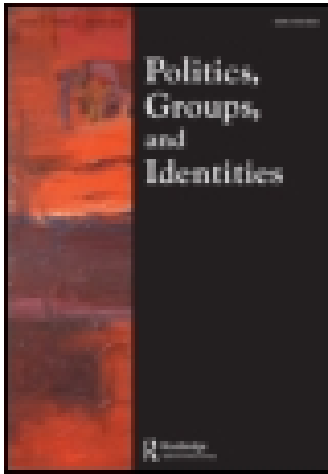


This article was downloaded by: [50.244.96.163]

On: 30 July 2015, At: 06:21

Publisher: Routledge

Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: 5 Howick Place, London, SW1P 1WG



Politics, Groups, and Identities

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/rpgi20>

Why do Americans dislike publicly funded health care? Examining the intersection of race and gender in the ideological context

Ling Zhu^a & Kenicia Wright^a

^a Department of Political Science, University of Houston, 447 PGH Hall, 4800 Calhoun Rd, Houston, TX 77204, USA

Published online: 29 Jul 2015.



CrossMark

[Click for updates](#)

To cite this article: Ling Zhu & Kenicia Wright (2015): Why do Americans dislike publicly funded health care? Examining the intersection of race and gender in the ideological context, *Politics, Groups, and Identities*, DOI: [10.1080/21565503.2015.1064007](https://doi.org/10.1080/21565503.2015.1064007)

To link to this article: <http://dx.doi.org/10.1080/21565503.2015.1064007>

PLEASE SCROLL DOWN FOR ARTICLE

Taylor & Francis makes every effort to ensure the accuracy of all the information (the "Content") contained in the publications on our platform. However, Taylor & Francis, our agents, and our licensors make no representations or warranties whatsoever as to the accuracy, completeness, or suitability for any purpose of the Content. Any opinions and views expressed in this publication are the opinions and views of the authors, and are not the views of or endorsed by Taylor & Francis. The accuracy of the Content should not be relied upon and should be independently verified with primary sources of information. Taylor and Francis shall not be liable for any losses, actions, claims, proceedings, demands, costs, expenses, damages, and other liabilities whatsoever or howsoever caused arising directly or indirectly in connection with, in relation to or arising out of the use of the Content.

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly forbidden. Terms &

Conditions of access and use can be found at <http://www.tandfonline.com/page/terms-and-conditions>

Why do Americans dislike publicly funded health care? Examining the intersection of race and gender in the ideological context[†]

Ling Zhu* and Kenicia Wright

Department of Political Science, University of Houston, 447 PGH Hall, 4800 Calhoun Rd, Houston, TX 77204, USA

(Received 21 August 2014; accepted 16 June 2015)

What explains individuals' support to government social policy provision? Many scholars consider economic factors, such as income and risk, as the key determinants of social policy preferences. However, economic self-interest is not the solo determinant of policy preference, particularly in the health care domain. The social identity approach of policy preferences argues one's social identification shapes her policy preferences. We recognize the strength of the social identity literature, but view its lack of consideration for the intersection of multiple identities as a shortcoming. Using an intersectional approach and data from the 2012 General Social Survey, we examine how political ideology colors the effects of two ascriptive identities – race and gender – in shaping individuals' health care preferences. Findings suggest that neither race nor gender independently explains health care attitudes. Instead, connecting ideology with the intersection between race and gender offers a more comprehensive account of how sub-population groups differ in their attitudes toward the role of government in health care. This timely analysis captures the complexity of Americans' health care attitudes and brings the intersectionality approach to the social policy literature.

Keywords: race; gender; intersectionality; ideology; health care preferences

Understanding the formation of citizens' preferences on the role of government in social policy provision is a core question of public policy. Mass preferences provide the legitimacy foundation of social policy provision in democracies; thus political scientists have long studied the question of what are key determinants of individuals' social policy preferences. A great deal of recent research focuses on economic factors, such as income and risk, as key explanations for social policy preferences. Under this view, those with lower incomes and greater economic risk are more likely to support government responsibility in social policy provision (Marglit 2013; Meltzer and Richard 1981; Rehm 2011).

However, the relationship between economic self-interest and support for government responsibility in social policy provision is not always airtight (Citrin et al. 1997; Gilens 1999; Schlesinger 2011; Sears and Funk 1990). Studies suggest that individuals adopt social policy stances that conflict with their economic self-interest (Bartels 2008; Hacker 2004; Jacobs and

*Corresponding author. Email: lzhu4@central.uh.edu

[†]An earlier version of this paper was presented at the 72nd Midwest Political Science Association Annual Conference in Chicago, Illinois (2014).

Skocpol 2007; Soss, Hacker, and Mettler 2007). Recognizing that economic interest only explains some policy preferences, many scholars turn to the social identity approach as an alternative. Under this view, identities are distinct individual-level traits or shared characteristics of members belonging to a social group. One's social identification reflects his value choices and the ideals important to his preferences about how to allocate resources in a society (Worell 2001). Empirical evidence shows that individuals' attitudes toward government spending in welfare programs can be affected by their social identities, such as race (Goren 2003) and gender (Page and Shapiro 1992; Shapiro and Mahajan 1986).

Despite significant empirical evidence for the social identity approach, there is a shortcoming in this literature – many scholars only focus on the effects of one identity (Brezna 2010; Klar 2013), such as considering race and gender in isolation. As Cassess, Barnes, and Branton (2015) suggest, evaluating attitudes by considering important ascriptive social groups as isolated categories can produce misleading conclusions. The idea that multiple social identities can interactively affect the formation of policy attitudes is central to research on intersectionality, which focuses on the “simultaneous and interactive effects of race, gender, class, sexual orientation and national origin” (Simien and Hancock 2011, 185). In this paper, we apply the intersectional approach to social policy preferences, but examine the interactive effects between race and gender in the context of political ideology. We contend that race and gender interactively shape one's social policy preferences, because both race and gender create boundaries between low-status and high-status groups, which translate into differentiable attitudes toward social policy. Moreover, we consider political ideology as an important context to further decipher how minority women may endorse different policy positions than white women, and men. Existing research suggests that ideological identification is an important determinant of social policy preferences (Jacoby 1991, 1994). Although ideological groups are not ascriptive groups (such as race and gender) that directly place individuals in low social status, one's political ideology can reinforce or mitigate social cues such as racial prejudice (Gilens 1999) and gender role identification (Rinehart 1992).

The US health care domain provides an excellent empirical context to examine how the joint effect of race and gender on policy preferences is conditioned by political ideology. While voters in most developed countries have stronger support for redistributive health policies than other social policy areas (Carpenter 2012), the USA appears to be an exception (Soss and Jacobs 2010). The key to understanding the more complex pattern of public options in this issue area is the racialized and gendered nature of health care in the American context (Lee and Roemer 2006; Soss and Jacobs 2010; Tesler 2012). Recent studies suggest that President Obama's national health care reform triggers racial cues in the health care debate (Tesler 2012). Moreover, social policies, especially health care issues, have long been deemed as “women's issues,” because of women's traditional gender role (Clark and Caro 2013; Page and Shapiro 1992; Rinehart 1992). This study also goes a step further by considering ideology as a divisive factor, which colors how race and gender jointly affect individuals' views regarding the role of government in health care provision. Health care in the USA has long been an issue that polarizes the mass ideology (Grogan and Rigby 2009; Jacobs and Skocpol 2012). The salience of race, gender, and ideology in the health care debate makes it an ideal policy area for examining how these identities work together to influence individuals' preferences.

Using the 2012 General Social Survey (GSS) data, we find evidence that neither race nor gender can fully account for varying public opinions on the role of government in health care. Rather, considering the intersection of race and gender in the context of ideology helps to better identify which sub-population group has the strongest support or opposition to publicly funded health care. We find that liberals uniformly have high support for more government health care. Among those who are moderate and conservative, however, minority women show

stronger support for more government health care than white women and men. Nevertheless, when respondents were asked about their willingness of paying more taxes for health care, support uniformly declines along the liberal-conservative (L-C) ideology scale, with white conservative females and white conservative males showing the lowest support. As for support to non-citizens' access to publicly funded health care, we observe both racial and gender-based differences across the L-C ideology spectrum, with whites showing substantially lower support than non-whites. Our key findings suggest that connecting ideology with the intersection between race and gender offers a more comprehensive account of how sub-population groups differ in their attitudes toward the role of government in health care. This timely analysis captures the complexity of Americans' health care attitudes and brings the intersectionality approach to the social policy literature.

