

# Citizen Engagement (and Disengagement) in Response to Social Ills

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## **Abstract**

Some social ills do not gain broad awareness, whereas others gain a prominent place on the political agenda because, in part, they successfully engage the wider citizenry. In this paper, we investigate how the evidence used to describe social ills affects this level of engagement. Using disparities in access to affordable health care – a focal aspect of economic inequality in the United States – as our main issue, we conduct a series of survey and field experiments showing how some forms of evidence hinder engagement while other forms foster it. Our results challenge common arguments about political communication and political behavior, while also shedding new light on one of the most fundamental questions in the study of American democracy: What determines the scope of a political conflict?

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## Introduction

Our society faces countless social ills, such as people lacking health insurance, lacking jobs, and living in poverty. Although some of these ills may not gain broad awareness, others gain a prominent place on the political agenda because, in part, they become focal points of campaigns and civic movements, stir up media attention, and ultimately engage part of the wider citizenry (Baumgartner et al. 2009). Indeed, this speaks to what Schattschneider (1960) referred to as one of the most fundamental questions of democracy: the scope of the conflict. By that, he meant the degree to which political conflicts get expanded outside the policy-making community and come to involve a much broader set of interested parties.<sup>1</sup>

A key piece of conflict expansion often entails a willingness among the wider citizenry to devote scarce resources of attention, time, and/or money to efforts designed to reduce social ills. This could mean donating money to an organization directly working on the problem, volunteering time with a candidate that promises to place the problem at the top of the political agenda, or perhaps simply paying attention to relevant news and information that could inform future choices and conversations. In this paper we investigate when ordinary citizens are willing to spend such scarce resources, and how that depends upon the information they receive about a problem. Many people, we suggest, may find a given social ill to be both problematic and important, but their willingness to devote personal resources to addressing it will critically depend upon their conceptualization (for instance, what comes to mind when they think about people lacking affordable health care, lacking jobs, and so on).

Intuition might suggest that the key to engaging citizens on an issue is to communicate its maximal scope. Indeed, such rhetoric can very much affect people's perceptions about the importance of a problem (Pingree et al. 2013). While we agree that communicating the scope of a problem can increase its salience and perceived importance, such features do little to spur action relative to other forms of evidence people might receive. The reason stems

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<sup>1</sup>See Kollman 1998 for a discussion of outside lobbying and Rosenstone and Hansen 1993 and Verba et al. 1995 for thorough discussions of political participation more broadly.

from one of the core features of our argument: people are most likely to take action when they conceptualize an issue in terms of the concrete experiences of an individual affected by that ill. The problem with communicating information about the overall scope of a problem, such as the total number of people affected, is that it leads people to conceptualize the problem as affecting a nameless, faceless large group of people, which is unlikely to spur action.

Our key argument thus rests on the relationship between the evidence people receive that a social ill exists, how they conceptualize that issue in their heads, and finally whether they are willing to take action. Specifically, we track whether there are certain types of evidence that can communicate the scope of the problem without leading people to believe that the issue is too abstract for a solution. While there is a long line of research focusing on the effect of communication on the policy attitudes and priorities that people hold (Iyengar 1991, Chong and Druckman 2007), the overwhelming amount of that work does not address the link to action that is critical in our investigation.

We proceed in four steps. First, we leverage research from behavioral decision theory to consider the link between evidence for a social ill, how people conceptualize that problem in their own heads, and when they are motivated to act. Second, we analyze how the media coverage of the focal issue in our studies (disparities in access to affordable health care) helps perpetuate people's inability to conceptualize it in a concrete way. Then, we present the results of three field experiments that test our main predictions. Lastly, we use a survey experiment to help provide more evidence of our proposed mechanism.

## **Theory**

Political communication about any topic, but especially a social problem, often relies on the presentation of some type of evidence about the nature of that problem. Indeed, as issues garner more and more news coverage, journalists must increasingly diversify the types of evidence they provide with each new story (Boydston 2013). In turn, the evidence used can

form a frame for a given news story.

Providing an exhaustive categorization of the different types of frames present in news coverage would be extraordinarily difficult. Instead, given our focus on social ills, existing literature suggests two important categories of frames: *thematic* frames and *episodic* frames (Scheufele 1999). Thematic frames focus on the broader context of the issue, often by providing numerical and statistical evidence (Iyengar 1991; Gross 2008). In contrast, episodic frames offer case-studies or descriptions of very specific instances of the problem – the type of evidence that people may often term to be “anecdotal” (Iyengar 1991; Gross 2008). Focusing on the issue of poverty, for example, Iyengar (1991:22) describes thematic evidence as “information bearing on general trends (e.g. the poverty rate, the number of states experiencing significant increases in hunger)” and episodic evidence as stories “covered in terms of personal experience – a particular instance of an individual or a family living under economic duress.”

Existing research suggests that these two approaches to conveying evidence about a social problem should have distinct consequences. In his foundational study of thematic and episodic frames, Iyengar (1991) argues that thematic frames are much more likely to lead people to form broader attributions of responsibility for the problem than episodic frames. So, for example, thematic news coverage of poverty would increase the likelihood that people believe that society as a whole is to blame for the fact that others live under such economic duress, whereas episodic framing would encourage viewers to blame the individual. More recently, however, scholars have argued that episodic framing may be somewhat more persuasive than Iyengar (1991) suggested. Although thematic frames lead to broader attributions of blame, under certain conditions episodic frames can lead people to form more emotional responses (Gross 2008) and can be more influential when people are already more emotionally involved with an issue (Aaroe 2011).

