Public Values, Health Inequality, and Alternative Notions of a “Fair” Response

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ABSTRACT

The fact that disadvantaged people generally die younger and suffer more disease than those with more resources is gaining ground as a major policy concern in the United States. Yet, we know little about how public values inform public opinion regarding policy interventions to address these disparities. This paper presents findings from an exploratory study of the public’s values and priorities as they relate to social inequalities in health. Forty-three subjects were presented with a scenario depicting health inequalities by social class and were given the opportunity to alter the distribution of health outcomes. Participants’ responses fell into one of three distributive preferences: (1) prioritize the disadvantaged; (2) equalize health outcomes between advantaged and disadvantaged groups; and (3) equalize health resources between advantaged and disadvantaged groups. These equality preferences were reflected in participants’ responses to a second, more complex scenario in which tradeoffs with other health-related values—maximizing health and prioritizing the sickest—were introduced. In most cases, participants moderated their distributive preferences to accommodate these other health goals, particularly in order to prioritize the allocation of resources to the very sick regardless of their socio-economic status.
Health equity has gained considerable momentum as a policy priority around the world. The World Health Organization’s recent report from its Commission on the Social Determinants of Health (2009) highlights eighteen government-wide initiatives to remedy health disparities in high, middle, and low-income countries. Here in the United States, social disparities in health have been gaining increasing attention in the media and among policy leaders, particularly as part of the federal *Healthy People 2010* initiative (U.S. Department of Health and Human Services 2000). Yet, U.S. reform efforts lag behind those of other nations (Exworthy, Blane, and Marmot 2003). To explain this laggard status, many cite the notion of American exceptionalism (Feldman 1988; Lipset 1996), particularly the conventional wisdom that Americans’ strong commitment to individualism leads to a general tolerance for inequality and wariness to intervene in response to inequalities in health or other policy domains.

In truth, we know little about public responses to health disparities in the United States or the role that value judgments play in structuring those responses. This information is vital for shaping policy initiatives aimed at eliminating health inequalities, particularly efforts that require marshalling substantial resources and sustained policy attention over time. We take up this question in this paper, presenting results of an exploratory study designed to elicit public values over how best to respond to health inequalities. Using a focus group methodology in tandem with a structured, social choice exercise, participants articulated their preferences for how to most fairly distribute health in a (highly simplified) society characterized by a health gap between advantaged and disadvantaged citizens. These scenarios were designed to elicit baseline preferences for equality maximization and to capture changes in these preferences as a result of induced value trade-offs (among equality, efficiency, and need).
Certainly, public values influence whether issues make their way onto a government’s policy agenda (Burstein 2003), as policy leaders and the general public alike use norms of equality and other values to judge and justify social policies (Schlesinger 2002). And we know that this value-based discourse varies across countries (Osberg and Smeeding 2006). In England, for example, where government action to remedy health inequalities has been described as the most advanced among European nations (Mackenbach and Bakker 2003), health inequalities are cast as unfair and their remedy a matter of social justice. Yet many believe that similar arguments grounded in notions of fairness would be unhelpful, potentially undermining public support, if used in the U.S. due to limited support for equality among the American public. The argument is that most Americans value individual traits such as initiative, freedom, and self-reliance (Glazer 2003; Hartz 1955; Hochschild 1981), resulting in a greater willingness to tolerate economic inequalities (Alesina, Di Tella, and MacCulloch 2004; Jackman 1994; Kluegel and Smith 1986; Osberg and Smeeding 2006; Shapiro 2003). Extending this conclusion to the health domain, a recent survey of the American public found lower levels of support for targeted interventions aimed at closing health gaps than those reported by researchers using a similar protocol among the British population (Lynch and Rigby, 2010; Tsuchiya and Dolan 2007).

This notion of Americans as individualists who simply overlook inequality in our midst has been challenged by Page and Jacobs (2008), who combine decades of public opinion polls to document a more complicated picture of Americans’ response to income inequality. Specifically, they argue that Americans are “conservative egalitarians” who are actually quite troubled by the current level of income inequality, who strongly endorse the notion of equality in the form of equal opportunity, and who are quite willing to pay taxes for government programs that promote equality of opportunity. Yet, at the same time, Page and Jacobs acknowledge that most
Americans hold conservative view characterized by broad support for our free-enterprise economic system, an insistence on individual responsibility, and a general distrust in government intervention. This philosophical conservatism is embraced alongside the more pragmatic egalitarian views Americans also endorse.

It is likely that this notion of conservative egalitarianism extends to Americans’ responses to other forms of inequality as well, of primary interest here: social group differences in health outcomes. Our findings indicate a range of approaches to distributing health resources across an unequal society, with some participants targeting new resources to closing health gaps, others attempting to equalize health outcomes across advantaged and disadvantaged groups, and others preferring to allocate equal increases to each group regardless of socio-economic status. Despite this pluralism, all three responses were rooted in a discourse of fairness and value-based preferences that embraced, rather than ignored, notions of equality. Further, as expected, these distinct notions of equality diverged further—into a broader typology of responses once competing values were introduced. Together, these findings refute simple notions of Americans as individualists, or as divided among those concerned about equality and those who easily tolerate inequality. Instead, our findings paint a picture of an American public that is committed to fairness; however, individual differ in how they define a fair distribution of health. Further, our results highlight how equality is only one priority—and often a secondary one at that—shaping public preferences for how to best respond to social inequalities in health.

BACKGROUND

Our study draws on a long line of empirical and normative research into notions of justice and fairness. Social scientific investigations of inequality in income, health care access, and health (Ginsburg, Goold and Danis 2006; Gold, Sofaer and Siegelberg 2007; Michelbach et al.
2003; Scott et al. 2001; Wagstaff 1993; Williams 1988, 1997) as well as ethical inquiry related to the distribution of such goods illustrate great diversity in definitions of justice and fairness.\(^1\) Despite this heterogeneity, formulations generally draw on a small set of distinct allocation principles that include equality, efficiency, and need (Scott et al. 2001), with each principle playing a key role in shaping public responses to inequality.

