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The Deservingness Heuristic and the Politics of Health Care

Carsten Jensen

Department of Political Science, Aarhus University
Bartholins Allé 7, DK-8000 Aarhus C, Denmark
Email: CarstenJ@ps.au.dk

Michael Bang Petersen

(corresponding author)
Department of Political Science, Aarhus University
Bartholins Allé 7, DK-8000 Aarhus C, Denmark
Email: michael@ps.au.dk

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The Deservingness Heuristic and the Politics of Health Care

Abstract: Citizens' social policy opinions are strongly influenced by a simple heuristic: Are the recipients of social benefits deserving or not? Adding to this growing literature, we provide evidence that the deservingness heuristic does not treat all social benefits alike. Already at the level of preconscious processing, the heuristic displays a bias towards tagging the recipients of health care—i.e., sick individuals—as deserving. This powerful, implicit effect overrides other opinion factors and produces broad-based support among the public for health care—across levels of self-interest, media frames, ideological divides, and national cultures. In contrast, when the deservingness heuristic is utilized for reasoning about unemployment benefits, implicit psychological constraints are fewer and political conflict erupts depending on differences in interest and worldviews. Using a variety of methodologies, we track this fundamental difference between health care and unemployment benefits from the level of implicit processing to the level of political attitudes.

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In the social policy landscape of advanced societies, health care stands out. Across the OECD, an average of 6.2% of the GDP is spent on public health care every year, up from 4.3% in 1980. Per capita public health expenditure has soared from an average of US\$689 to \$1,984 in constant prices, a 288% increase (OECD 2013). This state of affairs is endorsed by a majority of citizens. People around the world consistently say that it is the government's responsibility to ensure adequate health care for the sick and that more public spending is necessary to achieve this goal (e.g., Coughlin 1980; Jensen 2014; van Oorschot 2006). Even in the social policy laggard of the US, health care enjoys a special position. In a country renowned for the limited scope of government support for the jobless and working poor, the extent of public involvement in health care provision is striking. Medicare, Medicaid, and the Children's Health Insurance Program provide a safety net for the old, the poor, and children from uninsured families at an annual cost of US\$732 billion (Center of Policy and Budget Priorities 2013: 1). On the basis of such observations, Carpenter (2012) asked if health care is different from other policy areas. This article provides evidence that health care is indeed fundamentally special.

Compared to the risks stemming from an individual's position in the labor market, above all else joblessness, health care protects against the risks that flow from human biology. These are risks that have always been with the human species, constituting a threat to our ancestors across all social strata (Sugiyama 2004; Sugiyama and Chacon 2000). This stands in contrast to the risk of unemployment that first emerged as a significant risk—and, in particular so, only for the lowest social strata—during the industrial revolution in the 19th century (Wilensky and Lebeaux 1958). This article integrates this observation into research on the psychology of social policy attitudes. Previous research in this area has demonstrated the role of the so-called deservingness heuristic: Citizens support benefits for those they perceive as victims of uncontrollable events and,

hence, deserving of help, whereas they oppose benefits for those who are to blame for their own plight (Petersen 2012; Skitka and Tetlock 1993; van Oorschot 2000).

Drawing on an emerging biological approach to political psychology (Fowler & Schreiber, 2008; Hibbing, Smith, and Alford 2013), we argue that the deep prehistory of the risk of sickness and injury invites the possibility that the deservingness heuristic contains content that evolved specifically to respond to and manage this risk. Due to the particular nature of health problems over human evolutionary history involving primarily random infections and injuries rather than modern lifestyle diseases (e.g., Sugiyama 2004; Sugiyama and Chacon 2000), we suggest that the deservingness heuristic implicitly tags the sick and disabled as deserving of help. From this, we predict that individuals—across levels of self-interest, media frames, ideological divides, and national cultures—are psychologically biased towards perceiving the sick as more deserving than the unemployed. This produces broad-based, popular support for government spending on health care. In contrast, when the deservingness heuristic is utilized for reasoning about the novel risk of unemployment—where intuitions and biases are fewer—all of the available cues are utilized to form an impression on whether welfare recipients are deserving or not. Consequently, on this issue, political conflict erupts depending on differences in interests and worldviews.

Utilizing insights into the deep history of political issues adds to the rich literature on issue types. Perhaps most famously, Carmines and Stimson (1980) distinguish between “easy” and “hard” issues. Some issues are “easy” and, independently of education and knowledge, citizens can form opinions on such issues. Other issues are “hard” and require sufficient knowledge of politics to navigate. Another typology is about how polarized issue opinions are in the public. Some issues are “valence issues,” and the public shares opinions on such issues (Stokes 1963). Other issues are “position issues,” which politically polarize the public. In predicting whether a specific issue is hard or easy, valence or position, most previous research has taken a clearly top-down perspective and

pointed out the role of political elites (e.g., Carmines and Stimson 1980; Pollock, Lilie, and Vittes 1993). For example, it is argued that citizens find issues easy if they have been a central focus of elite debate and that issue opinions become polarized if elite opinions are polarized. Nevertheless, as already acknowledged by Converse (1964), the sources of constraint in issue opinions are psychological as well as social. Following this insight, we offer a bottom-up perspective on the nature of political issues. We argue that people reason differently about different issues because different issues activate different levels of psychological constraint. While health care and unemployment protection are both easy issues in the sense that they activate “gut reactions,” they differ sharply from each other because one of the issues (health care) is much more psychologically constrained than the other (unemployment) in terms of the input that goes into the opinion formation process. Consequently, health care emerges as a valence issue and unemployment as a position issue.

The Health Care Puzzle

The health care and unemployment issues share a number of key characteristics. They are both core social policy issues, constitute central areas for all modern welfare states, address ordinary risks that influence the lives of many citizens, and have been at the top of the political agenda for decades (Jensen 2014). Moreover, it is well-established empirically that health care and unemployment are quite similar in terms of their socio-demographic risk profiles (see Online Appendix I). One WHO study, referring to the experience of the United Kingdom, concludes that “people further down the social ladder usually run at least twice the risk of serious illness and premature death as those near the top. Nor are the effects confined to the poor: the social gradient in health runs right across society, so that even among middle-class office workers, lower ranking staff suffers much more disease and earlier death than higher ranking staff” (Wilkinson and Marmot 2003: 10). This social

gradient has been found in all of the modern societies surveyed; from the economically divided US to egalitarian Scandinavia. The materially well-to-do everywhere tend to be better off in terms of physical health (e.g., Elo 2009; Mackenbach et al. 2008; Marmot 2005; WHO 2008). The same applies to unemployment. Here, too, those already marginalized in terms of income and education suffer much greater risk of finding themselves unemployed (e.g., Cusack, Iversen, and Rehm 2006; OECD 2014: 102–31).

Despite these strong issue similarities, government spending on health care is uniformly more popular than government spending on unemployment - even in United States where health care legislation has recently been the subject of divisive political debates. Figure 1 reports the percentage of respondents thinking that the government is responsible for ensuring health care and income maintenance for the jobless. It combines data from the 2008 European Social Survey (ESS, Panel A) with data from the 2006 International Social Survey Programme (ISSP, Panel B) and covers 105,393 subjects from 41 countries. In each of these surveys, respondents were asked comparable questions about the responsibility of the government in relation to health care and the unemployed (see the Online Appendix for the exact wording and coding). The mean support for government spending on health care is 81.45% in the ESS data and 96.3% in the ISSP data. Across the surveys, the majority in favor is stunning and dwarfs that of unemployment protection. The cross-country variation is just as important and clearly visible from the graphs. For health care, the coefficients of variations are 0.09 and 0.03 in Panels A and B, respectively, while they are 0.33 and 0.17 for unemployment. In other words, around the world, health care is *uniformly* more popular than unemployment protection, which shows much greater variation.