Although these distinctions between frames are important, they tell us little about the relationship between the type of evidence and the eventual behavioral response. Much of the work on thematic and episodic framing focuses on the way people attribute responsibility

for social problems and the differences in the potential persuasiveness of the two frames. One can speculate that attributing blame more broadly is more likely to lead people to take political action on the topic, but there is little systematic evidence to suggest that this will necessarily be the case.

Stepping back, we do not dispute that the thematic and episodic distinction is a useful categorization of frames. Rather, we argue that the ability of a thematic frame to produce broader attributions of blame for a social ill need not correspond with its ability to spur people to act in ways that would help solve that problem. Some thematic frames do, but that depends upon how they lead individuals to conceptualize the problem.

### **Evidence and Conceptualization**

When people are exposed to evidence about a social ill, such as some people not being able to afford needed health care, they use the information to form conceptualizations of the issue at hand (Peterson and Aaroe 2013; Small et al 2007; Slovic 2007). These conceptualizations are, essentially, the images people form in their heads to represent a given problem – in other words, quite simply, what comes to mind when people think about that problem. Research suggests that when people receive evidence that political scientists would categorize as episodic – stories of a particular person or family dealing with a particular issue – they form individual conceptualizations (Slovic 2007). In other words, since the information focuses on a particular person or small group of people, people who receive such evidence also come to think about the problem in terms of actual people facing it.<sup>2</sup>

The relationship between thematic frames and conceptualizations of the problem, however, is more conditional. A key component of a thematic frame is statistical evidence (Iyengar 1991, Gross 2008, Aaroe 2011), and such evidence can be presented in raw numbers or it can be presented as a percentage (i.e. the likelihood that someone faces a given problem). A discussion about people who are below the poverty line, for example, can offer evidence like “45.3 million Americans live below the poverty line” or it can offer evidence

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<sup>2</sup>Note that we are assuming here, as in our empirical studies, a sympathetic portrayal. So, receiving episodic information does not lead people to argue against the person’s or family’s troubles.

that “14.5% of Americans currently live below the poverty line”.<sup>3</sup> If the denominator is clear (in this case, the total American population), then both types of evidence offer the same objective information, and both would certainly be considered thematic. Although the distinction between offering the raw number or offering the percentage may seem – at most – stylistic, research on social judgment suggests that this particular difference in evidence can have important consequences.

Slovic (2007) demonstrates that statistical information about a social ill presented in terms of raw numbers (i.e. the total number of people facing a problem) leads people to conceptualize the problem in terms of a large group of people. Indeed, these conceptualizations may be quite abstract because they do not lead to a particular focus on any given person, but rather lead people to visualize a crowd. Such visualizations, moreover, can induce “psychic numbing” – the idea that people are less likely to view human suffering as important as the number of those suffering increases (Slovic 2007). In other words, while reporting the number of those struggling may give people a sense of the issue’s wide scope, it may also numb them to the human impact of that struggle.

Communication that conveys evidence in terms of percentages – that is, the proportion of a set of people that are facing some ill – leads to a different type of outcome. Unlike raw numbers, percentages lead to conceptualizations that are quite similar to those produced by episodic evidence – that is, in terms of a single person or a very small group of (identifiable) individuals (Slovic et al. 2000; Slovic 2007, Fetherstonhaugh et al 1997). When people receive evidence in this form, they tend to neglect the denominator implicit in the percentage and instead focus on the relationship between the percentage itself and the upper and lower bounds of the scale (Fetherstonhaugh et al 1997; Slovic et al. 2000). This leads them to process the percentage by focusing on the chance that a single individual is more or less likely to be struggling with a particular issue (Slovic et al. 2000).

These arguments about episodic evidence, thematic evidence in terms of raw numbers, and thematic evidence in terms of percentages motivates our first set of predictions:

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<sup>3</sup>Source: US Census, Income and Poverty in the United States, 2013, Current Population Report, pg 12.

*Prediction 1a: Evidence about a social ill conveyed using percentages or episodic evidence leads people to conceptualize the problem in terms of an individual or a small group of (identifiable) individuals.*

*Prediction 1b: Evidence conveyed using raw numbers leads people to conceptualize the problem in terms of a large group of people.*

## **Conceptualization and Political Action**

How people conceptualize a problem in their heads can matter politically because it affects whether people will devote scarce resources of attention, time, and/or money to action that is designed to help redress it. When people conceptualize a problem in terms of an individual or small group facing it, they come to view it in more concrete and affect-driven ways. This kind of conceptualization, in turn, leads to a relatively high likelihood of taking action. In contrast, when people conceptualize issues in terms of large groups or masses of people, taking action (at least as an individual) is more likely to appear futile. “Numerical representations of human lives do not necessarily convey the importance of those lives,” writes Slovic (2007:86), noting that as a result people lack the necessary motivation to take action. In this case, the likelihood of taking action is much lower.

We can map these differences onto the different types of evidence for social ills discussed earlier. Raw numerical evidence, by referring to the thousands or millions of people affected by a problem, can be self-undermining (Levine 2015). Although it communicates the scope of the problem in ways that often heighten concern about it (Pingree et al. 2013), it also brings to mind considerations that undermine one other purpose it is trying to achieve: to convince people to act. In contrast, episodic evidence should lead to a relatively high likelihood of action, given that it produces individualized conceptualizations of the problem.

Percentage evidence leads people to conceptualize issues in individual terms, which may initially suggest that it would have a high likelihood of leading to action as compared with evidence conveyed in raw numbers. The connection between percentages and action, however, may hinge on the actual percentage. As noted earlier, the reason percentages lead to individualized conceptualizations of a problem is because people tend to ignore the denomi-

nator and focus on the upper and lower ends of the percentage scale. When the percentage is high, people come to believe that the problem is very likely to occur. When combined with an individual conceptualization of the problem that percentage evidence produces, the result is an overall conceptualization of the problem in terms of an individual that is highly likely to be facing a social ill, which motivates people to take action (Slovic et al. 2000).

