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Public Option Versus the Market: Perceived Value Violations Drive Opposition to Healthcare Reform

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The debate over healthcare reform in the United States has been divisive. Research demonstrates that beliefs that policy beneficiaries violate values strongly predict opposition to these policies. Similar dynamics may be happening regarding opposition to healthcare reform. Specifically, this study tested the hypothesis that opposition to a public option in healthcare reform results from stereotypes that public-option beneficiaries violate values. In two studies utilizing three samples, beliefs about beneficiaries violating values of hard work consistently predicted opposition to a public option and an alternative market-based healthcare reform plan, often proposed by public-option opponents. Results also suggest that assertions that a public option would lead to bigger government increases opposition to a public option by indirectly masking underlying stereotypes about value violations.

KEY WORDS: healthcare, healthcare reform, stereotypes, value violation, attributions, big government, conservative ideology

The debate over healthcare reform has been one of the most divisive in modern American history. For the past century, opponents of healthcare reform have justified their opposition with accusations that reform would lead to economic inefficiency, overreaching government intervention (also known as opposition to big government), and even socialism. Theodore Roosevelt was accused of "Bolshevism" after proposing reform in the early 1900s (Hoffman, 2003). Franklin D. Roosevelt failed at instituting reform twice after opponents fomented fears of socialism and bloated government (Przybyla, 2009). Harry S. Truman experienced a similar failure, as did William J. Clinton (Oberlander, 2007). Each of these failures was the partial result of pushback from mostly conservative opponents citing group-neutral attitudes, such as fear of government control and inefficiency as motives for opposition.

Immediately following his election in 2008, President Barack Obama entered the fray over healthcare reform. One of the most contentious features of his proposed reform plan was the possible addition of a "public option" to the healthcare system. Barack Obama described the plan as a government-managed health insurance option, similar to the one available to senators and state

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representatives, that citizens could purchase, and that would give lower-income citizens the option of receiving subsidies to pay for healthcare coverage (ABC News, 2009). Opponents of President Obama's healthcare reform plan once again cited philosophical rationales (e.g., distaste for government) for their opposition to the policy (ABC News, 2009). Instead, they claimed policy makers should use the "free market" to implement reform through a variety of measures designed to promote competition between private insurers, such as opening up the insurance market across state lines.

Contrary to the popularity of "anti–big-government" rhetoric in movements opposing government policies, anti–big-government attitudes often only weakly predict opposition to public policies, if they do at all (Gilens, 1996; Hasenfeld & Rafferty, 1989; Sears, Lau, Tyler, & Allen, 1980). On the other hand, stereotypes about the people who would benefit from a policy are a more reliable determinant of opposition to public policy (Allport, 1961; Reyna, Henry, Korfmacher, & Tucker, 2006; Rokeach, 1971; Sears & Henry, 2003). One stereotype that can be a powerful predictor of policy opposition is the belief that policy beneficiaries violate cherished values, such as hard work (Henry & Reyna, 2007; Henry, Reyna, & Weiner, 2004; Reyna, 2008; Reyna et al., 2006). For example, opposition to welfare (Henry et al., 2004) and affirmative action (Reyna et al., 2006) are both more strongly determined by perceptions that recipients of these programs violate the values of hard work than by either anti–big-government attitudes or prejudice.

In the context of public policy opposition, conservatives are more likely to view public aid beneficiaries as more responsible for their negative outcomes (Henry & Reyna, 2007) and thus undeserving of compensatory policies (Skitka, 1999). This does not necessarily indicate that conservatives are generally punitive or stingy (Farwell & Weiner, 2000). Rather, using public funds to provide services to large portions of the populace is at odds with conservative economic philosophies (Skitka, 1999; Zucker & Weiner, 1993). Furthermore, both liberals and conservatives see people who violate their values as more responsible for their circumstances (Morgan, Mullen, & Skitka, 2010) and thus less deserving of assistance. This suggests that, regardless of political orientation, people are less supportive of those who violate their values. However, conservatives are also more likely to infer personal responsibility for life outcomes (Crandall, 1994; Crandall & Biernat, 1990; Williams, 1984; Zucker & Weiner, 1993), so conservatives should be more prone to link low-status beneficiary groups to value violations (i.e., those who would benefit from a public option).

With these perspectives in mind, we could assume that opposition to a given policy may have less to do with the nature and details of the policy and more to do with assumptions about which groups it would benefit. For example, although the number of Blacks and Whites receiving government aid are very similar (U.S. Department of Health and Human Services, 2008), people might be more likely to imagine people of color, especially African Americans, when thinking of welfare beneficiaries (Peffley, Hurwitz, & Sniderman, 1997). Because African Americans are stereotyped as violating values of hard work, people who accept these stereotypes may be reluctant to support welfare policies. In the context of the healthcare debate, people may imagine certain groups in society as likely to take advantage of public healthcare programs because they are not working hard to better their own outcomes. Media rhetoric and imagery has suggested that a public option would primarily benefit lower-status individuals, such as the poor, unemployed, and illegal immigrants—i.e., groups frequently accused of violating values. This pattern suggests that such stereotypes may indeed contribute to opposition to a public option via beliefs that beneficiaries violate important values and thus do not deserve costly reform benefits.

The role that stereotypes play in swaying attitudes toward healthcare reform has been largely avoided in the present healthcare debate. However, given the importance of this policy, and the magnitude of its consequences, it is imperative that social scientists understand the underlying motives for the vitriolic opposition that has dominated the healthcare landscape. If stereotypes of

presumed beneficiaries are driving attitudes toward healthcare policies, then it is possible that anti–big-government rhetoric could be masking what are less rational motives for opposition. This is not to say that ideology is irrelevant. On the contrary, conservatism will likely play a role in driving attitudes toward any reform strategies. Conservatives have both an ideological distaste for government involvement in economic and private affairs (Skitka, 1999; Zucker & Weiner, 1993) and a tendency to attribute personal responsibility to life outcomes (e.g., Zucker & Weiner, 1993). Because of this, conservatism will most likely directly predict opposition to government-regulated healthcare reform, such as a public option.

Conservatives have offered their own solutions to the healthcare impasse. These optional healthcare reform plans, especially those that propose using existing dynamics of capitalism (referred to here as market-based reform) have been less intimately linked to stereotypes. Although market-based reforms have been touted as kinder on the pocketbooks of taxpayers, there has been less discussion of exactly which groups market-based reform would benefit. Therefore, it is possible that stereotypes about low-status groups and their implied value violations might be more closely linked to a public option than to market-based policies.

The Present Research

The present research examines the role that stereotypes of value violation play in influencing attitudes toward healthcare reform, particularly a public option. Although opponents of a public option have focused on the ill effects of government intervention, much less attention has been paid to the role stereotypes play in guiding attitudes toward healthcare reform. We will test the prediction that stereotypes about public-option beneficiaries depict them as violating the value of hard work. These beliefs, in turn, should drive greater opposition to a public option, over and above other predictors such as conservatism and/or distaste for government intervention (although both will likely play independent roles in attitudes toward healthcare reform).

In two studies, adult members of the community and students at a large Midwestern university were surveyed about their attitudes toward healthcare reform and potential beneficiaries of reform. Study 1 tested our central hypothesis that beliefs that public-option beneficiaries violate the value of hard work will drive opposition to a public option. In Study 2, using both student and community samples, we explored which specific groups are most likely to be seen as benefiting from a public option, whether these groups are associated with stereotypes of value violation, and whether or not these stereotypes drive attitudes towards this policy. We also explored the extent to which stereotypes of group value violation predict opposition to another frequently proposed, but rarely measured alternative to a public option: market-based healthcare reform. Finally, we assessed the possibility that group-neutral attitudes such as opposition to big government may mask underlying perceptions of value violations that drive opposition towards a public-option or market-based healthcare reform.

STUDY 1

In Study 1, we test the hypothesis that perceptions that reform beneficiaries violate the value of hard work increase opposition to a public option. Because conservatives tend to view public policy beneficiaries as violating these values (Henry & Reyna, 2007; Henry et al., 2004; Reyna et al., 2006) and are concerned about excessive government involvement in public programs in general, conservatism is expected to drive opposition directly as well as through perceptions of value violations.

