In September 2009, Jimmy Carter famously remarked to NBC’s Brian Williams, “I think an overwhelming portion of the intensely demonstrated animosity toward President Barack Obama is based on the fact that he is a black man.” This comment came in the wake of several racially significant political events, notably Representative Joe Wilson’s (R-SC) outburst directed at Barack Obama (“You lie!”) during the President’s congressional address on the status of illegal immigrants, Dr. David McKalip’s widely circulated “witch doctor” email, and the “9/12” protests in Washington. Carter reflected on the protests:

[Signs carried by protesters that say] “We should bury Obama with Kennedy” and “Obama is a Nazi” and Obama’s pictures with Hitler’s mustache on it—those kind of things are not just casual outcomes of a sincere debate over whether we should have a national program in health care or not. It’s deeper than that.¹

These protests gained notoriety after “Tea Party” demonstrators carried out acts of physical abuse and shouted profanities aimed at black politicians. On March 20, 2010, one protestor spat on Representative Emanuel Cleaver (D-MO), while another cried racial slurs at Representative John Lewis (D-GA). A third congressman, Representative James Clyburn (D-SC), remarked, “I heard people saying things that I have not heard since March 15, 1960 when I was marching to try and get off the back of the bus.”²

Media coverage of health care protests highlighted these incidents of racism, and the idea quickly spread that opposition to Obama’s health care reform was associated with racial prejudice. This sentiment was widespread enough to inspire a Rasmussen

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¹ Lawrence Belcher graduated from the University of Chicago in 2011, Phi Beta Kappa with honors in political science. He is currently a student in the postbaccalaureate premedical program at Bryn Mawr College.
poll asking respondents to rate whether “most opponents of President Obama’s health care plan are racist,” and even led to a popular YouTube video featuring anti-health-reform demonstrators indignantly arguing, “I guess I’m racist.” In the video, filmmaker Ray Griggs argued that, “Americans have every right to speak out against the ruinous direction our nation is currently heading without being labeled a racist.”

Altogether, a defining characteristic of media coverage of health care reform is its focus on racial prejudice aimed at President Obama (and, to a lesser extent, other black leaders). As a result of this coverage, the Affordable Care Act became a symbolic issue for the President—a piece of legislation that seemed to encapsulate Obama’s political agenda. Given this, racialized opposition to the policy can be imagined mostly as an attempt to prevent Obama from achieving his campaign goals (Glenn Beck and Sarah Palin’s rally chant, “Take back our country,” comes to mind.)

Marc Hetherington and Jonathan Weiler, who write a guest blog entry in the Washington Post, emphasize that Americans did not exhibit opposition to health care reform anywhere near this extent or intensity when President Clinton made a very similar proposal in the mid-1990s.

But health care reform should theoretically be subject to a more generalized racial resentment as well—a possibility that has largely been ignored in media coverage of the plan (as well as the scholarship surrounding it). The Affordable Care Act has the potential to substantially benefit African-Americans, who are uninsured and suffer from chronic diseases at rates higher than those of whites. Most salient among the Act’s provisions are the expansion of Medicaid coverage, elimination of the prescription coverage “loophole,” and government subsidies for low-income families to purchase private health insurance. More than half of the estimated fifty million Americans who will gain coverage as a result of the Affordable Care Act are racial minorities. The recent health care reform initiatives are probably the most important legislation for the improvement of minorities’ life chances since the Voting Rights Act. And given the racially stained history of public opinion on so-
cial welfare policies, we should be very interested to determine if attitudes on health care reform follow a similar pattern to opinion surrounding other "subtly" racial social issues like federal cash assistance or food stamps. Representative Clyburn remarked after the racially charged Tea Party protest, “I think a lot of those people today demonstrate that this is not about health care . . . It is about trying to extend a basic fundamental right to people who are less powerful.” The racial inequities that Representative Clyburn alludes to are precisely why studying the Affordable Care Act as a racialized issue is so important. Racism on social policy does not exist in a vacuum. It affects, and is affected by, very real gaps in health conditions and access to health resources—many of which have life-threatening consequences. Discrepancies in health outcomes between whites and blacks are large; the overall life expectancy for blacks is 68.8 years, six years shorter than that of whites. Mortality rates for heart disease and cancer, the two leading causes of death in the United States, are significantly higher for blacks. The proportion of blacks who are uninsured is nearly twice that of whites. These inequities are truly racial, as they persist net of economic status and other demographic variables that are correlated with both race and limited access to health resources. “The overall health of Black Americans is substantially less than that of white Americans . . . [and] their health mortalities and morbidities are also much greater due to continually increasing disparities in poverty, medical coverage, and access to care.”

The whirlwind of attention surrounding the Affordable Care Act has formed a unique opportunity to study the relationship between race, social policy, and politics. Not only does this legislation promise to reduce dire discrepancies in health conditions between blacks and whites, it is also a landmark accomplishment of America’s first black president. And while observational and experimental studies have already suggested that racial prejudice causes opposition to health care reform, we don’t know much about the specifics of this relationship (Knowles et al 2009; Hetherington and Weiler 2009). In particular, there is a need to separate anti-Obama prejudice from a more generalized racial resentment regarding the per-
ceived beneficiaries of health care reform. We should also prioritize learning more about the role of racial ideologies, since the expression of these ideologies can tell us a great deal about the social and psychological factors behind white reluctance to support the Affordable Care Act.

EXISTING STUDIES ON RACE AND HEALTH CARE REFORM

There is a growing body of empirical evidence that Jimmy Carter’s hunch about racism and health care reform may be correct. Two important studies carried out in 2009 have demonstrated that implicit racial prejudice is a driving factor in opposition to health legislation.

Marc Hetherington and Jonathan Weiler, social scientists at Vanderbilt University and the University of North Carolina, respectively, collected survey data in 2009 indicating that racial resentment and opposition to health care reform are “extraordinarily” strongly correlated. They found that individuals with above-average racial resentment were less than half as likely to favor government-run health care as individuals with below-average racial resentment. In a Washington Post column describing their initial results, the authors asserted that, “No such relationship between racial attitudes and opinions on health care existed in the mid-1990s during the Clinton effort.”

This is a tremendous finding in support of the general hypothesis that racial prejudice plays a role in public opinion on the Affordable Care Act. But the article’s reliance on observational data has implications that limit the predictive power of its results. First, there is no way to definitively determine a causal process with observational data. It is entirely possible that some third factor, known or unknown, is causing both increased racial resentment and decreased support for health care reform. Geographical surroundings, neighborhood context, political associations, and religious involvement come to mind.

Second, relying on explicit measures of racial attitudes, as
Hetherington and Weiler did, runs the risk of desirability bias: the result of respondents’ tendency to select answers that are seen as acceptable or desirable (even if these attitudes are not representative of their true beliefs). Measures of explicit racial prejudice, such as a racial resentment scale, are especially vulnerable to desirability bias. It may be difficult to make generalizable inferences about a population from this data. My study attempts to remedy this problem, as well as the problem of causation, by turning to an experimental design. The design of the present paper supplements these imperfect measures with an experimental treatment, emphasizing not the integrity of the survey items themselves but rather the changes observed as a result of experimental manipulations.