**Equality.** The principle of equality, often referred to as equity, has long been closely associated with ideas of justice and fairness. The moral concern is distributive in nature, namely, that all persons have a fair share of whatever good or set of goods is under consideration (e.g., income, opportunity, health care, or health). In the context of health, the principle of equity draws on the moral intuition that “people are owed roughly equal prospects for a good life, including prospects for a long and healthy life” (Marchand, Wikler, and Landesman 1998, p. 458). Although notions of what constitutes a fair allocation vary from strict equality to a sufficient level to some relational ideal (Powers and Faden 2006), each formulation shares a moral sensitivity to the disproportionate incidence of poor health and premature death among socially disadvantaged groups.

Increasingly, health organizations, notably the World Health Organization, have drawn on this principle to prioritize health equity as a social goal. In addition, empirical investigations have found support for health equity among, for example, Swedish politicians and the British public (Christopoulos, Crosier, and McVey 2008; Lindholm, Emmelin, and Rosen 1997; Lindholm, Rosen, and Emmelin 1996; Tsuchiya and Dolan 2007). Whether equality represents a compelling rationale for the American public is less certain, though a recent survey found lower levels of support among U.S. citizens for policies that close gaps in income, education, and

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\(^1\) The issue of social inequalities in health has only recently begun to receive sustained and systematic ethical analysis. See for example, Marchand, Wikler, and Landesman (1998); Scott et al., (2001, 750); Anand, Fabienne, and Sen (2004); Powers and Faden (2006); and Daniels (2008).
health than those reported by researchers using a similar protocol among the British population (Lynch and Rigby, 2010).

**Efficiency.** The American public’s tolerance of inequality may be attributable in part to the dominance of capitalism and an underlying economic philosophy that privileges considerations of efficiency. Standards of efficiency can vary but share the aggregative aim to achieve the greatest benefit for the least cost. In the context of health, the principle of efficiency expresses a preference for more overall health in a population, regardless of its distribution within that population. Unlike the principle of equity, efficiency is morally indifferent to the disproportionate incidence of morbidity and premature mortality among socially disadvantaged groups. Yet, the imperative to maximize the good (in this case health) may be construed as egalitarian because it gives equal weight to each person, regardless of their socioeconomic status (Sen 1992).

**Need.** Although public policies may in principle promote better overall health and reduced health inequalities (Anand 2004), health economists have long recognized that distributive goals are often in tension with aggregative ones (Okum1975; Sen 1992). U.S. studies have examined this “efficiency–equity tradeoff” primarily as it relates to the distribution of health care access, benefits, and rationing rather than health itself (Danis et al. 2007; Emanuel and Wertheimer 2005; Ginsburg, Goold, and Danis 2006; Gold, Sofaer, and Siegelberg 2007; Goold, Biddle, and Danis 2004; Goold et al. 2005). Empirical investigations of this tradeoff in health have been conducted for the most part outside of the United States (Dolan et al. 2002; Lindholm, Emmelin, and Rosen 1997; Lindholm and Rosen 1998; Lindholm, Rosen, and Emmelin 1996; Tsuchiya and Dolan 2007; Williams, Dolan, and Tsuchiya 2005) and have uncovered a third competing principle that relates to need—priority to the sickest (Michelbach et
al. 2003; Scott et al. 2001). This preference expresses one interpretation of who is neediest in the context of health and, like the preference for efficiency, is indifferent to social disadvantage as a moral criterion. Those who are the sickest, regardless of socioeconomic status, constitute the neediest group.

**Conflicting Values.** Despite the centrality of the values of equality, efficiency, and need to political debate, we know little about U.S. citizens’ preferences for and priorities among these values as they relate to health disparities (Ansolabehere, Behr, and Iyengar 1991; Scheslinger and Lee 1993; Stone 2005). Shedding some light on this question, a recent survey in Wisconsin examined support for government intervention to address health inequalities between the poor and middle class (Rigby et al. 2009). Most notable, support for government intervention was initially relatively high, yet began to decay as trade-offs were introduced: the nearly 86 percent of respondents who supported government intervention to address health disparities was reduced to 60 percent when respondents were asked whether they would support this government intervention if it required increased tax dollars. Support eroded even further to 51 percent when asked whether their backing would continue if the intervention required shifting health resources from the middle class to the poor. This survey provides insight into how political support for reducing health disparities includes many considerations—not only equity concerns. But, like other public opinion surveys, it fails to illuminate the value trade-offs that underlie respondents’ varied levels of support for government intervention or definitions of fair governmental responses.

**VALUES AND THE DEFINITION OF “FAIRNESS”**

Policy discussions of political will and public opinion often make a false assumption that support for policies that tackle health inequality rests on a single definition of fairness, which
automatically deems health disparities “unfair.” This approach assumes that those opposing these policies are not aware of the disparity, not bothered by it, and/or are simply unconcerned about equality as a policy goal. Page and Jacobs (2008) effectively challenge this conventional wisdom about public responses to economic inequality, which they show to be a much broader (but more complicated) concern among the American public. We expect to find a similar complex process of ethical and political reasoning at work when the public responds to health inequalities.

Based on a simple scan of the current political landscape, we do not expect to identify one American pattern of response to health inequality. Instead, we anticipate a good deal of variation in how individuals respond to a social inequality—expressing different priorities for social action to abate inequality. Documenting the most common patterns of response, as well as identifying the notion of equality or fairness underlying each, is the first aim of this project. Then, we examine induced value trade-offs (between equality and efficiency, as well as between equality and need), allowing us to examine the degree to which equality considerations are primary or secondary in shaping public responses to health disparities. We expect that the inclusion of efficiency and need (as competing values) will prompt changes in how individuals respond to health inequality, with the combination of these values proving much more influential than equality considerations alone.