Research also suggests that the name of a policy can affect opposition. For example, opposition to federal financial aid programs is stronger when they are framed as “welfare programs” compared to when framed as “government assistance to the poor” (Henry et al., 2004). In the lead up to the

development of a healthcare reform bill, opponents of public healthcare often referred to it as "socialized medicine" in order to highlight its potential for government overinvolvement and socialism. Supporters referred to it as "universal healthcare" in order to direct attention to its potential benefits. If it is the case that group-neutral opinions about healthcare policies (e.g., fear of socialism) drive opposition, then framing of the policy may affect attitudes toward the policy. Conversely, if underlying stereotypes portraying public healthcare recipients as value violators drive opposition, then program title should be largely irrelevant. Because liberals are generally supportive of government-subsidized healthcare, we only expected policy title to affect opposition amongst conservatives, if at all.

Method

Participants

The sample ($N = 140$; 51% men, 48% women) was composed of members of the general public surveyed in the greater San Diego, California area. The average participant age was 44 years and ranged from 19 to 81($SD = 15.68$). Seventy nine percent of the participants were White, 6% were Black, 6% were Asian or Pacific Islander, and 9% were Latino. The average participant's personal income was $57,000 per year.

Procedures

Data were collected during the summer of 2009 when healthcare reform strategies were still being developed. Participants were recruited from a variety of locations (shopping malls, beaches, parks). Participants were asked if they were willing to complete a paper-and-pencil survey about healthcare in the United States.

The survey contained a brief description of what was then being proposed as a government-subsidized healthcare plan (i.e., a public option). The policy was described identically except for the title it was given:

> In a [socialized medicine/universal healthcare] program, all citizens of the United States would be eligible to receive health services provided by the state, paid for by mandatory contributions from individuals. We are interested to know what people think about this topic. Please take a few minutes to think about the type of person that might benefit most from a [socialized medicine/universal healthcare] program and write it down in the following space. Think about what qualities they might have, and why they might benefit the most from a [socialized medicine/universal healthcare] program. When you think about the typical person who might be eligible for this program what comes to mind? Do you think they are married or have children? What beliefs do they have, what are their daily activities? There is no single right or wrong answer. We are simply interested to know how people feel about this.

Measured Variables

After reading the policy description, participants answered questions assessing opposition to a public option and perceptions of value violations. All items were measured on a 7-point scale (1 = *no agreement*, 7 = *agree very much*) unless otherwise indicated. In both conditions, all survey items were worded identically except for the use of the phrases "universal healthcare" and "socialized medicine" depending on the manipulation. The items used in the analyses, as well as their means and

Table 1. Correlations, Means, and Standard Deviations Used in Study 1 Path Model

	1	2	3
1. Opposition	–		
2. Value Violations	.44***	–	
3. Conservatism	.47***	.23**	–
M	3.72	3.73	3.93
SD	1.77	1.43	1.73

Note. Means and standard deviations for the scales used in the analysis are located in the bottom two rows.
$^{**}p < .01$, $^{***}p < .001$.

standard deviations are included in Appendix A, and the means, standard deviations, and correlations between all scales used in Study 1 are in Table 1.

Opposition to a public option was assessed using three items ($\alpha = .81$), (manipulation in brackets). The items were "I think a [universal healthcare/socialized medicine] system should be created in the United States"; "If a [universal healthcare/socialized medicine] system were implemented in the United States, how willing would you be to contribute financially to it?" (1 = *not at all*; 7 = *very willing*); and "If such a program were created what percent of the U.S. budget do you think should be spent on it (we currently spend around 15%)?" (1 = 0% to 7 = 30%). Items in this scale were reverse-coded such that high numbers represented greater opposition.

Perceptions of Value Violations

We were particularly interested in determining whether perceived beneficiaries of government-subsidized health care (i.e., those without health insurance who do not qualify for government programs like Medicare) would be perceived as violating the value of hard work. Perceptions of value violations were measured using three items. Participants were asked the extent to which they believed that people who cannot afford health care (1) put forth effort to get ahead, (2) work hard for what they have, and (3) believe in working hard. The three items were averaged to create a composite value violations scale ($\alpha = .87$). This scale was reverse-coded so higher values indicated greater perceptions of value violations.

Conservatism

To measure conservatism, participants were asked to "Please circle the number that indicates your political orientation. A response of 1 indicates very liberal, a response of 7 indicates very conservative" (1 = *very liberal*, 7 = *very conservative*). This measure has been shown to be a useful gauge of citizens' general ideological self-placement, as well as voting intentions (Jost, 2006).

Results and Discussion

We first assessed whether or not policy title affected either opposition or perceptions of value violations. To assess whether or not policy title affected opposition either directly or differentially by conservatism, we ran a 2 (policy title) by continuous (conservatism) ANOVA using the general linear model (Judd, McClelland, & Ryan, 2009). We included a contrast coded-condition variable, the centered political orientation variable, and their multiplicative interaction term in the model. Only a

main effect of conservatism emerged, $F(1,134) = 39.57$, $\beta = .37$, $p < .001$, such that increased conservatism lead to increased opposition. No differences in opposition emerged between the universal healthcare ($M = 3.50$, $SE = .19$) and socialized medicine conditions ($M = 3.91$, $SE = .19$), $F(1,134) = 2.35$, $p = .13$, and political orientation did not interact with policy title, $F(1,134) = .67$, $p = .41$. A second 2 (policy title) by continuous (conservatism) ANOVA on beliefs about value violations demonstrated similar results, with a significant main effect of conservatism predicting greater opposition, $F(1,136) = 7.15$, $\beta = .19$, $p = .008$. There were no differences between the universal healthcare ($M = 3.87$, $SE = .17$) and socialized medicine ($M = 3.63$, $SE = .17$) conditions on perceptions of value violation, $F(1,136) = 1.00$, $p = .32$, nor was there a conservatism by title interaction, $F(1,136) = 1.30$, $p = .26$. Taken together, these results suggest that policy title did not impact perceptions of the policy or its recipients. Political ideology was the only consistent predictor. Because of this, we collapsed across conditions when conducting the rest of the analyses.

To test the hypotheses that value violations would predict opposition to a public option, and that conservatism would predict value violations, we tested a path model in Mplus version 5. Mplus uses a full-information maximum-likelihood estimation procedure using all available data. This procedure is often considered a choice method when data are missing at random and may be less biased than traditional data imputation techniques (Peugh & Enders, 2004). Mplus is also capable of computing confidence intervals to test the significance of indirect effects by using a bias-corrected bootstrapping technique, in which data are resampled to generate nonparametric approximations of the sampling distributions of the indirect effects of interest (Muthén & Muthén, 1998–2007; Preacher & Hayes, 2008). A significant effect using bootstrapping is indicated by a bootstrap confidence interval that does not cross zero at the desired level of significance (95% in this study). Bootstrapping is considered an ideal method when testing mediation, especially in models including multiple mediators and smaller samples by accounting for unrealistic assumptions of nonnormality not often met with more traditional statistical tests (Preacher & Hayes, 2008). These techniques will be used throughout this article when estimating path models. Following the Preacher and Hayes (2008) recommendation that at least 1,000, but preferably as many as 5,000, bootstrap samples are used, bootstrapping procedures will use 5,000 samples. It is important to note that bootstrapping does not increase actual sample size, but rather it simply utilizes bias-corrected confidence intervals using robust standard errors to calculate the significance of indirect effects.

We specified a saturated-path model because all paths were expected to be significant. In support of our hypotheses and consistent with past research, perceptions of value violations (Reyna et al., 2006) and conservatism (Skitka, 1999; Zucker & Weiner, 1993) predicted opposition to public healthcare and perceptions of value violations. (See Figure 1 for path coefficients.) Examining the

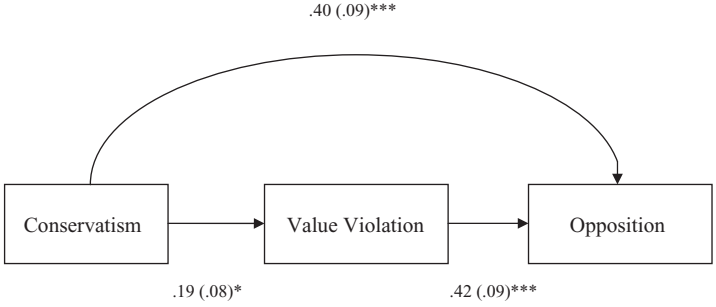


Figure 1. Path model used in Study 1 path analysis.
*$p < .05$, ***$p < .001$. Standard errors are in parentheses.

bias-corrected bootstrap confidence intervals indicated that the indirect effect of conservatism on opposition through value violations was significant (the confidence interval did not cross zero). The lower and upper bounds of the confidence interval were .018 and .17, respectively (estimate = .08, SE = .04).