The formation of social policy preferences: the literature

There are two major approaches for understanding individuals' social policy preferences: the political–economy approach and the social identity approach. The political–economy explanation of an individual's social policy preferences is that her economic self-interest (such as income and economic risk) shapes her attitudes toward social policy provision. Under this view, individuals with lower incomes and greater health or labor-market risks should be more likely to support redistributive policies and to desire more government involvement in social policy areas (Meltzer and Richard 1981; Moene and Wallerstein 2001; Iversen and Soskice 2001; Rehm 2009, 2011). The model of pocketbook voting makes a similar argument that voters cast ballots based on perceptions of their personal economic situation, as opposed to voting for the common good (Sigelman, Sigelman and Bullock 1991). The thermostatic model (Soroka and Wlezien 2005; Wlezien 1995) of policy preferences manifests a similar argument in its theory regarding aggregated policy preferences. The thermostatic model likens the responsiveness of the public to a thermostat and argues that policy preferences adjust according to the policy changes (Soroka and Wlezien 2005). Under the thermostatic model, a change occurs in public policy, the public assesses that change, and the preference of the public develops; policy-makers respond to public opinion by “adjusting” future legislation according to public opinion of existing policies. In the long run, changes in aggregated policy preferences in a subsequent time period are driven by the public's economic evaluation of the status quo policy.

The social identity approach is the second major approach for studying individual-level social policy preferences. Influenced by the social and political psychology perspectives (Conover 1984; Green, Palmquist, and Schickler 2002; Stryker and Burke 2000), scholars in this camp argue that one's social identifications, not economic interests alone, explain social policy preferences (Fong 2001; Klar 2013). For example, given their income and perception of economic benefits, the political economy approach would expect poor white males to adopt liberal stances on policy issues. However, Bartels (2008) finds that this is not the case as poor white males in the south are likely to support conservative policy issue stances. Because individuals adopt policy preferences that conflict with their economic interests, many scholars argue that the social identity approach is a valuable alternative to the political–economy approach in accounting for social policy preferences. The existing literature shows ascriptive social identities such as race (Dawson 1994; Gilens 1999) and gender (Shapiro and Mahajan 1986) influence policy preferences.¹ One of the most prominent arguments in this camp links a social group's low status to greater reliance on the government's role in providing safety net. In other words, because of lower social economic status, racial minorities and women are more likely to support generous social policy provision.

Despite all of its strengths, scholars using the social identity approach generally limit their focus to one identity. Far less attention is given to determining how multiple social identities interactively determine policy preferences. The authors that have studied interactive effects often find different identities may lead to competing interests (Klar 2013), but the mechanisms driving these complex effects have yet to be fully explored. Because individuals are able to have more than one identity, for example, white conservatives or black females – examining the intersectional effects of multiple identities is a research area ripe for exploration.

Race, gender, and preferences: applying the intersectional approach in the ideological context

Intersectionality research considers the interactive and simultaneous effects of multiple social constructions such as race, gender, class, sexual orientation, and national origin (Simien and Hancock 2011). The social groups that are the basis of this line of research are groups that can be categorized as facing social oppression or being socially dominated. Many scholars recognize the potential of applying an intersectional approach to political science research (Bratton, Haynie, and Reingold 2007; Crenshaw 1989, 1991; Simien 2007; Simien and Hancock 2011; Walby, Armstrong, and Strid 2012).²

Central to the intersectional approach is the concept of double disadvantage, that socially constructed attitudes based on two or more ascriptive identities can simultaneously contribute to structural inequality in a society (Cassess, Barnes, and Branton 2015). The intersectional approach recognizes such multiple categories of sociopolitical differences as mutually constitutive, thus focus on the interaction between different axes of sociopolitical marginalization (e.g., race and gender) (Hancock 2007; Weldon 2006). Applying the intersectional approach, a relatively new research paradigm in the public policy literature (Hankivsky and Cormier 2011), we theorize how race and gender work jointly shape policy preferences. We do this by conceptualizing one's ideological identification as a key political context that conditions the interactive effects between race and gender.

Health care preferences in the intersection of race and gender

There is a lengthy literature examining the role of race and gender as separate determinants of social policy preferences. Considering race a core social identity that influences one's social experiences, many scholars offer several theoretical mechanisms of how race shapes policy preference. First, the linked fate theory suggests that blacks will determine policy preferences based on how a policy is perceived as affecting other members of their race (Dawson 1994). Studies testing the linked fate theory find, regardless of education, income, or class, blacks will support politicians and policies perceived as helping other blacks (Dawson 1994; Shapiro and Jacobs 2013; Tate 1993, 2010).

Second, perceptions of beneficiary groups also shape social policy preferences. For instance, when the perceived beneficiary of a social policy belongs to a racial group that whites view unfavorably, whites will show less support for that policy than if the perceived beneficiary was a member of a more favorable racial group (Gilens 1999; Page and Shapiro 1992). Schneider and Ingram (1993) explain policy orientations are driven by social constructions surrounding perceived "targeted populations." Here, public policy is viewed as sending messages on appropriate government action and "deservingness" of targeted groups (Schneider and Ingram 1993). Attitudes about targeted groups affect preferences regarding health care, specifically. For example, Stone (2008) finds general attitudes toward helping the sick determine support or opposition toward health care policies and reform initiatives. Other scholars report similar findings

(Gollust and Lynch 2011), and some scholars go a step further by arguing that these perceptions are racialized (Tesler 2012).

The influence of racial attitudes also increases the importance of perceptions of “deservingness” on policy preferences (Gilens 1999; Nelson and Kinder 1996; Tate 2010). Gilens (1999) finds most Americans desire government involvement in providing welfare benefits, but racial bias results in a lack of public support for redistributive policies. Rigby et al. (2009) draw a similar conclusion, noting “Americans tend to view African Americans as less deserving of government assistance” (Rigby et al. 2009, 1337). In the health care domain, many Americans view racial minorities as the primary beneficiaries of government provision of health care and as standing to gain the most from changes to health care policies. The recent health care reform has only increased the influence of such racial attitudes in shaping policy issue stances of Americans. Tesler (2012) uses the term “racialization” to describe the increasing relevance of racial attitudes in health care preferences and finds that racial attitudes and race are more important when health care reform is associated with President Obama than when health care reform is associated with President Clinton.

In a different vein, scholars view gender as an important social identity for understanding policy preferences, and have focused on gender differences in opinion toward social welfare issues (Shapiro and Mahajan 1986). There is evidence that women tend to give higher priority than men to social policy issues (Poggione 2004; Sapiro 1986; Thomas 2001), have greater reliance on welfare state (Mettler 1998), and in many cases, are more supportive than men to generous government provision of safety-net programs (Shapiro and Mahajan 1986). The underlying mechanism of these gender differences is twofold. First, “the feminization of poverty” (Pearce 1978) suggests that women are the primarily targeted population of social welfare programs, thus would be more supportive to expanding government responsibility in welfare provision. Second, taking a socio-psychological perspective, some scholars contend that men and women have different childhood and political socialization, thus have different beliefs and priorities when considering government’s role in provisioning social safety-net programs (Mueller 1988). Empirical studies show that women are less individualistic than men and value non-hierarchical social relationships more than men (Bussey and Maughan 1982, 42; Gilligan 1982). Because of these unique gender-based beliefs, women are more likely to support greater role of government in social welfare policies.

Nevertheless, scholars are increasingly skeptical about treating race and gender as two separate identities that affect preference formation. As Rinehart (1992) reports, diverse opinions and attitudes on political parties, candidate preferences, and policy issues can be found among women. Similarly, Cassess, Barnes, and Branton (2015) contend that treating race and gender as two independent social identities could create “a false sense of unity” and lead researchers to overlook important within group heterogeneity. Conceptualizing race and gender as two mutually constitutive identities, scholars have started to connect multiple social identities to study public policy opinions. The key insight from this emerging literature on intersexuality is that individuals at the interaction (e.g., minority women) can experience multiple layers of marginalization (Hancock 2004). For example, racial prejudice can be reinforced by sexism that endorses a male-dominant social hierarchy, which further marginalizes minority women in the society. The stereotype image of “welfare queen” is a negatively constructed public identity based on both race and gender, which profoundly shapes society’s perceptions and attitudes on welfare recipients and welfare policies Hancock (2004). Consistent with Hancock (2004), Soss, Fording, and Schram (2011, 75) find that “the strongest stereotype effects [on welfare attitudes] are observed when we attend to the intersection between race and gender that underlies the iconic image of the welfare queen as a black women.”

