

Doctor Knows Best: Physician Endorsements, Public Opinion, and the Politics of Comparative Effectiveness Research

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Abstract

The Obama Administration has made a major investment in comparative effectiveness research (CER) to learn what treatments work best for which patients. CER has the potential to reduce wasteful medical spending and improve patient outcomes, but the political sustainability of this initiative remains unclear due to concerns that it will threaten the doctor-patient relationship. An unresolved question is whether it is possible to boost public support for the use of CER as a cost control strategy. We investigate one potential source of public support: Americans' trust in physicians as faithful agents of patient interests. We conducted two national surveys to explore the public's confidence in doctors compared to other groups. We find that doctors are viewed as harder workers, more trustworthy, and more caring than other professions. Through survey experiments, we demonstrate that the support of doctors' groups for proposals to control costs and use CER have a greater influence on aggregate public opinion than do cues from political actors including congressional Democrats, Republicans, and a bipartisan commission. Our survey results suggest that the medical profession's stance will be an important factor in shaping the political viability of efforts to use CER as a tool for health care cost control.

Health services researchers have long lamented the lack of evidence to support much of U.S. health care. According to the Institute of Medicine (IOM), less than half of all treatments provided to patients are based on clear evidence (IOM 2009). While the U.S. medical sector is one of the most technologically advanced in the world, many medical services have never undergone rigorous scientific study of their clinical benefits (CBO 2007). When there are two treatments available for the same condition—such as surgery versus medication—there is often no evidence about which works best. Instead, decisions about how to care for patients are often made on the basis of local custom, conjecture, and the personal experience of individual physicians (Eddy 1990; 2005; Eisenberg 2001; 2002a; 2002b; CBO 2007), and invasive operations can diffuse into widespread use on the basis of no hard evidence (Cohen et al. 2004; Gerber and Patashnik 2006). There have been cases where thousands of patients have undergone risky operations (e.g., high-dose chemotherapy with bone marrow transplants for breast cancer) that were later determined to be ineffective when properly evaluated (Mello and Brennan 2001). It has been argued that our lack of understanding about what works best and for whom contributes to unwarranted geographical variation in treatment decisions (Wennberg 2010), suboptimal care for patients (Brownlee 2007), and wasteful spending (Deyo and Patrick 2005; Hadler 2008).

To address these problems in health care quality and cost control, the Obama Administration has made a major investment in “comparative effectiveness research” (CER).

According to the National Institutes of Health,

[CER] is the conduct and synthesis of systematic research comparing different interventions and strategies to prevent, diagnose, treat and monitor health conditions. The purpose of this research is to inform patients, providers, and decision-makers, responding to their expressed needs, about which interventions are most effective for which patients under specific circumstances (<http://www.nlm.nih.gov/hsrinfo/cer.html>).

The American Recovery and Reinvestment Act (or, stimulus legislation) authorized a \$1.1 billion increase in CER funding. The Affordable Care Act (ACA) provided ongoing budget support and established a new public-private entity (the Patient-Centered Outcomes Research Institute, PCORI) to coordinate the research program.¹

CER was originally a technocratic reform idea, developed and endorsed by health care experts associated with both political parties. Yet, CER became highly politicized during the debate over the Obama Administration's health reform proposal due in part to concern that federal bureaucrats would use the information from medical studies to deny beneficial care and impose "one-size-fits-all" medicine (Avorn 2009; Gerber and Patashnik 2010; Patel 2010). To address these concerns, the ACA contains extensive language limiting how research findings can be used. The law gives PCORI no authority to mandate coverage or reimbursement decisions. It also prohibits the institute from developing or using cost-per quality-adjusted-life-years (QALYs) as a metric to determine the cost-effectiveness of health interventions (Neumann and Weinstein 2010; Tunis and Pearson 2010). Given these legislative restrictions (together with the many other economic and cultural factors that incentivize the provision of care with low marginal benefits), it remains unclear whether the Obama Administration's effort to enhance the medical evidence base can alter clinical practices and change the trajectory of health care spending. A plausible alternative outcome is that this effort could crumble under pressure from doctors, patients, and politicians like similar initiatives in the past (Avorn 2009; Gerber and Patashnik 2010).

¹ Starting in 2013, Medicare and private health insurance companies will pay a tax to support the activities of the new institute. This funding is estimated to reach \$500 million annually by 2015. See Iglehart (2010).

An unresolved question is whether it is possible to boost public support for CER and address the concern that this effort to evaluate alternative treatments is simply a cover for rationing. CER is clearly not an issue like gas prices on which ordinary citizens have direct personal knowledge nor is it an issue like abortion, gun control, or gay marriage on which average Americans have deeply anchored moral values. Public opinion about novel and highly technical efforts to promote the integration of medical evidence into clinical practice and public policy are likely to be heavily influenced by basic beliefs about the health care system (Page and Shapiro 1992) and by the positions of opinion leaders (Zaller 1992). No set of opinion leaders is more important in the health arena than physicians. Physicians will play a key role in implementation of CER because they bear responsibility for communicating evidence-based recommendations to patients. What has been less recognized is that physicians may also play a key *political* role in determining whether the new federal commitment to CER becomes politically sustainable (Patashnik 2008). The impact that physicians may have on the political fate of CER stems in part from the influence of medical societies over the development of clinical guidelines. At a deeper level, it reflects the public esteem in which the medical profession is held and the high degree of trust that most Americans place in doctors to make the right decisions about their own medical care (Blendon et al. 2006) as well as about steps for reforming the health care system (Gallup 2009). As the medical profession becomes increasingly enmeshed in contentious debates over medical evidence and cost control, it is critical for researchers to gain a better understanding of the public's assessments of physicians as potential arbiters of conflicting information about health reform proposals.

To gain insight into the mediating role of physicians in public views toward CER, this paper addresses three central questions. First, what do Americans believe about the motivations

of doctors compared to other professions? Second, what does the public believe about the motivations of medical societies when such organizations make policy recommendations? Third, how does physician support for or opposition to a health care policy affect public opinion about that policy? We address the last question through two survey experiments that provide a way to assess how the support or opposition of physicians and physician groups (i.e., the American Medical Association [AMA]) affects public opinion regarding health care policy independent of the effect of the position of political groups (e.g., the political parties).

Our study is motivated by the recognition that changes in what doctors and medical associations believe and communicate about CER may have a significant influence on the attitudes of the general public. If the positions of the physician community on CER were already solidified, there might be little reason to examine how these fixed positions affect public preferences. But this does not appear to be the case, and there is reason to believe that doctors' views on CER are still evolving. There is a general professional consensus, supported by the findings of the Institute of Medicine (IOM), that physicians lack adequate information on the relative effectiveness of different treatment modalities (IOM 2007; see also AMA 2011). At the same time, the financing system of health care in the U.S. creates "entrenched barriers" to the translation of hard data into improved care (Avorn and Fischer 2010). Advocates argue that CER is compatible with emerging approaches to personalized medicine (Epstein and Teagarden 2010). However, some doctors may be wary of CER for conceptual reasons, believing that studies focus on "average" treatment effects and miss the idiosyncratic ways in which an intervention works for a particular subgroup of patients. In addition, physicians who earn a significant portion of their income from performing a given procedure may fail to "implement the results of a study

that found the procedure to be no better than a less costly or safer alternative” (Avorn and Fischer 2010, 1894).

These diverging possibilities are reflected in both the opinions of individual doctors and the formal statements of major physician associations. For example, a recent survey of physician opinion found that more than half of physicians agree that having more hard data would improve the quality of care, but that two-thirds are concerned that CER will be used to restrict their freedom to select treatments for their patients (Keyhani, Woodward, and Federman 2010; also see Ray and Sokolovsky 2009). A 2011 survey of primary care physicians and specialists found 7 out of 10 doctors believe that implementing CER will be made difficult by conflict between clinical effectiveness and cost effectiveness (Deloitte 2011). And while groups such as the North American Spine Society and the AMA have released official statements expressing support for CER, these endorsements are contingent on the CER agency allowing physicians to exercise their professional discretion in treating individual patients (North American Spine Society 2009; AMA 2011). A 2012 letter from two former AMA presidents to the director of PCORI stated,

Physicians have always been hopeful that CER will be done in ways that actually support us in making decisions with our patients. But at the same time we’ve been deeply concerned that the research could easily be skewed towards a government cost-cutting agenda and misused in ways that come between doctors and patients (The Coalition to Protect Patients’ Rights 2011).