**Research Questions.** These expectations lead us to focus on three primary research questions: (1) What are the most common patterns of public response to social inequalities in health? (2) To what degree do equity concerns, particularly fairness, underlie each of these responses? And (3) how committed are people to their particular notion of a “fair” response once other, competing, values are brought into consideration? In the following section we
describe our approach to answering these questions to provide a better understanding of the public’s ethical and political reasoning over priorities for social action.

METHODOLOGY

**Study Protocol.** To probe a range of normative beliefs underlying social action aimed at reducing social inequalities in health, we developed a protocol to elicit public preferences and priorities pertinent to social inequalities in health. This protocol combined a qualitative, focus-group approach with a closed-choice activity that required participants to use a particular number of “health points” to alter health outcomes in a hypothetical community. This combination of methodologies allowed participants to identify their preferred health distribution, document it, and then share their choices and reasons for them with other participants who confronted the same set of facts. This process generated quantitative data used to map and compare participants’ choices, as well as qualitative data more helpful in illuminating the rationales for those choices.

In order to create a shared context for undertaking the social choice exercises and for participating in the moderated discussion, the participants received background information on the state of Americans’ health, how it compares to that of other wealthy countries, and various causes of poor health outcomes. The moderator then presented participants with two scenarios based on a hypothetical twenty-member community seeking independent health policy advice about how to best use limited resources to prevent disease and promote health. For both of the scenarios, the community was divided by social class. Half of the community was described as socially advantaged, comprised of individuals with college degrees, jobs with good incomes and benefits, and better health and longer lives. The other half was described as socially disadvantaged, comprised of individuals who lagged behind in all these respects. Participants, in
their role as advisors to these communities, had 12 points to allocate in each scenario; these represented all the available social resources for preventing disease and promoting health.²

In the first social choice exercise, the *Inequality Scenario* (presented in Figure 1), ten of the twenty individuals were predicted to become sick in the future. To illustrate a social inequality in health, these ten were disproportionately drawn from the disadvantaged group (six disadvantaged compared with only four from the advantaged group). The 12 points allowed participants to choose four individuals (at 3 points each) to prioritize for health improvement with three possible options. This point total limited participants’ options: (1) to equalize health between the two groups by choosing one of the advantaged and three of the disadvantaged, which we labeled “equal health”; (2) to prevent disease and premature death for all four disadvantaged people, which we labeled “priority to the disadvantaged”; (3) to distribute the 12 points equally between the two groups—choosing two advantaged and two disadvantaged people—which we labeled “equal shares;” or (4) to dedicate all 12 points to maximizing the health of the most advantaged.

<<insert figure 1 about here>>

The second social choice exercise, the *Trade-off Scenario* (presented in Figure 2), again depicted a community divided by social advantage with the attendant differences in social and health outcomes, but it introduced trade-offs with two additional principles hypothesized to compete with equality: efficiency (health maximization) and need (priority to the sickest). The efficiency–equality trade-off was introduced by raising the cost of prevention among the more disadvantaged individuals, making it twice as costly. Thus, those who expressed a strong preference for prioritizing the disadvantaged in the *Inequality Scenario* now faced a trade-off with efficiency since prioritizing the disadvantaged reduced their ability to maximize health for

² The script used to structure the focus groups is presented in Appendix A.
the largest number of people. The trade-off with the principle of need (specifically, priority to the very sick) was introduced in the scenario by differentiating between individuals who would develop a manageable illness and those who would become very sick as well as by doubling the cost of prevention for the latter. Thus, participants were forced to consider whether they would prioritize the gravely ill, regardless of social class or cost/efficiency.

<<insert figure 2 about here>>

The Trade-off Scenario was designed so that a participant who chose to equalize health between social groups in the Inequality Scenario could also equalize health in this scenario, such that within each social class six people would remain healthy, two would develop a manageable illness, and two would become very sick. However, many other allocation strategies also were possible. Of particular interest to this analysis are: (1) the degree to which participants traded overall health gains (maximization/efficiency) or the minimization of severe illness (priority to the needy/sick) for health equality between the two groups and (2) whether participants’ preferences expressed in the Inequality Scenario influenced their choices in the Trade-off Scenario, or whether these equality concerns were deemed secondary to efficiency or need as more pressing policy priorities.

Survey Data. Prior to undertaking this process, participants answered a survey gathering baseline data on demographics (gender, age, education, race, ethnicity, family income, and employment), existence of health problems, and two measures of political beliefs drawn from the standard protocol of the American National Election Survey. The first belief measure was a simple 5-point measure of liberal ideology, ranging from very conservative to very liberal. The second was a standard set of questions tapping the construct of egalitarianism in which respondents were asked to indicate agreement with a series of statements such as, “This country
would be a better place if we worried less about how equal people are,” with each item rescored so that higher values indicated greater agreement with egalitarian notions.

**Study Participants.** We recruited participants among citizens assigned to the Manhattan (New York City) jury pool on three days in January 2008. After a brief announcement describing the study, those waiting to be selected for jury duty could volunteer to participate in our study. We recruited the first 63 individuals to express interest and complete the baseline survey. Based on scheduling preferences, participants were assigned to one of six focus groups with an effort to divide participants on the basis of education to reduce status hierarchies among participants in the moderated discussion. In total, 68 percent (N=43) of the recruited participants attended the focus group for which they were scheduled. Each focus group lasted approximately two hours and included three to twelve participants in addition to a facilitator and research assistant.