Eric Knowles, Brian Lowery, and Rebecca Schaumberg conducted the second important study in the organizational behavior lab at Stanford’s Graduate School of Business. Like Hetherington and Weiler, these authors examined the relationship between racial prejudice and opposition to health care reform, but they used an experiment rather than an analysis of observational data. Examining implicit prejudice while controlling for explicit prejudice, the authors found that, “[t]he association between implicit prejudice and opposition to health care reform replicated when the plan was attributed to Obama, but not to Bill Clinton—suggesting that individuals high in anti-black prejudice tended to oppose Obama at least in part because they dislike him as a black person.”¹² They also found that implicit prejudice predicted “endorsement of specific concerns about the plan,” indicating that highly prejudiced individuals tended to hold concerns about health care reform (that it is a ‘dangerous step toward socialism’, etc.) at a higher rate than less-prejudiced individuals.¹³

But this study also leaves some important questions unanswered. First, assuming that “individuals high in anti-Black prejudice tended to oppose Obama at least in part because they dislike him as a Black person” may not be a fair conclusion. Attitudes about Clinton and Obama may be confounded with a whole host of political differences, not to mention that Clinton has been absent from the average American’s political consciousness for almost a decade.
Americans may also form opinions about the presidents based on any number of personal characteristics completely independent of their race—even independent of their politics. My study attempts to remedy this problem by using narratives and imagery of a fictional state with fictional politicians. This way, attitudes about the political agents are unconfounded, and any differences I observe in the treatment groups can be attributed to the race of the politicians. (See section Methodology.)

Finally, neither study addresses the formation and makeup of the racial opinions at hand, nor how they relate to common racial ideologies employed by opponents of liberal social policies. We should learn as much as we can about the social and psychological precursors of this effect, so that we can better understand its practical implications.

THEORETICAL APPROACHES TO RACIAL ATTITUDES IN AMERICA

Scholars disagree on the initial causes of racial opposition to social policies. There are three main schools of thought, each emphasizing either psychological, political, or sociological foundations. In their volume *Racialized Politics* (2000), David Sears, Jim Sidanius, and Lawrence Bobo outline three perspectives on racial opinion formation: new racism, principled conservatism, and group conflict theory. An adjacent body of literature is found in the study of colorblindness, which focuses on racial attitude expression rather than psychological formation of these attitudes. In addition, a multitude of research on local politics lays the framework for understanding whites’ attitudes toward black politicians.

**New Racism, Modern Racism, and Racial Resentment**

The first set of theories argues that while “Jim Crow” racism has largely faded into history, negative affect toward blacks and derogatory stereotypes remain powerful predictors of opinion on these policies. A “reservoir of racial antipathy decoupled from ra-
cialist beliefs” lingers from earlier, more overt forms of racism and is responsible in large part for opposition to policies that benefit blacks.\footnote{15}

Much of the "new racism" is presumed to arise from perceptions among whites that blacks reject traditional American values, including a strong "work ethic, self-reliance, impulse control and obedience to authority."\footnote{16} It is also associated with a belief that since overt racism is no longer a dominant player in racial discourse, discrimination no longer threatens the life chances of blacks, and government intervention in racial affairs is unnecessary.

New racism scholars point to evidence suggesting that racial resentment is the most powerful predictor of racial policy preferences, with political ideology holding less explanatory power.\footnote{17} In this study, a post-treatment racial resentment scale indicates the presence of new racism. (See section \textit{Methodology}.)

\textbf{Principled Conservatism}

A second set of theories emphasizes political considerations over racial ones in the formation of public opinion in social policy. Focusing on the observation that citizens can choose only among discrete political alternatives presented by the political infrastructure, principled conservatism theorists are reluctant to consider racism as a determinant of public opinion on racial policies.\footnote{18} Paul Sniderman, a political scientist at Stanford, is the leading proponent. He argues that the specific politics of each policy are more important to opinion formation than racial resentment or group conflict, pointing to evidence that opinion on racial policy is not developed consistently in different racial policies. Sniderman and his colleagues suggest that general political ideology and moral values should be the strongest predictors of opinion on racial and social policy.\footnote{19} The existence of political explanations for opposition to health care reform would be indicated in this study if I observe that racial attitudes are roughly equal across the treatment groups. In other words, we would have evidence for the Sniderman thesis if racial ideologies were expressed at a constant level, regardless of
Group Conflict Theory

A third set of theories argues that social structure and group interests are the strongest predictors of opposition to black-benefiting policies. The central assumption is that citizens tend to identify with their own racial groups, and that “competing interests” of these groups generate “intergroup conflict.” In turn, groups that hold power develop ideologies to justify their status. Opposition to social policies by members of an in-group, then, comes from the incentive to protect group interests. Donald Campbell promoted this school of thought and called it “realistic group conflict:”

From this perspective, whites’ political responses to racial issues should be driven by zero-sum competition with blacks for jobs, promotions, admission slots to colleges, government contracts, or other goods. Thus, their opposition to racially ameliorative policies—and their antipathy toward the civil rights movement, its leaders, and even blacks themselves—can be explained by the threat blacks pose to whites’ privileges.

Importantly, a number of studies have demonstrated that whites’ policy preferences are more closely related to group interests than individual self-interest. In other words, they challenge the idea that realistic group conflict is in fact “realistic.” For example, whites that do not have individual reasons to feel threatened by blacks (in terms of school busing, job placement, or college admissions) are not much less opposed to “black-benefiting” policies than whites that do claim individual threat. Many scholars have interpreted this as evidence that races tend to form opinions with group interest at mind; they predict that whites will oppose racially liberal policies when they feel that their own group status is threatened.

In the present study, group conflict is indicated by a post-treatment measure of intergroup threat, which is included in the “Specific Concerns Scale” (see Results section).

One caveat: in understanding both racial resentment and
group conflict, it is important to keep in mind that health care reform is not an overtly racial policy. Unlike affirmative action, school busing, or equal housing legislation, for example, the imprint of race on opinion formation is subtler and perceived rather than openly discussed. With this said, we still have ample evidence that racialized thought processes affect public opinion on subtly racial issues like welfare and food stamps. I argue that health care reform will be at least as vulnerable to racial influence as these policies, since the Affordable Care Act promises a profound improvement in health quality for a large population of underserved and underinsured blacks, and since it has been widely understood as a signature project of the country’s first black president.

Colorblind Ideology

If scholars disagree on the initial causes of racial opposition to social policies, they tend to agree on the types of ideologies that are employed by opponents to explain their policy preferences. While the previous section focused on racial attitude formation, this section addresses racial attitude expression.