Similar concerns that CER will lead to government interference with the doctor-patient relationship were raised in a recent statement from a Tennessee oncologist: “Comparative effectiveness research done right is a good thing for our country’s health care system. However, when the government begins telling physicians what medicines they should or should not prescribe, ultimately it’s the patient who suffers” (Patton 2013). The American Academy of Orthopaedic Surgeons (AAOS) and other doctors’ groups have given CER similarly qualified

endorsements (AAOS 2009). Because levels of support for the implementation of CER among both individual doctors and medical associations remain in flux, it is important to understand how changes in the public positions such actors and groups adopt—including whether they adopt a position at all—may affect public support for CER.

Previous Research

Before turning to our study, we briefly review the findings of previous research. Both focus group and survey research suggests that there are barriers to the broad acceptance of the need for evidence-based health care among consumers. Many health policy experts believe that a significant proportion of the care that patients receive does little to improve health (Deyo and Patrick 2005; Hadler 2008). This conclusion reinforces the view that the U.S. health care system is wasteful, and that the adoption of evidence-based medicine might promote better patient outcomes and a more efficient allocation of resources. The general public, however, places tremendous faith in the curative power of modern medicine. In a previous survey, we found that nearly 80% of Americans agreed with the statement that “the most recent medical innovations are more effective than treatments that were introduced 10 or 20 years ago” and over 55% agreed that “modern medicine can cure almost any illness [with] advanced technology and treatment.”² Many citizens assume that more medicine is always better, that more expensive treatments are better than cheaper alternatives, and that evidence-based guidelines necessarily limit the ability of doctors to provide appropriate care (Carman et al. 2010).

To be sure, a segment of the public does recognize that a great deal of medicine is not based on solid evidence. In a previous national survey, 50% of the public reported that half or

² Source: Gerber, Alan S. COOPERATIVE CONGRESSIONAL ELECTION STUDY, 2009: YALE CONTENT. [Computer File] Release: May 3, 2011. New Haven, CT.

less of the care they received is evidence based (Gerber et al. 2010a).³ The public's recognition that not all medical care is based on evidence does not, however, translate into strong support for the use of research studies to mandate changes in clinical practices or the allocation of health care resources. Previous survey research suggests that the public supports the use of CER to provide information to health care consumers (such as creating warning labels for treatments that are not supported by strong scientific evidence) but the majority of the public opposes the use of research findings to mandate treatment decisions, determine which groups of patients should be protected from budget cuts in Medicare, or charge patients more to get a treatment that research has not shown to be effective if the patient's own doctor recommends the treatment (Gerber et al. 2010a; also see Gerber et al. 2010b).

The greatest challenge for health reformers will be to use CER as a tool for cost control, especially given recent debates over government rationing of mammograms, prostate cancer screenings, and other health services (Wilensky 2010a; 2010b). Americans (like mass publics in other nations) are wary of a cost-benefit approach to health care decision making (Blendon et al. 2012). People are quick to believe that any effort to change how medical services are delivered will threaten the doctor-patient relationship and lead to rationing. Using a series of survey experiments, Gerber et al. (2010a) show that support for CER declines in response to general political debate about its consequences, but that arguments against CER can be countered to some degree by specific, targeted rebuttals. Significantly, telling people that *doctors* support the

³ Women were significantly more likely than men to say that less than half of their care is evidence-based (Gerber et al 2010a).

use of CER was found to be a particularly persuasive rebuttal to the claim that CER would lead to “one-size-fits-all” medicine (Gerber et al. 2010a).⁴

This result is consistent with the hypothesis that doctors and medical associations are distinctly influential and trustworthy actors when it comes to health care reform and the implementation of CER in particular. In the present study, we investigate *why* the public support of doctors is important to the public and how much the support of doctors can influence public opinion surrounding health care reform.

Data and Results

The data reported in this paper are drawn from two opt-in Internet-based surveys that were conducted by YouGov/Polimetrix under a contract with <redacted author institutional affiliation>, and approved by the institutional review board at <redacted author institutional affiliation>. The first survey was conducted from February 17-23, 2011 ($N = 1,500$). The final survey sample is constructed by drawing a target population sample that is representative of the general population on a variety of characteristics. Specifically, YouGov/Polimetrix interviewed 1,644 respondents who were then matched down to a sample of 1,500 to produce the final dataset. The respondents were matched on gender, age, race, education, party identification, ideology, and political interest. YouGov/Polimetrix then weighted the matched set of survey

⁴ Gerber et al. (2010a) compared the relative persuasiveness of the claim that “[m]any doctors’ groups and medical associations are calling for comparative effectiveness research because the research will give doctors the information they need to identify the best treatments for their patients” to the claim that “[t]he government and insurance companies will use the research to tell doctors how to practice medicine. They will force doctors to follow one-size-fits all treatment guidelines rather than being able to use their knowledge and expertise to tailor care to each individual patient.” Respondents used a sliding scale ranging from 0 (the anti-CER argument was more persuasive) to 100 (the pro argument was more persuasive). The mean score was 65.8.

respondents to known marginals for the general population of the United States from the 2006 American Community Survey. Full question wording is included in Section 1 of the Appendix. A follow-up survey using the same methodology was conducted from November 9-22, 2011 ($N = 3,600$). All of the analysis presented below uses the weights provided with the data sets.⁵

Beliefs about Doctors' Motivations and Abilities

Previous studies have documented a decline in the public's confidence in the medical profession and its leaders (Blendon, Hyams, and Benson 1993; Jacobs and Shapiro 1994). For example, in 1966, 73% of Americans "said they had a 'great deal of confidence in the people in charge of running medicine.' In 2010 only 34% expressed that level of confidence" (Buhr and Blendon 2011, 21). The decline in confidence in medicine likely reflects not only a general decline in public confidence in government and other major institutions over the past several decades (see Hetherington 2005), but also broad changes in the political economy of health care. Back in the 1960s, patients had relatively few treatment options, the health sector made up a small share of the economy, and organized medicine possessed an issue monopoly over health policy. Today, concerns about skyrocketing medical costs, rising premiums, and government budget deficits have engendered debates about the value of dollars spent and created a more open and contentious health politics (Buhr and Blendon 2011).

⁵ Although we cannot rule out the possibility of bias in this sampling method, it is reassuring that the nationally representative survey sample (i.e., using the weighted data) produced responses similar to other surveys on baseline questions about insurance coverage (23% report being uninsured) and health status (76% report their health as "good" or better). For more detailed information on this type of survey and sampling technique see Vavreck and Rivers (2008). More broadly, see AAPOR Executive Council Task Force (2010) for a report on the strengths and limitations of online panels.

These important developments should be kept in perspective, however. While the medical profession may not enjoy the same absolute level of confidence as it once did, what also matters is the status and influence of doctors *relative* to other actors in the health care arena like elected officials, drug companies, and health insurance companies. Many Americans recognize that the health care system does not always serve the interests of patients, but most blame actors other than doctors for the system's flaws. Despite the secular decline in confidence in the medical profession, Americans view doctors as being honest and generally trust doctors to recommend the right thing for the country on health care (Buhr and Blendon 2011). In a 2008 Gallup survey, 64% of Americans said doctors had very high or high ethical standards, up from 56% in 1976 (cited in Buhr and Blendon 2011, 22). In contrast, on a separate nationally representative survey, 68% of the public agreed with the statement that "drug companies keep cures for some serious medical conditions secret from the public to protect the profits they get from their current products."⁶ Despite the erosion of medical authority in American politics since the 1960s (Blendon et al. 1993; Jacobs and Shapiro 1994; Krause 1996; Peterson 1993; 2001; Schlesinger 2002), the public continues to display remarkable faith in physicians compared to other groups (Gallup 2009; Rasmussen Reports 2010).

Our survey randomly assigned respondents to evaluate one of four professions: doctors, lawyers, grade school teachers, or Members of Congress. They were asked to rate their agreement with a series of six statements about the motivations of people from their randomly assigned profession. For example, those in the "doctors" condition were asked how much they agreed with the statement: "Becoming wealthier is important for doctors." Responses were

⁶ Author analysis. <details redacted>

measured on a five-point scale ranging from “strongly disagree” (1) to “strongly agree” (5). Mean responses to these items for each profession are displayed in Figure 1.

<Figure 1 here>

The results indicate that doctors are viewed as harder workers, more interested in helping people, more trustworthy, and as caring more (“about people like me”) than each of the other professions. All of the differences in the public’s assessment of doctors compared to other professions are statistically significant at $p < .05$, two-tailed, with the exception of the differences between doctors and school teachers on the “interested in helping people” ($p = .26$) and “can be trusted” ($p = .25$) items. While the public does not see doctors as exclusively altruistic (see Schlesinger 2002), doctors are perceived to be less driven by a desire to gain greater wealth and prestige than members of other elite professions such as lawyers and Members of Congress.