Participant demographics are provided in Table 1. These participants were majority female (74 percent); represented diverse racial/ethnic backgrounds with 58 percent identifying as White, 16 percent as Black, and 9 percent as Hispanic/Latino; and ranged in age from 24 to 69 (M=48, sd=14). Of the sample, 65 percent worked at least part-time. The household income varied across the sample with 26 percent receiving less than $25,000, 23 percent between $25,000 and $50,000, 19 percent between $50,000 and $100,000, and 28 percent above $100,000. As could be expected by the relatively high income levels of some participants, the sample was skewed toward those with more education: 67 percent held a bachelors’ degree, while only 16 percent had not attended college (the other 16 percent had attended some college). With regard to political beliefs, the sample scored in the moderate-to-liberal range on a standard measure of egalitarianism (range=1–5, Mean=3.92, sd=.65), as well as liberal ideology (range=1–5, Mean=3.54, sd=.82).
As this sample of citizens lived in New York and was limited to those who volunteered to participate in the study, our ability to quantify the proportion of all Americans holding different views is clearly restricted. Luckily, that is not the primary aim of this study. (It is instead an aim best left to survey research that prioritizes generalizability over the increase in internal validity provided by the more in-depth, qualitative research design we employ here). We judge this sample to be adequate for our primary purposes: (a) to identify different patterns of response to health disparities held by a diverse group of American citizens, (b) to probe for the moral reasoning underlying these responses, and (c) to assess the saliency of equality as a goal when faced with competing values. We expect that the variation that we do find will actually undercount the true variation among the American public since our sample is skewed toward better educated and more liberal residents in a city that is more liberal and wealthier than other parts of the country.

RESULTS

We describe our findings in two parts. First, we examine participants’ responses to the Inequality Scenario; next, we assess the salience of these equality beliefs in the Trade-off Scenario in which participants had to balance their commitment to equality, efficiency, and need as alternative value priorities.

Responses to Inequality Scenario. When presented with a health disparity between advantaged and disadvantaged groups in the Inequality Scenario (Figure 1) and the opportunity to change the distribution, participants chose to allocate their health points in one of three ways. Eleven participants, or 26 percent, chose to prioritize the disadvantaged group, investing all 12 points in this group. Seventeen participants, or 40 percent, divided the points equally between the two groups. And, fifteen participants, or 35 percent, chose to equalize health between the groups.
No one choose to allocate all their resources toward improving the health of the advantaged group. We labeled these preferences, “priority to the disadvantaged,” “equal shares,” and “equal health,” respectively. Although we do not have nationally representative estimates of these preferences among all Americans, our findings are consistent with one survey that used a more simplified scenario to estimate preferences for targeting new health resources to the disadvantaged (preferred by 30 percent of respondents) versus providing “equal shares” by dividing new resources equally between the two groups (preferred by 70 percent; Lynch and Rigby, 2010).

Participants’ justifications for their choices provide insight into the moral reasoning underlying each, as described in the following sections.

**Priority to the Disadvantaged.** Participants’ stated reasons for allocating all 12 points to the disadvantaged group reflect a number of concerns but typically acknowledged the material and social vulnerability of disadvantaged persons. For example, one participant stated, “I am giving more points to the disadvantaged because they most likely got sick due to lack of information and financial means to prevent their illness.” Another stated, “The disadvantaged [are] suffering from stress, overworked, poor housing, no medical coverage, and poor working conditions.” And another mentioned that “education has such a huge impact on your ability to prevent disease in yourself. It also has to do with where you’re living and your access to healthy food.” Some participants also identified an obligation to assist disadvantaged persons, stating for example, “The most vulnerable should be helped first, given limited resources… I assumed that helping them… meant dealing with social inequality so that it would have a longer impact in the long run.” It was not clear to what extent participants understood this duty as a requirement of social justice; however, at least one participant spoke about redressing the underlying social and
economic circumstances that contribute to excess morbidity and premature mortality in disadvantaged groups stating: “Hopefully, helping them will show a willingness to rectify the economic and social inequalities that would have led to their illness to begin with.” Another participant identified this obligation as particularly important in the United States, in order “to sustain our vision of ourselves, as a community of people who care for [the vulnerable]… especially in America, which is the land of… equality.”

*Equal Shares.* The reasons identified for prioritizing the disadvantaged stand in stark contrast to those offered by participants who divided their points equally between the advantaged and disadvantaged groups. Participants tended to justify this allocation of resources on one of two grounds, both drawing on normative assumptions about fairness. Some reasoned that investing equally in both groups would promote community stability, productivity, and cohesion. For example, one participant stated, “Everyone is part of the same community, and as such I feel that focusing completely on one group would damage the morale and health of the community.” This participant went on to say, “A stable community requires unskilled workers as much as it requires doctors and lawyers.” Other participants, however, explained this allocation strategy in negative terms, flatly rejecting social class as a legitimate basis on which to make such decisions. For example, one participant said, “I feel it is wrong to discriminate against someone who has money or no money at all.” Another said even more directly, “Advantage/disadvantage should not matter.” One participant rejected social class as a criterion on which to make health policy decisions, saying, “Sick is sick, poor or rich.” As these quotes suggest, some participants rejected social class as a basis for making social policy decisions in general, while others rejected social class as a basis for making *health* policy decisions. Among participants who rejected social class as a basis for policy planning, some further explicated their reasoning by arguing that investing
differentially between the two groups would be biased and unfair; indeed, two of these participants said they sought to choose at “random” so as to not “discriminate” against anyone.

*Equal Health.* Unlike the other two groups who offered some form of explanatory rationale for their choices, participants who chose to equalize health between the advantaged and disadvantaged groups tended to simply assert the goal of equality. In contrast to the two other groups, these participants generally failed to identify reasons for their preference for equality. For example, one participant said, “I chose the way I did simply because it evened out the number of healthy and unhealthy people in both social groups.” Another explained, “My choices allow for seven advantaged persons to remain healthy as well as seven disadvantaged person to remain healthy, thus helping maintain communities in a proportionate manner.”