These results demonstrated that stereotypes about value violation significantly predict opposition to a public option. In addition, conservatism, which has been traditionally associated with distaste for government intervention, directly drove opposition as well. As predicted, the link between conservatism and opposition was partially mediated through perceptions of value violation. This suggests that stereotypes portraying healthcare beneficiaries as not hardworking can account for some of the relationship between ideology and opposition to subsidized healthcare.

Although these results are largely consistent with our initial hypotheses, there were some limitations. Study 1 was intended to assess whether public-option beneficiaries would be stereotyped as value violators and the effect of these beliefs on opposition to a public option. It is possible that, because we described those who would benefit from public healthcare as those who cannot afford it, we may have inadvertently primed poverty. Previous research suggests that people tend to see the poor as value violators (Henry & Reyna, 2007). Therefore, it is possible that our results reflect stereotypes about the poor more than stereotypes about public healthcare beneficiaries. It is still unclear who people think would benefit most from a public option. To fully explore the role of stereotyping in driving attitudes towards healthcare reform, it is important to assess which groups are thought of as likely beneficiaries of a public option and if they are associated with perceptions of value violations. To rectify this in Study 2, we will not define who would benefit from a public option. Rather, we will assess who participants believe will benefit.

Another limitation is that Study 1 only focused on a public option. It would be incomplete to analyze attitudes toward a public option and its recipients without considering healthcare reform alternatives. Conservative policy makers have proposed policies that free up the marketplace and allow competition to force down the cost and complexity of healthcare. What role, if any, do stereotypes play in support or opposition to these policies? This is an important distinction, as market-based reform plans are frequently mentioned in the media, but the possibility that beneficiary stereotypes related to value violations might differ between program types has not been tested to date. In light of the Study 1 results that different policy titles do not trigger different levels of perceived value violations, it is unclear whether or not different reform proposals (public-option versus market-based reform) would invoke different images of potential beneficiaries.

Finally, our measure of group-neutral ideology may not capture the core beliefs driving opposition. We used political ideology as a proxy for distaste for big government, but perhaps other aspects of conservatism were playing a role in the reported relationships (e.g., attitudes toward deservingness). To better examine the hypothesized relationships, we included a more detailed measure of opposition to big government as well as more detailed measures of perceived beneficiaries of both types of reform.

STUDY 2A AND STUDY 2B

In Study 1, stereotypes of value violations, as well as conservatism, predicted opposition to a public option in healthcare reform. Value violations partially mediated the link between conservatism and opposition, suggesting that conservatism may affect opposition via the endorsement of stereotypes. We expand on the findings of Study 1 in three important ways. First, we more thoroughly assess the specific groups seen as benefiting from a public option. Simply needing subsidized

healthcare may trigger perceptions of poverty, and thus value violation. This fact has not been lost on those framing the healthcare reform debate. Images of groups likely to be seen as value violators such as the poor, sick, abortion seekers, and illegal immigrants were often paired with mention of big-government intervention and inefficiency to stir ire towards a public option. In Study 2 we asked participants to indicate which groups would most likely benefit from a public option to assess their association to stereotypes of value violation.

Second, we expand our focus to include the effects of perceptions of group value violations on an alternative, namely, "market-based" reform plan. In the struggle to shape policy in the debate over healthcare reform, "market-based" reform was also at the center of national debate. Opponents of a public option touted "market-based" healthcare reform as a more viable alternative to a public option and less likely to lead to big government. In addition to these arguments, a market option was described as more likely to benefit the hardworking by providing healthcare benefits and protections for working individuals. It is interesting to note however, that while the public option was often described as a way to help the disadvantaged, there was little discussion about exactly which groups would benefit most from market-based reform. Because market-based options were often touted as benefiting the economically self-sufficient, people might associate the beneficiaries of market-based reform with upholding values of hard work. Hence, value upholding may be a strong determinant of support for this reform strategy. Although it is possible that people believe specific groups would benefit from a market option because of their tendency to work hard, the lack of specificity about who, exactly, would benefit from a market option may result in stereotypes that are less consensual or well formed. Because of this we make no specific predictions about which groups are perceived to benefit most from a market option.

Finally, we tested the extent to which each reform option is believed to lead to big government and the relation of this belief to perceptions of group value violation. Although opponents of healthcare reform often assert that fear of a larger, more controlling government drives their opposition to a public option, social scientists have shown that apparently group-neutral attitudes like opposition to big government are often related to underlying prejudices towards minority and other underprivileged groups in society (Federico & Sidanius, 2002; Reyna, Brandt, & Viki, 2009; Reyna et al., 2006). For example, Reyna and colleagues (Reyna et al., 2006) find that stereotypes about social groups (e.g., Blacks are lazy) mediate the relationship between principled justifications (e.g., affirmative action is unfair) and opposition to public policies that would benefit these groups. Ultimately, the belief held by opponents of a public option that it would lead to bigger government may be a vehicle to mask or even perpetuate another important determinant of opposition; stereotypes that beneficiaries violate the values of hard work and self reliance. Because market-based reform proposals were often touted as keeping far-reaching government involvement in check, we are not certain what role, if any, fear of big government will play in determining attitudes toward a market option.

In Study 2, we predict that people will be more likely to assume that public-option beneficiaries will be members of low-status groups (such as the poor and unemployed) compared to beneficiaries of market-based reform. We expect that low-status groups will be associated more with stereotypes of value violation, which will, in turn, drive opposition to a public option. Further, we expect the relationship between belief in big government and opposition to be mediated by perceptions of low-status group membership and value violations. Political conservatism is expected to influence opposition to a public option via this path as well.

Regarding market-based reform, we expect political conservatism to predict greater support for these policies and lower perceptions that beneficiaries violate values. However, because there is little prior research on perceived beneficiaries of market-based reform options, we are reluctant to make specific predictions regarding the relationship between beneficiary status, perceptions of value violations, and beliefs in big government concerning a market option.

Method

Participants

Two samples (2A: student sample; 2B: community sample) were used to test the Study 2 hypotheses. Because Study 2 utilized the same two conditions in both the student and community samples (public and market option), we will report the student and community data together for each condition (public first, followed by market) for ease of interpretation.

Study 2A: Student Sample. Participants were 209 undergraduate students enrolled in introductory psychology courses at a large Midwestern university. The average age of the participants was 20 years, and ranged from 18 to 53 (SD = 3.22) years. The average family income of the participants was between $80,000 and $100,000 per year. The participants were 83% female, 6% African American, 72% white, 1% Middle Eastern, 8% Asian or Pacific Islander, and 13% Latino/a.

Study 2B: Community Sample. Participants were 288 adults surveyed in Southern California. The average age of the participants was 36 years, and participant ages ranged from 18 to 79 years (SD = 14.28). The participants' average family income was between $60,000 and $80,000 per year. Participants were 54% women, 57% White, 6% African American, 25% Latino, 5% Asian, 6% multiracial, and 1% Middle Eastern.

Procedure

Study 2A: Student Sample. Student data were collected at the beginning of 2010. Students completed an online survey about healthcare reform from which the items here were drawn. Before taking the survey, participants were first informed that they would be giving their opinions about healthcare reform options being debated, as well as demographic information.

Study 2B: Community Sample. Community data were collected December 31, 2009 on the Rose Parade route in Pasadena, California.[1,2] Participants (from all over California, as well as surrounding states) who were camping out at the parade route the day before the Rose Parade were asked if they were willing to complete an anonymous pencil-and-paper survey about healthcare reform.

Measures

In both samples there were two possible survey conditions. All of the items in both surveys were worded identically except for the type of reform. The first survey condition described a "public-option," the second a "market-based" healthcare reform program:

Public Option

Some proponents of healthcare reform have proposed that a public-option approach be used. According to these individuals, a public option should be used so people could choose not to purchase private insurance and could instead pay into a public plan, which would be managed by the

[1] At the time of data collection for both samples, healthcare reform was still being debated. The official date of the passage of the healthcare bill was March 21, 2010.

[2] The Rose Parade route provides an ideal setting in which to conduct convenience sample research. The sample was diverse in terms of age, income, and race/ethnicity (see demographics), and participants have ample time to complete longer surveys. Because this is an experiment, and because participants were randomly assigned to survey conditions, convenience sampling is an acceptable method with which to test our experimental hypotheses. Convenience samples similar to this (e.g., drawn from airports, parks, shopping malls, and outdoor events) have been utilized in comparable research (see, e.g., Henry & Reyna, 2007; Reyna et al., 2005).

government. They argue that this would make health insurance more affordable because the government would be able to negotiate lower costs, which would lower prices and increase service.