The public expresses confidence in the professional competence of doctors. For example, the public expresses confidence in the ability of doctors to tailor care to the needs of individual patients. On a separate survey conducted from May 21-24, 2010 by YouGov/Polimetrix ($N = 2,200$), a majority (52%) agreed with the statement, “If a treatment only helps some patients who get it, your doctor knows whether you will be among those for whom the treatment is effective.” The public’s faith in doctors reinforces public concerns that CER would lead to “cookie-cutter” medicine and reduce physicians’ ability to exercise professional judgment when caring for individual patients.

Beliefs about the Motivations of Medical Associations

Although the public has the most direct contact with individual physicians, medical societies are involved in Medicare coverage and reimbursement decisions and have more direct influence over public policy. Medical societies take positions on proposed changes to federal

rules and make recommendations for coverage and reimbursement decisions under Medicare that affect program beneficiaries and taxpayers (Lillis 2010). When comparative effectiveness studies are published about the benefits, costs, and risks of a given treatment, medical societies may issue statements about the research methodologies used and the significance of the study findings (Wulff, Miller, and Pearson 2011). These statements may be quoted in the media and shape public beliefs about the effectiveness of particular treatment modalities as well as about the quality and efficiency of the U.S. medical system. In these respects, at least, medical associations are similar to other economic organizations, such as unions, trade organizations, or industry groups, that adopt positions and make recommendations to influence public policy. An important question is whether the public views doctor associations as having the same or different motivations than other groups.

Respondents to our survey were asked to evaluate the importance of several factors in explaining why various groups make policy recommendations. Each respondent was randomly assigned to evaluate the motivations of one of four groups: medical associations, unions, business organizations, or health insurance organizations. We investigated the importance of the following five motivations: maintaining high income for group members; preserving the group's influence over policy makers; ensuring that new laws and regulations help their industry; promoting the health of patients (for doctor's groups and health insurance organizations) or workers (for business organizations and unions); and protecting doctors from malpractice suits (for doctor's groups and health insurance organizations only). Responses were measured on a five-point scale ranging from "Not at all important" (1) to "Extremely important" (5). Figure 2 displays the percent who chose either of the top two response categories: "very important" or "extremely important."

<Figure 2 here>

The results indicate that the public sees the desire to maintain high incomes for group members and to preserve group influence over policy makers as being weaker motivations for medical associations than for unions and business organizations. Only 45% stated that “maintaining high incomes” was either very or extremely important to medical associations, whereas 60% and 55% said the same for unions and business organizations. The public also perceives medical associations as being more concerned about promoting patient health (65% selected very or extremely important) than health insurance organizations (56%), and to be more concerned about promoting patient health than unions (54%) and business organizations (42%) are concerned about promoting worker health. The public does, however, see the desire to protect doctors from malpractice suits as being a stronger motivator for medical associations (61%) than for health insurance organizations (50%).

Survey Experiment 1: The Effect of Physician and Political Cues on Support for a Generic Proposal

Taken together, the survey findings discussed above suggest that the public regards doctors, individually (Figure 1) and collectively (Figure 2), as trustworthy actors motivated to help patients. The public’s high level of confidence in doctors is striking compared not only to the degree of trust in other professional groups, but also relative to the deep mistrust Americans have in government, particularly with respect to health policy. The success of the new federal emphasis on CER may therefore depend in part on whether the public concludes that doctors are embracing the initiative or resisting it. To the extent the public is fearful that CER is simply an exercise in cost control that will impede doctors from tailoring treatments to the needs of

individual patients, the strong support of individual physicians and medical associations may help overcome it.

As mentioned, a prior study examined which substantive responses to claims that CER will lead to rationing or “one-size-fits-all” medicine are most effective (Gerber et al. 2010a). However, given the complexity of the issue, the *source* of arguments about CER policy may prove just as important (Druckman et al. 2010; Eagly and Chaiken 1993; Lupia 1994). We examined this possibility by performing two survey experiments. The design of the first allows us to assess how public support for a generic proposal to “help reduce the amount we spend on health care” is affected by the support or opposition of a physicians’ group (the American Medical Association) as well as the positions of “political” groups (congressional Democrats, congressional Republicans, and a bipartisan commission on deficit reduction). These support and opposition cues were randomly assigned across respondents and were designed to mimic common elements of the political debate over health care cost control.⁷ We did not give the proposal any substantive content beyond indicating that it would help constrain health care costs because cost control is the dimension of CER that has been most controversial. We sought to determine if the AMA’s position matters and to whom.

Two dimensions were experimentally manipulated. The first dimension varied the AMA position. One-third of the sample was told that the AMA endorsed the proposal; another third was told that the AMA opposed the proposal; the AMA’s position on the proposal was not mentioned for the remaining one-third of respondents. The second dimension of the experiment examined the effects of political cues. Each respondent saw a statement that described the

⁷ Like other work on public opinion concerning health care politics and policy (e.g., Gollust and Lynch 2011), we adopt Druckman et al.’s definition of a “cue”: Information “that enable[s] individuals to make simplified evaluations without analyzing extensive information” (2010, 137).

proposal as (a) “supported by congressional Democrats but opposed by congressional Republicans,” (b) “supported by congressional Republicans but opposed by congressional Democrats,” (c) “supported by congressional Democrats and Republicans” or (d) “supported by a bipartisan commission on deficit reduction.” An additional group was randomly assigned to receive no political cue. These five conditions were randomly assigned with equal probability independently of the AMA cue treatment.

In sum, some respondents were presented with the position of a single group (e.g., AMA endorsement or endorsement from a bipartisan commission) while others were presented with both a political cue and the position of the AMA. (No respondents were assigned to the condition in which neither a political cue nor the AMA cue was provided.) The outcome measure was respondents’ assessments of how the particular cue (or cues) would affect their own support for the proposal and was measured using a five-point scale ranging from “much less likely to support” (-2) to “much more likely to support” (2).⁸

For each of the 14 experimental conditions, Table 1 reports the average (weighted mean) for the outcome measure with standard errors in parentheses. The table also reports the weighted mean for each political cue condition, collapsing AMA conditions (in row 4), and the weighted mean for each AMA condition, collapsing political cue conditions (both including the “no political cue” cases [in column F] and not including those cases [in column G]).⁹

⁸ The full question wording stated that, “A variety of public policies have been proposed to help reduce the amount we spend on health care. Suppose you learned that a proposal was [American Medical Association cue conditions] and [political cue conditions]. Would this make you more or less likely to support the proposal?”

⁹ In the Appendix, we report tests of balance across treatment conditions (in Section 2) and additional data analysis where we test for interactive effects between the AMA conditions and the political cue conditions, but find no statistically or substantively significant effects (in Section 3). The results we

<Table 1 here>

Focusing on column G, we find that respondents who received the AMA support cue (row 2) were more likely to say this cue would increase their support for the proposal (mean=.30), while respondents who received the AMA opposition cue (row 3) were more likely to say it would decrease their support for the proposal (mean=-.11). This net difference between receiving AMA support or opposition cues of .41 is statistically significant ($p<.001$). In concrete terms, only 24% of the people who received the AMA opposition cue said they were (somewhat or much) more likely to support the proposal, while 38% of the people who received the AMA support cue said the same. Only 14% of those who received the AMA support cue said they were (somewhat or much) less likely to support the proposal, while 30% of those who received the AMA opposition cue did so.

We expected the position of a bipartisan commission on deficit reduction to affect public opinion as well but the results suggest it did not. Collapsing the AMA conditions (row 4 of Table 1), we find that in the absence of a political cue, average support for the proposal is .12 (column A). When the bipartisan commission cue is given, average support is also approximately .11 (column C). The bipartisan commission cue does not meaningfully affect responses: 20% of the people who received the bipartisan commission supports cue said they were (somewhat or much) less likely to support the proposal, while 17% of the people who received no political cue did so; 31% of the people who received the bipartisan commission supports cue said they were

present in the text are robust to a regression framework in which we regress the outcome measure on indicators for each treatment with no cue serving as the excluded category (i.e., indicators for AMA Support, AMA Oppose, Democrats Support, Republicans Support, Both Parties Support, and Bipartisan Panel Support). In this most basic specification, only the indicators for AMA Support and AMA Oppose are statistically significant. (We obtain the same results if we control for age, gender, race, education, income, turnout in 2008, and party identification.)

(somewhat or much) more likely to support the proposal, while 27% of the people who received no political cue said the same. These results imply that endorsements from bipartisan political committees are unlikely to increase public support for proposals to reduce health care spending.

Aggregate support for the proposal is also not significantly affected by the other political cues. The differences between the bipartisan commission and the other political cue conditions in row 4 are not statistically significant ($p > .10$ for all pairwise comparisons). Collapsing across AMA conditions (row 4), there are no statistically significant differences between any of the other political cues and the group that received no political cue or between the other political cue experimental conditions ($p > .10$ for all pairwise comparisons).