- Figure 1 about here -

In sum, while there are strong socio-demographic gradients in the need for health care, public support does not seem to exhibit such gradients. Everywhere around the world, citizens demand extensive health care. This stands in stark contrast to unemployment protection, where support at the mass level is much more muted and variable. Our goal is to understand why health care and unemployment protection exhibit these diverse patterns.

The Deservingness Heuristic and the Issue of Health Care

Citizens appear to reason *as if* exposure to health problems is randomly distributed across social strata, not noting or caring that this is not in fact the case. In the welfare state literature, psychological theory has been used to highlight the importance of such perceptions about the causes of a welfare recipient's need for benefits when forming welfare opinions (Petersen 2012; Petersen et al. 2011; Skitka & Tetlock, 1993; van Oorschot 2000). Multiple studies have converged on the notion that a psychological heuristic—the deservingness heuristic—prompts individuals to oppose welfare benefits when the need reflects a lack of motivation (i.e., “laziness”) but support benefits when the need is caused by random events beyond the individual's control (i.e., “bad luck”).

Health care and unemployment benefits are both core welfare issues and, in line with previous research, we argue that the deservingness heuristic shapes opinions on both issues (van Oorschot 2000; 2006). At the same time, however, we argue that the deservingness heuristic is built to automatically tag sickness-based needs as random events, while this is not the case of unemployment-based needs. This implies that opinions on health care and unemployment are constrained differently and give rise to the observed differences between the valence issue of health care and the position issue of unemployment.

The Deservingness Heuristic: Past Findings and Outstanding Questions

Studies show that people across welfare states form welfare opinions using the deservingness heuristic (Fong et al. 2005; Petersen et al. 2012). This universality has been used to argue that the heuristic likely reflects an evolved constituent of human nature; specifically, an adaptation for reciprocal social exchange and an orientation towards investing help in those most likely to reciprocate (Petersen 2012). Consistent with this view, recent empirical work has demonstrated that the deservingness heuristic engages deep-seated psychological processes. It operates (1) automatically (Petersen et al. 2011); (2) through mechanisms of affect, with anger being activated towards the unmotivated and compassion towards the unfortunate (Brandt 2012; Petersen et al. 2012); (3) on the basis of the exact same psychological machinery used to make help-giving decisions in everyday life (Petersen 2012); and (4) in psychologically powerful ways such that other relevant considerations (e.g., cultural stereotypes and political values) are down-weighted once the heuristic is activated (Aarøe and Petersen 2014; Petersen et al. 2011; 2012).

Past research on the deservingness heuristic has provided substantial insight into the psychological processes that are activated *after* a welfare recipient is categorized as in or without control, respectively. In contrast, we know less about the psychological processes that enable citizens to make the categorization of whether a need is controllable or uncontrollable in the first place. More generally, past research has only to a very limited extent utilized insights about the deservingness heuristic—or other psychologically heuristics—to account for the problem we seek to address: Why do citizens seemingly agree on levels of recipient deservingness on one issue (health care) but not another, structurally similar issue (unemployment)? Most of the existing research on the deservingness heuristic has focused exclusively on a single type of need (mostly financial needs) and not provided systematic comparisons across need types (though see, van Oorschot 2006).

Our argument is not simply that people view sick individuals as more deserving than the unemployed; rather, we argue that a feature of the deservingness heuristic is a built-in bias to tag sickness implicitly as a need that is randomly caused and, hence, deserving of help. Consequently, across strata and national cultures, people cannot be easily swayed in their perceptions of the former, while this is the case for perceptions of the latter. This generates the substantially different dynamics on the issues of health and unemployment.

An Implicit Bias for Perceiving the Sick as Deserving

Unemployment—being without a job while otherwise being fit for and actively seeking one—is a historically novel risk that is closely tied to the industrial revolution (Wilensky and Lebeaux 1958). Sickness and disability, in contrast, are age-old risks and health problems have most likely been a major cause of lack of access to calories over human evolutionary history (Sugiyama 2004; Sugiyama and Chacon 2000; see also Online Appendix II). Our ancestors evolved as hunters and gatherers and, hence, it was necessary to hunt or gather calories (Boyd and Silk 2000). Sugiyama (2004) interviewed present-day foragers in the Amazon jungle about their health-related history. Of the sample, a massive 88% of the sample had experienced injuries that disabled them from foraging for 2 weeks or more. Similarly, Sugiyama and Chacon (2000) found that, on average, pathologies prevented Amazonian tribesmen from participating in 10% of all hunting expeditions and estimated that just a single hunter being injured results in a substantial 18% reduction in the average calorie intake of the group members (Sugiyama and Chacon 2000, 376–377). Such observations emphasize the evolutionarily recurrent need for health care—both for individuals that need others to provide calories during periods of injury and for the collective because the injured hunters cannot contribute to the common, shared pool of calories. Indeed, one standard explanation in the evolutionary sciences for the relatively low mortality of humans is the recurrent availability of care in times of

injury and sickness (Gurven et al. 2012; Kaplan et al. 2000).

If humans naturally engage in health care it requires a psychology designed to detect health-related problems and respond with pro-social motivations (Petersen et al., 2012). In order for evolution to select for such a psychology of care, the standard requirements according to evolutionary biology are that the need is randomly dispersed at any given time and that all of the group members experience the need with sufficient frequency (Trivers 1973). The evidence suggests that these preconditions were indeed present ancestrally (Kaplan et al. 2000; Sugiyama 2004; Sugiyama and Chacon 2000). For example, among the Amazonian tribes, Sugiyama (2004; Sugiyama and Chacon 2000) observed that everyone required care frequently, and that accident-related (and, hence, randomly dispersed) pathologies, such as lacerations, infections, and stings, constituted 78% of the total number of pathologies.

In modern societies, the causes of health pathologies are very different from the patterns observed among foragers. Heart disease and cancer are now the two leading causes of death, responsible for a massive 47% of all deaths in the United States (Hoyert and Xu 2012). Risk factors for both diseases are highly non-random and, instead, highly correlated with socioeconomic status, which is largely due to social patterns in diet and lifestyle (Donaldsen 2004). Importantly, dietary patterns (with the exception of starvation) and lifestyle diseases are novel pathological threats. The existence of many modern health pathologies crucially hinges on features that have not existed in the nomadic hunter/gatherer groups that literally formed the basis of the existence of our species for millions of years, including sedentary lifestyles, high population density, and unrivalled access to fat and glucose (Diamond 2012; Voeks and Sercombe 2000). As most species-typical features of human evolved under conditions of foraging conditions (Boyd and Silk 2000), this invites the prediction that the human psychology of health care is designed to reason about the need

for health care in terms of randomly-dispersed infections and accidents rather than in terms of modern lifestyle diseases.

Psychological Constraints and Issue Dynamics: Health Care versus Unemployment

When people today hear that an economic need is caused by sickness, we suggest that it triggers a particular set of associations constrained by the evolutionary history of sickness as a risk and the significant role of help-giving in buffering against this risk (Sugiyama 2004; Sugiyama and Chacon 2000). Given the random nature of evolutionarily recurrent health problems and the corresponding need for reciprocal help, we hypothesize the existence of a species-typical implicit bias towards viewing sick people as the victims of random events beyond their control and, hence, deserving of help. In utilizing the term "implicit", we are not arguing that people are not aware that they perceive sick individuals as deserving but rather that the psychological *causes* of this perception operate spontaneously and outside of awareness and, hence, it feels more like an objective feature of world than a self-generated perception.