<<<insert table 1 about here>>>

*Socio-demographic Characteristics.* We were interested in assessing the role of socio-demographic characteristics and political beliefs in shaping participants’ responses. However, as shown in the comparison of means presented in Table 1, we found few significant differences in age, race, gender, employment, and health status among those endorsing each of the equality responses. In contrast, we found that socioeconomic characteristics did predict participants’ responses to the *Inequality Scenario.* The participants who gave priority to the most disadvantaged had the least education and household income. Those with higher income were more likely to equalize health across social groups, while those with higher education were more likely to divide resources equally between the groups. So, although we cannot specify the distribution of these values among all U.S. citizens, our findings suggest that there is a socio-demographic aspect underlying and shaping these responses.
Political Beliefs. As shown in Table 1, little prediction power was gained by knowing participants’ political ideology or participants’ scores on a standard measure of egalitarianism; this result supports our impression from the qualitative data that participants’ patterns of responses did not divide among those concerned about fairness versus those undisturbed by inequality. Instead, notions of what is fair (and to whom) were emphasized by participants choosing each of the three response patterns. Although our ability to identify significant relationships is limited by low statistical power in a sample of forty-three, the similarity in mean values suggests that the differences on most of these measures are not substantively significant either.

Responses to the Trade-off Scenario. Of additional interest is the degree to which participants’ responses to the Inequality Scenario persisted in the face of trade-offs with other health values. Here, we compared each participant’s response to the first trade-off (tapping equality responses alone) with their subsequent response to a more complex scenario in which the values of equality, efficiency, and need were in conflict. The most evident finding is that almost all respondents altered the degree to which they targeted the most disadvantaged once these other priorities were introduced.

In fact, only three participants’ preferences remained unchanged by the introduction of these other two value conflicts. All three of these participants had prioritized the disadvantaged in the Inequality Scenario and continued to allocate all of their points to the economically-disadvantaged in the Trade-off Scenario. These participants’ justified their choices on one of two grounds. Two participants spoke to the greater resources of well-off Americans, their access to health-related resources, and their ability to help themselves. One participant bluntly expressed this view: “[I]f you’re rich, you don’t need help!” The third participant offered a second
rationale, saying that investing in the disadvantaged might have a “longer impact in the long run” by reducing social inequality in general. This finding suggests that this prioritization of the disadvantaged remains a primary value shaping responses, even in the face of value trade-offs. However, this is only the case for a small segment of those who initially selected this definition of a fair response to inequality in health.

<<insert figure 3 about here>>

The other forty participants moderated their initial equality preferences once faced with value tradeoffs. Although these responses varied with different mixes of allocation strategies in this more complex scenario, a clear pattern was seen in which participants prioritized those who were the sickest. In fact, more than half (twenty-two) of the participants chose to prioritize all six of the people (whether advantaged or disadvantaged) in the very sick category. This priority was seen regardless of the equality preference expressed in the earlier Inequality Scenario; instead, participants were equally likely to prioritize the very sick (M = 4.5 of 6.0 very sick individuals prioritized), as shown in Figure 3.

Common reasons offered by participants for their prioritization of the very sick were to “minimize human suffering” and to relieve society of “the burden” imposed by gravely ill persons. A commonly expressed reason for preventing serious disease and premature mortality in all persons was the view that people with manageable illness can still “contribute to society.” But even more prevalent was the view that there was an absolute duty to prioritize the gravely ill. One participant declared, “It would be a crime to leave anyone in the very sick section.” Another participant offered a more nuanced justification: “I think the most harmful thing for the community is if people die an early death. So I wanted to prevent anyone from dying an early death because the community doesn’t have the value of those members any longer.”
As these data and remarks demonstrate, ethical concern to prioritize the very sick informed much of the response to the *Trade-off Scenario* and provided stiff competition with egalitarian concerns about social inequalities in health. Yet, among those prioritizing all six sick individuals, the participants’ equality preferences identified in the earlier *Inequality Scenario* played a key role in determining how they spent their remaining two points (those left after prioritizing all the very sick). As illustrated in Figure 4, after prioritizing the gravely ill, the “equal shares” participants were more likely to use the two left over points to move two advantaged people to the healthy category. This approach was adopted by seven of the eleven equal-shares participants. One participant offered a simple efficiency rationale that was commonly expressed by this group: “That only left me with two points, so I could take two from the advantaged to be healthy or I could take one from the disadvantaged, and I chose to help two people rather than one.”

<<insert figure 4 about here>>

In contrast, those who initially equalized health or prioritized the disadvantaged were much more likely (nine of the eleven who first prioritized the sick) to use both points to improve the health of one of the disadvantaged people. Participants tended to base this choice on two grounds: the greater need among the disadvantaged and a belief in an equal opportunity for health. As one participant said when explaining her choice, “I thought someone really should have the chance to have [a] healthy life in the disadvantaged community.” Another participant, speaking to the greater need among the disadvantaged, explained: “[T]he reason that I would so strongly advocate for prevention resources being spent on disadvantaged is that education… has such a huge impact on your ability to prevent disease in yourself. So, I think that… for the most part prevention should be focused on people who are unable to prevent [it in] themselves.”
A similar moderating influence of the value trade-offs is seen when comparing the prioritization of advantaged versus disadvantaged individuals in the Trade-off Scenarion. Across the three groups—priority to the disadvantaged, equal shares, equal distributions—we saw a similar prioritization of the disadvantaged group (M = 4.4 of 8.0 disadvantaged people prioritized). This level of prioritization was primarily driven by the preference for prioritizing the very sick, who were disproportionately disadvantaged. In contrast, we saw a distinct difference in the degree to which the three equality groups prioritized the four advantaged individuals. Figure 5 shows the prioritization of these individuals by equality group, illustrating the tendency for those initially prioritizing the disadvantaged to devote fewer resources to the advantaged group, even in the Trade-off Scenarion. In contrast, the other two groups were much more likely to prioritize more than half of the four advantaged people—likely driven by the increased efficiency in which fewer points were required to prevent illness among the advantaged than the disadvantaged. In this way, we see the importance of equality versus efficiency value judgments as secondary considerations after initial prioritization of the sickest.