Market-Based Reform

Some proponents of healthcare reform have proposed that a free market approach be used. According to these individuals, people could choose to purchase insurance from among a variety of private, independent, health insurance companies, instead of paying into a government health insurance plan. They argue that this would make health insurance more affordable because insurance companies would compete with each other by lowering prices and increasing service.

After reading one or the other description (based on random assignment), participants answered questions assessing their support for the target program, who they thought were the "typical people" who would benefit most from the particular program, whether beneficiaries were perceived as value violators, and beliefs in whether the program would lead to big government. Participants also completed demographic measures. The items used in the survey as well as their means and standard deviations are reported in Appendix B (unless otherwise noted).

Opposition to Healthcare Reform Policy

Attitudes toward a public option were assessed with the item "I want a PUBLIC OPTION to be used in healthcare reform in the United States." Attitudes toward market-based reform were assessed with the item "I want FREE-MARKET-BASED healthcare reform in the United States." Both items were measured on a 1–7 scale (1 = *not at all*, 7 = *very much*). Items were reverse-coded such that greater values indicated greater opposition to the type of reform.

Perceived Beneficiaries

To assess which groups people thought would most likely benefit from a public-option or market-based reform, participants rated a series of 1–7 bipolar scales with labels for 1, 4, and 7 on the scale. The endpoints of the scale corresponded to high and low levels of a trait, and the center represented an intermediate level of a trait where possible (e.g., 1 = *poor*; 4 = *middle class*; 7 = *wealthy*). Participants rated eight different social groups in terms of "the typical people who would benefit most from [a public-option/market-based reform] are most likely": e.g., wealthy versus middle class versus poor; work full-time versus work part-time versus unemployed. Where necessary, items were reverse-coded so that higher values indicate lower social status.

The perception that the typical people who would benefit most from a public-option/free-market approach to healthcare belonged to a variety of racial groups (six in total, including an item assessing the extent that recipients were seen as White) were measured on a 1–7 scale (1 = *not at all likely*, 7 = *very likely*). We included these measures because racial groups are stereotyped differently. For example, Blacks and Hispanics are stereotyped as lazy (Jackson, 1995; Peffley et al., 1997). Middle Easterners may be stereotyped as hostile to the United States and less likely to contribute (Izadi & Biria, 2007). Some groups, however, may be stereotyped as more industrious (e.g., Asians: Lin, Kwan, Cheung, & Fiske, 2005). Native Americans were also included because they are a prevalent minority group in California and are often seen as poor and less hardworking (Green, 1993). The inclusion of these groups provides a broader representation of how the racial status of beneficiaries affects policy support.

Perceptions of Value Violations

Perceptions of value violations were measured with four items on a 1–7 scale (1 = *not at all*, 7 = *very much*). They asked whether or not "The typical people who would benefit most from a [public-option in/free-market-based approach to] healthcare reform: "put forth effort to get ahead," "are self-reliant," "believe in providing for themselves," and "work hard for what they have." Scale reliabilities were good (αs >= .90) for both conditions in both samples. These items were reverse scored so that high numbers represent more value violation.

Big-Government Beliefs

Agreement with the idea that a public-option or market-based reform would lead to excessive government intervention in the healthcare system was measured on a 1–7 scale (1 = *not at all*, 7 = *very much*). Participants were presented with a stem: "I think that if [a public-option/market-based healthcare reform] were used in the United States:" and responded to the statements: "It would eventually lead to socialism," "It would lead to a government takeover of healthcare," and "It would lead to increased wasteful government spending." Reliabilities were good (αs = .86 in both community conditions, .76 in the student public-option condition, and .78 in the student market-option condition).

Political Orientation

Political orientation was measured on a 1–7 scale (1 = *very liberal*, 7 = *very conservative*), asking "In general, do you consider yourself a liberal, moderate, or conservative?"

Results and Discussion

Data analyses proceeded in several steps. First, we tested which of the two policies people preferred. Next we explored why people may or may not oppose each policy and the extent to which ideology and perceptions of beneficiaries drove these attitudes. To do this we needed to identify which social groups were seen as likely beneficiaries of each program by testing whether participants viewed public and market-option beneficiaries as members of different social and racial groups by comparing average ratings of the bipolar beneficiary scales between policy conditions. We then conducted exploratory factor analyses to see if items loaded onto distinct factors for both student and community samples separately. Following this, path models were estimated to test the hypothesized mediation sequence for each reform policy in each sample to assess whether the mechanisms driving opposition differed from those of the public option compared to the market-based option. The hypothesized model is described below.

Support or Opposition to a Public- versus Market-Based Option

Before exploring what drives attitudes toward healthcare reform, we first tested people's attitudes toward the two reform strategies: a public-option versus market-based reform. It was expected that conservatives and liberals would differ in their opposition to each program, so we regressed the opposition item on a contrast-coded condition variable, conservatism, and their multiplicative interaction term in each sample. In the student sample, only a marginally significant interaction between program type and conservatism emerged, $F(1,193) = 2.52$, $p = .096$. Simple effects tests revealed that

increased conservatism was a predictor of opposition towards a public option, $F(1,193) = 11.83$, $p = .05$, $\beta = .236$, SE = .17, but not a market option, $F(1,193) = .12$, *n.s.,* $\beta = -.04$, SE = .11. In the community sample, increased conservatism predicted opposition to healthcare reform in general, $F(1,244) = 4.66$, $p = .03$, $\beta = .17$, SE = .077. A significant interaction between conservatism and policy type emerged as well, $F(1,244) = 23.31$, $p < .001$. Simple effects tests indicated that conservatism predicted increased opposition to a public option, $F(1,244) = 21.73$, $p < .001$, $\beta = .53$, SE = .12 and decreased opposition towards a market option, $F(1,244) = 4.06$, $p = .05$, $\beta = -.20$, SE = .10.

Beneficiary Social- and Racial-Group Identity

Because we were interested in comparing the relative status (high vs. low) of perceived beneficiaries across the two reform options, we converted the race measures into bipolar scales to match the other beneficiary items. To do this, we created five difference scores by subtracting the five ethnicity ratings from the white rating (thereby assessing the degree to which a person was seen as White vs. a person of color). Higher values on this variable indicate beliefs that program recipients are White as opposed to a member of another racial group. These five difference scores were used separately in each analysis to assess the extent to which different racial groups were perceived as likely beneficiaries of a public- or market-based option. In addition, we assessed the extent to which participants perceived the beneficiaries of the two healthcare reform programs as members of different social and economic groups. To do this, a series of independent samples t-tests was conducted on the 13 beneficiary perception items.

Student (Study 2A) and Community (Study 2B) Sample t-*Tests*

The same eight items differed between the public and market option in each sample using a Bonnferoni corrected alpha level of .0038 (See Table 2 for test statistics). Public-option beneficiaries were seen as more likely to be poor, sick, unemployed, and illegal immigrants compared to market option recipients. They were also seen as more likely to be a member of a low-status racial/ethnic group (Black, Hispanic, Native American, and Middle Eastern vs. White). In summary, people did indeed assume that beneficiaries of a public option would more likely be members of low-status groups (lower economic and social status and racial minority groups). Conversely, people assumed that beneficiaries of market-based reform would likely be members of high-status groups (higher economic and social status and more likely to be White).

Next we wanted to see if the beneficiary items yielded separate factors. An exploratory factor analysis utilizing principle axis factoring and a direct oblimin rotation revealed a two-factor solution in each condition for each sample (see Table 3 for factor loadings, percent of variance accounted for by each factor, scale reliabilities, and correlations). Based on these factor analyses, social group and racial group scales were computed for each sample. These scales will be used in the subsequent t-tests and path models. We next tested whether these presumed beneficiary groups were associated with stereotypes of value violation (or upholding).