White male to the right? Connecting the intersection of race and gender to the ideological context

The intersectional approach offers a useful framework to decipher how multiple social identities, such as race and gender, work together to shape policy preferences. However, some recent studies point out the necessity in considering political ideology as an important context to explore the interactive relationship between race and gender. Ideology reflects an individual's core values and views of the proper role of government. There is a sizable literature focusing on how individuals' ideological predispositions shape their social welfare preferences (Erikson and Tedin 2001; Feldman and Zaller 1992; Jacoby 1994). Those who self-identify as liberals generally support more government involvement in everyday affairs than those who self-identify as conservatives or moderates. As such, left-leaning voters tend to be more supportive of more government involvement in social policy areas (Erikson and Tedin 2001). Health care policy scholars also find ideological identification determines voters' health care policy preferences (Barrilleaux and Miller 1988; Brady and Kessler 2010). Blendon et al. (2011) review more than 200 national opinion surveys on health care-related topics and find conservatives are more likely to desire less government spending in Medicaid and Medicare than liberals (175). Focused on health care reform, Jacobs and Skocpol (2012) describe a staunch opposition to health care reform by conservatives (184). An empirical section in Rudolph and Evans (2005) examines the effects of ideology on public support for government spending in various social policy areas and find conservatives usually dislike government spending in health care (Rudolph and Evans 2005, 667).

But beyond its direct impact on policy preferences, political ideology is also found to be a divisive factor among individuals who share the same racial and/or gender identity. For example, Gilens (1999) and Feldman and Huddy (2005) find that racial prejudice against ethnic minorities is more prominent among white conservatives than white liberals. Cassess, Barnes, and Branton (2015) find that white men and minority women have significantly different preferences regarding equal-pay policies, and political ideology moderates the link between race, gender and policy attitudes.

Thus, considering the intersection between race and gender in the ideological context is pertinent and may offer insight that considering these factors separately may overlook. This is particularly the case in the issue area of health care, whereby, both race and gender remain as power sources of political control, and those who enjoy their privileged status will not support policies that equalize status across different social groups. There are several underlying mechanisms explain why the intersection between race and gender affect health care preferences differently among conservatives and liberals.

First, both race and gender jointly define social positions for the privileged and the marginalized. In racially coded and gendered policy areas (such as health care), white males are deemed as the "privileged" while ethnic minority women are viewed as the disadvantaged (Song 2004; Soss, Fording, and Schram 2008). A similar socioeconomic hierarchy develops along ideology by considering trends in those who identify as conservatives. Though perceptions are those with higher incomes, higher education levels, and in the upper classes of the American society are more likely to identify as conservative, many scholars also highlight the role of moral and core values in determining ideology (Conover and Feldman 1981; Ellis and Stimson 2012). Conover and Feldman (1981) put forth six symbolic scales, each representing a different group in society. Among other social groups, *Protestants*, *whites*, *men*, and the *high-income* are described as those who prefer to maintain the status quo. Following the contentions of Conover and Feldman (1981), it is appropriate to view ideology as reflecting preferences for change; the author's argument suggests that those that benefit from an existing social hierarchy (white conservative males) desire maintenance of the status quo while liberals desire change to

the status quo. In other words, white males' racial prejudice against ethnic minorities and sexism against women can be reinforced by their conservative predispositions that favor the status-quo social hierarchy, thus they would have strong opposition to policies that are viewed to help ethnic minority women (Sears and Henry 2003). Maintenance of the status quo is likely desired by white males, but more so among those who have conservative ideological orientations because the privileged group in a power hierarchy accrues direct material benefits from their dominant social identities. Their social identities, such as "whiteness," "maleness," and "upper class," can also carry indirect benefits.

Second, conservative ideological principles emphasize on individualism and self-reliance, which can reinforce beliefs that poor minority women do not deserve help from the government (Feldman and Huddy 2005; Lee and Willcoxon 2013). Minority women, specifically, face stereotypes of being "welfare queens," who are accused of having a large number of children, committing welfare fraud, and of receiving and misusing funds they receive from federal assistant programs to take of their children. Hancock (2004) finds some of the most common words associated with "welfare queen" are "don't work," "teen mothers," and "single parents" (69). These examples of stereotypes and other negative perceptions about racial-gender groups influence the attitudes individuals have toward health care and welfare beneficiaries. These racial-gender stereotypes and racial attitudes remain important in predicting policy preferences, even when individuals are given vignettes offering information about those described as potential beneficiaries of government policies. For example, Gollust and Lynch (2011) use cues about an individual's ascriptive characteristics to determine how these factors shape health care-related attitudes and find racial cues about the individual suffering from poor health shape levels of support for social involvement in helping the individual.

Third, conservative ideology can be a divisive force that differentiates individuals' socio-political beliefs by both race and gender. Recent studies find that the mutually reinforcing influence from conservatism and prejudice against socially marginalized groups is more salient among whites than that in the non-white context. Feldman and Huddy (2005) find that white conservatives' opposition against policies that benefit blacks appear to be more ideological than blacks and white liberals. McDaniel and Ellison (2008) find that religious conservatism does not shape the political socialization of whites and non-whites in the same way, with the conservative identification driving whites to embrace the Republican party's policy platforms, but having much less of an effect on Latinos and blacks. Glass and Jacobs (2005) find that religious conservatism profoundly shapes white women's beliefs of their traditional family roles, yet has muted results for black women. In other words, political ideology, particularly conservatism, can be linked to differential beliefs and preferences by race and gender.

To summarize, we derive two hypotheses for how the joint effect of race and gender on health care preferences are conditional on one's political ideology. H1 follows the intersectionality literature and highlights that the combination of a dominant racial identity (white) and dominant gender identity (male) can jointly produce opposition to government provision of health care. H2 posits that the joint effect of race and gender on health care preferences is moderated by ideology. We only expect to see divergent public opinion by race and gender among conservative respondents rather than liberal respondents.

H1: White male respondents will have less supportive attitudes to government provision of health care than minority female respondents.

H2: The divergent health care preferences between white male respondents and minority female respondents are more salient among conservatives than among moderates and liberals.

Research design

We use data from the 2012 GSS to test our hypotheses on how ideology conditions the interactive effects of race and gender on individuals’ health care preferences. Since 1972, the National Opinion Research Center (NORC) at the University of Chicago has conducted the GSS. The GSS is an annual/biannual survey that asks respondents a variety of questions on their attitudes regarding issues, such as civil liberties, morality issues, social welfare, health care, etc. Since 2006, the GSS has used a two-stage probability sampling design to deal with non-response bias (Smith et al. 2012). It samples both the English- and Spanish-speaking population. The GSS is widely recognized as the single best data set on social trends. Table 1 presents the 2012 GSS sample by race, gender, and ideology. White female and white male respondents account for 43.03% and 35.53% of the sample, respectively. Non-white female counted about 12.82%, while non-white male respondents counted 8.62% of the sample.

Measuring health care preferences

We use four GSS questions to measure individuals’ preferences on publicly funded health care. Respondents were given the following four statements and asked to rate their responses using 5-point agree–disagree Likert scales.

1. “Government should provide only limited health care.”
2. “Government should help to pay for medical care.”
3. “I am willing to pay more taxes to improve health care for all.”
4. “Non-citizens should have access to publicly funded health care.”

To simplify the substantive interpretation of our empirical findings, we recode responses to the four aforementioned questions into 1–3 ordinal scales, whereby the highest value of each dependent variable (i.e., “3”) reflects support to more government involvement in providing health

Table 1. Sample size for sub-population groups by race, gender and ideology: General Social Survey 2012.

Sub-population group	<i>N</i>	% of total number of obs.
<i>Non-white female</i>	171	12.82
Non-white liberal female	16	4.57
Non-white moderate female	69	5.17
Non-white conservative female	41	3.07
<i>White female</i>	574	43.03
White liberal female	173	12.97
White moderate female	211	15.82
White conservative female	190	14.24
<i>Non-white male</i>	115	8.62
Non-white liberal male	32	2.40
Non-white moderate male	46	3.45
Non-white conservative male	37	3.52
<i>White male</i>	474	35.53
White liberal male	112	8.40
White moderate male	170	12.74
White conservative male	192	14.39

Note: We calculate sample size for each sub-population group based on the total number of in- sample observations for Model 1 in Tables 2 and 3 (i.e., *N* = 1334).

Downloaded by [50.244.96.163] at 06:21 30 July 2015

care,³ support to more government medical care spending in helping the sick, the willingness to pay more taxes to improve health care for all, and the agreement with providing non-citizens access to publicly funded health care. Figure 1 presents the distribution of responses to these four health care preference questions. Thirty percent of GSS respondents agree that government should provide only limited health care, while almost 37% respondents do not want to pay more taxes to improve health care for all. Nearly 46% of the respondents agree that government should help the sick by paying for medical care. Public opinion on immigrant-related health care provision is even more negative: 60% of the respondents believe that non-citizens should not have access to publicly funded health care.