This predicted role of implicit psychological constraints operating behind the support for government spending on health care has important political consequences, as suggested by decades of psychological research on explicit versus implicit processes (Greenwald et al., 2003; Haidt 2001). Implicit, intuitive factors often come to dominate judgments and behaviors at the expense of explicit, more effortful considerations related to, for example, ideological consistency and self-interest (see Haidt 2001; for political applications, see Lodge and Taber 2013; Petersen et al. 2011). In the context of health care politics, an underlying implicit bias could make health care support impervious to the kinds of considerations that form the basis of opinion formation on other political issues.

From this, we suggest that it is the existence of an implicit, psychological bias that renders the issue of health care different from the otherwise similar issue of unemployment. We seek to demonstrate this by directly comparing the processes behind opinions concerning health care and unemployment. When we hear that an economic need is related to the novel issue of unemployment, we argue that there are fewer implicit psychological constraints and that the associations that come to mind will be less uniform. As a result of the differences in self-interest and political position, some people will associate unemployment with being lazy, while others will associate it with misfortune (e.g., van Oorschot 2000). Consequently, benefits to the unemployed will be much more politically contested than health care for the sick. From these bottom-up psychological processes, the issue of unemployment emerges as a contested position issue, while the issue of health care emerges as a valence issue.

Study 1: Evidence for Bias at the Implicit Level

In testing this theory, we begin at the level of spontaneous, implicit intuitions. Specifically, on the basis of experimental methods from the laboratory, the first study is designed to show that a bias towards perceiving the sick relative over the unemployed as victims of uncontrollable events is traceable directly at the level of implicit processing. Hence, while previous studies have shown that people are more supportive of health care than unemployment benefits (Jensen 2014; van Oorschot 2006), we seek to test the key novel claim of our theory: that people also perceive sickness as more uncontrollable than unemployment and, furthermore, that this difference emerges in the earliest stages of processing, even before the activation of conscious control.

Methods

Social psychologists have developed laboratory methods for assessing implicit components of individuals' beliefs. The most common method is the implicit association task (IAT). As described by Greenwald et al. (2003: 197), the IAT "provides a measure of strengths of automatic associations...computed from performance speeds at...tasks in which association strengths influence performance." As IATs rely exclusively on comparisons of response latencies it is argued to provide unobtrusive measures that to a large extent evade conscious control.

Study 1 was carried out as a laboratory study and compared responses on an IAT designed to measure implicit perceptions of unemployed individuals with an IAT designed to measure implicit perceptions of sick individuals. Thirty-four Danish political science undergraduates were recruited. Each participant completed, in randomized order, two IATs: one about the unemployed and one about the sick. IATs are "pairing" tasks. In this study, subjects were asked to pair the categories "unemployed" and "employed" and the categories "sick" and "healthy," respectively, with words related to being unlucky and lucky, respectively (for further details on administration and scoring, see Online Appendix III). If, for example, subjects have a strong implicit association between "sick" and being unlucky, they should be able to perform this pairing faster than when asked to pair "healthy" and being unlucky. For the IATs used in Study 1, the calculated scores from the tasks reflect the degree to which the individual subject implicitly associates being sick and being unemployed, respectively, with being unlucky, i.e., uncontrollable causes. Higher positive scores reflect stronger associations. Thus, the prediction that people implicitly equate sickness relative to unemployment with uncontrollable causes implies that IAT scores for "sick" vs. "healthy" should be (1) positive and (2) higher than for "unemployed" vs. "employed."

- Figure 2 about here -

Results

Figure 2 shows the mean results for each of the two IATs. When examining the results from each IAT separately, it is clear that the mean scores in both tasks are positive and significantly different from 0 (sick: $t(33) = 13.14$, $p < .001$; unemployed: $t(33) = 8.36$, $p < .001$). Subjects tend to associate both being sick and being unemployed (relative to being healthy and being employed) with uncontrollable causes. In terms of effect size, the associations with employment status ($d=1.43$) are comparable to other culturally-learned associations assessed in IATs such as those relating to political party ($d=1.55$), race ($d=1.00$), gender ($d=1.05$) and age ($d=1.39$) (Greenwald et al., 2003: 210). The associations with health status, however, are substantially stronger than such culturally-learned associations ($d=2.25$). Consistent with this, people are significantly more inclined to equate sickness intuitively and implicitly with being unlucky compared to unemployment ($t(33) = 2.17$, $p = .038$). In line with our theoretical expectations, people are implicitly inclined to think of the ancestrally recurrent risk of sickness as caused by uncontrollable causes compared to the modern risk of unemployment.

Study 2: The Implicit Bias Dominates Explicit Information and Explicit Self-Interest

The first study provided evidence of a difference in perceptions of “sick” and “unemployed,” that this difference emerges at early stages of processing, and that it biases individuals towards perceiving the sick as the victims of uncontrollable events; a feature associated with deserving help.

This suggests that the deservingness heuristic implicitly tag sick individuals as victims of uncontrollable events and, hence, deserving of help.

On this basis, Study 2 investigates how this implicit bias (1) structures opinions about government aid on the issues of health care relative to the issue of unemployment and (2) operates in competition against two explicit types of consideration: considerations related to self-interest and considerations prompted by the frames available in political communications. These two factors constitute major alternative explanations for why citizens agree or disagree on political issues. If citizens support health care, it might be because everybody shares a self-interest in doing so or could be because everybody has received communications from political elites that sick individuals are deserving (see Pollock, Lilie, and Vittes 1993).

In modern societies, the mass media frequently bring stories explicitly linking lifestyle (e.g., diet, exercise) and health problems. Given research on the deservingness heuristic, information linking individual choice and the need for government assistance may be expected to reduce public support; that jobless individuals are easy to frame as undeserving has, in fact, already been documented (Petersen et al. 2011; Slothuus 2007). In contrast to these findings, we predict that the effects of more effortful, explicit considerations related to both self-interest and explicit information about controllability are much smaller for health care due to the implicit constraints identified in Study 1.

Psychological studies find that people rely on implicit, intuitive reasoning if it produces a sufficiently clear basis for decision-making (for an overview, see Alter et al. 2007). Only to the extent that sufficiently clear intuitions are not generated in response to a decision task will people begin to engage in more effortful processing (Alter et al. 2007; Gill, Swann, and Silvera 1998). In the context of deservingness and welfare opinions, for example, when clear cues of deservingness are not available, people rely more on political values (Petersen et al. 2011) and

cultural (Aarøe and Petersen 2014) and ideological (Petersen et al. 2012) stereotypes. When clear deservingness cues are available, however, the effect of these more cognitively demanding factors is effectively crowded out. In relation to the issue of health care, we predict that the information that an individual is sick will trigger the intuition that the individual is deserving because people implicitly associate illness with uncontrollable events. In contrast, the information that an individual is unemployed will trigger fewer intuitions. Consequently, people should be more confident (Gill, Swann, and Silvera 1998) and therefore less likely to attend to alternative sources of considerations—whether related to self-interest or external information—when forming opinions about sick relative to unemployed individuals. This is the key prediction tested in Study 2.