Perceptions of Value Violations

Independent samples t-tests were performed on the value violation scale comparing stereotypes that beneficiaries of a public-option versus market-based reform violate values. Participants in both student, $t(204) = 3.36$ $p < .001$, and community samples, $t(279) = 4.91$, $p < .001$, viewed public-option recipients as greater value violators (Student sample: M = 3.89, SD = 1.39; Community sample: M = 3.79, SD = 1.86) compared to market option recipients (Student sample: M = 3.25,

Table 2. Perceived Beneficiary Status for Study 2A and Study 2B

Student Sample					Community Sample				
Traits	Means Public	Means Market	*t*	*p*	Traits	Means Public	Means Market	*t*	*p*
Wealthy vs. Middle Class vs. Poor*	5.51	4.04	6.82 (.21)	<.001	Wealth vs. Middle class vs. poor*	5.13	3.65	7.13 (.21)	<.001
Elderly vs. Middle Age vs. Children	4.26	3.89	1.84 (.20)	.07	Elderly vs. middle age vs. Children	4.42	3.97	2.00 (.22)	.05
Legal vs. Illegal Immigrants*	4.15	3.08	4.48 (.24)	<.001	Legal vs. Illegal Immigrants*	4.32	3.50	3.26 (.25)	<.001
Full vs. Part Time vs. Unemployed*	4.89	3.67	4.57 (.27)	<.001	Full vs. part time vs. unemployed*	4.67	3.51	4.33 (.27)	<.001
Male vs. Female	4.08	3.72	2.89 (.12)	.004	Male vs. Female	4.14	3.94	1.96 (.10)	.05
Parents vs. Childless	3.29	3.72	2.02 (.21)	.04	Parents vs. Childless	3.67	4.00	2.07 (.16)	.04
Healthy vs. Sick*	4.83	3.76	4.43 (.24)	<.001	Healthy vs. sick*	4.69	3.53	6.10 (.19)	<.001
Not Seeking vs. Seeking Abortions	4.00	3.73	2.02 (.28)	.045	Not Seeking vs. Seeking Abortions	4.25	3.93	2.03 (.16)	.04
White vs. Black*	−1.18	.34	5.18 (.29)	<.001	White vs. Black*	−1.02	.42	5.32 (.27)	<.001
White vs. Latino*	−1.17	.40	5.26 (.29)	<.001	White vs. Latino*	−1.20	.65	6.60 (.28)	<.001
White vs. Asian	−.08	.26	1.98 (.17)	.049	White vs. Asian	−.20	.33	2.7 (.20)	.008
White vs. Native American*	−.36	.78	4.21 (.27)	<.001	White vs. Native American*	−.47	.80	5.00 (.25)	<001
White vs. Middle Eastern*	−.36	.46	3.63 (.23)	<.001	White vs. Middle Eastern*	−.50	.57	4.67 (.23)	<.001

Note. *indicates item differed significantly between conditions given the Bonferroni adjusted alpha of .0038. Numbers in parentheses represent standard errors. All *N*s > 200.

Table 3. Study 2A and Study 2B Factor Pattern Matrix and Correlations

Stereotype Items	Public Option Loadings				Market Option Loadings			
	Students		Community		Students		Community	
	1 PO	2 PO	1 PO	2 PO	1 MO	2 PO	1 MO	2 MO
Wealthy vs. Poor	.20	**.49**	−.08	**.95**	.02	**.81**	.29	**.44**
Sick vs. Healthy	−.12	**.67**	−.07	**.54**	.30	**.48**	.09	**.61**
Unemployed vs. Full Time	−.02	**.79**	.11	**.58**	−.14	**1.02**	−.05	**.93**
Illegal vs. Legal Immigrants	.02	**.50**	.11	**.41**	.09	**.53**	−.1	**.83**
White-African American	**.94**	−.03	**.97**	−.01	**.90**	.05	**.91**	.06
White-Latino/a	**.92**	.04	**.95**	−.02	**.95**	.04	**.94**	−.02
White-Native American	**.72**	−.01	**.71**	.07	**.86**	.05	**.91**	−.02
White-Middle Eastern	**.79**	.002	**.81**	−.02	**.89**	−.06	**.80**	−.02
Factor Correlations 1	–	.22	–	.39	–	.68	–	.47
2	.22	–	.39	–	.68	–	.47	–
Scale Reliability	.91	.70	.95	.85	.92	.70	.94	.82
Percent of Variance Explained	17.52	38.41	9.90	62.67	15.81	43.54	16.10	52.23

Note. PO = Public option; MO = Market option.

SD = 1.33; Community sample: M = 2.80, SD = 1.54). This supports our prediction that people stereotype public-option recipients as violating important values. In order to test whether these stereotypes are related to greater opposition, we turn to the path analyses.

Public-Option Path Analyses

In the path analyses, we tested the relationships between conservative ideology, big-government concerns, perceptions of policy beneficiaries, and related stereotypes on policy opposition. We predicted that stereotypes portraying beneficiaries as violating values would be the strongest predictor of opposition to a public option. We also predicted that perceptions of both low social and racial group status would predict perceptions of value violations and subsequent opposition. Finally, we tested the hypothesis that the belief that bigger government would ensue from a public option would actually predict endorsement of stereotypes, suggesting that ideology might serve as a vehicle to mask underlying stereotypes that beneficiaries violate values. A direct path from political conservatism to opposition was also included. In this and all further analyses, the error terms of the race- and social-group stereotype factors were allowed to covary. These tests were performed with both the student- and community-sample public-option data. For the sake of simplicity, we will first describe the paths that were common to both samples in each condition, followed by the paths that differed.

Correlations between all scales for both samples and both healthcare options, as well as their means and standard deviations are located in Table 4. Model fit for both the student $\chi^2(7) = 20.36$, $p = .005$, CFI = .78, TLI = .54, RMSEA = .14, CI(.06–.21) and community samples $\chi^2(7)$ 41.36, $p < .001$, CFI = .79, TLI = .56, RMSEA = .19, CI(.14–.25) required improvement. See the top half of Figure 2 for the hypothesized model coefficients and the bottom half for the final model coefficients. The paths that were common to each sample in the final model are represented in bold. In both samples, the hypothesized paths from conservatism to opposition through belief in big government, perceptions of low social status (but not race), and perceptions of value violations were present. Fit was improved in the student sample with the addition of paths from belief in big government to opposition and big government to value violations and removal of all insignificant paths $\chi^2(8) = 3.32$, $p = .91$, CFI = 1, TLI = 1, RMSEA = 0, CI(0–.04), $\chi^2(1) = 17.05$, $p < .001$. To improve fit in the community sample, we added paths from conservatism to perceptions of value violations and big government to opposition. A marginal path from racial groups to opposition was also added, and all

Table 4. Correlation Matrices Used in Both Studies

Simple Correlations	Public Option Students						Market Option Students					
	1	2	3	4	5	6	1	2	3	4	5	6
1. Opposition	–						–					
2. Big Government	.41***	–					.07	–				
3. Status Stereotypes	.15	.21*	–				–.28**	.39***	–			
4. Race Stereotypes	.04	.02	–.18+	–			.22*	–.14	–.68***	–		
5. Value Violations	.46***	.35***	.31*	–.08	–		.43***	.09	.16+	–.07	–	
6. Conservatism	.20*	.33***	.18+	–.08	.19+	–	.035	.25*	.16	–.21*	.06	–
M	3.41	3.60	4.84	–.77	3.89	3.17	3.89	3.47	3.64	.49	3.25	3.22
SD	1.71	1.46	1.13	1.56	1.39	1.47	1.70	1.47	1.56	2.00	1.33	1.49
	Public Option Community						Market Option Community					
1. Opposition	–						–					
2. Big Government	.53***	–					.03	–				
3. Status Stereotypes	.41***	.27**	–				–.04	.23**	–			
4. Race Stereotypes	–.23*	–.17**	–.33***	–			.27**	–.34***	–.46***	–		
5. Value Violations	.62***	.30**	.36***	–.14	–		.35***	.21*	.06	–.12	–	
6. Conservatism	.40**	.49**	.28**	–.13	.34***	–	–17*	–.06	.20*	–.17*	–.21*	–
M	3.42	4.34	4.70	–.79	3.79	4.02	3.03	3.26	3.53	.61	2.80	4.20
SD	2.19	1.96	1.28	1.70	1.86	1.60	1.90	1.92	1.56	2.11	1.54	1.62

Note. All student sample $N > 97$. All community sample $N > 112$. Means and standard deviations for all scales are located underneath each matrix.
$+p < .10$, $*p < .05$, $**p < .01$, $***p < .001$.

insignificant paths were removed $\chi^2(7)$ 8.95, $p = .25$, CFI = .99, TLI = .98, RMSEA = .06, CI(0–.12), $\Delta\chi^2(0) = 32.41$, $p < .001$.