Partisan endorsements are expected to have different effects depending on subject partisanship. Table 2 shows the results by respondent party identification. Although small samples limit our ability to draw reliable inferences, three aspects of the table are noteworthy. First, the effects of the AMA cues are very similar for Republicans (a .41 unit difference between AMA support and opposition), Democrats (.46 unit difference), and Independents (.38 unit difference). The differences across partisan groups are not statistically significant ($p > .10$ for all pairwise comparisons). These results suggest that public support of a proposal to help reduce health care spending is likely to be significantly and similarly (across party lines) influenced by the position of the AMA. Second, the effect of support from a bipartisan commission does not vary across respondents with differing partisan identities, including those who identify as Independent ($p > .10$ for all pairwise comparisons). In fact, none of the political cue treatment conditions significantly affected Independents relative to the no political cue condition.

<Table 2 here>

Finally, partisans do, however, differ substantially in their responses to directional partisan cues.¹⁰ Republican respondents who were presented with an endorsement cue from congressional Republicans and an opposition cue from congressional Democrats (column E) were more likely to say the information would increase their support for the proposal (mean=.95 in row 4, $p<.001$ for difference between no political cue); among Democratic respondents, this informational condition substantially decreased support for the proposal (mean=-.57, $p<.001$ for difference between no political cue). Conversely, Democratic respondents who received an endorsement cue from congressional Democrats and an opposition cue from congressional Republicans (column B) were more likely to say the information would substantially increase their support for the proposal (mean=.71, $p=.02$ for difference between no political cue), while this combination of cues considerably decreased support among Republican respondents (mean=-.67, $p<.001$ for difference between no political cue).

In additional analysis, we also find evidence of “cue substitution”—respondents giving particular weight to the cues they see as most informative (e.g., Schaffner, Streb, and Wright 2001; Ansolabehere et al. 2006). Specifically, respondents who identified as Republicans or Democrats (rather than as Independents) relied particularly heavily on cues from the AMA when no directional party cue was provided (i.e., in the Bipartisan Commission Supports, Both Parties Support, and No Political Cue conditions). In the absence of a directional party cue, the effect of an AMA endorsement—rather than AMA opposition—was .566 ($p<.01$) among partisan respondents. However, when a directional party cue (i.e., the Republicans Support or Democrats Support conditions) *was* given to partisan respondents, the effect of the AMA position was substantially smaller and not statistically significant (estimated effect=.171; $p=.305$). In other

¹⁰ This finding is consistent with prior work on the effect of partisan cues (e.g., Kam 2005; Popkin 1994; Rahn 1993).

words, partisans relied on cues from their party when available; but when cues from their own party were not available, partisans were influenced by information about the AMA's position. There was less evidence of cue substitution among self-identified Independents. When a directional partisan cue was given to Independents, the estimated effect of an AMA endorsement was somewhat larger (estimated effect=.548) than it was when no directional partisan cue was given (estimated effect=.234). However, this difference in effect size falls short of conventional levels of statistical significance ($p=.135$).¹¹

In summary, the results from Experiment 1 suggest that the AMA's position may significantly influence public opinion. Although respondents who identified with a political party were strongly affected by directional cues from their party, the effects of Democratic and Republican partisan cues are largely offsetting given the aggregate distribution of partisan preferences in the overall population (as seen in Table 1). Only the position of the AMA influences the attitudes of the public as a whole. Contrary to our expectations, neither the positions of a bipartisan commission, nor a cue indicating that both parties support a proposal significantly influences public opinion—even among Independents. These experimental results thus underscore the important role that doctors' groups like the AMA may play in determining the political future of health care cost control proposals. Even without giving respondents

¹¹ This analysis was conducted by estimating a regression model (available upon request) predicting support for the proposal with indicators for each of five treatment conditions (1. Directional Party Cue, AMA Supports; 2. Directional Party Cue, No AMA Cue; 3. No Directional Party Cue, AMA Supports; 4. No Directional Party Cue, No AMA Cue; 5. No Directional Party Cue, AMA Opposes). The model also included an indicator set to 1 for respondents who identified as either Democrats or Republicans and 0 otherwise. Finally, the model included interactions between this "partisan indicator" and each of the treatment indicators.

specific reasons why a proposal would be good or bad for patients, the AMA's position has the potential to significantly increase public support or opposition.

Survey Experiment 2: The Effect of Physician and Political Cues on Support for a CER-based Proposal

The results of the first survey experiment suggest that medical associations (in this case, the AMA) have the ability to influence public opinion on a health reform issue, but the question remains whether the support or opposition of the AMA (or, physicians more generally) would be less (or more) effective when the endorsement or opposition cue explicitly references CER. Our second survey experiment addresses this question. Respondents were told that,

Some people have suggested that we allow the government and insurance companies to refuse payment for treatments or procedures if their effectiveness has not been demonstrated by rigorous scientific evidence. Suppose you learned that [group cue conditions] and [political cue conditions]. What about you? Would you support this policy?¹²

The five political cue conditions were almost identical to those used in the first experiment, but with slightly different phrasing that fit the vignette better: (a) “congressional Democrats support this policy but congressional Republicans oppose this policy,” (b) “congressional Republicans support this policy but congressional Democrats oppose this policy,” (c) “both congressional Democrats and Republicans support this policy,” (d) “a bipartisan commission supports this policy,” or (e) no political group cue was given. These five conditions were randomly assigned with equal probability independently of the group cue treatments.

¹² The outcome measure was respondents' support for a policy that would “allow the government and insurance companies to refuse payment for treatments or procedures if their effectiveness has not been demonstrated by rigorous scientific evidence” and was measured using a 100-point sliding scale ranging from “strongly oppose” (0) to “strongly support” (100) where the midpoint of scale indicated that respondents “neither support nor oppose this policy.”

The group cue conditions, however, were different. We randomly assigned respondents to one of four groups—“leading doctors,” “leading patient advocacy groups,” high-level government administrators,” or “top drug companies”—or to receive no group cue. The support or opposition of the group for those assigned to one of the four groups was also randomly assigned, such that there were nine total group cue conditions.¹³ As in the first experiment, some respondents were presented with a single cue (e.g., the endorsement of leading doctors) while others were presented with both a political cue and a group cue.¹⁴

For each of the 45 experimental conditions, Table 3 reports the average (weighted mean) for the outcome measure. The table also reports the weighted mean for each political cue condition, collapsing group cue conditions (in row 10), and the weighted mean for each group condition, collapsing political cue conditions (both including the “no political cue” cases [in column F] and not including those cases [in column G]).¹⁵ We focus on three results.

<Table 3 here>

First, the support of doctors increases public support for the CER health care cost control proposal. Focusing on column G, we find that respondents who received the leading doctors support cue (row 2) had a higher level of support for the proposal (mean=47.75) than respondents who received the leading doctors oppose cue (row 3, mean=42.08). This net difference (of 5.67 units) is statistically significant ($p=.09$, two-tailed), and is consistent with the

¹³ These nine conditions were randomly assigned with equal probability, except that 20% of respondents were randomly assigned to receive no group cue and every other condition (e.g., leading doctors oppose) was assigned to 10% of respondents.

¹⁴ In this experiment we did assign respondents to the condition in which neither a political cue nor a group cue was provided.

¹⁵ Full question wording is included in Section 1 of the Appendix. Section 2 of the Appendix reports tests of balance across treatment conditions.

results of the first experiment.¹⁶ Taken together, the results from both experiments provide evidence that public support of a proposal to use CER to help control health care spending is likely to be significantly influenced by the support of physicians.

Second, the influence of doctors is distinctive in that only their support boosts public acceptance of the CER cost control proposal. The support of other groups either has no effect or else diminishes public support for the proposal (in comparison to opposition from the group). Perhaps surprisingly, the position of patient advocacy groups has no effect on public opinion about the proposal ($p=.90$ and $.80$ for the difference between these two conditions in columns G and F, respectively). Two groups—top drug companies and high-level government administrators—have so little standing with the public when it comes to CER and cost control that their *opposition* (not their endorsement) boosts respondents' support for the proposal. In column G, the -4.72 unit difference between support and opposition of high-level government administrators is statistically significant ($p=.09$), as is the -5.60 unit difference between the support and opposition of top drug companies ($p=.04$).¹⁷ In short, of the (non-political) group cues we tested, only the *support* of leading doctors increases public support of a CER proposal to help control health care spending. The support of other groups was either inconsequential or counterproductive (compared to the same group's opposition).

Third, as in the first experiment, we find only small differences across political cue conditions. Collapsing the group cue conditions (row 10 of Table 3), we find that in the absence of a political cue, average support for the CER proposal is 42.44 (column A). The largest

¹⁶ The 5.37 net difference between leading doctors support (48.07) and leading doctors oppose (42.70) in column F is also statistically significant ($p=.07$).

