed by a majority of Americans as “undeserving” or otherwise responsible for their own ill fortune, could have unintended consequences. We find that respondents are less likely to find health *status* inequalities (i.e., life expectancy differences) than health *care* differences (i.e., quality of care or access to insurance) to be unfair, perhaps because, as Stone (2006) theorizes, respondents are more likely to think that people disadvantaged

by the former are personally responsible for their bad fortune. We also find in this article that evaluations of the fairness of health disparities depend on the social group that is depicted as disadvantaged and on beliefs about the causes of disparities (which also vary consistently depending on the social group depicted). Other research has shown that the social group affected by an inequality influences not only the public's beliefs about the causes of that inequality but also the preferred policy response (Rigby et al. 2009; Gollust and Lynch 2010).

Because different groups in society are likely to hold different beliefs about causal responsibility and deservingness of populations disadvantaged by health inequalities, a focus on such inequalities may have polarizing effects (Gollust, Lantz, and Ubel 2009). To make matters worse, public attention to inequalities that are not uniformly perceived as unfair may undercut support for government action to remediate even those inequalities that the public finds troublesome. Gilens (1999) cites just such a pattern of declining support for poverty alleviation programs in the United States following increasing media attention to poverty among African Americans.

Taking into account the potential “double-edged sword” of promoting health and health care inequalities, then, we offer several recommendations. First, future research endeavors should capitalize on the changing information environment with respect to health care reform in 2009 and 2010 to generate new theories about how politicians and other elites use various types of messages to mobilize the public to support policy change. Second, much more work is needed to attend carefully to the particular ways in which policy makers and other elites frame(d) persuasive appeals for health reform, and especially the specific groups and types of inequalities elites evoke and how these are framed. Content analyses of elite discourse and media attention, experimental designs, and longitudinal survey-based research could each contribute clarification on the nature and consequences of inequality- and fairness-based frames. Finally, policy advocates, for their part, would be well advised to consider just how much attention to health inequalities, and what kind, will best serve their goals. Attending to the unfairness of health-care-related inequalities among groups considered deserving of sympathy is a potentially promising way to mobilize support for government health insurance programs, above and beyond the support likely to be gained from appealing to partisan identities and self-interest.

Appendix: Detailed Survey Questions and Measures

Definitions of Fairness in General

People may have different beliefs about what fairness means. Which of the following comes closest to what YOU mean when you say that something is fair? It may be difficult to choose only one, but please try.

- 1 = everyone has an *equal chance* to begin with
- 2 = everyone is *treated equally*, no matter what
- 3 = everyone ends up with *equal amounts* (e.g., same health, same income, same amount of learning)
- 4 = everything is happening according to a *divine plan*
- 5 = everyone has a *decent standard of living*
- 6 = everyone gets to *keep what they have earned*

[response options rotated]

Opportunity versus Outcomes

Which of the following would you say people need most in order to have a good life?

- 1 = access to a good-quality education
- 2 = access to a well-paying job
- 3 = access to affordable health care

Some people think that having [R's most important] access to [a good-quality education/access to a well-paying job/access to affordable health care] is *mainly* important because it ensures that each person in society has an equal chance to get ahead in life. Other people think that having [R's most important] is *mainly* important because in a good society everyone has a right to [be decently educated/have a decent income/be in decent health]. Other people's opinions lie somewhere in between. Where would you place yourself on this scale:

Having [R's most important] is *mainly* important because . . .

- [1] it ensures equal chance to get ahead
to
[10] everyone has a right to [be decently educated/have a decent income/
be in decent health]

Fairness of Inequalities in Health Outcomes: Life Expectancy Vignettes

Four different versions of the vignette (gender, race, income, and education) were randomly assigned to respondents. The bracketed text indicates the differences in the vignette wording across the four treatments.

“As you might know, the average number of years people can expect to live is different among different groups in society. For example, there is a five-year gap in the life expectancy of [American women versus American men/white Americans versus African Americans/wealthy versus low-income Americans/Americans who have attended college versus those with less than a high school education]: on average, [American men/African Americans/low-income Americans/Americans with less education] live five years less.”

Would you say that this difference in life expectancy is

- 1 = very fair
- 2 = somewhat fair
- 3 = neither fair nor unfair
- 4 = somewhat unfair
- 5 = very unfair

There are likely many causes of the difference in life expectancy between [women versus men/white Americans versus African Americans/wealthy versus low-income Americans/Americans who have attended college versus those with less than a high school education]. Although you may find it difficult to choose only one, please say which of these is, in your view, the *most important* reasons why [American men/African Americans/low-income Americans/with less than a high school education] have shorter lives:

- 1 = just bad luck
- 2 = personal behavior of [men/African Americans/low-income Americans/with less than a high school education] themselves
- 3 = prejudice and discrimination
- 4 = inborn characteristics (genetic or biological)
- 5 = failure of the health care system
- 6 = failure of the economic system

For the health care access and quality vignettes below, respondents were assigned to the same group treatment as in the life expectancy vignette. The exception is that those previously assigned to the gender vignette instead viewed a null condition for health care access and quality.

**Fairness of Inequalities in Health Care:
Access to Insurance Coverage Vignettes**

“About 45 million people in the United States do not have health insurance.”