<<insert figure 5 about here>>

Summary of Findings. We identified three distinct notions of what constitutes a fair response to social inequalities in health. Although these responses ranged from devoting all resources to the disadvantaged to allocating resources evenly without consideration of economic resources, all participants described their choices in value-based terms—emphasizing issues of equality and fairness. This confirms our expectation that the American public is not indifferent to equality but instead is committed to alternative definitions of a “fair response” to health inequality. These distribution preferences varied by participants’ socioeconomic status but not by other demographic or political/ideological characteristics expected to influence such responses.
Specifically, those initially choosing to prioritize the disadvantaged tended to also have lower education levels and lower incomes than participants in the other two groups.

Although participants expressed strongly voiced rationales for these preferences, equality preferences were only one of the values shaping distributional preferences once value trade-offs were introduced in the second scenario. The exception was for a small proportion of those participants who initially expressed priority to the disadvantaged and who, once faced with trade-offs, remained committed to that goal alone. Everyone else moderated their equality preferences with a strong bias toward prioritizing the very sick. Only after addressing this needy group did participants seem to turn back to their equality preferences as secondary considerations shaping how best to use remaining resources.

DISCUSSION

Results from this study reveal both commonality and variation in the public’s views and values as they relate to social inequalities in health. Most participants expressed a priority to the very sick (those most in need)—as a primary value shaping responses to social inequalities in health. Equality concerns, although reflecting distinct patterns and definitions of fairness, tended to be compromised (at least partially) when placed in conflict with other values. Despite this common response, we also identified salient differences in definitions of fairness and equality among study participants. This variation is more nuanced than the stereotypical depiction of a liberal egalitarian who embraces health equity pitted against a conservative unconcerned with egalitarian principles and health equity. Rather, participants expressed three distinct notions of what constitutes a fair public response to social inequalities in health. Far from revealing moral confusion in public opinion, these results affirm the value pluralism found in previous empirical studies and in moral and social theory.
Despite the heterogeneity that characterizes notions of fairness, it merits noting that all participants shared a concern with fairness in some form, which may explain why participants’ scores on the common measure of egalitarianism did not map clearly onto their responses to the Inequality Scenario. Notably, those scoring high (as well as low) on egalitarianism were equally likely to choose among the three fairness responses. This finding challenges the conventional view that those who express concern about fairness will necessarily lend greater support to targeted and redistributive policy approaches. Rather, different conceptions of fairness as it relates to the distribution of health are likely to lead to different policy responses.

The heterogeneity that characterizes the meaning of fairness presents both opportunities and challenges to proponents of health equality. To the extent that proposed policies are projected to produce health outcomes that satisfy more than one value, in particular targeting groups who are both disadvantaged economically and particularly sick, there exists an opportunity to build a coalition of support for health equity reforms. This diversity, however, also can produce support for competing policy proposals. For example, those who endorse an “equal shares” view of fairness would likely support policies that equalize resources for treatment, disease prevention, and health promotion but resist policies that target disadvantaged groups in an effort to close remaining gaps in health. This group would then favor public policies that secure equal opportunities for health, but not equal outcomes. Those who are morally troubled by the persistence of health disparities, however, would likely favor policies that go beyond securing equal resources for health to support targeted programs that aim to reduce the gap in health outcomes.

Finally, it is also worth noting the potential policy implications of the limited salience of equity preferences. Recall that almost all participants moderated their equity preferences
(however defined) when faced with choices to maximize health and to prioritize the very sick. Additionally, concern for the very sick in particular was an overriding value for many participants. The tendency among participants to moderate their preferences for fairness (however defined) in the face of tradeoffs with others values raises additional questions worth pursuing. In particular, it would be useful to explore the public’s ethical assessment of policy interventions that both increase overall population health—a result we aligned with efficiency—and increase health disparities, yet also improve the health of the least advantaged group. Policies that yield such a result might attract the support of those committed to efficiency and to prioritizing the least advantaged, even as it might alienate those ethically troubled by the remaining inequalities between better and worse off groups.

When health equity proposals are or are perceived to be competing with policies responsive to the very sick—perhaps funding for biomedical research and experimental treatments—they may lose broad public support. This suggests that proponents of health equity need to articulate an inclusive agenda with strategies to improve both the health and the health care of all Americans. Developing such an agenda will surely prove a difficult task given the health equity movement’s commitment to primary care and the non-medical determinants of health.

CONCLUSION

Inequalities in health related to social class have gained ground as a U.S. policy concern in the last decade. Robust research programs, high profile policy statements, philanthropic initiatives, media attention, and a growing number of ethical accounts of “health justice” have all drawn attention to the issue. Yet, few studies have focused on understanding the values underlying Americans’ views of these inequalities and preferences for policies to remedy these
disparities. Our study revealed a public uniformly concerned about the state of Americans’ health but whose policy preferences are motivated not only by divergent notions of fairness but also by other competing values, particularly a priority to those who are most sick regardless of their socio-economic status. Garnering support for policy action to address social inequalities in health will require grappling with the alternative notions of fair responses to these inequalities, rather than simply assuming a bifurcated public in which some care about equality and others do not. Additionally, the high priority placed on the reduction of severe illness suggests that those committed to addressing social inequalities can capitalize on the reality that those who are most sick are disproportionately also the most disadvantaged. Therefore, targeting resources to the disadvantaged in our society often overlaps with efforts to target the gravely ill.
References


Appendix A. Research Protocol Script

[SLIDE #1]
Welcome everyone. Thank you all for coming today and agreeing to talk with us today. As you all know we are researchers from Columbia University conducting a focus group study that has been funded by the Robert Wood Johnson Foundation, a philanthropic organization committed to improving the health and health care of all Americans.