By far, the most commonly observed expressions can be attributed to colorblindness—an ideology that asserts race should not be a consideration in drawing conclusions, forming judgments, or planning government policies. Eduardo Bonilla-Silva, a Duke sociologist, authored a modern revision of colorblind racial theory, *Racism without Racists*. In this text, he attempts to explain the “strange enigma” of race: that virtually all whites claim to support equal racial opportunity, yet “blacks and most minorities are at the bottom of the well” with regard to life chances and conditions. Bonilla-Silva argues:

Whites have developed powerful explanations—which have ultimately become justifications—for contemporary racial inequality that exculpate them from any responsibility for the status of people of color. These explanations emanate from a new racial ideology that I call colorblind racism. This ideology, which acquired cohesiveness and dominance in the late 1960s, explains
Bonilla-Silva outlines four frames that colorblind racism establishes in the consciousness of whites. The two that are most important for this study are abstract liberalism and minimization of racism. Abstract liberalism involves reframing ideas typically associated with political and economic liberalism to account for racial issues. “By framing race-related issues in the language of liberalism, whites can appear ‘reasonable’ and even ‘moral,’ while opposing almost all practical approaches to deal with de facto racial inequality.” Minimization of racism invokes arguments that racism has diminished with time and that discrimination is no longer a salient force. Leslie Carr, a sociologist at Old Dominion University and one of the first researchers to outline colorblind racism, notes that, “[t]he roots of color-blind ideology are found in the classic liberal doctrines of freedom—the freedom of the individual created by the free capitalist marketplace.” Proponents of colorblindness often assert that the Constitution is a color-blind document, and are opposed to government intervention in matters of racial opportunity, claiming that such intervention is “unconstitutional, immoral, and racist because the government is not [acting] color-blind.” Carr’s data suggests that about 77 percent of whites describe themselves as colorblind, while only 40 percent of blacks do.

The 2009 study by Eric Knowles and colleagues, which experimentally demonstrated that racial prejudice predicts opposition to contemporary health care reform, also makes the case that colorblindness is important to a complete understanding of public opinion formation:

The present work is also consistent with social-psychological research highlighting the manner in which individuals maintain a positive view of self even as their sociopolitical views are shaped by prejudice. Because most people wish to appear fair-minded—both to others and to themselves—they often embrace more principled, “color blind” rationales for their race-based views . . . high-prejudice individuals in the present study expressed a number of race-neutral objections to Obama’s health care plan—
cluding the notion that it represents a dangerous step toward socialism—that may function to obscure the racial dimension of their attitudes.\textsuperscript{32}

A number of other studies in political psychology have explored the principles of colorblind racism. Sidanius, Pratto and Bobo (1996) note that, “Conservatives generally reject suggestions that their opposition to civil rights legislation is motivated by racism. Instead they maintain that this opposition is strictly driven by a principled consideration of fairness, equity, and the goal of establishing a truly color-blind society.”\textsuperscript{33} And David Sears, P.J. Henry, and Rick Kosterman (2000) outline the transition over the past several decades from classic prejudice and stereotyping to the “more politically important . . . intense white opposition to policies explicitly intended to increase racial equality, such as busing, affirmative action, and vigorously [sic] enforcement of fair employment and fair housing regulations.”\textsuperscript{34}

I believe that the expression of colorblind racial ideology is critical to learning more about the opinion formation of whites. As David Sears and his colleagues point out, these ideologies are incorporated into the three schools of thought outlined previously, and their relationship to public opinion is a point of contention that divides the arguments. For group conflict theorists, colorblindness is an outcome and justification of racism. For political theorists, colorblindness is a legitimate and static school of thought that causes opposition to racial policies on principled grounds. For new racism theorists, it exists as both an independent and dependent variable—both a justification employed by dissenters and a cause of some of the dissent itself:

In the hands of social structuralists, political ideology is to a significant degree a tool used by dominant groups to maintain their hegemony. In contrast, politically oriented theorists argue that it composes principles of self-governance reached through careful consideration and education and plays a central causal role in determining attitudes toward racial policy. In the middle, perhaps, are new racism theorists, who see components of conservative ideology as intertwined with racism, but with both making independent
contributions to racial policy preferences.\textsuperscript{35}

In short, colorblindness is important to this study because it is the racial ideology most commonly associated with opposition to socially liberal policies. It also allows us to get a glimpse of some of the social and psychological precursors to policy preference by examining its expression across the four treatment groups. (For example, observing that colorblindness remains constant even as health care attitudes change has different implications than observing that colorblind attitudes are correlated with opposition to the new laws.)

**White Response to Black Leadership**

While the previous sections have outlined the prevailing schools of racial theory as they relate to policy opinion, an adjacent body of work addresses the attitudes of whites with regard to black political leaders. This field offers limited background for the present study, since scholarship on black leaders has until very recently excluded consideration of the presidency. Nevertheless, a wealth of research on racial politics at the local level may lay a framework by which we can understand whites’ opinions of black politicians in general.

In his landmark book *Changing White Attitudes Toward Black Political Leadership*, Zoltan Hajnal, a political scientist at the University of California, San Diego, categorizes existing scholarship into two camps: the prejudicial camp, which points to evidence that the racial attitudes of white Americans are so profoundly ingrained that they cannot be modified by the prospect or reality of black politicians,\textsuperscript{36} and the white backlash camp, which argues that the political successes of blacks inspire whites to attempt to upend these achievements, given the incentive to maintain an advantageous racial hierarchy\textsuperscript{37}.

On the other hand, Hajnal finds evidence that black office-holding can actually improve race relations and whites’ opinions of blacks in general. He writes that many whites initially fear that black politicians will favor black interests over white interests, but
that once blacks are elected, “whites gain access to better information about the policy preferences of black leaders and the effects of black leadership. They become able to judge black candidates on their records. And because the white community rarely suffers under black incumbents, these records are, in almost every case, better than white stereotypes and fears suggested they would be.”

Hajnal argues that while black representation in politics has been disappointing in its ability to improve racial equality and the general welfare of black Americans, its “information effect” on whites’ racial attitudes has been significant.

In Voting Hopes or Fears? White Voters, Black Candidates and Racial Politics in America, Keith Reeves, a political scientist at Swarthmore College, points out that by 1997 (the year of his book’s publication) only nine blacks in the history of the United States had been elected to represent mostly-white electoral districts in Congress. He argues that racial prejudice, racialized campaign coverage in the media, and the political exploitation of race in appealing to white fears have historically prevented black candidates from winning white votes. This mobilization of fear is particularly important; as a revealing example, Reeves highlights Jesse Jackson’s comments in 1983 upon the election of Harold Washington as Chicago’s first black mayor: “There was an unfounded fear [among white Chicagoans] . . . the idea that blacks once they take power will engage in retributive justice is just not so.”

A unifying theme in the literature involves the phenomenon of white fear. Group conflict, information effects, white backlash, and colorblindness theorists all point to evidence that whites equate black officeholding with black policies, in turn benefiting black beneficiaries. Whites’ reluctance to elect blacks to office, then, can be understood as a mechanism of protecting an advantageous spot at the top of the racial ladder.

RESEARCH QUESTIONS

The goal of this paper is to shine empirical light on a phenomenon of great stakes but little scholarly attention. Popular media
outlets have speculated on the role of racism in Americans’ reactions to the Affordable Care Act since the plan was first proposed in 2009.43 But to date, only one published study and one paper in progress have examined the topic, and as outlined in the Existing Studies section, neither of these approaches can account for the possibility that health care reform is a racially significant policy outside of its endorsement by President Obama.44

Given this background, the principal goal is to confirm previous studies’ findings that racial prejudice has an effect on health care reform attitudes—this time in a politically isolated setting without confounding allusions to Presidents Obama or Clinton. Second, this study aims to separate racial prejudice at the politician level (analogous to anti-Obama prejudice) from resentment regarding the race of perceived beneficiaries. Third, it aims to test the hypothesis that colorblind racial attitudes and racial resentment are affected by the race of the stakeholders in proposed health care plans. Finally, it aims to learn as much as possible about the practical implications of this effect.