Methods

To investigate the clash between implicit attitude constraints and other types of considerations, we recruited 228 Danish university students to participate in an online experimental study. Subjects were randomly assigned to one of four experimental conditions organized in a two-by-two factorial design. Following previous experimental studies on social welfare opinions (Aarøe and Petersen 2014; Petersen et al. 2012), in each condition subjects were asked to “imagine a man,” received information on the lifestyle of this man, and then asked to judge whether “people like him” deserve to be helped by the government. We experimentally varied, first, whether the man was described as “long-term unemployed” or “seriously ill” and, second, whether his lifestyle was described as indolent or active; that is, key attributes associated with having versus lacking control over one’s need for public assistance (van Oorschot 2000). The Online Appendix provides the full texts of these vignettes. The descriptions of the lifestyles were kept constant across the two types of need (health care versus unemployment benefits) and, hence, the wordings were carefully chosen to be applicable for both. After reading the vignette, the subject indicated the extent to which they

supported that people like the individual in question received government aid on a 7-point scale from 0 (“to a very limited extent”) to 6 (“to a very large extent”). Answers were recoded to vary from 0–1, 1 indicating high support for government aid.

The experimental conditions allow us to investigate the role of the implicit bias to view sickness as uncontrollable in the face of explicit information to the contrary. In Study 2, we also wanted to address the role of this bias in the face of considerations of self-interest. We obtained two additional measures in order to do so, where we asked about the subjects’ concerns about becoming seriously ill and long-term unemployment, respectively. Answers were recorded on 4-point scales ranging from “very much” to “not at all.” From these two measures, we created a measure of relative concern by subtracting the degree of concern about sickness from the degree of concern about unemployment and, hence, obtain a measure ranging from –3 (“very much” concerned about sickness and “not at all” concerned about unemployment) to +3 (“not at all” concerned about sickness and “very much” concerned about unemployment). If people are more likely to help the sick simply because most people think sickness is the most threatening risk for themselves, we ought to find the opposite effect for anyone who is more concerned about unemployment.

Results

Figure 3, Panels A and B show the mean level of support across the experimental conditions. As can be seen, subjects support government aid significantly more for both sick and unemployed recipients when they are framed as being low in control (i.e., unlucky) ($p < .001$ in both cases). Importantly, however, at the same time we find a significant, two-way interaction ($F_{1, 224} = 11.83, p < .001$), such that explicit information about the recipients’ level of control is a massive 200% *less* influential when the recipient is framed as sick rather than unemployed. In essence, even in the face

of explicit information that sick individuals are in control over their fate, subjects remain overwhelmingly supportive. Furthermore, if the explicit self-interest argument is correct, there should be a reversal of the effects documented in Figure 3 among those who are explicitly more concerned about becoming unemployed than about becoming sick. Yet there is no evidence that the experimental, two-way interaction is moderated by explicit concerns ($F_{1, 218} < 0.01$, $p = .989$). In the Online Appendix V, we provide further details on this analysis.

- Figure 3 about here -

Study 3: A Second Test of Implicit Bias versus Explicit Considerations

In line with the argument that the deservingness heuristic implicitly tag sick individuals as deserving, Study 2 showed that people are reluctant to integrate information to the contrary into opinion formation, even if doing so might be in their own self-interest. Importantly, comparing the effects of explicit information on support for government aid for the sick and unemployed recipients, respectively, requires that the information is equally applicable to the two issues. In Study 2, we used the same type of explicit information to manipulate perceptions of deservingness for both the sick and unemployed recipients. Study 3 seeks to replicate the effects in Study 2 but by using information that is specifically tailored to each of the two issues, thereby maximizing applicability. In this way, Study 3 increases the internal validity of our claims. In addition, we seek to increase their external validity by utilizing a nationally representative sample.

Methods

YouGov, a survey agency, recruited a sample of 1005 Danes to participate in an online experiment. On the basis of quota sampling, the samples were selected to be representative for the Danish

populations on the dimensions of sex, age, geographical region, and education. The basic two-by-two factorial design of the study was exactly the same as in Study 2, but the vignettes were changed. In all of the conditions, the subjects were asked to imagine a man named “Simon.” In the “Unemployed Recipient” conditions, Simon was an unskilled worker who was now unemployed. In the “Sick Recipient” conditions, Simon was a long-term smoker who has recently been diagnosed with lung cancer. In all conditions, Simon had received numerous offers of help by an expert source (his union or doctor) to take concrete actions that would have reduced the risk of the aversive event (either more training or quitting smoking). In the “Low Control” conditions, Simon accepted the help but still suffered the risk. In the “High Control” conditions, Simon refused the help and suffered the risk. After reading the vignette, the subject indicated the extent to which they agreed that the man deserved government aid on a 7-point scale from 0 (“not at all”) to 6 (“to a very large extent”). Answers were recoded to vary from 0–1, 1 indicating high support for government aid. We also obtained the measures of subjects’ concerns about becoming seriously ill and long-term unemployment, respectively.

Results

Figure 3, Panels C and D shows the mean level of support across the experimental conditions. Replicating the findings from Study 2, subjects support government aid significantly more for both the sick and unemployed recipients when they are framed as being low in control (i.e., unlucky) ($p < .001$ in both cases). Once again, however, we also observe a significant, two-way interaction ($F_{1, 1001} = 5.64, p < .018$), such that explicit information about the recipients’ level of control is significantly and substantially (about one-third) less influential when the recipient is sick rather than unemployed. Even using extremely well-tailored stimuli, we find that subjects are reluctant to accept explicit information that suggests that sick people are undeserving. Furthermore, we once

again find that this effect is unmoderated by explicit self-interest relating to illness and unemployment ($F_{1, 894} = 1.34, p = .247$). This replication lends strong confidence to the existence of a bias towards tagging sick individuals as deserving.

Study 4A: Implicit Bias across Cultures

Our theoretical argument implies that the dynamics we observed in Studies 1, 2 and 3 reflect a general inbuilt feature of the deservingness heuristic. Perceiving sick individuals as victims of uncontrollable events is not something unique to Danes (the nationality of the subjects in Studies 1, 2, and 3). The first goal of Study 4 was therefore to provide an externally and cross-culturally valid replication of the finding that people are biased towards associating sickness rather than unemployment with uncontrollable causes.

Methods

Study 4 is based on a survey experiment embedded in three approximately nationally representative surveys. The surveys were collected in the US, Denmark, and Japan. On the basis of quota sampling, the samples were selected to be representative for the general populations on the dimensions of sex, age, geographical region, and education. In each country, we collected data from more than 500 participants ($n_{US} = 519$; $n_{Denmark} = 510$; $n_{Japan} = 528$). The selection of countries is based on a most different systems design: The three countries have widely diverse welfare state models (Esping-Andersen 1990) and cultural outlooks (Hofstede 2001; Inglehart and Welzel 2005). In short, Study 4 allows us to test the presumed universality of the bias identified in Studies 1, 2, and 3.

To test our predictions, we need a measure of the participants' perceptions of whether sickness and unemployment are controllable. To this end, we designed a unique survey experiment.