The process, however, may work differently when the percentage is low. In these cases, even if people conceptualize an individual, ignoring the denominator may lead people to underestimate the scope of the problem. Applying the percentage to the individual may lead people to believe that any given person is highly unlikely to be experiencing the issue, which produces very little urgency to take action (Slovic et al, 2000; Fetherstonhaugh et al 1997).

This relationship between evidence, conceptualization, and action motivates our second set of predictions:

*Prediction 2a: Episodic evidence and high percentage evidence are both expected to have a relatively high likelihood of action.*

*Prediction 2b: Evidence conveyed using raw numbers will have a relatively low likelihood of action.*

Table 1: Predictions

Type of Evidence	Conceptualization	Rate of Action
Episodic	Individual	High
Raw Numbers	Large Group	Low
High Percentage	Individual	High
Low Percentage	Individual	Low

Table 1 contains a summary of our predictions. Before we present our empirical analyses, it is worth underscoring an important distinction between our predictions and past work on episodic and thematic frames. While we started our theoretical discussion with that distinction (like much past work), we argue that explaining people’s willingness to act requires going beyond that distinction. Some forms of thematic evidence (e.g. raw numbers and evidence with low percentages) might not spur much action, but other forms of thematic

evidence might be highly mobilizing.

## **Empirical Analyses: Political Action**

Our theoretical arguments can apply to a variety of social ills, but in this manuscript we focus on one aspect of economic inequality. Inequality has received a good deal of media coverage and has been a focal part of the broader political conversation in the United States. There is substantial evidence that, using a variety of different income and wealth measurements, the lived experiences of those in the middle and lower reaches of the income distribution have become increasingly unlike those at the very top (Piketty and Saez 2003, with updated data to 2014). A key part of that divergence, beyond just objective income and wealth, is also the fact that lower and middle-income Americans are now far more likely to be experiencing diminished job security, lower access to affordable health care, and heightened retirement insecurity (Hacker 2006, Kalleberg 2012, Levine 2015). While we could focus on any of these disparities for our empirical analysis, in this paper we've chosen to focus on disparities in access to affordable health care.

Our empirical case proceeds as follows. First, we use a content analysis of newspaper coverage to verify that the various forms of evidence in our theoretical argument actually appear in discussions of the issue. Then we use a series of field experiments to track the relationship between evidence and political behavior. Finally, we rely on a survey experiment to consider the link between evidence and conceptualization of issues. This final study is the bridge that connects our field studies and our theoretical arguments by providing evidence in support of a key aspect of our mechanism: the conceptualizations of issues that people hold.

### **Content Analysis: Evidence in the News**

Before we analyze the relationship between evidence, conceptualizations, and political behavior we first consider the extent to which the different types of evidence we discuss in

our predictions are represented in media coverage of health care disparities. There are two benefits to this initial step. First, we can ensure that our studies mirror the types of information people are likely to receive in their day-to-day lives. Second, considering the relative proportions of different types of evidence will allow us to make broader arguments about the implications of our studies.

We track the variance in evidence using a content analysis. The content analysis focuses on articles published in 2009 in the *New York Times* and *Washington Post*.<sup>4</sup> We chose 2009 so that our analysis would overlap with the time period when most of the debate over health care reform took place, which provided a larger starting pool of stories dealing with health care disparities.

Our sample of articles was collected using the following two-step approach: first, a search using the terms “uninsured patients” or “underinsured patients” produced an initial pool.<sup>5</sup> Articles in this pool were then manually-coded for mentions of health care insecurity. This process produced a sample of 270 articles that were then coded for the type of evidence presented: evidence in terms of the percentage of people facing a problem, evidence in terms of the number of people facing a problem, and evidence presented in terms of a specific individual or small set of individuals (like a family) facing a problem.<sup>6</sup> Our coding process did allow for multiple codes per article, meaning that if a story presented both a description of a particular person’s struggle and the percentage likelihood that a prototypical person is facing some form of health care insecurity, then this story would receive two codes.<sup>7</sup>

We find that, by a wide margin, raw numbers comprise the modal type of evidence in coverage of health care insecurity (see Figure 1). While 49.6% of all articles coded across both newspapers included raw numbers, 15.2% included percentages and 17.8% included evidence in episodic form. When we consider the two newspapers separately, we see largely similar patterns. In sum, an overwhelming amount of evidence individuals received about

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<sup>4</sup>See Levendusky (2011) for a discussion of *The New York Times* as a representative of all mainstream media.

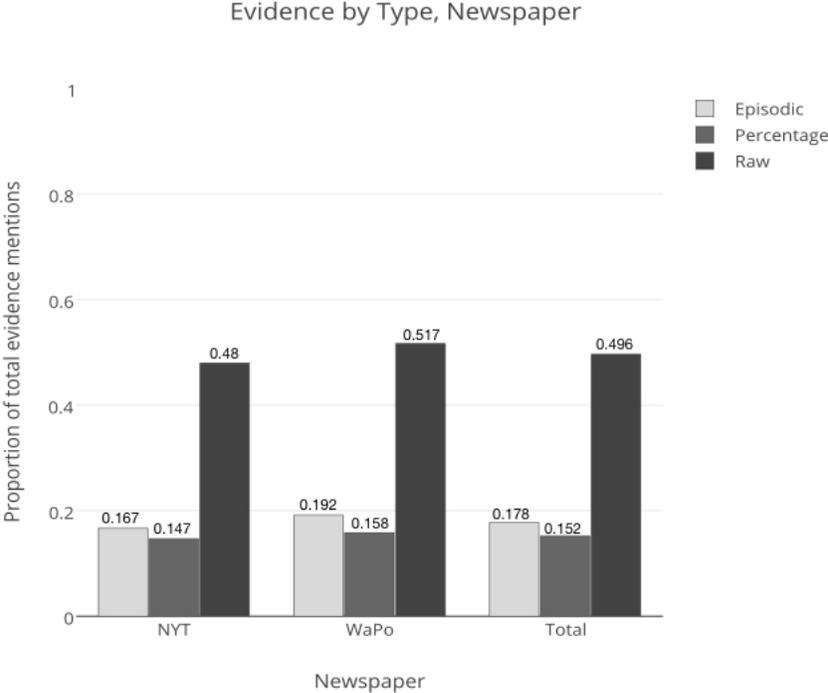
<sup>5</sup>The sample was collected by the search terms “uninsured patients” and “underinsured patients” in Lexis Nexis. These search terms were derived after several pre-tests.