¹⁷ The difference between the support and opposition of high-level government administrators is also statistically significant in column F ($p=.07$), whereas the difference between the support and opposition of top drug companies in column F is not ($p=.32$).

difference from this baseline condition is obtained when Democrats support the proposal but Republicans oppose it (mean=45.57), a statistically significant ($p=.09$) 3.13 unit difference. When the bipartisan commission cue is given, average support is approximately 44.80 (column C), a 2.36 unit difference from the no political cue condition that is not statistically significant ($p=.24$).¹⁸ Thus, we again find that the support of a bipartisan commission does not significantly increase public support for a proposal to help reduce health care spending—in this case, one specifically linked to CER. Moreover, as with the first experiment, the effect of support from a bipartisan commission does not vary across respondents with differing partisan identities, including those who identify as Independent ($p>.10$ for all pairwise comparisons; results not shown, but available upon request). Finally, collapsing across group cue conditions (row 10), there are no statistically significant differences between the four political cue treatment conditions ($p>.10$ for all six pairwise comparisons). In sum, the findings from this survey experiment broadly corroborate the results of the first experiment and underscore the distinctive capacity of doctors' groups to shape public opinion in this policy arena.¹⁹

Limitations and Directions for Future Research

The results of the present study suggest that physicians and medical associations have the ability to influence public support for CER. Some limitations should be kept in mind. The magnitude of the effect sizes we identify in the survey experiments are modest (e.g., the

¹⁸ Aggregate public support for the proposal is also not significantly affected by the support of both parties ($p=.30$) or the support of Republicans and opposition of Democrats ($p=.48$).

¹⁹ The results of this experiment are also robust to a regression framework similar to the one discussed in footnote 9. Specifically, we reach the same conclusions if we regress the outcome measure on indicators for each treatment with no cue serving as the excluded category (i.e., 12 treatment indicator variables in all). We also obtain the same results if we control for age, gender, race, education, income, turnout in 2008, and party identification.

estimated effect of receiving the “leading doctors support” rather than “leading doctors oppose” was approximately 6 points on a 100 point scale [0.25 standard deviations]). This is particularly important to note given that these experiments present respondents with a highly simplified representation of the world and, thus, may overstate the size of the effects that would occur outside of the experimental context (Jerit and Barabas 2010). Thus, although this stripped-down framework demonstrates that physician and medical association endorsements are potentially important to public support of health policy proposals, we cannot assume that such endorsements would result in similar effects when other information is available to citizens. While we believe the public’s high level of confidence in doctors and medical associations is robust to alternative models, further experimentation that embeds more detailed and complex information about the health care system may provide a more complete picture of the types of information people encounter in the real world and the potential effects that doctors and medical associations can have on public opinion.

Additionally, our finding that bipartisan commissions do not appear to boost public support for a policy proposal should be replicated outside of the health care context. Although it is noteworthy that Independents do not view a health policy proposal backed by a bipartisan commission more favorably than one that is not, it is unclear whether this finding is domain specific or if bipartisan commissions have a limited capacity to affect public opinion about public policy matters more generally. This is an important topic for future inquiry given the emphasis that policymakers and scholars often place on the need to establish bipartisan

commissions to build public support for painful decisions such as tax increases, spending cuts, and program terminations.²⁰

Conclusions

The U.S. spends about twice as much as other OECD nations on health care yet it ranks poorly on many measures of health status (Schoen et al. 2007; Schoen et al. 2010; Squires 2011). While there are many reasons for the inefficiency of the U.S. health care system, one is the failure to generate and use hard evidence about the relative benefits of treatment alternatives. The promise of CER is that better data and its integration into clinical practice and public policy decisions can help promote better quality and value in health care. This aspect of CER is reasonably straightforward. The radical element of CER is its implicit challenge to the widespread public belief that doctors *already* know what is best for patients and *already* practice evidence-based medicine. To the extent that CER is viewed as imposing a constraint on the ability of doctors to exercise their professional judgment, much of the American public is likely to oppose it (Gerber et al. 2010a). If CER is, instead, seen as an objective tool that helps physicians make the best treatment decisions for and with their patients, Americans are likely to be become more comfortable with it (Gerber et al. 2010a).

Medical knowledge is esoteric and asymmetrically distributed, and this is cited as a rationale for why the United States delegates vast decision-making authority to physicians (Arrow 1963). It is critical to remember that the medical profession is also a political institution that has the “power to distract, encourage, limit, and inform public recognition of and

²⁰ Of course, even if bipartisan commissions have less influence on public opinion than is often supposed, they could still be useful to partisan politicians for blame-avoidance purposes. On the politics of blame avoidance, see Weaver (1986).

deliberation over social problems” (Dzur 2002, 178). The American public overwhelmingly trusts physicians and views them as faithful agents of patient interests and does not see doctors as a typical self-interested economic interest group. Given the deep mistrust many Americans have for government, and the widespread suspicion of health insurance companies and the pharmaceutical industry, doctors may be the only group that commands the prestige and standing to persuade the American public that investments in CER is needed and that the findings from well-designed studies should be translated into clinical practice and eventually into payment rules and other cost-control incentives.

The political controversy over CER stems in part from a recognition that studies could challenge the usefulness of common treatments, as well as the income streams of drug companies, device firms, and provider groups. Given the financial unsustainability of the projected growth rate of health care spending, however, the question is not whether the nation will seek to control health care costs but how. Physician leadership in promoting public acceptance of CER as the scientific foundation for cost control measures may help reduce the need for blunter and less patient-centered methods of cost control in the future (Reuben and Cassel 2011). Several national medical societies recently launched an effort called Choosing Wisely to discourage clinicians from performing scores of diagnostic tests, procedures, and treatments that do patients little good (Knox 2012). While the campaign lacks an enforcement mechanism (individual doctors are still free to practice medicine as they think best), it generated significant media attention and could begin to change public opinion about the need for patients to avoid unnecessary care. The findings we present underscore the importance of doctors’ associations to public opinion surrounding and, as a consequence, the political sustainability of health care cost control policies such as CER.

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Appendix for “Doctor Knows Best”

This document includes the following supplementary material.

1. Question Wording
2. Balance Tests
3. Testing for Interactions between the AMA and Political Cue Conditions in Survey Experiment 1 (Table A1)

1. Question Wording

A. February 17-23, 2011 (N = 1,500) YouGov/Polimetrix Survey

Health Insurance

SINGLE CHOICE

Special Instructions: None

Which of the following four statements comes closest to your own view about your current health insurance coverage?

- 1 My health insurance is good and I feel well-protected when it comes to my health care needs.
- 2 My health insurance is adequate, but I worry that I might have health care needs that it won't pay for.
- 3 My health insurance is inadequate, and I feel very worried about my health care needs not being paid for.
- 4 I don't have health insurance.
- 5 Don't know

Overall Health

SINGLE CHOICE

Special Instructions: None

In general, how would you rate your overall health?

- 1 Poor
- 2 Fair
- 3 Good
- 4 Very good
- 5 Excellent

Doctors' Motivations

GRID

Special Instructions: [Blank] should be assigned with equal probability to "doctors" or "lawyers" or "grade school teachers" or "Members of Congress". Randomize order of rows.

How much do you agree with each of the following statements?

Columns:

- 5 Strongly agree
- 4 Somewhat agree
- 3 Neither agree nor disagree
- 2 Somewhat disagree
- 1 Strongly disagree

Rows:

- [Blank] work harder and longer hours than do people in most other jobs
- [Blank] are interested in helping people
- Becoming wealthier is important for [Blank]
- [Blank] are mainly interested in gaining greater prestige
- [Blank] care about people like me
- [Blank] can be trusted

Doctors Groups

GRID

Special Instructions: Randomize order of rows. Randomly assign participants to one of four treatment conditions – doctors groups, unions, business, insurance – with equal probability.

Sometimes [A. medical associations such as the American College of Cardiology or the American College of Radiology / B. unions such as the United Auto Workers (UAW) or the Service Employees International Union (SEIU) / C. business organizations such as the Chamber of Commerce or National Business Association / D. health insurance organizations such as the Health Insurance Association of America and America's Health Insurance Plans] make recommendations about public policy. When developing their recommendations, how important do you think each of the following considerations is to these groups?

Columns:

- 5 Extremely important
- 4 Very important
- 3 Moderately important
- 2 Slightly important
- 1 Not at all important

Rows:

- Maintaining high incomes for their members
- Preserving the influence their group has over policy makers
- Ensuring that new laws and regulations help their industry
- Promoting [A. and D. patient health / B. and C. worker health]
- [A and D. only. Protecting doctors from malpractice suits]

AMA and Political Cues Experiment

SINGLE CHOICE

Special Instructions: The treatments follow a (3 x 5) design. Please randomly assign respondents to one of 14 of these 15 conditions with equal probability. No respondents should be assigned to the TREAT1=NONE AND TREAT 2=NONE condition. Randomize order of TREAT 1 and TREAT 2 if BOTH <>NONE.