What we are going to do this session is talk with you about an important public health issue. Our goal for this session is to really understand your views, preferences and values so it will be very important to us that you speak your mind and share your thoughts with us today. Keep in mind that there are no ‘right’ or ‘wrong’ answers in this room. During the session we may ask you to clarify your views and press you to dig deeper for the reasons that underlie them, but that is only because we really want to understand what you are saying and why you are saying it. Let’s start by having everyone introduce themselves. [Ask participants to share their name and to tell us something about themselves that they want us to know. Introduce ourselves last.]

THE PROBLEM
The topic we want to talk with you about today is the nation’s health. As you all may know, the United States spends a lot of money to improve people’s health.

[SLIDE #2]
In fact, we spend about $2 trillion a year on health care – more money on health care than any other wealthy country in the world.

[SLIDE #3]
Despite spending this vast sum, Americans are not very healthy. Each year, almost two million Americans die from a chronic disease.

And many more Americans live with day-to-day health challenges, such as recurrent back pain or other problems that limit their ability to engage in physical or social activities; to hold a job, go to school, or do housework; or to feed, bathe, and dress themselves. One in eight Americans report having to regularly miss work due to health problems. And when Americans are asked directly about whether they feel physically and mentally healthy, Americans say they feel unhealthy about six days per month. For Americans with diagnosed diseases, that number is even higher.

The fact that Americans are unhealthy becomes particularly apparent when we compare Americans’ health to that of people living in other (similar) wealthy countries, such as England, Germany, France, Italy, and Canada.

[SLIDE #4]
For example, as this figure shows, American’s are more likely to die before the age of 70 than are citizens in other wealthy countries. And research studies show that Americans are not only more likely to die before the age of 70 than are citizens from other wealthy countries. They also are much sicker than people in these other countries. For example, a recent study compared Americans between ages 55 to 64 to British people of the same age living in England and found that these Americans were twice as likely to have diabetes than their English counterparts.

But even when we compare Americans’ health to that of people living in poorer countries, we find that Americans are not faring well. Another study shows that tens of millions of Americans are experiencing levels of health that are typical of citizens who live in middle and low-income countries.

**Question for group discussion:** Now let me stop here for a minute and get your initial thoughts on this issue. Do you see the current state of Americans’ health as a minor problem, major problem, or not really a problem facing our society today?
THE CAUSATION STORY
Like many of us, policy leaders are troubled by the poor state of Americans’ health. As a result, a number of initiatives and policies focused on preventing these health problems from ever occurring are being discussed and debated. But, in order to best prevent illness from developing, we need to target the range of factors that determine who gets sick and who stays healthy.

SLIDE # 5
These factors include genetics of course, but researchers have determined that genetics matter much less than most people think. Experts estimate that genetics explain less than 30 percent of the health problems that occur.

SLIDE #6
Another factor that people often think about is health care. But, similarly, it is only a minor factor in preventing health problems from occurring. For example, recall the study I just mentioned in which it was shown that Americans are much sicker than the English? The reason for that difference cannot be explained by the fact that all English citizens have access to health care while all Americans do not. Access to health care in that case was not a significant factor.

SLIDE #7
One of the most important contributors to health probably will not surprise you: health-related behaviors. The choices individuals make everyday with regard to what they eat, whether they exercise, whether they use drugs and drink excessive alcohol, and their sex-related behaviors represent perhaps the single most prominent domain of influence over health prospects in the United States today.

SLIDE #8
Another significant contributor to health are the social conditions in which people live and work. A person’s family, community, education, occupation, and other social factors influence human health by exposing them to different kinds and levels of health risks. People are less likely to develop illnesses when they live in healthier communities, which have grocery stores selling affordable nutritious foods, streets with sidewalks for walking, parks that are safe for playing and exercising, and supportive neighbors who look out for one another. Similarly, the level of stress, responsibility, job security, and income influences health.

SLIDE #9
So, all of these factors – genetics, health care, health behaviors, and social factors – contribute to who gets sick and who stays healthy, and behaviors and social factors appear to play especially strong roles.

Does anyone have any questions about what I have said thus far?

THE EXERCISES: INEQUALITY AND TRADE-OFF
Today, we want to ask you what, if anything, should be done to prevent these health problems from occurring. To do that, we have created a scenario in which you should imagine that you have been selected to advise a make-believe community on how to spend a limited set of resources to improve its health. Specifically imagine that your decisions will automatically change the health outcomes for 20 people who currently experience no health problems.

[SLIDE #10]
Imagine that we could perfectly predict any health problems that will develop for these people over the next 60 years. And imagine that your advice will be used now and over the course of their lives in ways that will prevent some of these people from developing an illness or disease that they would have otherwise developed at some point in their later life. This is an important point to remember as you make your choices: your recommendations will be used to prevent disease in some people.

You are going to be asked to make recommendations in four scenarios, each of which specifies a different set of circumstances for an imaginary community of 20 people. In each instance you have 12 “points” to spend to improve the health outcomes of these people. These points represent all of the public and private resources available for improving these individuals’ health through a broad array of proven interventions. There are no other points available to improve these people’s health. Before we begin the first exercise, remember that you are being asked to
give advice to this community as an outside consultant. You are not a member of this make-believe community and no one you know is. OK, so let’s start the first exercise.

[SLIDE #11]

INEQUALITY SCENARIO
In the first community of 20 people, it is predicted that many of them will develop illness and disease sometime in the future. The important difference to focus on in this scenario is that some of the people in this community come from more advantaged families with higher incomes and greater educational achievement than others. This characteristic – often called social class – is an important predictor of health problems. In general, socially disadvantaged groups – such as people who are poor, have low levels of education, and often minorities – tend to be sicker and to die younger than their better off counterparts.