<sup>6</sup>The coding was done by a third party who was unaware of the specific hypotheses being tested or the broader purpose of coding these articles. We did not distinguish between high versus low percentage evidence here.

<sup>7</sup>Note, this approach is different than the coding approach used by Iyengar (1991) who allows newspaper articles to take only one code as Iyengar “classified on the dominant frame” (18).

health care insecurity during this time relied on raw numbers, though all three types of evidence appeared in a nontrivial percentage of articles.

Figure 1: Variance in Evidence on Health Care Insecurity, 2009



### Field Experiments

Keeping in mind the variation observed in the content analysis, we next turn to our analyses of political action. To analyze the relationship between evidence and behavior, we rely a series of field experiments. These studies provide naturalistic settings in which people can take meaningful political action, and are thus highly useful for testing our proposed relationships between evidence and action. At the same time, they are less useful for probing the link between evidence and conceptualizations that underlies the behavioral predictions. For that, we turn in a later section to a survey experiment.

Here we present the results of three field experiments. One is a direct mail study canvassing for new donors to an organization that allows us to compare the effects of episodic and high percentage evidence. The second and third are email studies to existing members

of the same organization, in which one compares high percentage evidence to raw numerical evidence and another one compares low percentage evidence to raw numerical evidence. While one may wish to compare all types of evidence at the same time, resource constraints in each of the field experiments (due in large part to attributes of our partner organization in addition to our own personal resource constraints) did not allow it.

To conduct our experiments we partnered with the Ithaca Health Alliance (IHA), a 501(c)3 organization based in Ithaca, NY that serves the residents of Tompkins County, NY. IHA focuses on access to health care and has three major components: it funds a free health clinic, provides small grants for health services, and develops and hosts free education programs for the community (related to current events that affect their health, as well as new research related to healthy living).

It is worth underscoring that, due to its tax designation, IHA is not a political organization like an election campaign or political action committee. It does engage in voter education programs that are allowed within its 501(c)3 status, but it does not engage in any lobbying nor does it endorse candidates for office. Thus, although we cannot be certain that our results would generalize to overly partisan groups, we do know that 501(c)3's are a widespread type of organization for issue entrepreneurs who wish to identify and redress social ills. In addition, we have some reason to believe that any findings we obtain in these studies would be reasonably generalizable given that the kind of rhetoric that IHA uses to describe social ills is very similar to what other organizations use and what appears in political news (and, moreover, our treatments are designed to be similar to previous work on thematic and episodic framing within political science, such as Iyengar (1991), Gross (2008), and Aaroe (2011)).

Collectively, our three field experiments will focus on the kinds of actions that IHA most often requests: to donate money to help fund its operations (via direct mail and other donation solicitations), and to become informed about current events related to the organization (through its email mailing list). IHA does request volunteers, but the overall number of volunteers is low and thus the likelihood that we would observe meaningful variation in

that outcome measure across treatment groups is low. Thus, while we acknowledge that volunteering time is a critical way in which people take action in response to problems they want to address, especially during electoral campaigns (Enos and Hersh 2015), we do not use volunteering as an outcome measures in this paper.

### **Direct-Mail Study**

In cooperation with IHA we first designed a direct mail experiment in March 2015 that consisted of a single donation request sent to a set of likely new donors drawn from registered voters in three geographically proximate towns. Each mailing consisted of a single-sided solicitation letter signed by the organization’s Executive Director and Board President, along with a self-addressed envelope with a donation pledge card.

Recipients were randomly assigned to receive one of three solicitation letters. Our control group received a letter that was very similar to IHA’s standard solicitation letter for potential new donors. It introduced the organization to readers and discussed its general goals.

The other two experimental groups received letters that included additional language inserted in the middle, providing specific evidence regarding health care disparities that the organization is working to address. The language focused on the uninsured. Our first treatment group (the percentage evidence group) received information stating that “57% [of uninsured working-age adults] reported a cost-related barrier to getting the care they need” and then describing some of the possible barriers in more detail. While we do not expect a stark cut-off between what counts as “high” for the purpose of our theoretical expectations, we expected that a percentage greater than 50% would likely lead to an individual conceptualization that included someone affected by the ill rather than not. We present evidence in support of this assumption in the survey experiment described later in the paper.

Our second treatment group (the episodic evidence group) received similar information about the uninsured experiencing cost-related barriers to getting health care they need, though here the evidence focused on the situation of one uninsured individual that was facing this situation. The person described was based on a real-life client of IHA, and the

language we used to describe her situation was as close as possible to the statistics that we cited in the other treatment group.<sup>8</sup> The exact text of all three solicitation letters appears in the appendix.