A variety of public policies have been proposed to help reduce the amount we spend on health care. Suppose you learned that a proposal was [TREAT 1: NONE / supported by the American Medical Association / opposed by the American Medical Association] [IF TREAT 1<> NONE AND TREAT 2<> NONE then “and”] [TREAT 2: NONE / supported by congressional Democrats but opposed by congressional Republicans / supported by congressional Republicans but opposed by congressional Democrats / supported by congressional Democrats and Republicans / supported by a bipartisan commission on deficit reduction].

Would this make you more or less likely to support the proposal?

- 1 Much more likely to support
- 2 Somewhat more likely to support
- 3 Neither more nor less likely to support
- 4 Somewhat less likely to support
- 5 Much less likely to support

B. November 9-22, 2011 (N = 3,600) YouGov/Polimetrix Survey

Group and Political Cues Experiment

RULER WIDGET

Special Instructions: The treatments follow a (10 x 5) design. The tenth condition for TREAT 1 is NONE again, i.e., the NONE condition for TREAT 1 should be given a “double share.”

Please randomly assign respondents to one of these 50 conditions with equal probability. Also, please randomize order of TREAT 1 and TREAT 2 if BOTH <>NONE.

A variety of public policies have been proposed to help reduce the amount we spend on health care.

Some people have suggested that we allow the government and insurance companies to refuse payment for treatments or procedures if their effectiveness has not been demonstrated by rigorous scientific evidence.

Suppose you learned that [TREAT 1: NONE / leading doctors support this policy / leading doctors oppose this policy / nationally recognized patient advocacy groups support this policy / nationally recognized patient advocacy groups oppose this policy / the high-level government administrators who run Medicare and Medicaid support this policy / the high-level government administrators who run Medicare and Medicaid oppose this policy / top drug companies support this policy / top drug companies oppose this policy] [IF TREAT 1<> NONE AND TREAT 2<> NONE then “and”] [TREAT 2: NONE / congressional Democrats support this policy but congressional Republicans oppose this policy / congressional Republicans support this policy but congressional Democrats oppose this policy / both congressional Democrats and Republicans support this policy / a bipartisan commission supports this policy].

What about you? Would you support this policy? (Selecting the midpoint of the scale would mean that you neither support nor oppose this policy.)

RULER WIDGET: Strongly oppose – Strongly support

2. Balance Tests

A. Survey Experiment 1

To test for observable differences across treatment groups we performed two separate multinomial logits (one for the AMA cues, one for the political cues), predicting treatment assignment (a nominal experimental treatment condition variable) with the following covariates: gender, age, race (indicators for Black, Hispanic, and other, non-White), education, income, income missing, reported turnout in 2008, and party identification. We approximated an exact randomization test by comparing the chi-square test statistic for the joint significance of all variables (from the multinomial logit models) to the distribution of the statistic across a set of 1,000 alternative assignments with treatments permuted at random. The actual chi-square test statistics were 24.94 and 58.23 for the AMA and political cues, respectively. Both of these test statistics fell inside the 2.5th and 97.5th percentiles from the 1,000 alternative assignments, suggesting they are not unusual test statistics. (For the AMA cues, the 2.5th percentile was 11.09 and the 97.5th percentile was 39.71. For the political cues, the 2.5th percentile was 27.70 and the 97.5th percentile was 70.56.)

B. Survey Experiment 2

To test for observable differences across treatment groups we performed two separate multinomial logits (one for the group cues, one for the political cues), predicting treatment assignment (a nominal experimental treatment condition variable) with the following covariates: gender, age, race (indicators for Black, Hispanic, and other, non-White), education, income, income missing, reported turnout in 2008, and party identification. We approximated an exact randomization test by comparing the chi-square test statistic for the joint significance of all variables (from the multinomial logit models) to the distribution of the statistic across a set of 1,000 alternative assignments with treatments permuted at random. The actual chi-square test statistics were 185.10 and 131.99 for the group and political cues, respectively. Both of these test statistics fell inside the 2.5th and 97.5th percentiles from the 1,000 alternative assignments, suggesting they are not unusual test statistics. (For the group cues, the 2.5th percentile was 126.05 and the 97.5th percentile was 243.65. For the political cues, the 2.5th percentile was 51.34 and the 97.5th percentile was 135.95.)

3. Testing for Interactions between the AMA and Political Cue Conditions in Survey Experiment 1

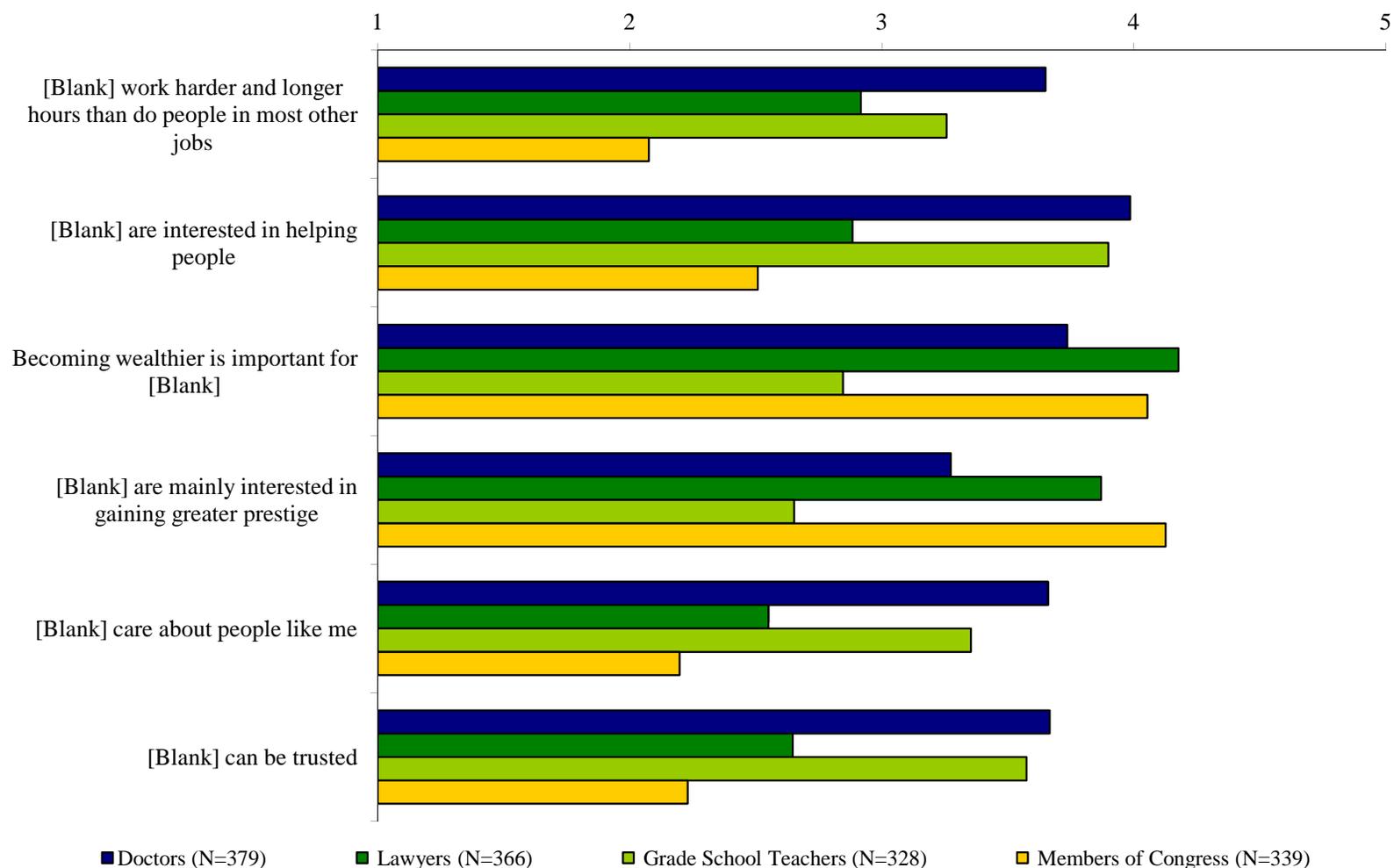
There were no statistically significant interaction effects between the two experimental dimensions. Focusing on the cases in which an AMA cue was given (either support or opposition), in a regression model where the outcome is the response variable and indicators for treatment conditions (AMA Support/Oppose, Democrats Support, Republicans Support, Both Parties Support, and Bipartisan Commission Supports) as well as interactions between the four political cue treatment conditions and AMA Support/Oppose, none of the four interaction coefficients are statistically significant (all $ps > .10$). The results of this analysis are reproduced below as Table A1.