Participants were randomly assigned to one of two conditions. In the first, they were asked to state their beliefs about “people who are long-term unemployed.” In the second condition, they were asked to state their beliefs about “people with serious illnesses.” For both conditions, the participants were asked to express whether they agreed or disagreed with five statements that, together, form a scale—the “controllability of need” scale—which is designed to measure the extent to which outcomes are perceived to be controllable or non-controllable. In the two conditions, the questions were exactly the same and only varied in terms of whether they were asked with reference to the sick or unemployed. For example, respondents were asked about the extent to which they agreed with the statement, “people are not in control over whether they become [seriously ill/long-term unemployed] or not” (see the Online Appendix for the full wording of all items). The level of agreement was stated on a 7-point scale ranging from “fully disagree” to “fully agree.” In each condition, the items were summarized to form reliable scales (sickness: US: $\alpha = .61$; Denmark: $\alpha = .75$; Japan: $\alpha = .65$; unemployment: US: $\alpha = .76$; Denmark: $\alpha = .82$; Japan $\alpha = .69$).

Results

In a first set of analyses, we seek to provide a cross-cultural replication of the observation from Study 1 using explicit observations: that people more readily associate sickness relative to unemployment with uncontrollable causes. This can be tested by comparing the mean responses to the controllability of need scales in the two experimental conditions across the three countries. Figure 4 displays the results.

The results support the prediction. While there is an interesting cross-cultural pattern in terms of how participants interpret and respond to the controllability of need scales, there is a highly systematic pattern across the countries when the responses to the two scales are compared within countries. In both Denmark, the United States, and Japan, participants are significantly more

inclined to think of sickness as being caused by uncontrollable causes as compared to unemployment (United States: $t(509) = 4.25, p < .001$; Japan: $t(521) = 7.98, p < .001$; Denmark: $t(500) = 7.01, p < .001$). The difference in mean responses ranges between 7–12 percentage points on the full scale and is highly significant in all of the countries.¹

- Figure 4 about here -

Study 4B: Implicit Bias and The Role of Political Ideology

Implicit biases, we suggest, are politically important not just because they push opinions in specific directions but also because they immunize these opinions from other influences. In particular, the automatic and subconscious operations of implicit biases leave less room for other, more explicit factors to enter opinion formation. The implicit bias towards viewing sick individuals as deserving provides citizens with an instantaneous intuition about what is morally right and wrong on health care. In such cases, it is plausible that citizens would not feel a need to consider more cognitively demanding factors, such as their political values, or, as documented above, their self-interested concerns. Essentially, we predict that, on the issue of health care, the implicit bias *crowds out* the factors that otherwise fuel political conflict. From this psychological dynamic, the issue of health care is predicted to emerge as a valence issue characterized by shared opinions. Opinion formation on unemployment, in contrast, is much less cognitively constrained and, hence, it predicted to emerge as a position issue.

We focus on a key source of political conflict: political ideology. A person's left–right ideological position can be seen as the primary summary indicator of politically relevant individual differences from childhood socialization over current socio-economic circumstances to basic

¹In Study 4, we also obtained measures relating to the subjects' explicit concerns about becoming seriously ill and long-term unemployment, respectively. These are reported in the Online Appendix.

biological differences in physiological sensitivity and genetics (Hibbing, Smith, and Alford 2013). It has been argued to be a strong predictor of opinions about the welfare state specifically (Feldman and Zaller 1992; Jacoby 1994) and serves as a key input to the deservingness heuristic (Skitka and Tetlock 1993). According to this line of thinking, the ideology of individuals should correlate strongly with perceptions and beliefs that either justify or de-legitimize government involvement in all forms of social protection. Conversely, our argument opens up for the possibility that the influence of ideology is confined to unemployment. The universal nature of the cognitive constraints on perceptions of the uncontrollable nature of health risks could leave little room for ideological conflict.

Methods

Study 4B is conducted on the three-country sample described in Study 4A. Focus is again on the controllability of need scales described above. To explore how the answers in each condition were moderated by the political ideology of the participants, after obtaining our dependent variable, we asked the participants to place themselves on an 11-point scale designed to measure ideological self-placement from “left” to “right.”²

- Figure 5 about here -

Results

In Figure 5, the participant’s scores on the controllability of need scales in each experimental condition are correlated with their ideological position. The pattern of correlations across countries is striking. In all three countries, we see that ideology significantly conditions responses in the

² In addition, we have standard control variables available: gender, age, education, income, and country. In the Online Appendix XI, we replicate the findings in models that include these controls.

“unemployment” condition but not responses in the “sickness” condition. Consistent with this, regression models with two-way interaction terms between the participants’ assigned conditions and their ideologies show that the effects of ideology are significantly different in the two conditions (United States: $F_{1, 412} = 18.75$, $p < .001$; Japan: $F_{1, 358} = 4.84$, $p = .028$; Denmark: $F_{1, 451} = 3.98$, $p = .047$).³

Consistent with previous studies (e.g., Skitka and Tetlock 1993), we find that perceptions of unemployed welfare recipients depend highly on ideology. Left-wingers typically view the unemployed as being unlucky victims, whereas right-wingers view them as lazy. For sickness, conversely, no effect of ideology is discernible. In line with our argument, perceptions of the causes of sickness appear to emerge under the influence of implicit constraints that outweigh ideological differences and prompt people to view the sick as unlucky victims deserving of help independently of the general ideological outlook. Across three very different cultures and countries, the causes of sickness are, in other words, outside the confines of ideological conflict.

Conclusion

Health care stands out from many other political issues. Across countries, ideological divides, differences in issue framing, and differences in subjective self-interest, people support the provision of health care. In the language of issue typologies, health care is a clear-cut valence issue where support cuts across standard political cleavages and people from the left and right stand united in their demand for more and better health care. Unemployment, in contrast, is a clear-cut position issue. People disagree on whether unemployment benefits should be increased or decreased, whether eligibility should be tightened or relaxed, and take their position on the basis of key political differences such as ideological values, partisanship, or self-interest. In this way, the issue

³ While Study 4B focuses on ideology, another correlate of opinions about social protection is partisanship. In Online Appendix XIV, we replicate the findings in Study 4B using measures of partisanship.

of unemployment benefits is like many other political issues such as affirmative action, redistribution, gay marriage, and abortion. It is health care that stands out.

We have argued that the politics of health care are unique because of deep-seated psychological constraints that motivate citizens to view the sick and injured as deserving, which, in turn, leads to a belief that it is the government's responsibility to ensure adequate health care for everyone. Even if people think that it is much more likely that they will become unemployed than sick, they remain more supportive of health care. We have proposed that a plausible cause of these psychological constraints—and an explanation for why it is deeply embedded in human psychology—is the random nature of the infections and accidents that the human species has been exposed to for millions of years and the pronounced need for the exchange of help under conditions of infection or injury in a world in which high calorie nutrients must be foraged.

This implicit psychological disposition to support health care independently of political factors such as ideology and self-interest should create a forceful incentive for political elites to increase rather than limit health care spending. This could explain why public health care spending in affluent nations has been rising constantly for decades, as outlined in the introduction; an expansion occurring in an era in which many other social programs experienced retrenchment (Jensen 2014). Traditionally, researchers have explained this development by noting that health service production is technologically intensive and that the development of new, expensive treatments fuels spending increases (e.g., Fuchs, 1996). However, such a supply-side account cannot explain why politicians permit spending to drift upwards by adopting all of the new technologies and treatments. For that, we need a demand-side account; that is, one that allows us to understand why health care is so popular that politicians risk serious electoral consequences if they block expansion. The argument presented in this article constitutes such a demand-side account.