Before presenting the results, a few caveats about our direct mail study are in order. First, it was only designed to compare the behavioral implications of episodic and (high) percentage evidence. In our e-mail studies described later, we will incorporate a solicitation that includes evidence presented in raw numbers. Second, we decided to include a control group even though all of our predictions are about the effect of one kind of evidence relative to another. We acknowledge that our control group does not actually include any issue evidence (beyond two somewhat vague sentences at the beginning). We decided to include this group because it mirrored a standard mailing that IHA had used in the past, though at the same time comparisons between it and our two treatment groups are hard to interpret. This is because the other two groups necessarily vary two things at once: the provision of evidence in the first place and, also, the provision of it in particular way (i.e. using either episodic or percentage evidence). Assuming that our evidence is viewed as credible, we should observe that both treatment groups lead to an increase in donations relative to the control group. While we will certainly test for that, from a theoretical perspective we are most interested in comparing the behavioral implications of episodic and thematic evidence with each other.

In total, we mailed donation solicitations to 7,998 registered voters. Following Miller and Krosnick (2004) and Levine (2015) we directed our mailings toward a set of people that, based on the organization's previous experience, had the highest likelihood of responding to cold donation solicitations. Specifically, we targeted females who were not current donors and were not registered as Republicans. Also following the organization's previous experience, we closed data collection eight weeks after the letters were mailed, at which point responses to our mailing had stopped anyway. Approximately 3.3% (N=267) of our solicitations were returned as undeliverable, leaving us with a sample of 7,731 that were evenly divided across

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<sup>8</sup>In addition to IHA's clientele, this treatment was also developed based on advertising in New York state that featured a single mother. In our treatment she is deliberately described as a widow to ensure that there are no confounding effects.

the three experimental groups.

We present the results in Table 2. We consider our results in several ways: the range of donations, the number of people entering the donor pool, and the average size of the donation. As a first step, we simply look at the range of the donations. We see that across all three conditions the range of donations is similar, with the exception of one larger donation in the condition that received a mailer with percentage evidence.

As a next step, we estimate a model to compare the number of donations across the three groups. The results in Table 2 (Row 2) are based on a test of proportions between the control group and each of the two treatment groups. Here we see that both the mailer with episodic evidence and the mailer with percentage evidence produced significantly more donations than IHA’s traditional solicitation mailer. However, we see no differences in the number of donations between the two types of mailers with evidence ( $z = 0.33, p = 0.74$ ), which is consistent with our predictions in Table 1. Since not all conditions yielded more than 10 donations, we were concerned that an approximating assumption of normality for the proportion of donations in each condition would lead to inaccurate assessments of our treatment effects. While an exact test was not possible in our case, we did verify that the results from Table 2 hold using randomization inference.<sup>9</sup>

As a final comparison we also consider the average donation in each group. Again, the results show that both mailers with evidence led to significantly more donations than the IHA existing solicitation mailer (Table 2, Row 3). Consistent with Table 1, we also do not have evidence that the two treatments led to different average donation levels ( $t = 1.29, p = 0.20$ ) and again all results are robust to using randomization inference.<sup>10</sup> In sum, our results suggest that the mailer with episodic evidence and the mailer with (high) percentage evidence lead to similar donation outcomes (both of which are much higher than a baseline letter).

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<sup>9</sup>Randomization inference allows us to generate a p-value for evidence against the null of no treatment effect nonparametrically, by resampling treatment assignments under the assumption that all treatment effects are identically zero (Gerber and Green 2012). Under randomization inference, the conservative Rosenbaum (2002) two-sided p-value was approximately 0.02 for the episodic to control comparison, approximately 0.01 for the percentage to control comparison, and approximately 0.63 for the comparison of the two treatment groups. Thus, all of our conclusions from the test of proportions in Table 2 continue to hold.

<sup>10</sup>Randomization inference generates p-values as follows: 0.05 for the episodic to control comparison, approximately 0.05 for the percentage to control comparison, and approximately 0.22 for the comparison of the two treatment groups.

Table 2: Patterns in Engagement (Direct Mail Study)

		Control (IHA Basic Mailer)	Episodic Evidence	Percentage Evidence
(1)	Range of Donation	\$0.00 to \$100	\$0.00 to \$100	\$0.00 to \$100 + one \$250 donation
(2)	Number of Donations	5	19 $z = 2.86, p = 0.004$	17 $z = 2.56, p = 0.01$
(3)	Average Donation	\$0.07	\$0.057 $t = 2.06, p = 0.04$	\$0.45 <sup>a</sup> $t = 2.02, p = 0.05$

All significance calculations are two-tailed.

All comparisons are to the IHA basic mailer group.

<sup>a</sup> Without the outlier donation the average donation in this group is \$0.43

### E-Mail Studies

In order to compare the effects of percentage-based evidence with raw numbers, we conducted two studies over email. Subjects in our two email experiments were members of the Ithaca Health Alliance’s existing electronic mailing list, all of whom had proactively joined the list in order to hear about recent news related to the organization and/or receive updates about health care and public health-related topics. The mailing list had 1,017 people at the time of our first email experiment.

The content of our emails drew upon findings from a survey with a nationally-representative sample of uninsured adults ages 18 to 64 that the Robert Wood Johnson Foundation (RWJF) conducted in May 2015. A focal aspect of this survey concerned the reasons why the uninsured do not have insurance as well as what they do when they need medical care. Two key findings stood out. One was that the large majority of the uninsured (79%) reported not having insurance because they did not believe they could afford it (as opposed to not thinking it was important, or some other reason). A second is that approximately one-quarter (26%) reported skipping care even when it was needed. Both of these findings were highlighted when the results from this survey were released, and thus they provided reasonable starting points for our emails.