Measuring race

GSS identifies respondents' race in three categories: "white," "black," and "other." In the GSS sample, nearly 79% respondents are identified as white, nearly 15% are black. About 6% respondents are identified as the "other" category. In our empirical models, we include a dummy variable, non-white, coding minority respondents as "1" and white respondents as "0."⁴

Measuring gender

We use a dummy variable to capture respondents' gender. This variable is coded as "0" for males, and "1" for female respondents.

Measuring ideology

Our measure for ideology asks respondents to identify themselves on a seven-point ideological scale. Responses range from "1" (extremely liberal) to "7" extremely conservative. As Table 1 presents, in our empirical sample, nearly 28% respondents identify themselves as being liberal, nearly 38% as being moderate, and 34% as being conservative. Liberal minority females account for 4.57% of the full sample, and conservative minority female account for 3.07% of

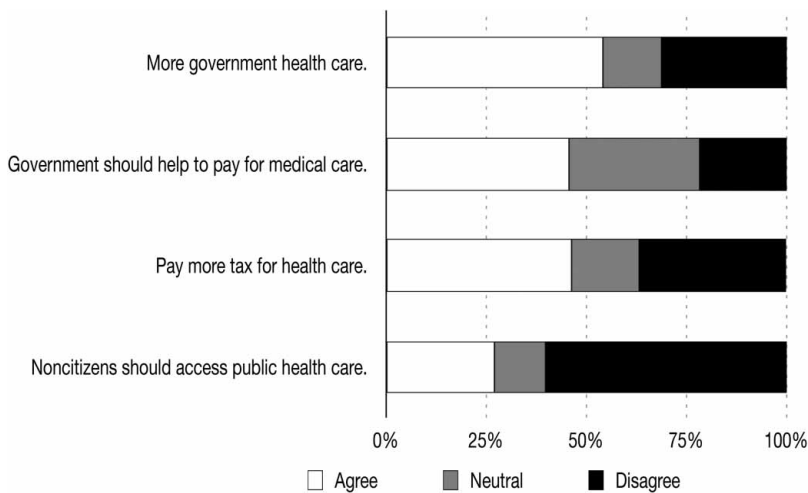


Figure 1. The distribution of preferences on Government's role in health care provision: General Social Survey 2012.

the full sample. Liberal minority males account for 2.4% of the full sample, and conservative minority males account for 3.52% of the full sample.

Control variables

We control for other factors that are likely to influence preferences on government health care provision. Considering the political economy perspective, we control for family income level, education, self-identified class, and labor force status (Iversen and Soskice 2001). Since perceptions and attitudes of beneficiary groups influence health care policy preferences, we control for individual perceptions that being poor can cause one's health to suffer (Schneider and Ingram 1993; Stone 2008). The social policy literature suggests other micro-level factors, such as age (Erikson and Tedin 2001; Gilens 1999), party identification (Page and Jones 1979; Tesler 2012), and marital status, affect policy preferences. Therefore, we control for each of these factors.⁵

Model specification

We use an ordered logistic regression with robust standard errors to perform the empirical analysis. All of our empirical models include a full set of fixed-effects dummy variables for respondents' region. We control for regional fixed effects for two reasons. First, individuals in the South may particularly be prone to linking racial bias to their health care preferences because of the long history of racial segregation in the South. Second, regional fixed effects help to control for unobserved macro-level contexts, such as the racial diversity of populations and regional variation in existing health care policies.

Findings

Table 2 presents four models that include the linear terms of all explanatory variables. Across the four models, we find consistent evidence that conservative ideology depresses support to government provision of health care. Compared with liberals, conservatives are significantly less likely to agree with government providing more health care, less likely to support government's responsibility in paying for health care for the sick, much less willing to pay more taxes to improve health care for all, and less likely to agree with non-citizens have access to publicly funded health care. Turning to the two social identity variables, as Table 2 presents, neither race nor gender independently affects health care preferences in a uniform way. We find that, comparing with white respondents, non-white respondents are significantly more likely to support greater government provision of health care, and to agree with providing non-citizens access to publicly funded health care. Yet, when turning to the two questions specifically asking respondents' opinion about government spending on health care and their willingness to pay for more taxes for health care (Models (2) and (3)), although the coefficients of *Non-white* are positive (as expected), they are not statistically significant. Similarly, when considering gender (coded as *Female*) as an independent factor, we do not find a monotonic relationship between respondents' gender and their attitudes toward publicly funded health care. Models (1) and (3) show that females are more likely to support more government health care provision than males yet they are less likely to pay more taxes to improve health care for all.⁶

Table 3 presents four models, in which we examine how political ideology conditions the interactive relationship between race and gender on health care preferences.⁷

Each model in Table 3 includes a three-way interaction of *Non-white*, *Female* and *L-C Ideology*. As expected, we find significant interactive relationships between *Non-white*, *Female* and

Table 2. Race, gender, ideology, and preferences on public health care.

Variable	Model 1	Model 2	Model 3	Model 4
	<i>Govt. provision</i> Coefficient (SE)	<i>Help the sick</i> Coefficient (SE)	<i>More taxes</i> Coefficient (SE)	<i>Non-citizen access</i> Coefficient (SE)
Non-white	0.364* (0.164)	0.209 (0.195)	0.089 (0.147)	0.846* (0.143)
Female	0.312** (0.116)	0.165 (0.138)	-0.329** (0.114)	0.146 (0.122)
L-C Ideology	-0.250** (0.049)	-0.420** (0.063)	-0.251** (0.050)	-0.254** (0.050)
Income	-0.054 (0.038)	-0.007 (0.035)	-0.029 (0.031)	-0.021 (0.033)
Education	-0.014 (0.022)	0.011 (0.024)	0.047* (0.020)	0.038† (0.023)
Class	-0.307** (0.090)	-0.259** (0.100)	0.063 (0.087)	-0.057 (0.089)
Married	-0.046 (0.123)	-0.356* (0.144)	-0.016 (0.122)	0.095 (0.127)
Full-time worker	0.295* (0.119)	0.016 (0.142)	-0.200† (0.117)	0.104 (0.125)
D-R Party ID	-0.243** (0.035)	-0.265** (0.043)	-0.241** (0.036)	-0.164** (0.036)
Poverty causes poor health	-0.122* (0.057)	-0.216** (0.070)	-0.295** (0.059)	-0.184** (0.061)
<i>N</i>	1334	911	1322	1328

Note: D-R, Democrat-Republican.

†Significance at the 10% level.

*Significance at the 5% level.

**Significance at the 1% level.

L-C ideology, but in a more complex, yet interesting way. To substantively interpret the interactive effects of race, gender and ideology, we use the *clarify* program to generate interaction figures with predicted probabilities (King, Tomz, and Wittenberg 2000). Holding all the control variables constant at their means, we graph mean predicted probabilities of supporting government health care provision and their corresponding 95% confidence intervals for sub-groups by race and gender. Using these interaction figures, we examine (1) whether we observe different preferences by race and gender, (2) more specifically, whether minority women have different health care preferences from white men, and (3) whether we observe the joint effects of race and gender vary along the ideology scale.

Figure 2 compares the predicted probabilities of supporting more government involvement in health care for white female, minority female, white male and minority male respondents, across the L-C ideology scale. We find that liberals uniformly have high level of support for more government health care. Among those who self-identified as moderates and conservatives, we do not observe different preferences among male respondents. For moderates and conservatives, minority females exhibit greater support for government health care than white females. Further comparing the two subfigures, we observe that white conservative males have a substantially lower level of support to government health care compared with minority women across the full ideology scale. In other words, political ideology is a divisive factor, but only among female respondents. The findings in Figure 2 provide some support to *H2*.

We now turn to the remaining figures to determine whether we find consistent evidence for *H2*. The left-hand-side panel in Figure 3 compares non-white female and white female

Table 3. Joint influence of race and gender on health care preferences in ideological context.