METHODOLOGY

I use a survey-embedded experiment to assess how racial prejudice may affect policy opinion, colorblind racism, racial resentment, and attitudes about President Obama among a representative sample of voting-age Americans. Specifically, the experiment is designed to measure how these indicators vary depending on the race of the stakeholders in a proposal for health care reform. By “stakeholders,” I mean the politician proposing the plan and the beneficiaries (or patients) expected to benefit from it.

Respondents are randomly assigned to one of four treatment groups, each of which includes an identical narrative of a proposed health care reform plan in Maryland, but different images of the politician who endorses the plan and of the beneficiaries affected by it. Images of the politicians are portrait-style, with the two men dressed in navy business suits and in office settings. They both appear to be between forty and fifty years of age. Patients are photo-
graphed in similar clinical settings, surrounded by medical equipment, and each treatment group shows one adult patient as well as one child.

The narrative describes expanding coverage very similar to the Affordable Care Act: expanding Medicaid services to all citizens under age sixty-five, subsidizing private insurance plans for families with income below $70,000, and increasing funding for free clinics and community health centers. Funding for the plan is attributed to raising income taxes for the highest-earning 2 percent of Maryland residents, taxing residents who purchase high-end “Cadillac” insurance plans, and taxing insurers and pharmaceutical companies.

The treatment narratives include brief summaries of pro and con arguments for the proposal. “Supporters of the plan argue that this expanded coverage is necessary to provide basic health benefits to individuals and families who do not have them,” and, “Opponents of the plan argue that the state cannot handle the expense of the program, that it penalizes wealthy taxpayers, or that people in medically underserved areas should take the initiative to find care on their own.” In each treatment, the plan is attributed to a gubernatorial candidate with a race-neutral name, “Dominic Evans,” whose portrait (an image of either a black politician or a white politician) is displayed prominently. The script used in the four treatment groups is reproduced in the Appendix.

This structure follows a 2x2 (Governor x Patient) factorial design, with the goal of separating anti-black animus surrounding politicians (i.e. “Dominic Evans” or President Obama) from anti-black animus surrounding the perceived beneficiaries of expanding health coverage. This design also has the benefit of minimizing demand effects, as the policymakers and beneficiaries differ only by their race. Since the narratives are identical in each group, the political platforms attributed to both iterations of Dominic Evans are identical, as are the benefits granted to both sets of patients.
Dependent Variable Measurement

Post-treatment, subjects were asked to provide their overall assessment of the plan, from 0 (“strongly oppose”) to 10 (“strongly support”). The mean response is 6.64 (sd=2.65).

The survey also asked subjects to respond to a bank of “specific concern” statements taken from media reports of opposition to health care reform. They are:

- “This plan is too expensive, especially right now. Governor Evans should be focusing on other things.”
- “This plan makes me feel like I’m losing control of a system that already works.” (This is an indicator of intergroup threat. See section Theoretical Approaches to Racial Attitudes in America.)
- “What would you say is the likelihood that this plan would result in health rationing, where not everyone gets all the care they need?”
- “What would you say is the likelihood that this plan would result in benefits going to people who don’t deserve them?”
- “What would you say is the likelihood that this plan would result in a government takeover of the health care industry?”

These concerns were compiled into an additive index (Cronbach’s alpha = 0.70).

Next, respondents completed a modified Colorblind Racial Attitudes Scale, or CoBRAS. This scale measures attitudes that could be classified as “colorblind racism.” To reduce attrition due to the survey’s length, the original twenty-item CoBRAS was trimmed to twelve items. The questions that remained were chosen by the factor analysis included in Neville’s original paper: the four highest-scoring factors within each of three dimensions (Racial Privilege, Institutional Discrimination, and Blatant Racial Issues) were retained. Cronbach’s alpha for this modified scale was 0.82, only slightly reduced from .86 in Neville’s initial validation. Some questions were reverse coded in my analysis so that a higher
value consistently indicated “more colorblind.” Respondents then completed the six-item Racial Resentment Scale. This was also compiled into an additive index (Cronbach’s alpha = 0.84). Some questions were reverse coded so that a higher value consistently indicated higher levels of racial resentment.

Finally, respondents were asked to give their overall assessment of President Obama, and to compare the Maryland proposal with their overall sentiments toward Obama’s national health care reform plan.

Sample

The survey was offered to a socioeconomically, ideologically, and racially diverse panel managed by the Chicago Research Lab at the University of Chicago Booth School of Business. Subjects needed only to live in the United States and be eighteen years of age or older to meet the inclusion criteria. In the online portal used by survey respondents, the study was entitled, “Win $75! Political Opinion Survey.” Respondents were not directly compensated, but were given the chance to enter a drawing for a seventy-five dollar prize. Data were collected for two weeks.

One hundred sixty-five respondents completed the survey, ninety-six of which (or 58 percent) were white. Because this study focuses on the attitudes of voting-age white Americans, only these ninety-six respondents were included in the final analysis. The attitudes of members of other races, particularly African-Americans, are theoretically relevant to this topic, but the sample of blacks and other minorities was not large enough to draw generalizable conclusions.

Among the eligible whites, between 85.4 percent and 92.7 percent were included in the analysis, depending on the outcome variable. The remainder were excluded because they omitted responses for variables of interest. Participants who omitted these responses do not appear to be demographically different from participants who answered them; in other words, they are not consistently poorer, less educated, or ideologically different from respon-
dents who completed the survey (analysis not shown here).

This study unintentionally oversamples for young adults, political independents, women, and people who are well-educated, non-religious, uninsured, and who live in urban areas. These biases require attention, but they do not impede the ability to draw generalizable conclusions. As I will discuss in the following sections, this paper’s experimental design, aided by covariates, is a robust method of controlling for the demographics and ideological predispositions that play into public opinion formation.

Analysis Methods

Differences in dependent variables between treatment groups are analyzed using ordinary least squares regression. Regression models are designed to make inferences from a 2x2 factorial design, where the effects of being exposed to the black or white governor, and being exposed to the black or white patients, are evaluated separately. (The interactive effect of being exposed to the governor and patients of the same race is also tested.) Two dummy variables (coded 0 for white governor or white patients, and 1 for black governor or black patients) are constructed from the four treatment groups, and correspond to the two exposures of interest.

Regression equations presented in the Results section follow a general equation:

\[ Y = \beta x_{\text{governor}} + \beta x_{\text{patients}} + \beta x_i \cdots \beta x_n + \epsilon \]

where \( \beta x_{\text{governor}} \) is the effect of exposure to the black governor (1=black, 0=white), \( \beta x_{\text{patients}} \) is exposure to the black patients, \( \beta x_i \cdots \beta x_n \) are the effects of covariates, and \( \epsilon \) is the error term.