This sentence was followed by the following additional content, depending on the vignette.

[Null condition]: Above passage, with no additional wording.

[Race condition]: “A higher percentage of whites than African Americans have insurance.”

[Income condition]: “A higher percentage of middle-income than low-income Americans have insurance.”

[Education condition]: “A higher percentage of college graduates than high school graduates have insurance.”

Would you say that the fact that some Americans do not have health insurance is:

- 1 = very fair
- 2 = somewhat fair
- 3 = neither fair nor unfair
- 4 = somewhat unfair
- 5 = very unfair

**Fairness of Inequalities in Health Care:
Quality of Care Vignettes**

“The following information is from the Web site of the federal government’s Agency for Healthcare Research and Quality:

“Many Americans receive excellent health care. But researchers have begun to take note of problems with the quality of health care that some Americans receive. Each year, almost twenty thousand people in the United States die unnecessarily because they do not receive needed medical treatments. A recent study of heart attack sufferers found that beta blockers, inexpensive drugs that can dramatically increase the chance of surviving a heart attack, were given to only one in five patients who could have benefited from them. Last year over seven thousand deaths were attributed to medication errors.”

This passage was followed by the following additional content, depending on the vignette.

[Null treatment: no additional text]

[Race, income, education treatments: additional paragraph below, with text as indicated in square brackets]

“Although quality problems affect all groups in society, they are particularly severe among [no additional text/ethnic and racial minorities/ those with low incomes/ those with low levels of education]. For example, researchers found that life-saving ‘clot buster’ drugs for heart-attack patients were underused for all groups, but [African American patients/ low-income patients/patients with lower levels of education] were less likely than [whites/higher-income patients/better-educated patients] to receive this treatment.”

Would you say that the fact that some Americans do not get high-quality medical care is . . .

- 1 = very fair
- 2 = somewhat fair
- 3 = neither fair nor unfair
- 4 = somewhat unfair
- 5 = very unfair

Self-Interest Variables

SELF-ASSESSED HEALTH

In general, would you say your physical health is . . .

- 1 = excellent
- 2 = very good
- 3 = good
- 4 = fair
- 5 = poor

HISTORY OF UNINSURANCE

Even if you now have health insurance, have you been without any form of health coverage for one month or longer *at any time in the past three years?*

- 1 = yes
- 2 = no

SERIOUS MEDICAL CONDITION

Yes to one or both of the following:

Please think now about not only yourself, but anyone you might have been caring for: a spouse/partner, parent or child. Have you or any of these people had a medical problem requiring an *overnight stay in the hospital* at any time during the last three years?

- 1 = yes
- 2 = no

What about a medical problem requiring *more than one visit to a medical specialist?*

- 1 = yes
- 2 = no

POVERTY

Household income less than or equal to 200 percent of 2008 federal poverty level for a household of the same size as that of the respondent.

UNEMPLOYED

Yes to one or both of the following:

Has the main income earner living in your household been unemployed (this means without work and looking for a new job) for one month or longer *at any time during the past three years*?

- 1 = yes
- 2 = no

Have you been unemployed (this means without work and looking for a new job) for one month or longer *at any time during the past three years*?

- 1 = yes
- 2 = no

WORKING CLASS

Household income between 200–300 percent of 2008 federal poverty level for a household of the same size as that of the respondent.

Group Interest Variables

PARTY IDENTIFICATION

Standard partisanship questions resulting in seven-point scale, rescaled to 0–1:

- 1 = strong Democrat
- 2 = Democrat
- 3 = Independent leans Democrat
- 4 = Independent
- 5 = Independent leans Republican
- 6 = Republican
- 7 = strong Republican

IDEOLOGY

Standard seven-point scale, rescaled to 0–1:

In general, do you think of yourself as . . .

- 1 = extremely liberal
- 2 = liberal
- 3 = slightly liberal
- 4 = moderate, middle of the road
- 5 = slightly conservative
- 6 = conservative
- 7 = extremely conservative

Values

EGALITARIANISM

Index constructed as mean of following six items, with scale reversed and converted to 0–1 scale:

Please say how much you agree or disagree with each of the following statements:

1. Our society should do whatever is necessary to make sure that everyone has an equal opportunity to succeed.
2. We have gone too far in pushing equal rights in this country. [Item reversed]
3. One of the big problems in this country is that we don't give everyone an equal chance.
4. This country would be better off if we worried less about how equal people are. [Item reversed]
5. It is not really that big a problem if some people have more of a chance in life than others. [Item reversed]
6. If people were treated more equally in this country we would have many fewer problems.

- 1 = agree strongly
2 = agree somewhat
3 = neither agree nor disagree
4 = disagree somewhat
5 = disagree strongly

HUMANITARIANISM

Index constructed as mean of following four items, with scale reversed and converted to 0–1 scale:

Please say how much you agree or disagree with each of the following statements:

1. One should always find ways to help others less fortunate than oneself.
2. It is best not to get too involved in taking care of other people's needs. [Item reversed]
3. A person should always be concerned about the well-being of others.
4. People tend to pay more attention to the well-being of others than they should. [Item reversed]

- 1 = agree strongly
- 2 = agree somewhat
- 3 = neither agree nor disagree
- 4 = disagree somewhat
- 5 = disagree strongly

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