These illnesses and diseases may be the result of a number of factors, including genetics, access to quality health care, health behaviors and the social conditions in which people grow up, live and work. For example, whether people smoke, eat well, exercise, and visit their doctor regularly contributes to whether they develop disease. Also important is the quality of people’s neighborhoods, jobs and work environments, social relations and networks, as well as the level of stress in people’s lives.

In this scenario, we are asking you to choose how to spend the 12 points when ten of the people were born to families in which their parents have a college degree and a good paying job and the other ten were born to more disadvantaged families in which parents had limited education and income. Since we know that social disadvantage is related to health, it is not surprising that more of the disadvantaged people become sick. In fact, in the disadvantaged group, six of the people will become very sick as adults, while in the advantaged group only four will. Under these conditions, how would you recommend spending the 12 points? Whose illness would you choose to prevent? Remember that your 12 points are the only resources available to change these outcomes. The individuals you choose to use your points on will remain healthy, while the others will develop illness or disease as indicated in the figure. Neither group has additional resources to spend. To indicate your answers, circle those people you wish to move into the healthy category.

Once you have indicated your choices, please spend a few minutes jotting down why you chose to spend the points the way you did. What reasons do you have for preventing illness in the people you chose to prevent illness in?

[Slide #12]

TRADE-OFF SCENARIO
Next, you are being asked to advise the community on how to best prevent illness in this community of 20 people in which you face somewhat more complicated choices. So, in this instance, half the people are from advantaged families and half from disadvantaged families, some will be sicker than others, and the cost to prevent some people’s illnesses is higher than for others. As you can see, among the advantaged group two people will be very sick, two will experience a manageable illness, and six will remain healthy. Among the disadvantaged group, four will become very sick, four will develop a manageable illness, and two will stay healthy. Health promotion and disease prevention cost more for disadvantaged groups. Under these conditions, how would you recommend spending the 12 points? Whose illness and/or early death would you choose to prevent? Remember that anyone who you do not choose to use your points on will develop the level of illness indicated. There are no other factors that might change the distribution of health. To indicate your choices, draw arrows from each person you are using your points on to the category in which you are moving him or her.

[Once everyone completes their choices, a moderated discussion will follow.]

Now that everyone has had a chance to discuss the reasons for their choices in each scenario, we are curious whether anyone would want to change their earlier responses? If you would like to, please complete the Tradeoff Scenario again on the final page of your packet.

[Once everyone completes their choices…] Question for group discussion: Did anyone change their choices? If so, how and why?
Table 1. Descriptive Statistics for Full Sample, and by Response to Inequality Scenario

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Note: Study participants were presented with this figure representing a very simple scenario in which a community of 20 healthy people was seeking outside advice on how best to allocate healthy improvement resources. They were told that they could use 12 “points” to prevent the illness of some of the individuals predicted to become sick in the future (four of whom were advantaged and six of whom were disadvantaged). They were asked, “Under these conditions, how would you recommend spending the 12 points? Whose illness and/or early death would you choose to prevent? Remember that anyone who you do not choose to use your points on will develop the level of illness indicated. There are no other factors that might change the distribution of health.” We classified participants into “inequality response groups” based on the number of disadvantaged people they prioritized, which ranged by design from zero (priority to advantaged) to four (priority to disadvantaged).
### Figure 2. Trade-off Scenario

<table>
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<th>Advantaged</th>
<th>Disadvantaged</th>
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</thead>
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<td></td>
<td>College degree &amp; good job</td>
<td>No college &amp; low paying job</td>
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<tr>
<td>Will Remain Healthy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Will Develop Manageable Illness</td>
<td>1 pt. 1 pt.</td>
<td>2 pts. 2 pts.</td>
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<tr>
<td>Will Become Very Sick</td>
<td>1 pt. 1 pt.</td>
<td>2 pts. 2 pts.</td>
</tr>
</tbody>
</table>
Note: Study participants were presented with this figure representing a more complex scenario in which the response to inequality now involved consideration of two other forms of trade-offs: (1) efficiency, because it required fewer points to prioritize an advantaged person and (2) priority to the sick, because the individuals were now divided into those who would develop manageable illness and those who would become very sick, with the very sick “costing” 4 points to move to healthy (2 for each step) versus the manageable illness, which required only 2 points to get to healthy. Participants were asked, “Under these conditions, how would you recommend spending the 12 points? Whose illness and/or early death would you choose to prevent? Remember that anyone who you do not choose to use your points on will develop the level of illness indicated. There are no other factors that might change the distribution of health.”
Figure 3. Prioritization of the Very Sick, in *Trade-off Scenario*

Note: $N=43$. Box-and-Whisker plot presents the number of very sick individuals prioritized, by the three equality groups identified in the earlier Inequality Scenario. Boxes mark the 25th to 75th percentile; whiskers mark the range of responses within each group.
Figure 4. Illustration of Equality Consideration in the Trade-off Scenario

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<tr>
<td>Will Develop Manageable Illness</td>
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<tr>
<td>Will Become Very Sick</td>
<td><img src="image5" alt="Diagram" /></td>
<td><img src="image6" alt="Diagram" /></td>
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</tbody>
</table>

Note: A critical point in which the initial disparity response emerged in the Trade-off Scenario was seen among the 22 participants who prioritized the very sick. After using their first ten points to prevent severe illness (those individuals with an X over them), these individuals then had to choose how to use the remaining two points. These choices made were highly related to the participants’ initial disparity response (as indicated above).
Figure 5. Prioritization of the Advantaged, in *Trade-off Scenario*

Note: $N=43$. Box-and-Whisker plot presents the number of advantaged individuals prioritized, by the three equality groups identified in earlier Inequality Scenario. Boxes mark the 25th to 75th percentile; whiskers mark the range of responses within each group.