Variable	Model 1	Model 2	Model 3	Model 4
	<i>Govt. provision</i> Coefficient (SE)	<i>Help the sick</i> Coefficient (SE)	<i>More taxes</i> Coefficient (SE)	<i>Non-citizen access</i> Coefficient (SE)
Non-white	0.089 (0.215)	0.404 (0.254)	0.014 (0.201)	0.738** (0.205)
Female	0.217† (0.126)	0.239 (0.150)	-0.357** (0.127)	0.099 (0.134)
L-C Ideology	-0.263** (0.045)	-0.409** (0.063)	-0.256** (0.051)	-0.262 (0.051)
Non-white × female × ideology	0.127† (0.068)	-0.093 (0.085)	0.034 (0.062)	0.048 (0.062)
Income	-0.052 (0.038)	-0.008 (0.035)	-0.028 (0.031)	-0.018 (0.033)
Education	-0.014 (0.022)	0.013 (0.024)	0.047* (0.020)	0.038 (0.023)
Class	-0.304** (0.090)	-0.263** (0.100)	0.065 (0.087)	-0.058 (0.089)
Married	-0.046 (0.123)	-0.360* (0.144)	-0.016 (0.122)	0.097 (0.127)
Full-time worker	0.293* (0.119)	-0.011 (0.142)	-0.202† (0.117)	0.101 (0.125)
D-R Party ID	-0.243** (0.036)	-0.268** (0.043)	-0.240** (0.036)	-0.163** (0.036)
Poverty causes poor health	-0.124* (0.057)	-0.218** (0.070)	-0.296** (0.060)	-0.184** (0.061)
N	1334	911	1322	1328

Note: D-R, Democrat-Republican.

†Significance at the 10% level.

*Significance at the 5% level.

**Significance at the 1% level.

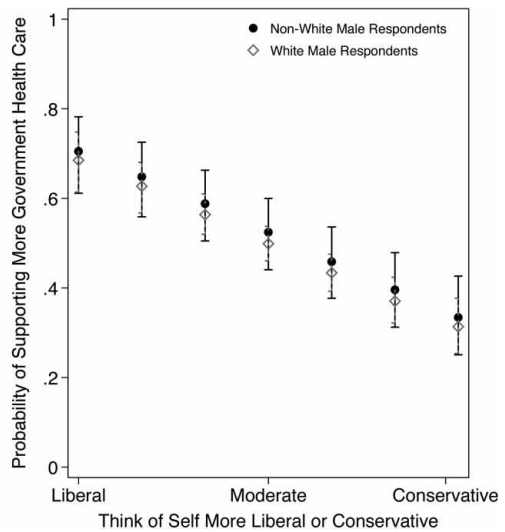
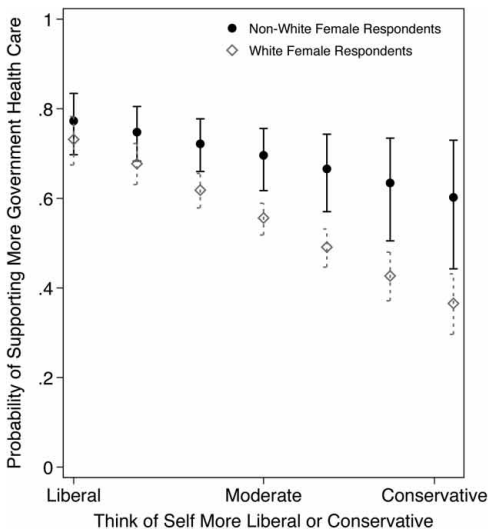


Figure 2. Comparing respondents' support for more Government health care by gender, race, and ideology: General Social Survey 2012.

Downloaded by [50.244.96.163] at 06:21 30 July 2015

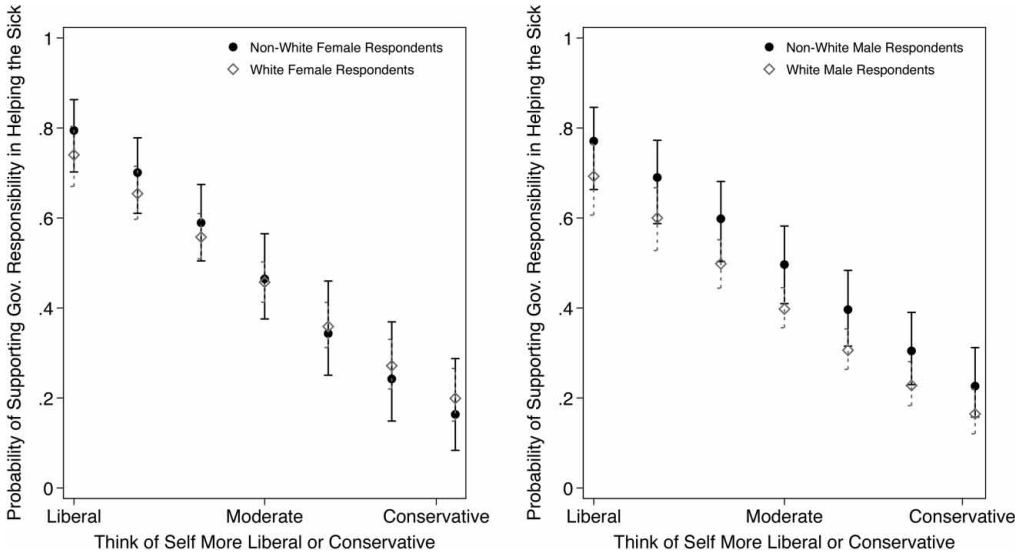


Figure 3. Comparing respondents' support for Government responsibility in helping the sick by gender, race, and ideology: General Social Survey 2012.

preferences on government's responsibility in helping the sick (i.e., paying for medical care) across the ideology scale. The right-hand-side panel in Figure 3 compares non-white male and white male preferences on government's responsibility in helping the sick across the ideology scale. We find that liberals uniformly have supportive attitudes toward government responsibility in helping the sick. Among conservative respondents, however, we do not observe significant difference between white female and non-white female preferences. Nor do we find significantly different preferences when comparing white male and non-white male preferences.

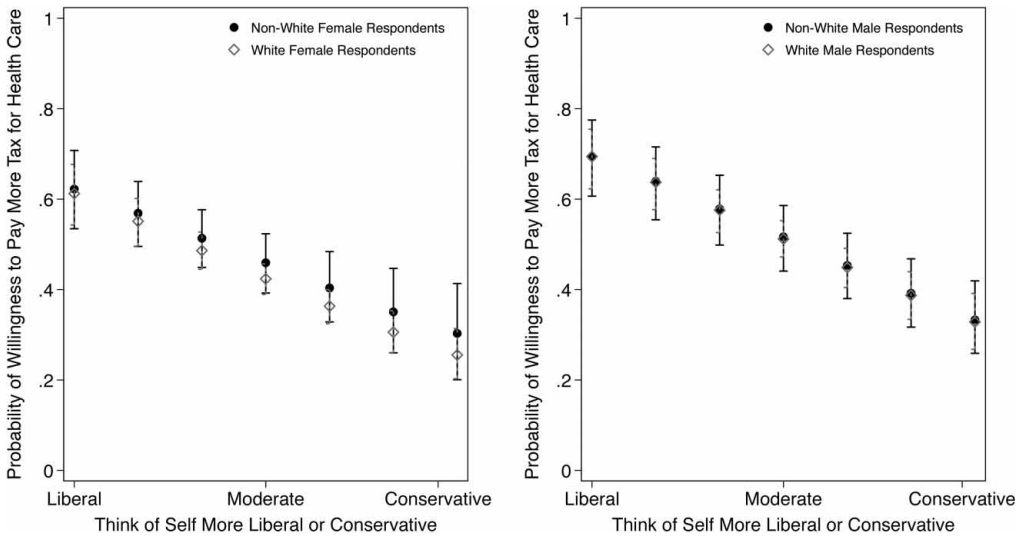


Figure 4. Comparing respondents' willingness to pay more taxes for health care by gender, race, and ideology: General Social Survey 2012.