The psychological constraints operating on health care attitudes create a forceful obstacle for political elites seeking to limit health care expenditures. At the same time, we should emphasize that evolved motivations to support healthcare need not always lead to a demand for government provided healthcare. United States, for example, has recently experienced intensive debate about universal health care in the context of the reform referred to as Obamacare. Studies suggest that part of the opposition was driven by racial resentment given the association between President Obama and the reform (Tesler, 2012) but we would suggest that this opposition was further facilitated by a distinction between health care coverage and government-funded health care. We expect people to be primarily concerned about efficient coverage - i.e., that they and others are covered in times of health problems - and less about whether this coverage necessarily stems from government funding or private insurance. While citizens are motivated to support government-funded health care in general, the US debates suggest that if elites raise questions about efficiency and provide alternative policy solutions to the issue of coverage, then citizens can come to support these alternatives along partisan lines (see also Feldman & Steenbergen, 2001; Jensen 2014).

Furthermore, it is important to note that not all problems the health care system tackles will conform to people's evolved intuitions about disease and injury. As consequence, some parts of the health care system might be viewed as less worthy of government funding. During the data collection for Study 3, we also presented respondents with a list of 20 problems that are often handled by the health care system. We asked the respondents about their perceptions of whether this problem was caused by disease and whether it was the government's responsibility to help people with this problem. The relationship between the average answers for these questions for each of the 20 problems is displayed in Figure 6. Consistent with our argument, the figure shows an exceptionally strong relationship between the answers to these questions: problems that reflect

“disease” are much more likely to be viewed as problems that the government should handle ($r = .71, p < .001$).

- Figure 6 about here -

Notably, the figure also shows that not all of the problems that the health care system is handling fit how people intuitively understand “disease.” In particular, obesity and smoking-related health problems (in the survey we used a common Danish term for chronic bronchitis that directly links to smoking: “Smoker’s Lungs”) is less viewed as diseases and also less likely to be viewed as deserving of help—presumably because people feel that these problems are under a person’s control to some extent, which clashes with their intuitive understanding of “disease.” This observation is important. People do not reason backwards from the fact that the health care system takes care of a problem to the notion that this problem is therefore worthy of government funding. Rather, people seemingly assume that the health care system first and foremost deals with needs that conform to their intuitive notion of “disease” and, hence, deserve to be alleviated. In fact, when we asked which of these problems were most characteristic for the health care system, 68% said cancer and 12% said cardiac problems (located in the upper-right corner in Figure 6). No other problem was viewed as “most characteristic” by more than a few percent.

These observations suggest that there is room for politicians to counter-balance upward spending drift if they engage in careful political communications. Political entrepreneurs that want to cut government-funded health care need to frame health care in a way that emphasizes institutional efficiencies and health problems that conform less to people’s intuitions about “disease”. In this way, the psychological constraints operating behind the political issue of health

care are not deterministic for health care policies. If their origin and structure is well understood, they can be successfully circumvented.

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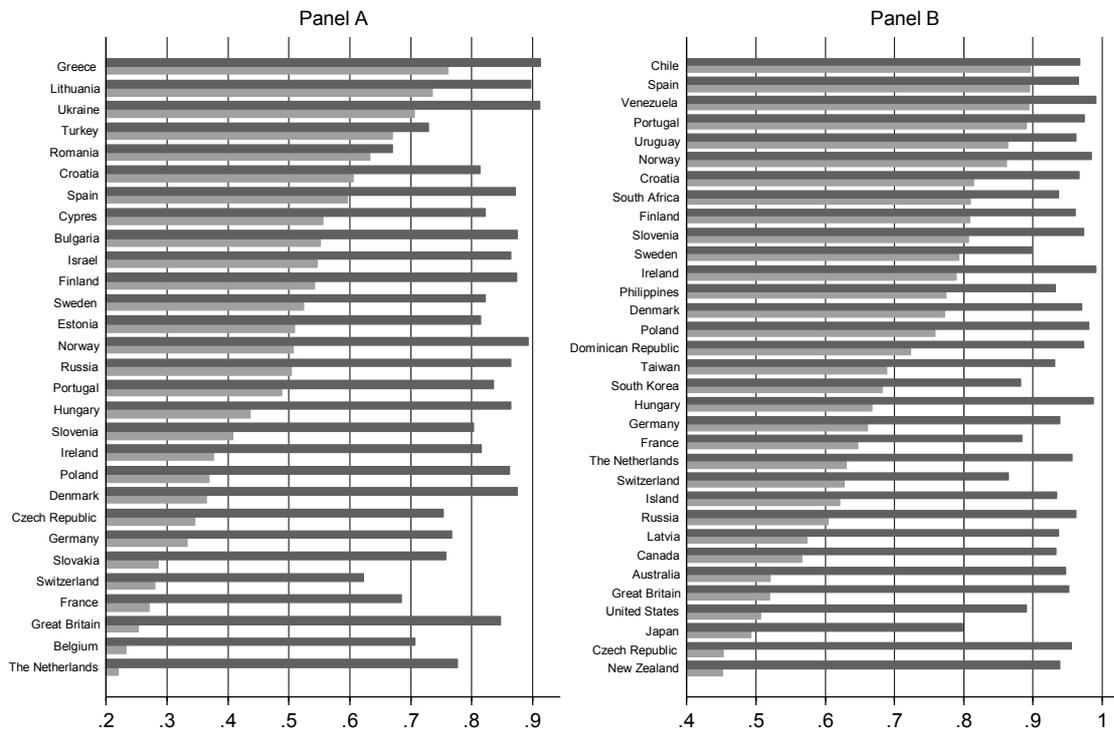
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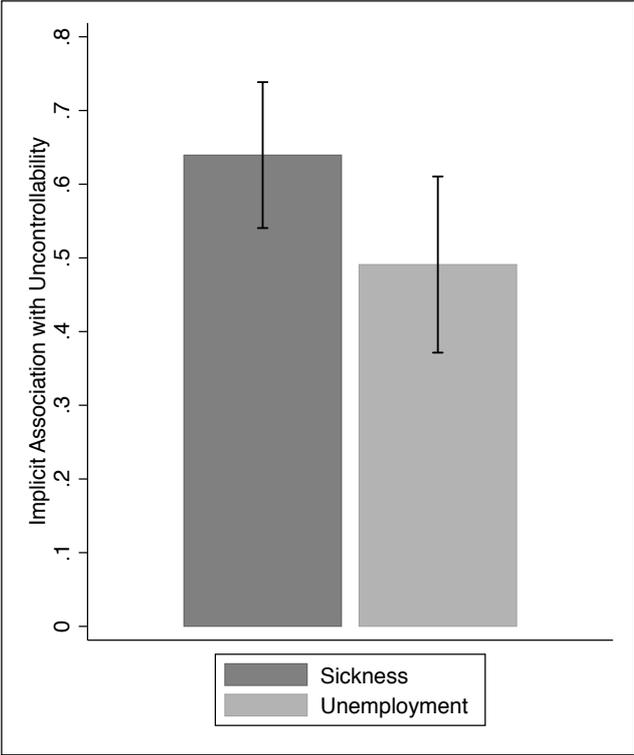
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Figure 1. Popular Support for Public Health Care and Unemployment Protection