As predicted, in the student and community samples, stereotypes that beneficiaries violate values was one of the strongest predictors of opposition to a public option. Also, in both samples, conservatism indirectly predicted opposition through big-government concerns, perceptions of low status and value violations, with student confidence-interval lower and upper bounds of .001 and .024 (estimate = .007, SE = .005), and community lower and upper bounds of 004 and .06 respectively (estimate = .021, SE = .01). Overall, these results suggest that in both samples, political conservatism drove opposition to a public option through perceptions that it would lead to big government. However, concern over big government was partially mediated by stereotypes that beneficiaries are of low social status and violate the value of hard work. There was a direct relationship between belief in big government outcomes and opposition in both samples, suggesting that although big-government beliefs are associated with stereotypes, they also may influence policy attitudes directly. Conservatism drove perceptions of value violation directly in the community sample, and community members showed a small increase in their opposition to a public option to the extent that they viewed its beneficiaries as racial minorities. In light of recent research suggesting that racism plays a part in opposition to democrats', and specifically Barack Obama's, reform plans (Knowles, Lowery, & Schaumberg, 2010), this may represent a separate effect of racism on opposition.

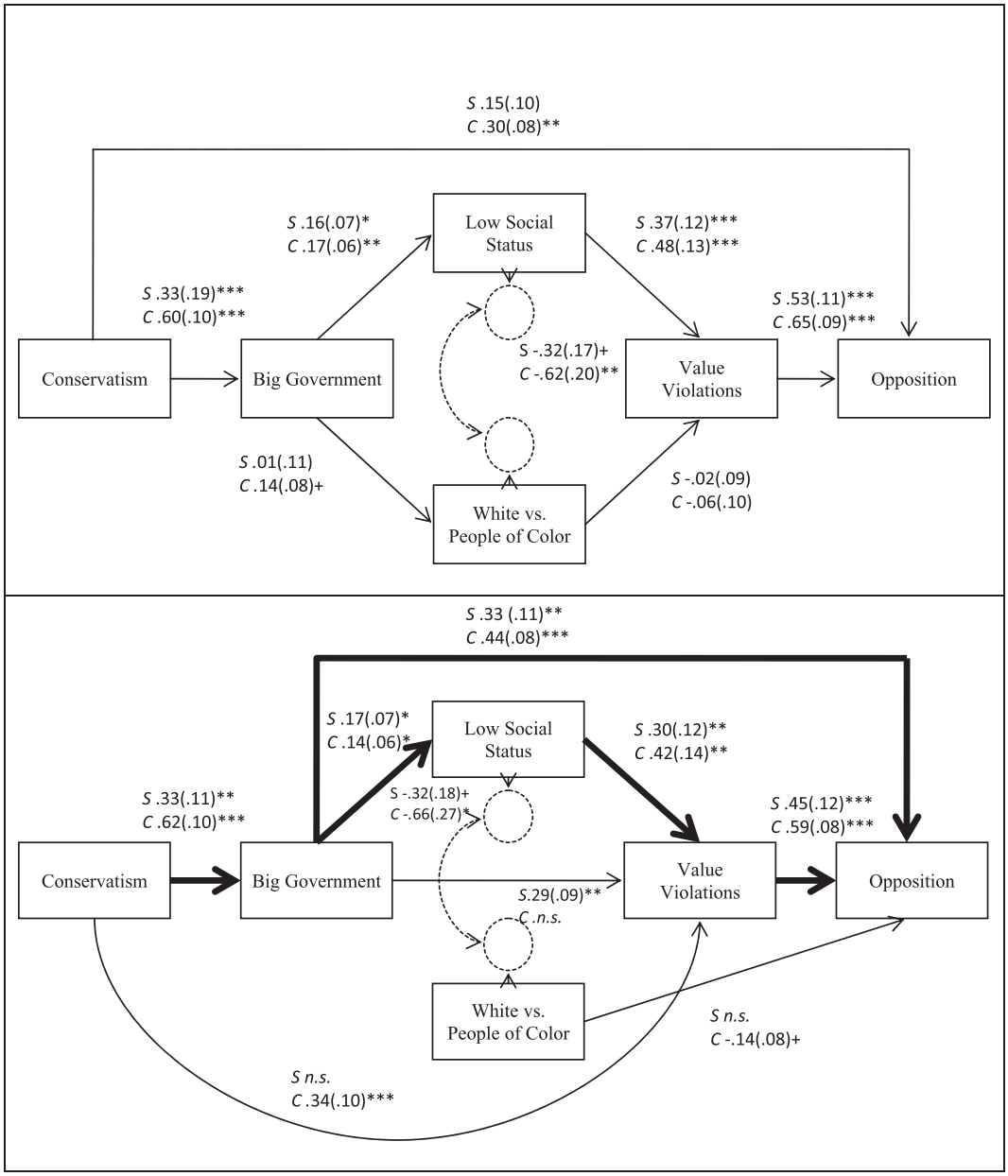


Figure 2. Study 2 public-option path analyses for student and community samples.
Note: The top figure represents the hypothesized model, and the bottom figure represents the final model. Coefficients labeled "S" represent the student sample and coefficients labeled "C" represent the community sample. Student $N = 104$ (one case with data missing on all variables was dropped), community sample $N = 151$. All Coefficients in bold are common paths between samples.
$+p < .10$, $*p < .05$, $**p < .01$, $***p < .001$.

Overall, the public-option analyses support the study hypotheses that opposition is powerfully determined by stereotypes that beneficiary groups violate the value of hard work and that group-neutral justifications for opposition (such as big government outcomes) may help to mask these stereotypes with seemingly group-neutral rhetoric.