Downloaded by [50.244.96.163] at 06:21 30 July 2015

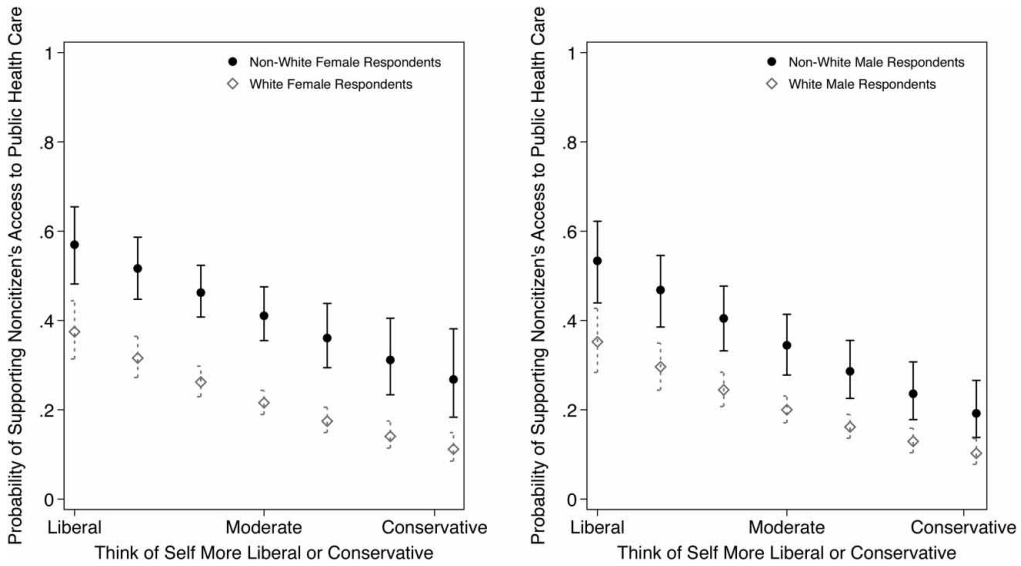


Figure 5. Comparing respondents' support to non-citizens' access to public health care by gender, race, and ideology: General Social Survey 2012.

Figure 4 shows preferences on paying more taxes for improving health care for all across the ideology scale, for the four demographic groups. Figure 4 shows a similar pattern as Figure 3. We observe that liberals are uniformly associated with a high probability of being willing to pay more taxes for improving health care for all. Yet, among conservatives, we do not observe significant differences between white female and non-white female respondents. We also do not find significant differences in the willingness to pay for tax between white male and non-white male respondents.

Figure 5 compares non-white and white respondents' support for non-citizens' access to publicly funded health care by gender and across the ideology variable. Again, we observe that liberals are uniformly more supportive to granting non-citizens access to publicly funded health care, and moving from liberal to conservative along the ideology scale, the probability of supporting non-citizens' access to public health care decrease substantially. Across the full ideology scale, we observe divergent preferences between white and non-white female respondents, with minority female respondents showing higher probabilities than white female respondents of supporting granting publicly funded health care to non-citizens. We observe the comparable pattern among male respondents, with minority male respondents showing higher probabilities than white male respondents of supporting non-citizens' access to publicly funded health care. Among those self-identified as the most conservative, minority female respondents exhibit greater probability of supporting non-citizens' access to public health care than white female, and male respondents. In addition, for most conservative respondents, we do not observe significant differences between minority male and white male respondents. Similar to Figures 2–4, we observe that white conservative males are least likely to support non-citizens' access to publicly funded health care. Figure 5 provides additional evidence for H2.

Concluding discussion

In this paper, we view health care as one of the most suitable social policy issues to apply the intersectional approach to understand mass policy preferences. Americans have long been

Downloaded by [50.244.96.163] at 06:21 30 July 2015

divided on the issue of health care and are exceptional in the significant number of voters who dislike government-provided health care (Starr 2013). Traditional self-interest arguments offer limited insight as conservative white males often adopt health care policy stances that counter their best interests (Gilens 1999). Recognizing this dynamic President Obama's recent association with health care makes this policy area ideal for examining the intersectional effects of race, gender, and ideology. We offer a timely analysis of Americans' health care preferences by placing the race-gender nexus in the ideological context. Our findings suggest that the joint effects of race and gender are altered by political ideology. In the two empirical models that depict preferences regarding the general government role in health care provision and responsibility in providing access to non-citizens, we find that white conservative males hold the strongest opposition to government-funded health care, while minority females have more supportive attitudes toward government responsibility in health care. But the divergence in preferences is not observed among liberals. These findings offer insight on how two important ascriptive identities – race and gender – interactively shape health care preferences in America. Though conservative opposition toward health care policy has been found elsewhere in the literature (Erikson and Tedin 2001; Page and Shapiro 1992), our results suggests that considering the intersectional effects of race and gender together with the influence of political ideology offers a more comprehensive picture of health care preferences.

Moreover, in the two empirical models that depict health care preferences specifically tied to fiscal responsibilities, political ideology seems to trump both race and gender. We find that the conservative ideology uniformly decreases support to more government spending on medical care and the willingness of paying more taxes for improving health care for all. These findings are indicative that when fiscal responsibilities are concerned, ideological predispositions many converge differences across racial and gender groups. The nuances regarding how health care opinions differ across the four survey questions call for future research that further explore the relative influence of different identities.

There are also several other ways to extend this study. First, our intersectional approach can be generalized to study the combined effect of other social identities such as sexual orientation, the status of welfare reciprocity, citizenship, and partisanship identification. A second empirical extension of this line of research would be considering the interactive effects of race, gender, and ideology across different policy issue areas. Applying an intersectional approach to other policy issue areas may contribute broader scholarly understanding of the key determinants of policy preferences. For example, giving our interesting findings on who endorse and oppose non-citizens' access to publicly funded health care, it will be worthwhile to apply the intersectional approach to attitudes toward immigrants' access to other welfare programs outside of the health care domain.

To conclude, theories of identity politics emphasize the importance of social identities in understanding social inequality and policy solutions to social discrimination in a plural society. Intersectionality research defines the new edge of the identity politics literature by focusing on how multiple identities interactively shape the politics of social policy. Although gaining its popularity in other disciplines, intersectionality research receives limited attention in public policy research (Manuel 2007). Following the recent scholarly efforts in applying the intersectional approach in study public policy (Hancock 2007; Hankivsky and Cormier 2011; Simien 2007), we apply the intersectional approach in the ideological context and bring the multiple-identity approach to the social policy literature. We show that linking the interactive effects of multiple ascriptive identities to political ideology enhances our understanding of differences between and within groups (Crenshaw 1991). The key to understanding the divided American electorate on social policy issues is the social prejudice against marginalized groups, and how conservative political ideology reinforces the multiple axes of social prejudice.

Acknowledgements

We thank Jason Casellas, Jennifer Clark, Andrea Eckelman, Markie McBrayer, and Spencer Piston for their helpful comments. We also thank the editors and the anonymous reviewers for making valuable suggestions. All errors remain ours.

Disclosure statement

No potential conflict of interest was reported by the authors.

Supplemental data

Supplemental data for this article can be accessed <http://dx.doi.org/10.1080/21565503.2015.1064007>.

Notes

1. In a similar vein, scholars contend that one's partisan identification is a generic form of social identification and works similarly as political ideology in shaping policy preferences (Bolsen, Druckman, and Lomax Cook 2014; Green, Palmquist, and Schickler 2002; Leeper and Slothuus 2014; Taber and Lodge 2006).
2. There are different approaches and classifications within the intersectional approach. For example, (McCall 2005) discusses three approaches for using intersectionality: intra-categorical, anti-categorical, and inter-categorical. Hancock (2007) also puts forth a classification for intersectionality but uses three different approaches: the unitary, the multiple, and the intersectional approach (Walby, Armstrong, and Strid 2012).
3. Because the first health care question is a negative statement, which asks respondents if they think "government should provide only limited health care." The responses are originally coded as "1" = strongly agree (that government should provide only limited health care), "2" = somewhat agree, "3" = neutral, "4" = somewhat disagree, and "5" = strongly disagree. We recoded responses "1" and "2" as "1," the neutral response "3" as "2," and responses "4" and "5" as "3." As such, the recoded value "3" refers to disagreement with the statement that government should provide only limited health care, i.e. supportive attitudes toward more government health care.
4. In the Supporting Information (Section 3), we present model results using the alternative coding of the race variable, by differentiating black respondents from Hispanics and other racial/ethnic groups. Our substantive findings about white conservative males' policy preferences remain the same. One may also argue that racial identity (or identification with a race group) can also be manifested by group affect (Conover 1984), thus the link between race and policy preferences needs to be evaluated by gauging one's racial prejudice toward an out-group. Following the existing literature (Gilens 1999), we specify an alternative model by replacing the objective race variable with a measure of racial prejudice toward African Americans. We provide more details in the Supporting Information.
5. The *Family Income* variable is categorical with 12 categories ranging from \$1 to \$250,000 or more. *Married* is coded as a dummy variable, whereby "1" refers to married respondents and "0" otherwise. The *Age* variable ranges from 1 to 89 and older. The *Education* variable asks the highest year of school a respondent has completed; it ranges from 0 to 20. There are four categories for our subjective class measure—lower, working, middle, and upper class. The *Full-Time Worker* variable is a dummy variable, coded as "1" for full-time workers and "0" otherwise. The *Party Identification* variable is coded as a categorical variable, ranging from strong democrats to strong republicans. The variable *Poverty Causes Poor Health* is coded as a five-point Likert scale, which asks a respondent if he suffers from health problems because of being poor. Summary statistics of all the variables used in this paper are in the Supporting Information (see Section 1).
6. For simplicity, coefficients for the two cut-points and the regional fixed effects are not reported in Table 2. In the *Supporting Information* (Section 2), we also present four empirical models that only include a two-way interaction term between *non-white* and *female*. In these alternative models, we find robust evidence that liberals are uniformly more supportive to publicly funded health care than conservatives. Similar to Table 2, these models also show that neither race nor gender independently shape health care preferences in a monotonic way.