Table A1. Testing for Interactive Effects between the AMA and Political Cue Conditions

	(1)	(2)	(3)	(4)
	Support for proposal (-2=much less likely to support; 2=much more likely to support)			
AMA Support Cue	0.387 [0.069]***	0.296 [0.128]**	0.388 [0.070]***	0.281 [0.127]**
Democrats Support Cue	-0.004 [0.110]	-0.035 [0.156]	-0.010 [0.109]	-0.055 [0.156]
Republicans Support Cue	0.160 [0.104]	0.167 [0.157]	0.150 [0.106]	0.137 [0.160]
Both Parties Support Cue	-0.081 [0.102]	-0.234 [0.148]	-0.096 [0.103]	-0.251 [0.149]*
Bipartisan Panel Support Cue	-0.040 [0.098]	-0.123 [0.146]	-0.059 [0.098]	-0.152 [0.145]
AMA Support x Democrats Support		0.042 [0.219]		0.064 [0.217]
AMA Support x Republicans Support		-0.033 [0.208]		0.003 [0.210]
AMA Support x Both Support		0.316 [0.201]		0.318 [0.203]
AMA Support x Bipartisan Commission Supports		0.147 [0.197]		0.165 [0.197]
Constant	-0.107 [0.075]	-0.054 [0.092]	0.100 [0.172]	0.151 [0.174]
Covariates Included	No	No	Yes	Yes
Observations	968	968	963	963
R-squared	0.038	0.042	0.055	0.058

Note: Weighted OLS regression coefficients with robust standard errors in brackets. In columns (3) and (4) the included covariates are: age (in years), gender (indicator for female), race (indicators for Black, Hispanic, and Other, non-White), education (linear scale), income (linear scale and indicator for income missing), turnout (indicator for reported voting in 2008), and party identification (three-point linear scale). * significant at 10%; ** significant at 5%; *** significant at 1%

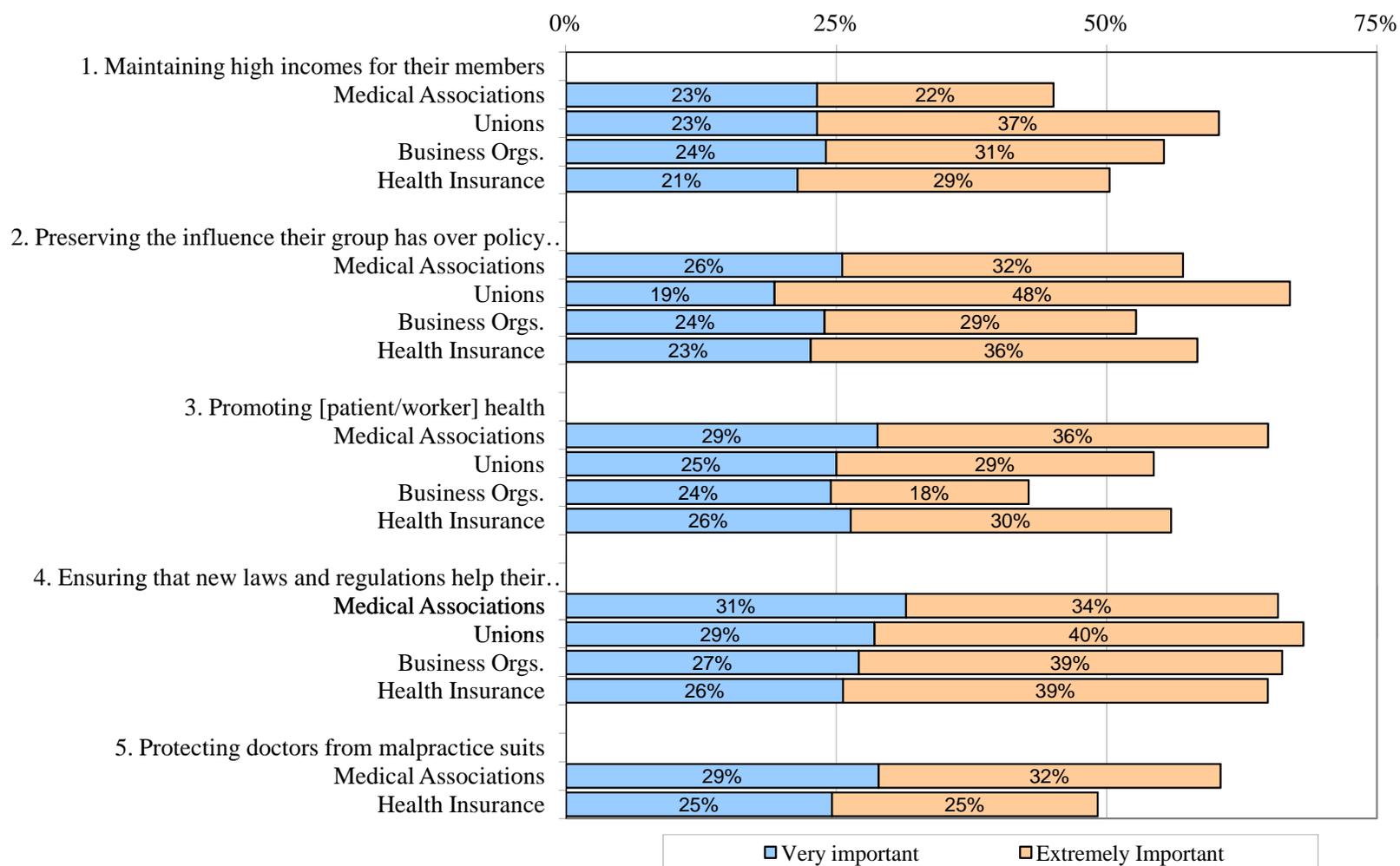
Figure 1 Beliefs about the Motivations of Doctors Compared to Other Professions



Source : February 17-23, 2011 YouGov/Polimetrix survey. See text for details.

Notes : Mean responses to the question “How much do you agree with each of the following statements?” Responses were measured on a 5-point scale ranging from “strongly disagree” (1) to “strongly agree” (5). Full question wording is included in the Appendix. All of the differences in the public’s assessment of doctors compared to other professions are statistically significant at $p < .05$, two-tailed, with the exception of the differences between doctors and school teachers on the “interested in helping people” ($p = .26$) and “can be trusted” ($p = .25$) items.

Figure 2 Beliefs about the Motivations of Medical Associations Compared to Other Groups



Source : February 17-23, 2011 YouGov/Polimetrix survey. See text for details.

Notes : Responses to the question “When developing their recommendations, how important do you think each of the following considerations is to these groups?” Number of observations for each group were 348 (medical associations), 352 (unions), 370 (business organizations), and 342 (health insurance organizations). Responses were measured on a 5-point scale ranging from “Not at all important” (1) to “Extremely important” (5). Full question wording is included in the Appendix. The figure displays the percent who responded that the consideration was “very important” and “extremely important” (the top two response categories).

Table 1 Results of AMA and Political Cues Experiment (Survey Experiment 1)

	A	B	C	D	E	F	G
	No Political Cue (<i>N</i> = 203)	Democrats Support (<i>N</i> = 299)	Bipartisan Commission Supports (<i>N</i> = 318)	Both Parties Support (<i>N</i> = 294)	Republicans Support (<i>N</i> = 298)	All Political Conditions, with “No Political Cue” (<i>N</i> = 1412)	All Political Conditions, without “No Political Cue” (<i>N</i> = 1209)
1 No AMA Cue (<i>N</i> = 444)	N/A	0.01 (0.11)	0.23 (0.09)	0.18 (0.08)	-0.20 (0.13)	0.06 (0.05)	0.06 (0.05)
2 AMA Support (<i>N</i> = 477)	0.24 (0.08)	0.25 (0.13)	0.27 (0.09)	0.32 (0.10)	0.38 (0.10)	0.29 (0.05)	0.30 (0.05)
3 AMA Opposition (<i>N</i> = 491)	-0.05 (0.09)	-0.09 (0.12)	-0.18 (0.11)	-0.29 (0.11)	0.11 (0.13)	-0.10 (0.05)	-0.11 (0.06)
4 All AMA Conditions (<i>N</i> = 1412)	0.12 (0.06)	0.04 (0.07)	0.11 (0.06)	0.06 (0.06)	0.09 (0.07)	N/A	N/A

Source: February 17-23, 2011 YouGov/Polimetrix survey. See text for details.

Notes: Cell entries are weighted means with standard errors in parentheses. Total *N* = 1412.