For simpler interpretation, I also provide first differences calculated by King et al’s Clarify package for Stata.\(^{47}\) This gives the predicted difference in scale units when an experimental treatment is changed (for example, the predicted difference in an average re-
spondent’s policy assessment if the race of the politician were to change from white to black).

Covariates

Strictly speaking, randomization by itself is the best way to eliminate the influence of confounding variables. That is, by virtue of randomly assigning subjects to treatment groups, we are also randomly assigning the myriad covariates—both known and unknown—that have a confounding influence on the dependent variables. Since the confounds are randomly (and equally) distributed in a sufficiently large sample, we can be reasonably confident that any observed differences can be attributed to our treatments and not to confounds.

But there are a few compelling reasons why covariates can aid in the analysis of randomized data. For example, covariates can increase the predictive power of models; they ensure that confounding variables were in fact randomly distributed among the treatment groups, and they can help identify nonrandom attrition, providing a statistical control where this problem exists. Where a sample is not ideally representative of the population being studied (as is the case in this paper), covariates enable statistical control or stratified analyses for demographics that are disproportionately represented.

However, for the purposes of this study, covariates are most important because they provide information about interactions between pre-treatment conditions (for example, political ideology or income) and the treatments themselves. The Results section discusses this in greater detail.

In all, six covariates are taken into consideration in my analysis. Four of these are indicators of ideological predisposition: sex, educational attainment, household income, and political party identification. The final two are indicators of self-interest in a health care policy: insurance status and self-rated health.
In the context of existing studies on the relationship between health care reform and racial prejudice (particularly Knowles, Lowery, and Schaumberg 2009), the methods I employ have two unique advantages.

First, this paper treats health care reform as a social issue subject to two potentially distinct manifestations of racial prejudice: anti-black attitudes stemming from the design and endorsement by President Obama and anti-black attitudes related to the perceived race of beneficiaries of the plan. This approach takes into account the work of Knowles, Lowery, and Schaumberg in addressing the role of politician race in predicting whites’ public opinion. But it also takes into account work similar to Nicholas Winter, Donald Kinder, Lynn Sanders, and Martin Gilens insofar as it considers the possibility that health care reform is manifested as a racial issue in the minds of Americans, much like other social policies (especially those that fall under the category of welfare programs).

Second, this paper eliminates the political and personal confounds that arise from studying Bill Clinton and Barack Obama directly. Knowles, Lowery, and Schaumberg compare policy opinions after randomly assigning subjects to read an “Obama frame” or a “Clinton frame.” This paper instead compares reactions to two politicians whose only difference is their race. Since these policymakers are fictional, any confounding political attitudes (like those that affect Presidents Obama and Clinton) do not influence the results in this study.

RESULTS

The following analysis is organized by dependent variable.

Overall Policy Opinion

Respondents were asked to rate their overall opinion of the proposed policy on a 0-10 scale, where “10” is most supportive. This
variable was regressed on the experimental treatments and covariates to measure the effect of racial exposures on respondents’ overall policy opinion. Results are presented in Table 1.

We see that exposure to the black governor predicts a moderate \(^{49}\) (coefficient=-1.47) and significant \((p<0.05)\) decrease in policy opinion. There is no significant effect found for exposure to black patients. Main effects and interactions were tested, and no significant interaction effect was found for exposure to the black governor and black patients together (not shown here). These results indicate that we can expect white respondents, on the aggregate, to be less supportive of a health care reform plan when the policymaker is black. There is no evidence that whites’ opinions on the plan are affected by the race of presented beneficiaries. These effects are preserved when covariates are included in the model.

The estimated first difference for governor race is -1.47 points on a 0-10 point scale (95 percent confidence interval: [-0.19, -2.74]). This means that if we change the race of the policymaker from white to black, the expected decrease in support from a typical white respondent would be 1.47 points. This is the equivalent of moving from a score of 5 (perfectly ambivalent) to 3.53 (leaning to unsupportive), displayed in Figure 1. The expected difference upon manipulation of patient race was included for comparison, although this effect is not statistically significant.

**Specific Concerns Scale**

Respondents were asked several questions designed to measure their attitudes on specific criticisms of the policy. These criticisms were inspired by common concerns highlighted in media coverage of federal health care reform. (See previous section for details.) Five of these items were scaled into an additive index (Cronbach’s alpha = 0.70). This scale was regressed on the experimental treatments and covariates to measure the effect of racial exposures on respondents’ specific concerns regarding the proposed health care plan. Results are displayed in Table 2, available in the online supplement.
We see that exposure to the black governor predicts a small (coefficient=-1.55) and significant (p<0.05) decrease in the Specific Concerns Scale. A lower score on this scale indicates that respondents agree with criticisms of the law; in other words, a lower score indicates greater concern. Therefore, our results indicate that we would expect whites to express higher levels of specific concern regarding a health care plan when the policymaker is black. This increase applies to concerns such as undeserving beneficiaries, government takeover of the health care system, and health rationing. There is no evidence that the race of the beneficiaries has an effect on whites’ concerns about the law. These effects are preserved when covariates are included in the model.

The estimated first difference for governor race is -1.54 points on a 5-19 point scale (95 percent confidence interval: [-.165, -2.97]). This means that if the race of the politician were to change from white to black, the resultant decrease in specific concerns score is expected to be 1.54 points.

INTERACTIONS WITH COVARIATES: PARTY IDENTIFICATION AND INCOME

In predicting policy opinion scores, significant interactive effects were found between exposure to the black governor and two covariates: party identification and household income. A third covariate, insurance status, is also examined.

Party Identification

Results presented in Table 3 (online) show a large (coefficient=-2.04) and significant (p<0.05) interaction between party identification and exposure to the black governor.

Since the party identification variable is coded [1=Democrat, 2=independent, 3=Republican], this model suggests that either an Independent or a Republican identification (or both) modifies the effect of exposure to the black governor on policy opinion. For a more precise view, Table 4 (online) shows the regression model
stratified by party identification.

Results in Table 4 show a large (coefficient=-2.97) and significant (p<0.01) effect for exposure to the black governor among Independents. This exposure has no significant effect among Democrats or Republicans when these groups are examined in isolation. While the Republican group appears to have an effect size comparable to that of independents, this effect is not significant, probably because my sample of Republicans is too small to make a confident inference. There is no significant effect for exposure to black patients in any of the stratified groups.

These results suggest that exposure to the black policymaker predicts a large decrease in policy opinion among independent (unaffiliated) whites. This might be interpreted as evidence that independent whites approach political issues like health care reform without strong or inflexible opinions, many of which are associated with partisanship. In the absence of this policy “cueing” from a political party, independents might be more sensitive to racial priming. Effectively, partisan tendencies may serve to buffer the racial effect, and the people with the least powerful buffers (independents) experience the racial effect at a greater magnitude.

To clarify the ideological makeup of the independents group, an identical regression was executed (not shown here), replacing Party Identification with Political Ideology [1=Liberal, 2=Moderate, 3=Conservative]. The results from Table 4 were replicated: we see a large and significant decrease in opinion with exposure to the black governor among ideological moderates. There is no significant effect found among conservatives or liberals, initially suggesting that most of the independents in the Table 4 models are likely “unaffiliated” moderates, and not members of an independent party (with the major caveat that the sample sizes are unequal, making generalizable inference difficult).