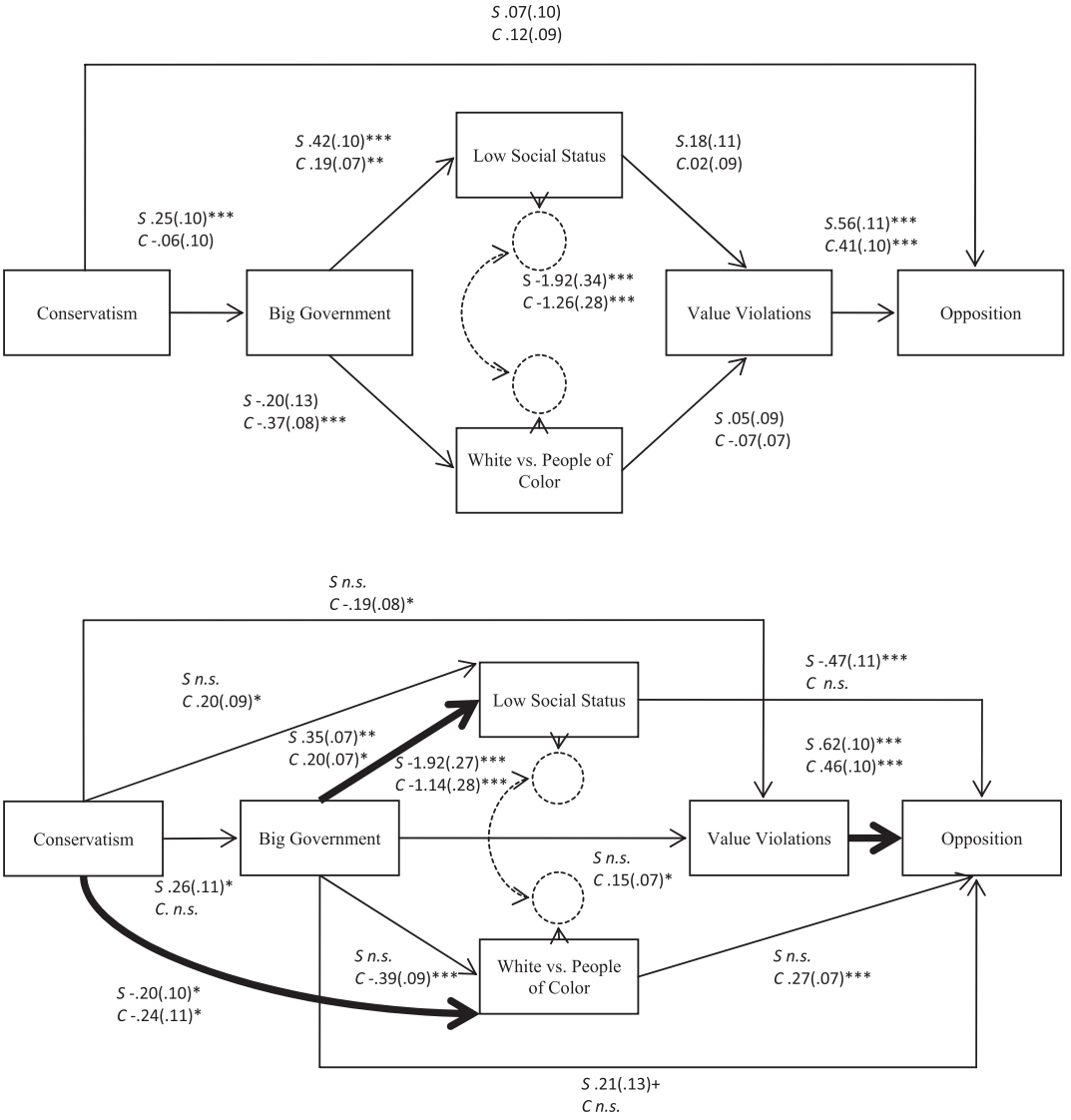
Market-Option Path Analyses

In order to assess whether or not opposition to market-based healthcare reform operates through the same mechanisms proposed for a public option, we used the same hypothesized model from the public option to analyze the market-option data. The models required modification in both the student [$\chi^2(7) = 26.25$, $p < .001$, CFI = .85, TLI = .67, RMSEA = .16, CI(.1–.23)] and community samples [$\chi^2(7) = 35.23$, $p < .001$, CFI = .70, TLI = .35, RMSEA = .16, CI(.11–.21)]. See Figure 3 for the hypothesized and final market-option models. In the models from both samples, paths from stereotypes of value violations to opposition, belief in big government to perceptions that beneficiaries are low status, and conservatism to perceptions of racial minority status were present. To improve model fit in the student sample, direct paths were added from low-status group perceptions and big-government concerns to opposition (although the latter path was marginal), and conservatism to big-government beliefs. All nonsignificant paths were removed [$\chi^2(8) = 5.55$, $p = .69$, CFI = 1, TLI = 1, RMSEA = .00, CI(0–.09), $\Delta\chi^2(1) = 20.7$, $p < .001$]. In the community sample, paths were added from conservatism to perceptions of value violation and perceptions of racial minority status to opposition. All nonsignificant paths were removed [$\chi^2(6) = 2.98$, $p = .81$, CFI = 1, TLI = 1, RMSEA = .00, CI(0–.91), $\Delta\chi^2(1) = 32.25$, $p < .001$].

Although some of the paths in the market-option condition were unexpected, the overall results are consistent with the study hypotheses. Perceptions of market-option beneficiaries' higher social status did not drive perceptions of value violations. Results from the *t*-tests suggest that market-option beneficiaries were seen as value upholders overall, but this was not predicted by perceptions that they belonged to specific beneficiary groups, suggesting that the link between market-based reform and hard work are more abstract and not based on conceptualizations of specific beneficiaries. The common paths from conservatism to perceptions of racial minority status may reflect a general tendency of conservatives to view reform beneficiaries in general as minorities. Interestingly, the perception amongst conservative community members that market beneficiaries were racial minorities increased support for a market option, suggesting conservatives may be amenable to programs that would help racial minorities as long as the program reflects their values. Perceptions of high status drove opposition in the student sample. The students were more liberal (M = 3.19, SD = 1.48) than the community members (M = 4.11, SD = 1.60), $t(458) = 6.26$, $p < .001$, and this path may reflect a tendency of the more liberal students to reject social programs that primarily benefit people of high status.

Belief that market-based reform would lead to big government played a small role in driving opposition overall. In the student sample, big-government concerns (which were stronger amongst conservatives) exerted a small effect in predicting opposition directly, but did not predict opposition directly in the community sample. In the community sample, big government directly predicted perceptions of value violation. The common paths between big-government beliefs and perceptions of low social status may reflect a tendency for people who associate healthcare reform in general with bigger government to see its beneficiaries as lower status. More conservative community members however, viewed market-option recipients as greater value upholders, which is consistent with the idea that a market option reflects conservative values to reward the hardworking.

Overall, the results of the market-option analyses demonstrated, once again, that the perception that its beneficiaries violate the values of hard work and self-reliance was a powerful predictor of



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$+p < .10$, $*p < .05$, $**p < .01$, $***p < .001$.

opposition. Conservatives were more likely to see market-option beneficiaries as value upholders than liberals. This perception was unrelated to group-status perceptions of any type, suggesting that when it comes to market-based reform, perceptions of recipients' social status do not drive perceptions of value violations. Rather, beliefs that recipients work hard (regardless of who they are) determine support or opposition.

These results also suggested that fears over big-government outcomes played a small role, if any, in attitudes towards market-based reform policies. This effect occurred via different paths between

samples: a small effect emerged in the student sample, and bigger government indirectly predicted opposition though beliefs that beneficiaries would be lower in status. In the community sample, big-government concerns only influenced opposition through perceptions of value violations and racial minority status. The relationship between conservatism, increased perceptions of minority status, and decreased opposition highlights conservatives' willingness to offer solutions to healthcare disparities using free-market strategies. For example, beliefs that racial minorities would be likely beneficiaries predicted conservative opposition to a public option but support for a market-based option. This suggests that, in the context of race, conservatives feel more comfortable offering solutions to racial disparities in healthcare if they jibe with conservative approaches.

GENERAL DISCUSSION

Across three samples and two types of healthcare reform strategies, stereotypes suggesting that people who would benefit most from healthcare reform violate the value of hard work emerged as a powerful predictor of opposition. Results from Study 1 demonstrate that opposition is driven indirectly by conservatism and directly by stereotypes of value violations. The fact that this relationship did not differ by policy title suggests that it is not simply perceptions of wasteful "socialized medicine" that drives opposition, but underlying beliefs about people who benefit from government healthcare programs in general. The only direct predictor of opposition to reform consistent across all samples and two different policies was judgments of value violation. These consistent and powerful effects present a compelling case that social scientists and policy makers should be examining the role of stereotypes more carefully in dialogs and debates about healthcare reform.

These studies also revealed the nuanced relationship between political ideology, stereotypes, and attitudes toward healthcare reform. Regarding a public option, concerns over bigger government drove opposition indirectly via beliefs that beneficiaries were low status and violate values. However, a different pattern emerged in the market option, where concerns over big government played a minimal and largely inconsistent role in predicting opposition. Instead, stereotypes about status and value violations drove opposition directly but independently (although status stereotypes only exerted an effect on opposition in the student sample). Specifically, market-option beneficiaries were seen as higher status than public-option beneficiaries, but unlike in the public option, beliefs about value violation were unrelated to perceived status. Thus, only the beneficiaries of a public option were stereotyped as *low-status* value violators. When it comes to market-based reform, judgments of value upholding or violation are more abstract and driven by ideological beliefs (conservatism and big-government concerns), which could reflect the more abstract way this strategy has been discussed in the media. Regardless, for both policies, whether or not beneficiaries are seen as violating values of hard work was the most consistent predictor of attitudes toward reform policies.

Despite its link to stereotypes, group-neutral ideologies were independently predictive of opposition to healthcare reform (at least with a public option), suggesting that people were genuinely concerned about bloated and inefficient government. The fact that these relationships were small at best, and at times inconsistent in the market-option condition, demonstrates that these fears primarily operate in relation to a public option, which would be largely managed by the government. This suggests that concerns about big government resulting from a public option are not solely a smokescreen for stereotypes about value violations, but are also a unique concern in the healthcare debate.

It was interesting that believing public-option beneficiaries were more likely racial minorities did not predict stereotypes of value violations, but directly influenced opposition. Although racial stereotypes are often related to perceptions of value violations (Henry & Reyna, 2007; Reyna, 2008),

it is possible that racism directly influenced opposition to a public option independent of beliefs about value violations (Knowles et al., 2010). This provides unique evidence that group-based attitudes are playing a role in driving opposition to a public option, which conflicts with perspectives that opposition to policies are driven more by group-neutral ideologies than by race (e.g., Sniderman, Crosby, & Howell, 2000; Sniderman & Piazza, 1993). However, the role of race becomes more nuanced when examining patterns across both policies. The extent to which people support a particular reform policy for racial minorities may be influenced by the ideological positions propagated by the policy. Conservatives, who promote principles of free-market reform but are averse to public assistance are more accepting of market-based programs, but more opposed to public-option programs, when they benefit racial minorities (at least among community respondents). These results suggest that the role of race in policy decisions depends on the match between one's ideological proclivities and the particular policy, but this warrants further research.