Complete question wording: “A variety of public policies have been proposed to help reduce the amount we spend on health care. Suppose you learned that a proposal was [Three AMA Treatment Conditions: NONE / supported by the American Medical Association / opposed by the American Medical Association] [IF AMA Treatment <> NONE AND Political Treatment <> NONE then “and”] [Five Political Treatment Conditions: NONE / supported by congressional Democrats but opposed by congressional Republicans / supported by congressional Republicans but opposed by congressional Democrats / supported by congressional Democrats and Republicans / supported by a bipartisan commission on deficit reduction]. Would this make you more or less likely to support the proposal?” Outcome measure ranges from -2 (“much less likely to support”) to +2 (“much more likely to support”).

Table 2 Results of AMA and Political Cues Experiment, by Respondent Party Identification (Survey Experiment 1)

	A	B	C	D	E	F	G
	No Political Cue	Democrats Support	Bipartisan Commission Supports	Both Parties Support	Republicans Support	All Political Conditions, with “No Political Cue”	All Political Conditions, without “No Political Cue”
Republicans	(<i>N</i> = 57)	(<i>N</i> = 87)	(<i>N</i> = 89)	(<i>N</i> = 83)	(<i>N</i> = 78)	(<i>N</i> = 394)	(<i>N</i> = 337)
1 No AMA Cue (<i>N</i> = 132)	N/A	-0.71 (0.20)	0.43 (0.18)	0.06 (0.17)	1.13 (0.17)	0.20 (0.11)	0.20 (0.11)
2 AMA Support (<i>N</i> = 134)	0.20 (0.18)	-0.58 (0.21)	0.24 (0.18)	0.44 (0.21)	0.83 (0.19)	0.24 (0.09)	0.25 (0.11)
3 AMA Opposition (<i>N</i> = 128)	-0.21 (0.15)	-0.71 (0.24)	-0.34 (0.22)	-0.36 (0.22)	0.87 (0.24)	-0.17 (0.11)	-0.16 (0.13)
4 All AMA Conditions (<i>N</i> = 394)	0.03 (0.12)	-0.67 (0.12)	0.14 (0.12)	0.07 (0.12)	0.95 (0.11)	N/A	N/A
Democrats	(<i>N</i> = 78)	(<i>N</i> = 105)	(<i>N</i> = 123)	(<i>N</i> = 106)	(<i>N</i> = 106)	(<i>N</i> = 518)	(<i>N</i> = 440)
1 No AMA Cue (<i>N</i> = 162)	N/A	0.85 (0.15)	0.29 (0.14)	0.38 (0.12)	-0.89 (0.14)	0.12 (0.08)	0.12 (0.08)
2 AMA Support (<i>N</i> = 182)	0.43 (0.13)	0.71 (0.18)	0.54 (0.15)	0.50 (0.15)	-0.15 (0.19)	0.41 (0.07)	0.41 (0.09)
3 AMA Opposition (<i>N</i> = 174)	0.20 (0.16)	0.59 (0.17)	-0.08 (0.17)	-0.22 (0.16)	-0.57 (0.24)	-0.01 (0.09)	-0.05 (0.10)
4 All AMA Conditions (<i>N</i> = 518)	0.35 (0.10)	0.71 (0.10)	0.25 (0.09)	0.22 (0.09)	-0.57 (0.11)	N/A	N/A
Independents	(<i>N</i> = 68)	(<i>N</i> = 107)	(<i>N</i> = 106)	(<i>N</i> = 105)	(<i>N</i> = 114)	(<i>N</i> = 500)	(<i>N</i> = 432)
1 No AMA Cue (<i>N</i> = 150)	N/A	-0.10 (0.14)	-0.05 (0.17)	0.01 (0.15)	-0.40 (0.19)	-0.13 (0.08)	-0.13 (0.08)
2 AMA Support (<i>N</i> = 161)	0.01 (0.11)	0.50 (0.21)	-0.01 (0.14)	0.07 (0.17)	0.51 (0.13)	0.19 (0.07)	0.24 (0.08)
3 AMA Opposition (<i>N</i> = 189)	-0.15 (0.15)	-0.42 (0.17)	-0.16 (0.18)	-0.30 (0.20)	0.25 (0.14)	-0.14 (0.08)	-0.14 (0.09)
4 All AMA Conditions (<i>N</i> = 500)	-0.06 (0.09)	-0.07 (0.10)	-0.07 (0.09)	-0.10 (0.10)	0.14 (0.09)	N/A	N/A

Source: February 17-23, 2011 YouGov/Polimetrix survey. See text for details.

Notes: Cell entries are weighted means with standard errors in parentheses. Total *N* = 1412. See Notes to Table 1 for question wording.

Table 3 Results of Group and Political Cues Experiment (Survey Experiment 2)

	A	B	C	D	E	F	G
	No Political Cue (<i>N</i> = 728)	Democrats Support (<i>N</i> = 739)	Bipartisan Commission Supports (<i>N</i> = 709)	Both Parties Support (<i>N</i> = 708)	Republicans Support (<i>N</i> = 674)	All Political Conditions, with “No Political Cue” (<i>N</i> = 3558)	All Political Conditions, without “No Political Cue” (<i>N</i> = 2830)
1 No Group Cue (<i>N</i> = 759)	38.60 (1.85)	44.04 (1.78)	47.11 (1.86)	46.37 (1.91)	43.36 (1.72)	43.70 (0.82)	45.10 (0.91)
2 Doctors Support (<i>N</i> = 362)	49.65 (3.69)	40.16 (2.88)	54.32 (3.41)	46.96 (3.08)	48.49 (2.19)	48.07 (1.39)	47.75 (1.49)
3 Doctors Oppose (<i>N</i> = 354)	44.35 (2.61)	43.67 (2.59)	36.04 (2.94)	41.11 (3.03)	48.05 (3.62)	42.70 (1.32)	42.08 (1.53)
4 Patient Adv. Groups Support (<i>N</i> = 317)	43.15 (2.64)	43.69 (2.68)	42.00 (2.58)	45.36 (2.99)	41.31 (3.23)	43.16 (1.25)	43.16 (1.42)
5 Patient Adv. Groups Oppose (<i>N</i> = 358)	44.60 (2.45)	51.19 (2.76)	37.23 (3.03)	44.79 (2.52)	40.61 (2.58)	43.74 (1.21)	43.50 (1.39)
6 Gov’t Admin. Support (<i>N</i> = 361)	39.68 (2.66)	47.00 (3.29)	44.18 (3.03)	42.25 (2.63)	37.40 (3.41)	42.41 (1.34)	43.20 (1.55)
7 Gov’t Admin. Oppose (<i>N</i> = 364)	42.90 (3.65)	50.79 (2.34)	43.98 (2.23)	44.98 (2.44)	52.47 (2.94)	46.98 (1.23)	47.92 (1.26)
8 Drug Comp. Support (<i>N</i> = 330)	47.86 (3.95)	42.97 (2.74)	42.66 (2.94)	40.21 (2.37)	39.49 (2.63)	42.51 (1.31)	41.39 (1.35)
9 Drug Comp. Oppose (<i>N</i> = 353)	35.80 (3.16)	47.96 (3.20)	51.01 (2.49)	46.35 (2.66)	40.91 (3.02)	45.26 (1.31)	46.99 (1.41)
10 All Group Conditions (<i>N</i> = 3558)	42.44 (0.94)	45.57 (0.88)	44.80 (0.90)	44.37 (0.86)	43.77 (0.90)	N/A	N/A

Source: November 9-22, 2011 YouGov/Polimetrix survey. See text for details.

Notes: Cell entries are weighted means with standard errors in parentheses. Total *N* = 3558.

Complete question wording: “A variety of public policies have been proposed to help reduce the amount we spend on health care. Some people have suggested that we allow the government and insurance companies to refuse payment for treatments or procedures if their effectiveness has not been demonstrated by rigorous scientific evidence. Suppose you learned that [10 Group Treatment Conditions: NONE / leading doctors support this policy / leading doctors oppose this policy / nationally recognized patient advocacy groups support this policy / nationally recognized patient advocacy groups oppose this policy / the high-level government administrators who run Medicare and Medicaid support this policy / the high-level government administrators who run Medicare and Medicaid oppose this policy / top drug companies support this policy / top drug companies oppose this policy] [IF Group Treatment <> NONE AND Political Treatment<> NONE then “and”] [Five Political Treatment Conditions: NONE / congressional Democrats support this policy but congressional Republicans oppose this policy / congressional Republicans support this policy but congressional Democrats oppose this policy / both congressional Democrats and Republicans support this policy / a bipartisan commission supports this policy]. What about you? Would you support this policy? (Selecting the midpoint of the scale would mean that you neither support nor oppose this policy.) Outcome measure ranges from 0 (“strongly oppose”) to 100 (“strongly support”).