In both of these experiments our key treatment is the subject line of the email. In our first experiment we randomly assigned members of IHA’s mailing list to receive an email with a subject line that mentioned the 79% figure or a subject line that mentioned the numerically

equivalent raw number (22.8 million uninsured).<sup>11</sup> The body of the email was the same in both cases – only the subject lines differed between groups (see the full text of the email body in the appendix). In our second experiment, we randomly assigned people to receive either a subject line that contained the relatively-low 26% figure or an equivalent raw number (7.5 million uninsured).<sup>12</sup> Again, the body of the email was the same for both groups.

The subject lines for the emails read as follows:

Email Study 1:

Please help! 22.8 million uninsured still can't afford insurance

Please help! 79% of the uninsured still can't afford insurance

Email Study 2:

Please help! 7.5 million uninsured skip needed care

Please help! 26% of the uninsured skip needed care

We sent the two emails within two weeks of each other, one at the end of July 2015 and one at the beginning of August 2015. The first one was sent to all 1,017 respondents on the mailing list, of which 6 emails bounced back and are thus not included in our final results. The second was then sent to 1,011 remaining respondents, and this time there were another 6 emails that bounced back. During the short time period between the two emails the topic of health insurance was not at the top of the political agenda (either nationally, or locally in Tompkins County NY), and thus we have no reason to believe that any such broad contextual factors would be affecting our results in a measurable way.<sup>13</sup> Indeed, the fact that this RWJF study was not receiving very wide press was one of the primary motivations for why IHA was interested in communicating with its members about the findings in the first place.

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<sup>11</sup>This was based on 11.9% of adult Americans being uninsured as of spring 2015 (<http://www.gallup.com/poll/182348/uninsured-rate-dips-first-quarter.aspx>), and the adult population estimated at 242,753,600 in 2013 (<http://quickfacts.census.gov/qfd/states/00000.html>). Based on these figures, we estimated the total uninsured adult population as approximately 28.9 million Americans. 79% of that group is 22.8 million people.

<sup>12</sup>Expecting that, at most, no more than 20% of respondents would likely pay enough attention to our emails to even consider opening them, we were conservative with our a priori power analysis and wanted to ensure that our total sample size was sufficiently large to detect very small differences (assuming, at the very least,  $\alpha = 0.9$  and power=0.9). Even for a difference between two means, this meant that we would need a total sample size of  $N=858$ . For this reason, we decided to conduct two separate email studies rather than do one study at the same time with four experimental groups.

<sup>13</sup>We randomized subjects separately for the first and second emails, in order to avoid contextual effects. Even still, we also tested for interactive effects in the results of our second email study – that is, whether people's responses were a function of the email they received in the first study – and found no evidence for this.

Given that our primary manipulation is the subject line of the email, we focus on the act of opening the email as our main outcome measure. We acknowledge that open rates are imperfect measures of the objective number of recipients that viewed our emails, as email programs differ in how they record whether the recipient has actually read the email. Nevertheless, open rates are an extremely common and useful metric when they are used in a situation like ours: having two groups in which recipients are randomly assigned to receive different subject lines and the purpose is to test whether one subject line leads to higher engagement with the email than the other one.<sup>14</sup>

We also acknowledge that simply opening an email may not seem like much in the way of citizen engagement in response to a social ill. Nevertheless, at a fundamental level it does indicate a respondent's willingness to spend scarce resources of time and/or cognitive resources focusing on the content of the email and not paying attention to other matters. It is quite reasonable to believe that the content of the email body might inform later thoughts and conversations about the topic (not to mention responses to subsequent donation or volunteer requests). Learning about the problem, such as by reading an email, is arguably a critical first step.

While the body of our emails did include a link to the RWJF study, the content was designed to be self-contained. Thus, the links were presented in terms of "if you want more information" rather than stating that respondents would need to click in order to get the main point (moreover, the emails did not contain any other fundraising or volunteer appeal that encouraged clicking). It's not surprising, therefore, that very few of our respondents (approximately 1%) actually clicked on a link in any of the emails.

Table 3 displays the mean differences in open rates for both experiments. In both cases we see a statistically significant difference in open rates between those who received subject lines with raw numerical evidence versus those who received percentage evidence. Yet, the direction of this effect is reversed across the two experiments. Those who received information

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<sup>14</sup>Email marketing firms themselves will often present a lengthy discussion about the potential pitfalls of interpreting open rates. At the same time, experimental testing of subject lines is typically cited as one of the most beneficial uses of open rates. For example, see this post by the CEO of Comm100: <http://emailmarketing.comm100.com/email-marketing-tutorial/email-open-rate.aspx>

that a high percentage of the uninsured could not afford insurance were 4.0 percentage points *more* likely to open the email than those who received numerically-equivalent information in terms of the raw number of uninsured people (or, put differently, 96 recipients opened the email with a high percentage subject line versus 77 otherwise). In contrast, subjects who received a subject line telling them that a low percentage of the uninsured skipped needed care were 3.4 percentage points *less* likely to open the email than those who received a subject line that focused on the raw numerical equivalent (or, put differently, 62 recipients versus 78). These results are consistent with the predictions in Table 1.

Table 3: Patterns in Engagement (Email Studies)

		Open Rate	N
Email Study 1	Stats-N	15.1%	n=510
	High % Evidence	19.1%	n=504
	Difference (S.E.)	<b>4.0</b> <b>(2.3)</b>	
	two-sided p-value	<b>0.09</b>	
Email Study 2	Stats-N	15.6%	n=499
	Low % Evidence	12.2%	n=508
	Difference (S.E.)	<b>-3.4</b> <b>(2.1)</b>	
	two-sided p-value	<b>0.10</b>	

## Survey Experiment: Evidence and Conceptualization

Taken together, the three field experiments provide a set of evidence broadly consistent with our expectations. People who received the episodic evidence and high percentage evidence were about equally likely to act. People who received the high percentage evidence were more likely to act than those who received the raw numerical evidence. Those who received the low percentage evidence were less likely to act still. Our final step is to investigate the underlying mechanism that we propose is driving these outcomes: conceptualization of the issue. To do so we turn to a survey experiment that is designed to directly measure what comes to mind when people receive different forms of evidence, rather than the behaviors that they ultimately do or do not engage in.