The estimated first difference for exposure to the black governor among independent whites is -2.97 points (95 percent confidence interval: [-0.91, -5.11]) on a 0-10 scale. This means that if we change the race of the policymaker from white to black, the expected decrease in opinion among white independents is 2.97
points, or the equivalent of moving from a score of 5 (perfectly ambivalent) to 2.03 (unsupportive).

Income

A second interactive effect is found between household income and exposure to the black governor. Table 5 (online) presents these findings.

We see a tremendous (coefficient=-4.25) and significant (p<0.01) negative effect for the interaction between high income and exposure to the black governor. High income is coded as $60,000 or greater, which constitutes roughly the top half of the income distribution in the sample. Table 6 (online) presents results stratified by income for a closer look.

We see a very large (coefficient=-3.23) and significant (p<0.01) decrease in policy opinion with exposure to the black governor among higher-income whites. This effect is not replicated for lower-income whites. Exposure to the black patients does not appear to have a significant effect in either stratum.

This suggests that we should expect politician race to have a significant sway on the policy assessments of higher-income whites. The first difference for exposure to the black governor among whites with income of $60,000 or greater is -3.21 points on a 0-10 scale (95 percent confidence interval: [-1.05, -5.33]). This means that we would expect opinion among this group to decrease by 3.21 points when the governor changes from white to black—the equivalent of moving from a score of 5 (perfectly ambivalent) to 1.79 (very unsupportive), shown in Figure 2.

Insurance Status

No statistically significant interactive effect was found for insurance status, but this variable should be of special interest. Do whites that stand to gain a material benefit from health care reform (i.e. insurance coverage) react differently to racial priming than whites who are already insured?
The results reported in Table 7 indicate that uninsured whites are almost completely insensitive to racial priming. There is no significant (or substantial) effect found for either politician race or patient race. Fully-insured whites, on the other hand, see a moderate decrease in support for the health plan when a black politician designs it (coefficient = -2.28, p < .01). This suggests that we should expect uninsured whites to pay little attention to the racial stakes of a health care plan, while insured whites who do not expect a material gain are heavily swayed by the race of the politician in charge. The estimated first difference of this effect is -2.27 points on a scale from 0 to 10 points (95 percent confidence interval: [-0.61, -4.00]). This is the equivalent of moving from a score of 5 (perfectly ambivalent) to 2.73 (unsupportive).

CORRELATED IDEOLOGIES: COLORBLINDNESS, RACIAL RESENMENT AND SUPPORT FOR BARACK OBAMA

After evaluating the proposed health care plan, respondents were asked to complete a twelve-item modified Colorblind Racial Attitudes Scale (CoBRAS) and the six-item Kinder and Sanders Racial Resentment Scale. They were also asked to provide an overall assessment of their feelings toward President Obama.

Colorblindness

A regression analysis for CoBRAS scores and experimental treatments is presented in Table 8 (available online). We see a modest (coefficient = 5.84) and significant (p < .01) increase in expressed colorblindness among white subjects when exposed to the black governor. Exposure to the black patients does not appear to have a significant effect.

These results indicate that we expect whites to express modestly higher levels of colorblind racial attitudes when exposed to a health care plan endorsed by a black politician as compared to an identical plan put forth by a white politician. The first difference for this effect is 5.82 points on a scale from 12 to 64 points (95 percent
confidence interval: [1.42, 10.14]).

**Racial Resentment**

Regression analysis for racial resentment scores and experimental treatments is presented in Table 9 (available online). We see a modest (coefficient=3.41) and significant (p<.01) increase in racial resentment among whites exposed to the black governor. There does not appear to be a significant effect for exposure to the black patients.

These findings indicate that we should expect whites to express modestly higher levels of racial resentment when exposed to a health care plan attributed to a black politician as compared to an identical plan put forth by a white politician. The first difference for this effect is 3.52 points on a scale from 6 to 36 points (95 percent confidence interval: [0.89, 6.37]).

**Support for Barack Obama**

Respondents were asked to rate their overall feelings toward President Obama on a 0 to 10 scale, where 10 indicates that a respondent feels "very positively." Regression analysis for Obama support and the experimental treatments is presented in Table 10. We observe a moderate (coefficient=-1.79) and significant (p<.01) decrease in support among whites exposed to the black patients. Notably, Obama support is the only dependent variable that is significantly affected by exposure to black beneficiaries (and the only variable not affected by exposure to the black policymaker).

These results indicate that we should expect whites to express moderately lower levels of support for President Obama when considering a health care plan whose perceived beneficiaries are black, as compared to a plan whose perceived beneficiaries are white.

The first difference for exposure to black patients is -1.81 points on a scale from 0 to 10 points (95 percent confidence interval: [-0.57, -3.05]). This means we would expect the average white respondent’s support for Barack Obama to decrease by 1.81 points.
when considering a health care plan whose beneficiaries are presented as black as compared to an identical plan whose perceived beneficiaries are white. This is the equivalent of moving from a score of 5 (perfectly ambivalent) to 3.19 (somewhat negative), displayed in Figure 3.

This is a fascinating finding. It demonstrates that whites are less satisfied with Obama when health care benefits blacks, yet from findings in previous sections we know that black beneficiaries do not inspire whites to dislike the plan itself. This offers compelling evidence in favor of Hajnal’s “information effect,” as I will discuss in the next section.

DISCUSSION

This experiment provides strong evidence that race plays a substantial role in public opinion formation on health care reform. The race of the politician and beneficiaries at stake in a health care plan accounts for about 7 percent of the total variance in policy opinion among whites—more than the effects of four covariates (sex, education, self-rated health, and insurance status) combined. This proportion is higher in certain populations. Among whites with a household income above $60 thousand, the race of the politician and beneficiaries explains about 20 percent of the variance in policy opinion. Among independent voters, the proportion is 23 percent. Among whites who are both independent voters and wealthy, race can predict about 32 percent of the variance in opinion. All of these are tremendous figures, even the aggregate 7 percent, considering the incredible plethora of influences on policy opinion. In light of all the factors that play into an individual’s assessment of a political proposal—personal predispositions, partisan alignments, material self-interest, ethical instincts, details of the plan, and others—the race of the stakeholders in a health care plan has a powerful sway on public opinion.

In the context of other studies, the contribution of this paper is the discovery that different stakeholders do not affect public opinion equally. The race of the politician promoting a health
reform plan has a much larger impact on opinion than the race of the plan’s beneficiaries. This may help understand some of the intensely-demonstrated (and well-publicized) opposition to President Obama’s health care plans. It is also consistent with Marc Hetherington and Jonathan Weiler’s conclusion that the relationship between racial resentment and health care attitudes observed in 2009 did not exist in the 1990s with Bill Clinton’s similar proposal, even though both plans disproportionately benefit African Americans. In a vacuum, whites demonstrate opposition to health care reform under a black politician when their attitudes are neutral under a white politician. This supports the assertion that President Obama’s race can help explain why Americans exhibited a much stronger resistance to health care reform in 2009 than they did in the 1990s, supporting Hetherington and Weiler’s (as well as Jimmy Carter’s) hunch.

Is Health Care Reform a Type of Welfare?