The Importance of Values in Policy Opposition

Understanding the varied and complex elements that drive the national debate over healthcare is critical as the federal government, states, and other stakeholders wrestle with implementing (or stymieing) the new healthcare reform laws. Although much of the focus has been on practical and ideological concerns, these data suggest that ideology or economics are not monolithic issues, but rather are informed by the perceived worthiness of healthcare beneficiaries as determined by whether or not they are seen as hardworking.

Although some of these themes have emerged in the context of other policies (e.g., Henry & Reyna, 2007; Henry, Reyna, & Weiner, 2004; Reyna et al., 2006; Sears & Henry, 2003), these data reveal the importance of these judgments for a policy that has yet to be explored from the perspective of recipient stereotypes. Past research on value violations and policy opposition has examined policies that are more directly linked to specific social groups whose value violating stereotypes are salient (affirmative action for Blacks, welfare, gay marriage). This makes the present research especially novel given that healthcare reform is purported to benefit the majority of Americans, so (in theory) should be only weakly linked to beneficiary groups and their stereotypes. The present data suggest that this is not the case in the minds of some Americans.

What exactly do value violations represent in the context of healthcare reform? Although the present research does not test this directly, prior research suggests that value violations may be linked to perceptions of deservingness (Henry & Reyna, 2007). Deservingness is a powerful criterion for determining fairness, especially where aid to the needy is concerned (Farwell & Weiner, 2000; Skitka & Tetlock, 1992, 1993; see also Weiner, 1995, for review). Deservingness becomes especially relevant when resources are limited (Skitka & Tetlock, 1992), which is the case with dwindling U.S. tax dollars. Benefitting those who are perceived to contribute to society with hard work and denying those who have exploited the system with laziness and irresponsibility fit well with Americans' concerns for equity and fairness. This could explain why perceptions of hard work play such an important role in attitudes toward healthcare reform and indeed a host of other policies designed to distribute limited resources.

The implications of this are profound for policy makers and reformers. If the American people do not believe that beneficiaries deserve what is portrayed by some opponents as a healthcare "hand-out," any reform efforts that make healthcare more available to the needy would continue to face fierce opposition. Stereotypes and certain policies may be difficult to decouple if the policies themselves are the trigger for beliefs about laziness, exploitation, and undeserved benefits. A further challenge is that some policies might be seen as disproportionately benefitting low-status groups (e.g., a public option) who are already associated with stereotypes of poor work ethic. These preexisting associations can sour the American public to these policies. Policy makers who are

pushing for a more accessible system of healthcare should focus more attention on how potential beneficiaries of reform are framed in the media and/or find ways to ensure a skeptical public that public healthcare will be protected from exploitation.

Another contribution of the present research that might also provide clues to how reform efforts are perceived is the examination of attitudes about market-based reform. Our findings that people in general, but especially conservatives in the community, see market-option beneficiaries as greater value upholders demonstrates that perceptions of hard work lead to greater support for healthcare reform. These effects were independent of perceptions of beneficiaries' social status. It is especially interesting that conservatives supported market-based reform to the degree that it would benefit people of color (independent of value violations). These patterns, in combination, suggest that conservatives are open to reform strategies that benefit low-status groups as long as the policy is consistent with their ideological views (e.g., utilizing the free market). This finding underscores the context-driven nature of role of stereotypes in guiding judgments about reform. Stereotypes linking low-status groups to laziness and irresponsibility are prevalent in the context of a public option, but are more abstract in the context of market-based reform.

Concluding Remarks

The debate over healthcare reform has raged in the United States for a century. Despite the many arguments that have been leveled against healthcare reform plans, and specifically government-managed care such as a public option, it is rarely stated explicitly that opposition is driven by stereotypes of potential beneficiaries. Instead, public figures tend to focus on group-neutral concerns as the source of opposition, such as beliefs that reform would lead to government expansion. The results presented here demonstrate that stereotypes implying program beneficiaries violate cherished values such as hard work are powerful predictors of opposition, lending further credence to the notion that perceptions of value violations are a primary source of opposition to not only a public option, but multiple types of healthcare reform.

Not only did we find strong support for these hypothesized relationships, but the hypothesis that beliefs in apparently group-neutral attitudes, such as the belief a public option would lead to big government, may actually be related to underlying stereotypes of value violations. Although fear of bigger government may predict opposition to healthcare reform to some degree, it appears that stereotypes that likely reform beneficiaries violate cherished values are the most consistent, yet one of the most overlooked, influences in the healthcare debate.

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Appendix A

Study 1 Survey	M	SD
Opposition (the following were reverse scored)	3.72	1.77
I think a [socialized medicine/universal healthcare] system should be created in the United States.	3.49	2.32
If a [socialized medicine/universal healthcare] system were implemented in the United States, how willing would you be to contribute financially to it?	3.93	2.23
If such a program were created, what percent of the United States budget do you think should be spent on it (we currently spend around 15%)?	3.73	1.65
Value Violations Scale: Do you think the typical person who cannot afford healthcare programs and does not qualify for health programs:	M	SD
Puts forth effort to get ahead?	3.84	1.68
Is self-reliant?	3.78	1.55
Believes in working hard?	3.58	1.58

Note. Wording in brackets represents the healthcare frame manipulated in Study 1. The item assessing conservatism was last, and its mean is reported in Table 1. All variables in the survey were presented in the order they appear in Table 1.

Appendix B

Study 2 Survey

	Students				Community			
	Public Option		Market Option		Public Option		Market Option	
	M	SD	M	SD	M	SD	M	SD
Opposition: I want [a PUBLIC OPTION to be used in/FREE-MARKET BASED] healthcare reform the United States (R).	3.41	1.71	3.89	1.70	3.42	2.19	3.03	1.90
Value Violations Scale: The typical people who would benefit most from a PUBLIC OPTION in healthcare reform	M	SD	M	SD	M	SD	M	SD
Put forth effort to get ahead (R).	3.85	1.54	3.41	1.49	3.79	2.02	2.85	1.73
Are self-reliant (R).	4.02	1.51	3.25	1.57	4.12	1.89	2.92	1.83
Believe in providing for themselves (R).	4.14	1.65	3.07	1.56	3.80	2.01	2.67	1.75
Work hard for what they have (R).	3.51	1.65	3.19	1.43	3.48	2.06	2.66	1.78
Low Social Status: Please circle the number that best represents your opinion on the following scales. The typical people who would benefit most from (a PUBLIC OPTION/ MARKET-BASED) approach to healthcare reform are most likely:								
Poor	Middle Class			Wealthy(R)				
Children	Adults			The Elderly(R)				
Illegal Immigrants	Both			Legal Immigrants(R)				
Unemployed	Work Part Time			Work Full Time(R)				
Male	Both			Female				
Childless	Both			Parents(R)				
Sick	Both			Healthy(R)				
Not Seeking Abortions	Neutral			Seeking Abortions				
People of Color: How likely is it the typical people who would benefit most from a (PUBLIC OPTION/FREE-MARKET BASED) approach to healthcare reform belong to each of the groups that are listed below? An answer of 1 means you think the likelihood is **low**, an answer of 7 means the likelihood is a **high.**	M	SD	M	SD	M	SD	M	SD
African American/Black	5.32	1.43	4.61	1.66	5.47	1.46	4.58	1.89
Latino/Hispanic	5.31	1.42	4.56	1.66	5.64	1.43	4.35	1.94
White/Caucasian	4.13	1.46	4.95	1.40	4.45	1.73	5.00	1.53
Asian/Pacific Islander	4.22	1.38	4.69	1.29	4.64	1.73	4.67	1.46
Native American	4.50	1.55	4.17	1.63	4.92	1.70	4.21	1.95
Middle Eastern	4.50	1.35	4.50	1.36	4.95	1.60	4.43	1.61
Big Government Stem: I think that if a (PUBLIC OPTION/FREE-MARKET BASED approach to healthcare reform were used in the United States:	M	SD	M	SD	M	SD	M	SD
It would eventually lead to socialism.	3.24	1.68	3.07	1.82	3.86	2.34	3.05	2.12
It would lead to a government takeover of healthcare.	3.99	1.79	3.79	1.74	4.58	2.14	3.36	2.23
It would lead to increased wasteful government spending.	3.57	1.86	3.56	1.76	4.54	2.21	3.31	2.12

Note. Items marked with (R) were reverse scored. The item mean for the social status stereotypes and conservatism scale are located in Table 3. Items are in the order they were presented in the survey instrument