In this survey experiment we randomly assigned participants to receive short descriptions of health care disparities that closely mirrored our direct mail study, though were designed for a non-local audience (i.e. did not mention Tompkins County NY or IHA). Subjects received one of four short passages. One group received information containing episodic evidence that mentioned the same 35 year-old widow as in the direct mail solicitation. A second group received high percentage evidence that also mirrored the direct mail study: the fact that 57% of uninsured adults face a cost-related barrier to receiving affordable health care. A third group received evidence that referred to the equivalent raw figure: 29.5 million adults who were uninsured facing this kind of health care insecurity.

We also included a fourth group as a check on our (email) results. One might argue that our percentage and raw number treatments from the email studies were not really equivalent because we did not explicitly offer people the denominator – the total number of uninsured people. It could be that perhaps our raw numerical evidence would have led people to conceptualize an individual if only we had provided a denominator that contextualized the 29.5 million figure. To address this potential alternative explanation we included a fourth group in our survey experiment in which subjects received two sets of raw numbers: the 29.5 million people who face cost-related barriers to healthcare and the 51.8 million total uninsured. Indeed, in this treatment participants were even informed that the 29.5 million is “out of a total of 51.8 million.”

Other than these differences in evidence, our treatments contained the same information and were designed to be as equivalent as possible. And all treatments cited a source for the evidence presented (with the exception of the treatment with episodic evidence). The full text of the treatments appears in the appendix.

Note that, as with the email studies, in this study we do not include a specific control group. It would be nearly impossible to construct an equivalent treatment that offers no evidence of any kind (and, even if we did, any treatment would be manipulating two things at once – the presentation of evidence in the first place and then also the presentation of that evidence in a particular way – which could make interpretation of any treatment effects

difficult). Alternatively, were we to include a treatment that presented some vague information such as “millions” or “large percentage,” participants would be likely to apply their own considerations and biases in order to interpret this vague information. This application of individuals’ own biases would produce many more confounds (Dafoe et al. 2015), making its value as a baseline questionable.

The participants in this study (N=463) were recruited using Amazon’s Mechanical Turk (MTurk) during April 2015. Although there have been some questions about the validity of studies using MTurk participants (especially when experiments feature commonly-used treatments; see Krupnikov and Levine 2014), research also suggests that in many cases MTurk samples lead to similar results as national samples (Mullinix et al. 2015). Generally, the existing research on this mode of recruitment suggests that the validity of MTurk is dependent on the content of the study (Krupnikov and Levine 2014; Berinsky et al. 2012). Given the characteristics of the MTurk population (Huff and Tingley, forthcoming), and the fact that our treatments were reasonably short and (as far as we know) uncommon, we see no evidence that this subject pool would be problematic for the study at hand.

Our primary goal in this survey experiment is to consider the way individuals conceptualize issues given the evidence offered. Since it would be difficult to track revealed preferences for political action in an online experiment, here we simply inquired about what comes to mind when people are exposed to evidence about health care disparities. Our key outcome measure was the following: “When you think about cost-related concerns to obtaining needed health care, which of the following comes to mind?” We offer our participants four response options: (1) An individual who cannot afford health care, (2) A large group of people who cannot afford health care, (3) Both, and (4) Neither.

We calculated the percentage of respondents in each category who selected the first category: “An individual who cannot afford health care.” Relative to the others, this category unambiguously refers to the types of conceptualizations that leave people with the highest likelihood of taking political action. Of course, people who report that *both* individuals and groups of individuals come to mind may have also conceptualized the problem in individual

terms, but in that case we cannot be certain of people’s precise conceptualizations and the interplay between the individual and group. Focusing on the first category provides the cleanest possible comparison.

We find that among people who received episodic evidence 26.3% reported that a single individual comes to mind when they think about health care and cost concerns. Those who received percentage evidence responded in a strikingly similar manner: 26.7% report that a single individual comes to mind. In contrast, among people who received raw numbers, only 17.9% selected this category. Importantly, it does not matter if people also received a denominator in order to contextualize this information. Among those randomly assigned to receive evidence as a raw number with a denominator only 15.5% reported that a single individual comes to mind.<sup>15</sup> Overall, then, this comparison provides a reasonable look at how the evidence that people receive about a problem affects the thoughts that come to mind when people think about the problem.

## Conclusion

Taken as a whole, our findings shed new light on when the wider citizenry is likely to become active in response to a social ill. We have argued that the key to answering this question lies in the kinds of conceptualizations that people form about the issue. In the case of disparities in access to affordable health care, the key question is whether evidence about the problem brings to mind a sympathetic individual who is facing such problems or whether it brings to mind a more “faceless” large group of people. Such conceptualizations are consequential because they can powerfully affect whether people are willing to spend scarce resources helping to solve the problem.

The pattern of behavior in the field experiments is especially interesting in light of our content analysis. Recall that the major finding of the content analysis was that the raw numerical evidence was much more likely to be present during much of the debate over

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<sup>15</sup>Differences between episodic/percentage and raw/raw denominator are significant at  $p < 0.05$ ; other differences are far from conventional levels of statistical significance.

health care reform. While it is perhaps not surprising that topical experts might wish to focus on the scope of the problem, the more that readers (who might be in a position to help) hear such evidence the more likely it is that they will conceptualize the issue in a way that is not particularly motivating.