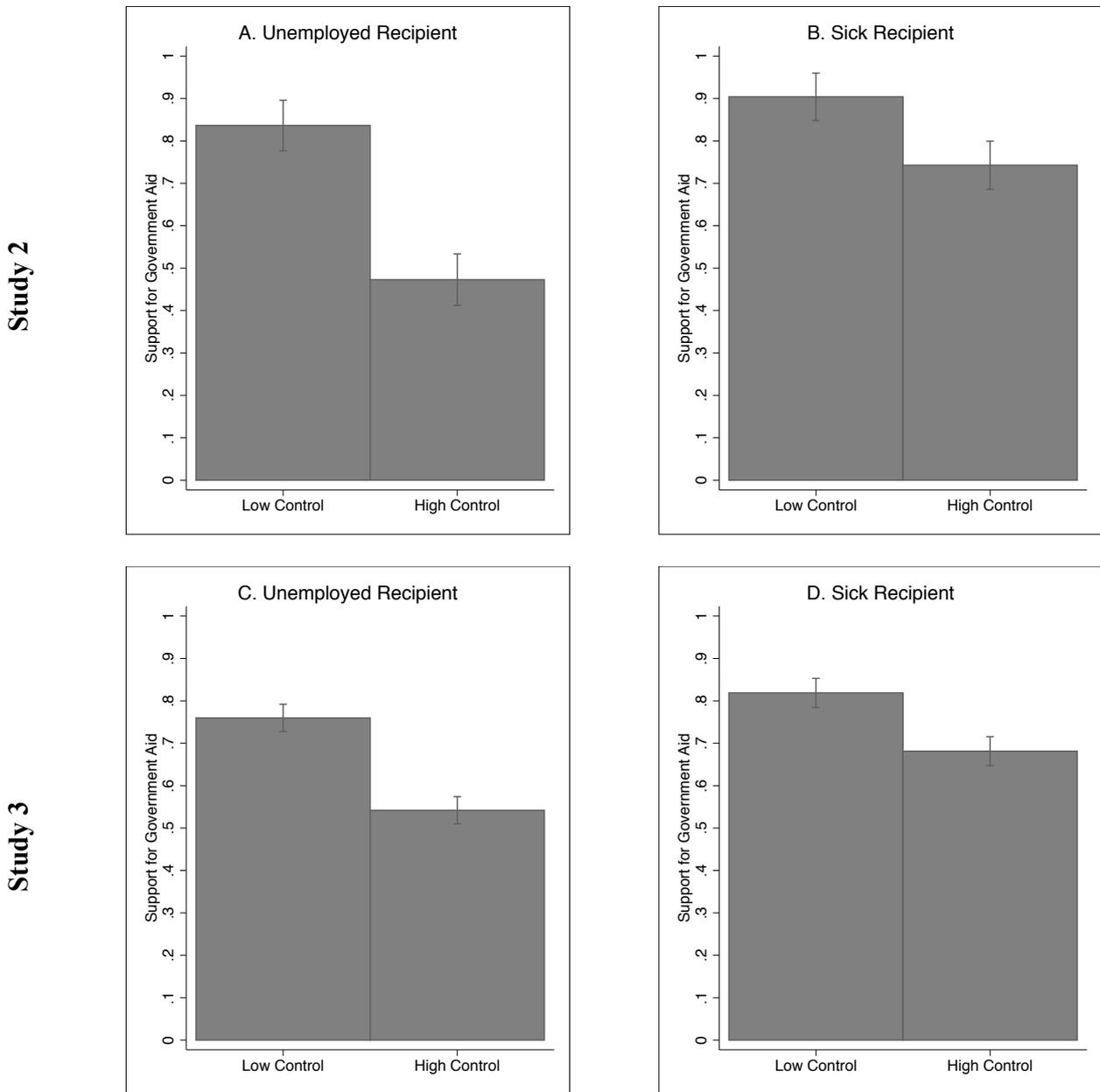
Note: Dark grey bars represent percentage of a population strongly supporting public health care; light grey bars represent the percentage of a population strongly supporting unemployment protection. See Online Appendix for wording and coding details.

Figure 2. Implicit Associations between Lacking Control and Type of Risk



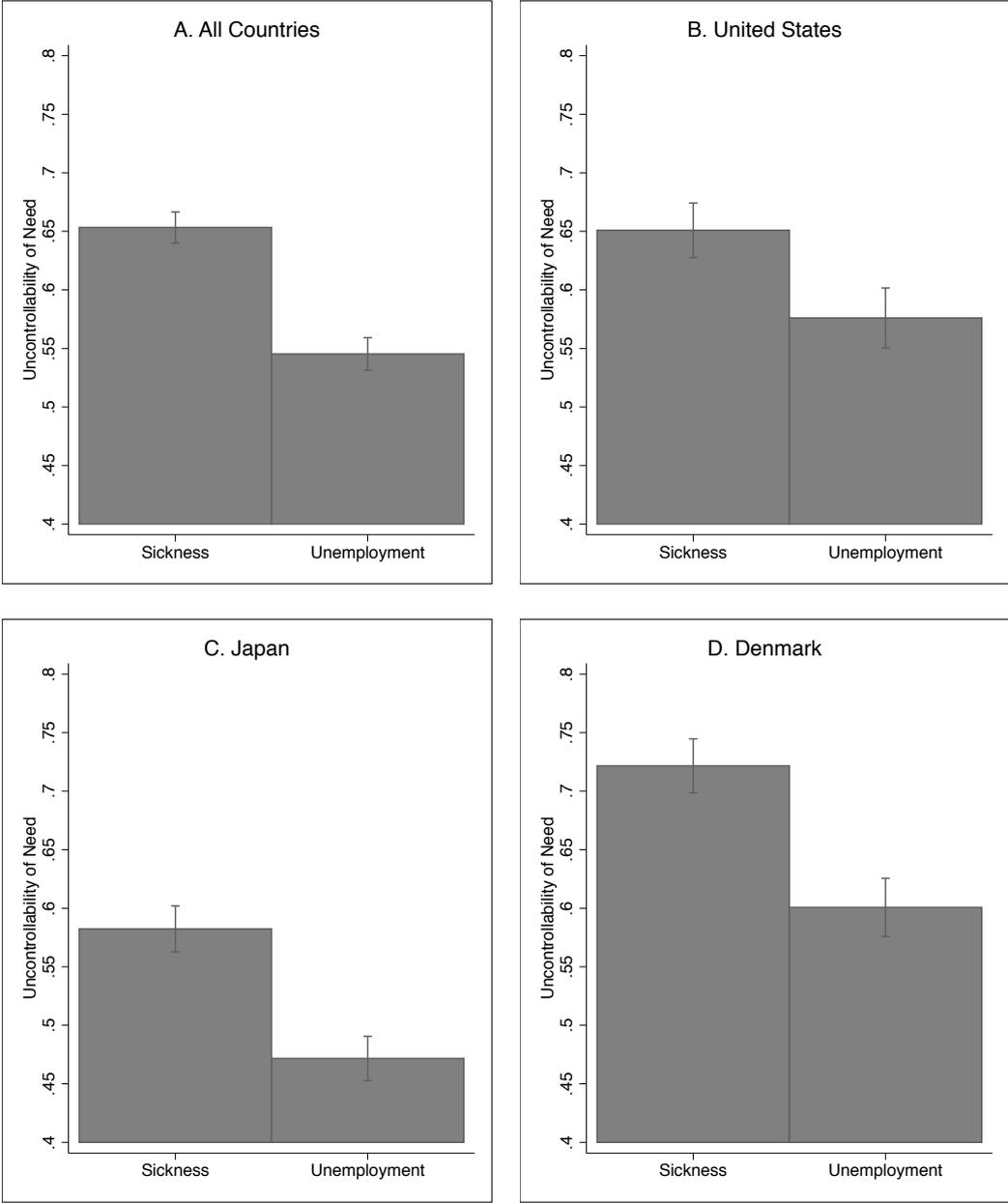
Note: Bars represent mean levels of implicit association in each implicit association test as calculated in the *Free IAT* software. Whiskers are 95% confidence intervals of the individual means.