On the other hand, how might we interpret the finding that the race of a plan’s beneficiaries has little effect on whites’ public opinion formation? This runs contrary to my initial assertion, as well as a wealth of scholarship that suggests that this relationship might exist. Part of the theoretical justification for this paper rests on the possibility that health care reform, legislation that tremendously benefits blacks and other minorities, could be affected by both anti-Obama prejudice and a more generalized racial resentment. That does not appear to be the case.

This finding is slightly out of tune with most social policy research. There is ample evidence that “the American public thinks that most people who receive welfare are black,” and that “whites’ attitudes toward poverty and welfare are dominated by their beliefs about blacks.” If this were the case with health care reform, we would expect to see changes in both policy opinion and specific concerns when comparing reactions to two plans that are presented to benefit different races. No such relationship is observed in this study.
Do whites conceptualize the expanding coverage provided by the Affordable Care Act the same way they conceptualize other social welfare programs? This study is not equipped to provide a definitive answer, but the initial evidence seems to suggest that white Americans view health care reform no differently than other forms of social policy. Forty-eight percent of whites in the sample agreed or strongly agreed that the proposal they viewed constitutes “a form of welfare,” compared to half as many (24 percent) that disagreed or strongly disagreed. The rest were unsure. This variable by itself was not significantly affected by the exposure to the experimental treatments. But not coincidentally, whites who characterize health care reform as a welfare program are significantly less likely to support the plan. The mean policy opinion score for the ‘welfare’ group was 5.07; it was 7.89 for the ‘not welfare’ group.

It is possible, though not demonstrable under this research design, that whites imagine the beneficiaries of social redistribution policies like health care reform to be black regardless of the racial priming provided in an experimental setting. Alternatively, it is also possible that whites are sincerely ambivalent about the race of a health plan’s beneficiaries, although this seems unlikely given their sensitivity to the race of the politician and existing evidence that shows a strong connection between whites’ unflattering characterizations of blacks and their public opinion on social policies. A third possibility is that whites imagine the beneficiaries of health care reform to be mostly black, but that the redistribution of ‘benefits’ (e.g. health insurance) resulting from the Affordable Care Act is more palatable than what is found in other government welfare programs (such as cash payouts or food stamps).

Self-Interest and Rational Choice

The role of self-interest in racial prejudice is a second area of scholarly debate that this paper has examined. Researchers disagree on the way that self-interest is incorporated into racialized thinking on social policy, with ‘realistic’ or ‘zero-sum competition’ theorists in one camp, and ‘group conflict’ theorists in the other.
This paper gives mixed evidence with regard to self-interest. First, the data indicate that fully insured respondents are much more receptive to racial priming than uninsured respondents. Insured whites were significantly (and substantially) less supportive of the health care plan designed by the black politician. This effect was not observed among uninsured whites, indicating that self-interest buffers racialized thinking. In other words, whites with something to gain from health care reform (e.g., insurance coverage) do not care, on the aggregate, about the race of the politician behind the plan. Thus, it appears that self-interest matters.

But if insured whites cannot expect to gain from the policy no matter who endorses it, why should they care about the race of the politician any more than uninsured whites do? In the framework of colorblindness, to which the majority of whites ascribe, rational actors should not care whether whites or blacks endorse their legislation. They may support a plan more or less depending on their own self-interest, but within strata of material interest, rational whites should support the black-endorsed plan as much as the white-endorsed plan. From the data presented here, this is not the case. Absent the promise of a direct material gain, whites react negatively to health care legislation put forth by a black politician. Why is this?

In his book, Voting Hopes or Fears? White Voters, Black Candidates & Racial Politics in America, Keith Reeves argues that, “racial discrimination by whites . . . still remains a prodigious barrier for black candidates competing in majority-white electoral settings.” Of course, black candidates do not completely lack political success in majority-white settings (including in statewide campaigns and, as of 2008, the presidency). But Reeves cautions that “the success of some black office-seekers in getting sufficient numbers of whites to vote for them” does not nullify the continuing influence of racism. He points to research conducted by Richard Pildes in 1995, who argues that, “the increase in black officeholding is not the result of changing attitudes or voluntary reforms.”

Public opinion on social policy and voting patterns for black candidates are not exactly the same, but the overarching message
from the present study (as well as existing research) is that whites are reluctant to support the political efforts of black politicians. In this experiment, exposure to the black politician triggered increased racial resentment among whites, indicating that implicit prejudice (akin to the “New Racism” theories explained in the Theoretical Approaches section) may hold a powerful influence on public opinion formation.

This study also finds that exposure to the black politician leads to higher levels of colorblind racial attitudes, consistent with Eduardo Bonilla-Silva’s theory that these “principles” are used to “explain away” racial resentment. The results are inconsistent, however, with Paul Sniderman’s assertion that “principled conservatism” is at the root of white reluctance to black-benefiting policies. This is not to say that one theory is more accurate than the other, but Bonilla-Silva’s framework is more capable of explaining the results observed in this study.

I am unable to find evidence for the existence of “realistic group conflict” in the context of health care reform, since this would be indicated by an increase in specific concerns and decrease in overall opinion when whites are prompted to believe the primary beneficiaries of the law are black. In other words, realistic group conflict theory operates on the assumption that health care is a limited resource, and whites would aim to prevent blacks from benefiting. In the context of the Affordable Care Act, a more likely possibility is that whites interpret their group status to be threatened when a black politician is at the helm.

Indeed, one of the most fascinating discoveries in this study centers on the last variable discussed in the Results section: support for President Obama. The data indicate that support for Obama decreases when whites are exposed to imagery of black beneficiaries, but not images of black politicians. Support for Obama is the only dependent variable that was triggered by beneficiary race. This is extremely compelling evidence for Zoltan Hajnal’s “information effect,” a theoretical framework based on the observation that whites fear having blacks in office because they believe black politicians will meet the policy needs of black constituents, ostensibly at the
expense of whites.

In the case of health care reform, we observe that support for a black politician (President Obama) decreases when whites are primed to believe that the beneficiaries of a health care plan are also black. This is concrete evidence for Hajnal’s basic assumption. What’s more, Barack Obama, as the first black president, plays a special role in information effects theory. Hajnal remarks:

Prior to the election of a black candidate, most white voters have little or no experience with black leadership. For this reason, many rely on racial stereotypes and past patterns in race relations to assess the likely consequences of a black candidate’s victory. The result is that many whites fear that a black leader will . . . redistribute income, encourage integration and generally channel resources toward the black community . . . Once a black candidate is elected, however, whites gain access to better information about the policy preferences of black leaders and the effects of black leadership . . . When blacks have the power (or are perceived as having the power) to inflict harm on the white community and they choose not to do so, many whites are forced to reevaluate their assumptions.56

Voters’ reactions to President Obama in this study are consistent with the information effects framework, offering evidence that the racialized enigma surrounding Obama’s health care plan can be traced to the political psychology surrounding new black leadership. Absent a history of black officeholding in the Oval Office, whites speculate that the beneficiaries of the president’s agenda will be black—and when images of black patients in the treatment groups confirm this suspicion, their support for the black president decreases.