7. In the *Supporting Information* (Sections 5 and 6), we provide two additional robustness checks: we check whether our findings hold when we consider health care preferences in years prior to 2012, and when we consider *Ideology* as an endogenous regressor. The robustness analysis shows we reach similar substantive conclusions. A look at the control variables in both [Tables 2](#) and [3](#) show the expected relationships. The self-reported class variable is negatively associated with support for more government in health care. Individuals that affiliate with the Republican Party are more likely to oppose generous and inclusive government health care provision. The findings of our models also suggest those that believe being poor can cause one to suffer from health, are less supportive of government provision of health care.

References

- Barrilleaux, Charles J., and Mark E. Miller. 1988. "The Political Economy of State Medicaid Policy." *The American Political Science Review* 82 (4): 1089–1107.
- Bartels, Larry M. 2008. *Unequal Democracy: The Political Economy of the Gilded Age*. Princeton, NJ: Princeton Press.
- Blendon, Robert J., Mollyann Brodie, John M. Benson, and Drew E. Altman. 2011. *American Public Opinion and Health Care*. 6th ed. Washington, DC: CQ Press.
- Bolsen, Toby, James N. Druckman, and Fay Lomax Cook. 2014. "The Influence of Partisan Motivated Reasoning of Public Opinion." *Political Behavior* 36 (2): 235–262.
- Brady, David W., and Daniel P. Kessler. 2010. "Who Supports Health Reform?" *Political Science and Politics* 43 (1): 1–6.
- Bratton, Kathleen A., Kerry L. Haynie, and Beth Reingold. 2007. "Agenda Setting and African American Women in State Legislatures." *Journal of Women, Politics, and Policy* 28 (3–4): 71–96.
- Brezna, Nate. 2010. "Economic Equality and Social Welfare: Policy Preferences in Five Nations." *International Journal of Public Opinion Research* 22 (4): 458–484.
- Bussey, Kay, and Betty Maughan. 1982. "Gender Differences in Moral Reasoning." *Journal of Personality and Social Psychology* 42 (4): 701–706.
- Carpenter, Daniel. 2012. "Is Health Politics Different?" *Annual Review of Political Science* 15: 287–311.
- Cassess, Erin C., Tiffany D. Barnes, and Regina P. Branton. 2015. "Racializing Gender: Public Opinion at the Intersection." *Politics and Gender* 11 (1): 1–26.
- Citrin, Jack, Donald P. Green, Christopher Muste, and Cara Wong. 1997. "Public Opinion Toward Immigration Reform: The Role of Economic Motivations." *The Journal of Politics* 59 (3): 858–881.
- Clark, Jennifer H., and Veronica Caro. 2013. "Multi-member Districts and the Substantive Representation of Women: An Analysis of Legislative Cosponsorship Networks." *Politics and Gender* 9 (1): 1–30.
- Conover, Pamela Johnston. 1984. "The Influence of Group Identifications on Political Perception and Evaluation." *The Journal of Politics* 46 (3): 760–785.
- Conover, Pamela Johnston, and Stanley Feldman. 1981. "The Origins and Meaning of Liberal/Conservative Self-identifications." *American Journal of Political Science* 25 (4): 617–645.
- Crenshaw, Kimberle. 1989. "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory, and Antiracist Politics." *University of Chicago Legal Forum* 140: 139–167.
- Crenshaw, Kimberle. 1991. "Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color." *Stanford Law Review* 43 (6): 1241–1299.
- Dawson, Michael C. 1994. *Behind the Mule-Race and Class in African-American Politics*. Princeton, NJ: Princeton University Press.
- Ellis, Christopher, and James A. Stimson. 2012. *Ideology in America*. New York: Cambridge University Press.
- Erikson, Robert S., and Kent L. Tedin. 2001. *American Public Opinion*. 6th ed. Boston, MA: Addison Wesley Longman.
- Feldman, Stanley, and Leonie Huddy. 2005. "Racial Resentment and White Opposition to Race-Conscious Programs: Principles or Prejudice." *American Journal of Political Science* 49 (1): 168–183.
- Feldman, Stanley, and John Zaller. 1992. "A Simple Theory of the Survey Response: Answering Questions versus Revealing Preferences." *American Journal of Political Science* 36 (3): 579–616.
- Fong, Christina. 2001. "Social Preferences, Self-interest, and the Demand for Redistribution." *Journal of Public Economics* 82 (2): 225–246.
- Gilens, Martin. 1999. *Why Americans Hate Welfare: Race, Media and the Politics of Antipoverty Policy*. Chicago, IL: University of Chicago Press.

- Gilligan, Carol. 1982. *In a Different Voice: Psychological Theory and Women's Development*. Cambridge, MA: Harvard University Press.
- Glass, Jennifer, and Jerry Jacobs. 2005. "Childhood Religious Conservatism and Adult Attainment among Black and White Women." *Social Forces* 84 (1): 555–579.
- Gollust, Sarah, and Julia Lynch. 2011. "Who Deserves Health Care? The Effects of Causal Attributions and Group Cues on Public Attitudes about Responsibility for Health Care Costs." *Journal of Health Politics* 36 (6): 1061–1095.
- Goren, Paul. 2003. "Race, Sophistication, and White Opinion on Government Spending." *Political Behavior* 25 (3): 201–220.
- Green, Donald, Bradley Palmquist, and Eric Schickler. 2002. *Partisan Hearts and Minds: Political Parties and the Social Identities of Voters*. New Haven, CT: Yale University Press.
- Grogan, Colleen M., and Elizabeth Rigby. 2009. "Federalism, Partisan Politics and Shifting Support for State Flexibility: The Case of the U.S. State Children's Health Insurance Program." *Publius* 39 (1): 47–69.
- Hacker, Jacob S. 2004. "Privatizing Risk without Privatizing the Welfare State: The Hidden Politics of Social Policy Retrenchment in the United States." *American Journal of Political Science Review* 98 (2): 243–260.
- Hancock, Ange-Marie. 2004. *The Politics of Disgust: The Public Identity of the Welfare Queen*. New York: New York University Press.
- Hancock, Ange-Marie. 2007. "When Multiplication Doesn't Equal Quick Addition: Examining Intersectionality as a Research Paradigm." *Perspectives on Politics* 5 (1): 63–79.
- Hankivsky, Olena, and Renee Cormier. 2011. "Intersectionality and Public Policy: Some Lessons from Existing Models." *Political Research Quarterly* 64 (1): 217–229.
- Iversen, Torben, and David Soskice. 2001. "An Asset Theory of Social Policy Preferences." *American Political Science Review* 95 (4): 875–893.
- Jacobs, Lawrence R., and Theda Skocpol. 2007. *Inequality and American Democracy: What We Know and What We Need To Learn*. New York: Russell Sage Foundation.
- Jacobs, Lawrence R., and Theda Skocpol. 2012. *Health Care Reform and American Politics: What Everyone Needs to Know*. 2nd ed. New York: Oxford University Press.
- Jacoby, William G. 1991. "Ideological Identification and Issue Attitude." *American Journal of Political Science* 35 (1): 178–205.
- Jacoby, William G. 1994. "Public Attitudes Toward Government Spending." *American Journal of Political Science* 38 (2): 336–361.
- King, Gary, Michael Tomz, and Jason Wittenberg. 2000. "Making the Most of Statistical Analyses: Improving Interpretation and Presentation." *American Journal of Political Science* 44 (2): 347–361.
- Klar, Samara. 2013. "The Influence of Competing Identity Primes on Political Preferences." *The Journal of Politics* 75 (4): 1108–1124.
- Lee, Woojin, and John E. Roemer. 2006. "Racism and Redistribution in the United States: A Solution to the Problem of American Exceptionalism." *Journal of Public Economics* 90 (6/7): 1027–1052.
- Lee, Taeku, and Nicole Willcoxon. 2013. "Race, Public Opinion, and the Media." In *Oxford Handbook of American Public Opinion and the Media*, edited by Robert Y. Shapiro and Lawrence R. Jacobs, 605–622. Chicago, IL: University of Chicago.
- Leeper, Thomas J., and Rune Slothuus. 2014. "Political Parties, Motivated Reasoning, and Public Opinion Foundation." *Political Psychology* 35 (Suppl1): 129–153.
- Manuel, Tiffany. 2007. "Envisioning the Possibilities for a Good Life: Exploring the Public Policy Implications of Intersectionality Theory." *Journal of Women, Politics & Policy* 28 (3–4): 173–203.
- Marglit, Yotam. 2013. "Explaining Social Policy Preferences: Evidence from the Great Recession." *American Political Science Review* 107 (1): 80–103.
- McCall, Leslie. 2005. "The Complexity of Intersectionality." *Signs* 30 (3): 1771–1800.
- McDaniel, Eric L., and Christopher G. Ellison. 2008. "God's Party? Race, Religion, and Partisanship over Time." *Political Research Quarterly* 61 (2): 180–191.
- Meltzer, Allan H., and Scott Richard. 1981. "A Rational Theory of the Size of Government." *Journal of Political Economy* 89 (5): 914–927.
- Mettler, Suzanne. 1998. *Divided Citizens: Gender and Federalism in New Deal Public Policy*. Ithaca, NY: Cornell University Press.
- Moene, Karl Ove, and Michael Wallerstein. 2001. "Inequality, Social Insurance and Redistribution." *American Journal of Political Science* 95 (4): 859–874.
- Mueller, Carol M., ed. 1988. *The Politics of the Gender Gap: The Social Construction of Political Influence*. New York: Sage.