Figure 3. Support for Government Aid as a Function of Type of Risk and Explicit Information about Controllability of Motivation in Study 2 (Panels A and B) and Study 3 (Panels C and D).



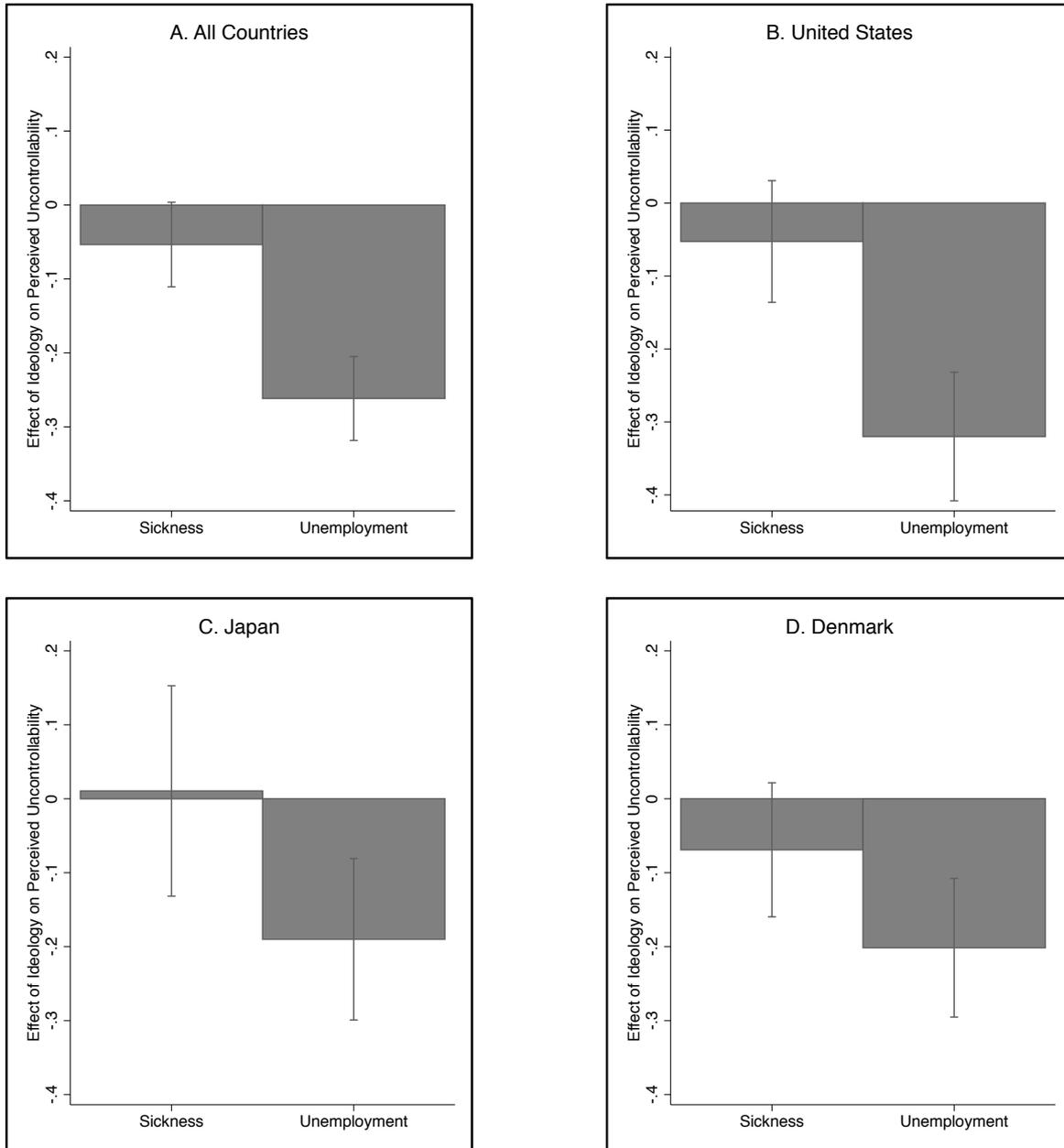
Note: Bars represent mean levels of support for government aid to the needy person in the experimental condition (ranging from 0–1). Whiskers are 95% confidence intervals.

Figure 4. Uncontrollability of Sickness and Unemployment across Countries



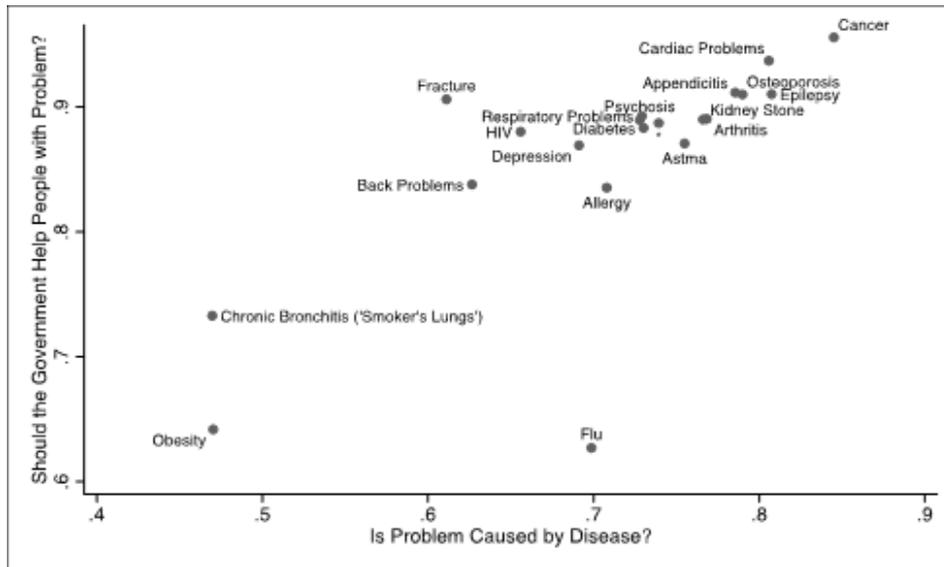
Note: Bars show predicted mean levels of perceived uncontrollability of need for sick and unemployed individuals, respectively. Whiskers are 95% confidence intervals. The variable ranges from 0–1.

Figure 5. Predicted Effect of Ideology on Perceived Uncontrollability of Need as a Function of Type of Need.



Note: Bars show the effect of ideology on the perceived uncontrollability of need for sick and unemployed individuals, respectively. Unstandardized OLS regression coefficients from regressions with all variables ranging between 0 and 1 are shown. Whiskers are 95% confidence intervals. Ideology is measured with right-wing ideology as “1;” hence, a negative correlation indicates that right-wing individuals view the need as less uncontrollable.

Figure 6. Disease-Related Conditions and Perceived Government Responsibility



Note: The figure is based on the sample for Study 3. The figure shows a scatterplot of mean ratings of 20 disease-related problems on two parameters: (1) whether this problem is caused by disease (x-axis) and (2) whether it is the government's responsibility to help people with this problem (y-axis). Ratings have been recoded to vary between 0 and 1. The * indicates the label "Liver inflammation," which did not fit in the graph.