Unanswered Questions

This study has partially elucidated the relationship between racial prejudice and public opinion on American health care reform. However, several important questions remain unanswered and will require further research.

First, since this study focuses exclusively on white attitudes,
a full inference of American public opinion is not possible. More research is required to examine the racial attitudes of blacks and other minorities, as their reactions to health care reform are likely different from those of whites. We should be especially interested to see how the race of stakeholders (politicians and patients) in proposed health care plans affects public opinion among minorities.

Second, we do not know the exact consequences of using a slightly biased sample, which overrepresented students, women, political independents, and people in urban settings. It is especially prudent to note that the majority of the sample lived in or near Chicago, which may mean that the results are most generalizable for populations in racially diverse metropolitan areas. They may be less useful for predicting racial attitudes in less populated or more homogenous regions.

This being said, I do not feel that this sample biased the results in any significant way, since many demographics that were disproportionately represented in the sample (female sex and higher levels of education, for example) were shown to have null effects on outcome variables. In addition, the demographics that did interact with the experimental treatments were analyzed in detail using stratified analyses, and the sample was sufficiently large to enable significant results within subcategories or strata of demographic variables. Nevertheless, while this study attempts to account for a slightly biased sample, ideal future research will use representative sampling to ensure that the pool of participants matches the population being studied.

Third, this paper provides a significant and theoretically intuitive analysis of the role of politician race in shaping whites’ policy support, but the data are less clear with regard to the role of beneficiary race. As described above, the insignificant effect for beneficiary race is somewhat mystifying. I proposed three possible explanations for the apparent absence of this relationship, but future research is required to determine if these are plausible.

Finally, this study was unable to consider the potential influence of intergroup contact, which represents a major school of
thought in academic work on racial attitudes. Intergroup contact theorists argue that geographical and/or interpersonal proximity to blacks is the most powerful predictor of racial attitudes among whites. Interracial contact appears to powerfully reduce racial prejudice, and theoretically it would have a protective or mediating effect in the relationship between racial prejudice and public opinion on social policy. Ideally, this relationship would have been tested, but because the sample is made up almost entirely of participants from the Chicago metropolitan area, its predictive power would be very limited. Living in Chicago does not guarantee interracial contact, but to fully address intergroup contact would require a much more geographically diverse sample (especially since the South appears to play a somewhat anomalous role) and a research design incorporating some metric of intergroup contact beyond what is achievable in a survey.

CONCLUSION

In the end, this paper provides a somber reminder that racism remains a powerful influence on the political opinions of whites. Despite that the vast majority of white Americans claim to be colorblind and ambivalent with regard to race, this study provides evidence that they react negatively to health legislation put forth by black politicians. Whites evaluating a black-endorsed health care plan also express higher levels of colorblind racial attitudes, racial resentment, and specific concerns about the plan (such as the belief that it will lead to “health rationing” or a government takeover of the health care industry). This effect is highest among insured, wealthy, and politically independent whites.

As discussed in the previous section, the potential for a protective effect in intergroup contact compels us to search for ways that racism’s influence in public opinion formation can be diminished. From the perspective of public health, the stakes could not be higher. Blacks are diagnosed with the most crippling diseases at higher rates than whites. After being diagnosed with these diseases, blacks are more likely to die from them. To make matters worse,
blacks are almost twice as likely to be uninsured as whites. The success of any practical attempt to resolve these dire inequities is contingent upon the support of the public.

This is not a normative reflection on the Affordable Care Act nor an argument that its provisions are the only reasonable approach to fighting racial health gaps. There will always be, and should always be, variations in support for legislation depending on an individual’s predispositions and reasoning. Ethical orientation, partisanship, material self-interest, financial considerations, details of specific legislation, and so many more elements of public opinion will come into play.

But the interference of racism has no place in the reasoning process. It is a dangerous imposition on rational thought, one that is most tragic when it suppresses the feasibility of legislation that would otherwise see higher levels of enthusiasm. The Affordable Care Act was a victory for minority health, but its path was tumultuous, and its success should not be taken for granted. Alwyn Cohall and Hope Bannister, writing for the anthology “Health Issues in the Black Community,” conclude:

> Failure to act aggressively to counter the pathogens of poverty, lack of health insurance, and cultural insensitivity is no less a disgrace than withholding treatment for syphilis. While the cure for health disparities is not as simple as a shot of penicillin, there are concrete, tangible efforts that can be made today.59

While we are far from providing a solution to eliminate these health discrepancies, the influence of racism in the public’s assessment of our most promising attempts is a shameful cancer on society. We should be prepared to do all we can to end its damaging and undemocratic influence.

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and encouragement invaluable.

To view all charts and tables, visit:
http://www.helvidius.org/2012/belcher

Notes


7 Stein, “Tea Party Protests: Ni**er, Fa**ot Shouted at Members of Congress”.


10 Ibid, p. 18.


14 David O. Sears is a political psychologist at UCLA; Jim Sidanius holds faculty positions in Psychology and African-American Studies at Harvard; and Lawrence Bobo holds faculty positions in Sociology and African-American Studies at Harvard.


16 Ibid, p. 17.

17 Ibid, p. 18.

18 Ibid, p. 27.

19 Ibid, p. 28.

20 Ibid, p. 22.


22 Bobo and Kleugel 1993, 1997; Bobo and Hutchings 1996; Kinder and Sanders


26 Ibid, p. 2.

27 Ibid, p. 28.

28 Ibid, p. 29.


31 Ibid, p. 150.

32 Eric Knowles, Brian Lowery, and Rebecca Schaumberg, “Racial Prejudice Predicts Opposition to Obama and His Health Reform Plan”, p. 423.


35 David O. Sears, Jim Sidanius, and Lawrence Bobo, Racialized Politics: The Debate About Racism in America, p. 34.


39 Ibid, p. 3.


42 Ibid, p. 2.


44 Eric Knowles, Brian Lowery, and Rebecca Schaumberg, “Racial Prejudice Predicts Opposition to Obama and His Health Reform Plan”; Marc J. Hetherington and Jonathan D. Weiler, “Health Care, Race, and Political Polarization”.

Donald R. Kinder and Lynn M. Sanders, *Divided by Color: Racial Politics and Democratic Ideals.*


Throughout this paper, the following terms are used to classify magnitudes when they apply to a 0-10 point scale: “small” effects have coefficients of less than one point; “moderate” effects have coefficients between one and two points; “large” effects have coefficients between two and three points; and “very large” effects have coefficients greater than three points. These classifications do not apply to variables that are not coded on a 0-10 point scale.

This is based on a comparison of $R^2$ (coefficient of determination) values. $R^2$ is not always an ideal indicator of the proportion of variance explained in a model, but most criticisms of its usage point to multivariate regressions with several independent variables. $R^2$ is an adequate indicator of explained variance for this paper because only two predictors (patient race and politician race) are included in the models being referenced. Regression analysis of the four covariates alone provides an $R^2$ value of 0.06; regression analysis of the experimental treatments on a subsample of independent, insured, wealthy whites provides an $R^2$ value of 0.32. These analyses are not shown here; others are shown in previous subsections.


Keith Reeves, *Voting Hopes or Fears? White Voters, Black Candidates & Racial Politics in America,* p. 7.