- Nelson, Thomas E., and Donald R. Kinder. 1996. "Issue Frames and Group-Centrism in American Public Opinion." *The Journal of Politics* 58 (4): 1055–1078.
- Page, Benjamin I., and Calvin C. Jones. 1979. "Reciprocal Effects of Policy Preferences, Party Loyalties and the Vote." *American Political Science Review* 73 (4): 1071–1089.
- Page, Benjamin I., and Robert Y. Shapiro. 1992. *The Rational Public: Fifty Years of Trends in Americans' Policy Preferences*. Chicago, IL: University of Chicago.
- Pearce, Diane. 1978. "The Feminization of Poverty: Women, Work and Welfare." *Urban and Social Change Review* 11 (1–2): 28–36.
- Poggione, Sarah. 2004. "Exploring Gender Differences in State Legislators' Policy Preferences." *Political Research Quarterly* 57 (2): 305–314.
- Rehm, Philipp. 2009. "Risks and Redistribution: An Individual Analysis." *Comparative Political Studies* 42 (7): 855–881.
- Rehm, Philipp. 2011. "Social Policy by Popular Demand." *World Politics* 63 (2): 271–299.
- Rigby, Elizabeth, Joe Soss, Bridget C. Booske, Angela MK Rohan, and Stephanie A. Robert. 2009. "Public Responses to Health Disparities: How Group Cues Influence Support for Government Intervention." *Social Science Quarterly* 90 (5): 1321–1340.
- Rinehart, Sue T. 1992. *Gender Consciousness and Politics*. New York: Routledge.
- Rudolph, Thomas J., and Jillian Evans. 2005. "Political Trust, Ideology, and Public Support for Government Spending." *American Journal of Political Science* 49 (3): 660–671.
- Sapiro, Virginia. 1986. "The Gender Basis of American Social Policy." *Political Science Quarterly* 101 (2): 221–238.
- Schlesinger, Mark. 2011. "Making the Best of Hard Time: How the Nation's Economic Circumstances Shaped the Public's Embrace of Health Care Reform." *Journal of Health Politics, Policy and Law* 36 (6): 989–1020.
- Schneider, Anne, and Helen Ingram. 1993. "Social Construction of Target Populations: Implications for Politics and Policy." *American Political Science Review* 87 (2): 334–347.
- Sears, David O., and Carolyn L. Funk. 1990. "The Limited Effect of Economic Self-interest on the Political Attitudes of the Mass Public." *The Journal of Behavioral Economics* 19 (3): 247–271.
- Sears, David O., and Patrick J. Henry. 2003. "The Origins of Symbolic Racism." *Journal of Personality and Social Psychology* 85 (2): 259–275.
- Shapiro, Robert Y., and Lawrence R. Jacobs. 2013. *The Oxford Handbook of American Public Opinion and the Media*. New York: Oxford University Press.
- Shapiro, Robert Y., and Harpreet Mahajan. 1986. "Gender Differences in Policy Preferences: A Summary of Trends from the 1960s to the 1980s." *Public Opinion Quarterly* 50 (1): 42–61.
- Sigelman, Lee, Carol K. Sigelman, and David Bullock. 1991. "Reconsidering Pocketbook Voting: An Experimental Approach." *Political Behavior* 13 (2): 129–149.
- Simien, Evelyn M. 2007. "Doing Intersectionality Research: From Conceptual Issues to Practical Examples." *Politics and Gender* 3 (2): 264–271.
- Simien, Evelyn M., and Ange-Marie Hancock. 2011. "Mini-Symposium: Intersectionality Research." *Political Research Quarterly* 64 (1): 185–186.
- Smith, Tom W., Peter V. Marsden, Michael Hout, and Jibum Kim. 2012. *General Social Surveys, 1972–2012*. NORC ed. Chicago, IL: National Opinion Research Center.
- Song, Miri. 2004. "Introduction: Who's at the Bottom?: Examining Claims About Racial Hierarchy." *Ethnic and Racial Studies* 27 (6): 859–877.
- Soroka, Stuart N., and Christopher Wlezien. 2005. "Opinion-policy Dynamics: Public Preferences and Public Expenditure in the United Kingdom." *British Journal of Political Science* 35 (4): 665–689.
- Soss, Joe, Richard C. Fording, and Sanford F. Schram. 2008. "The Color of Devolution: Race, Federalism, and the Politics of Social Control." *American Journal of Political Science* 52 (3): 536–553.
- Soss, Joe, Richard C. Fording, and Sanford F. Schram. 2011. *Discipline the Poor: Neoliberal Paternalism and the Persistent Power of Race*. Chicago, IL: University of Chicago Press.
- Soss, Joe, Jacob S. Hacker, and Suzanne Mettler. 2007. *Remaking America: Democracy and Public Policy in an Age of Inequality*. New York: Russell Sage Foundation.
- Soss, Joe, and Lawrence R. Jacobs. 2010. "The Politics of Inequality in America: A Political Economy Framework." *Annual Review of Political Science* 13: 341–364.
- Starr, Paul. 2013. *Remedy and Reaction: The Peculiar American Struggle over Health Care Reform*. New Haven, CT: Yale University Press.
- Stone, Deborah. 2008. "Protect the Sick: Health Insurance Reform in One Easy Lesson." *The Journal of Law, Medicine and Ethics* 36 (4): 625–659.

- Stryker, Sheldon, and Peter J. Burke. 2000. "The Past, Present, and Future of Identity Theory." *Social Psychology Quarterly* 63 (4): 284–297.
- Taber, Charles S., and Milton Lodge. 2006. "Motivated Skepticism in the Evaluation of Political Beliefs." *American Journal of Political Science* 50 (3): 755–769.
- Tate, Katherine. 1993. *From Protest to Politics: The New Black Voters in American Elections*. Cambridge, MA: Harvard University Press.
- Tate, Katherine. 2010. *What's Going On?: Political Incorporation and the Transformation of Black Public Opinion*. Washington, DC: Georgetown University Press.
- Tesler, Michael. 2012. "The Spillover of Racialization into Health Care: How President Obama Polarized Public Opinion by Racial Attitudes and Race." *American Journal of Political Science* 56 (3): 690–704.
- Thomas, Sue. 2001. "The Impact of Women on State Legislative Policies." *The Journal of Politics* 53 (4): 958–976.
- Walby, Sylvia, Jo Armstrong, and Sofia Strid. 2012. "Intersectionality: Multiple Inequalities in Social Theory." *Sociology* 46 (2): 224–240.
- Weldon, S. Laurel. 2006. "Critical Perspectives on Gender and Politics." *Politics and Gender* 2 (2): 235–248.
- Wlezien, Christopher. 1995. "The Public as Thermostat: Dynamics of Preferences for Spending." *American Journal of Political Science* 39 (4): 981–1000.
- Worell, Judith. 2001. *Encyclopedia of Women and Gender: Sex Similarities and Differences and the Impact of Society on Gender*. San Diego, CA: Academic Press.