We are not the first to link news coverage and conceptualizations in this way. In his book on political language, Edelman (1977) notes how much news coverage about social ills is divorced from the lived experiences of the people facing such ills, which makes it difficult to foster engagement and political action. A prominent example would be unemployment, as news coverage about this very severe form of job insecurity often focuses on the rate itself rather than the experience of losing one's job and having to look for a new one (all the while potentially losing one's health insurance and experiencing other forms of psychological distress). Our results underpin Edelman's central concern about both the lack of episodic rhetoric as well as what happens when people receive low percentage evidence (as the unemployment rate, even if relatively high, is almost always a low percentage of those in the labor force).

Lastly, from the perspective of organizations that are trying to expand their membership (i.e. expand the scope of whatever conflicts they work on), one possible way to interpret our results is to argue that one should always just use episodic information. This approach is often infeasible, however. Campaigns and civic movements are battling for scarce attention and presenting a sympathetic portrayal of an individual facing a problem can take up more space than they have to work with. While we purposefully kept our episodic evidence as close as possible to the other forms for the purpose of experimental control, episodic evidence typically takes more room (and, certainly, rarely fits into an email subject line). Thus, our main takeaway for campaigns and civic movements is that they should be seeking rhetoric that leads to individual conceptualizations. High percentage evidence, which can often be described relatively quickly, should be sufficient to achieve that goal.

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# Supplementary Information

## Direct Mail Study: Example of Mailing

Figure 2: Solicitation Mailing as It Appeared to Recipients



February 28, 2015

Dear Community Member,

Did you know that thousands of local residents cannot afford to see a doctor for routine visits or even urgent health problems? Did you know that such challenges remain, even with the Affordable Care Act? That's why it's critical that many of our friends and neighbors can depend upon the Ithaca Health Alliance.

Disparities in access to affordable health care are wide. Some people have insurance with low out-of-pocket costs. They don't think twice about seeing a doctor. Yet for thousands of uninsured Tompkins County residents, cost-related concerns weigh heavily.

It's no wonder that the demand for the Ithaca Health Alliance's Free Clinic has remained high for the past four years.

The Clinic provides non-emergency health care to thousands of uninsured Tompkins County residents who, just like many other Americans, would otherwise face prohibitively high costs. We are able to do this thanks to a dedicated volunteer staff that includes physicians, registered nurses, registered dietitians, acupuncturists, chiropractors, herbalists, massage therapists, social workers and occupational therapists. We also offer employment physicals so that individuals can get or keep their jobs.

In addition to the Clinic, the Alliance provides free health education through our newsletter and community programs open to all. Topics relate to personal health as well as issues of broader concern to the community, such as healthy eating and gas drilling. We also offer financial advocacy and assistance for emergency medical and dental services through the Ithaca Health Fund.

To accomplish all this, the Alliance depends upon financial contributions from local residents like you for over half of its annual operating budget. We invite you to join us in making a tax-deductible gift. All donations will be acknowledged with a letter of receipt as a record of your generosity.

With gratitude,

Abbe Lyons  
Executive Director

C. Kelly White  
President, Board of Directors

## **Text of Direct Mail Solicitations**

### **Control Group**

Dear Community Member,

Did you know that thousands of local residents cannot afford to see a doctor for routine visits or even urgent health problems? Did you know that such challenges remain, even with the Affordable Care Act? That's why it's critical that many of our friends and neighbors can depend upon the Ithaca Health Alliance.

Disparities in access to affordable health care are wide. Some people have insurance with low out-of-pocket costs. They don't think twice about seeing a doctor. Yet for thousands of uninsured Tompkins County residents, cost-related concerns weigh heavily.

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To accomplish all this, the Alliance depends upon financial contributions from local residents like you for over half of its annual operating budget. We invite you to join us in making a tax-deductible gift. All donations will be acknowledged with a letter of receipt as a record of your generosity.

With gratitude,  
[signatures of directors]

## Episodic Evidence mail solicitation

Dear Community Member,

Did you know that thousands of local residents cannot afford to see a doctor for routine visits or even urgent health problems? Did you know that such challenges remain, even with the Affordable Care Act? That's why it's critical that many of our friends and neighbors can depend upon the Ithaca Health Alliance.

Disparities in access to affordable health care are wide. Some people have insurance with low out-of-pocket costs. They don't think twice about seeing a doctor. Yet for thousands of uninsured Tompkins County residents, cost-related concerns weigh heavily.

Consider the following real-life situation. A 35-year-old uninsured widow starts having abdominal pain and migraines. At first, the pain is not debilitating, though taking care of her young son becomes difficult. She would love to see a doctor immediately, but she shudders to think about the potential out-of-pocket expenses for treatments and/or prescription drugs. She feels sicker and sicker each day, yet remains terrified of what will happen if she's not well enough to take care of her son. She hopes things will get better on their own. But in the end her illness gets more serious and her treatments and drugs end up costlier. Moreover, she is forced to spend more time away from her son.

Given stories like her's, it's no wonder that the demand for the Ithaca Health Alliance's Free Clinic has remained high for the past four years.

The Clinic provides non-emergency health care to thousands of uninsured Tompkins County residents who, just like many other Americans, would otherwise face prohibitively high costs. We are able to do this thanks to a dedicated volunteer staff that includes physicians, registered nurses, registered dietitians, acupuncturists, chiropractors, herbalists, massage therapists, social workers and occupational therapists. We also offer employment physicals so that individuals can get or keep their jobs.

In addition to the Clinic, the Alliance provides free health education through our newsletter and community programs open to all. Topics relate to personal health as well as issues of broader concern to the community, such as healthy eating and gas drilling. We also offer financial advocacy and assistance for emergency medical and dental services through the Ithaca Health Fund.

To accomplish all this, the Alliance depends upon financial contributions from local residents like you for over half of its annual operating budget. We invite you to join us in making a tax-deductible gift. All donations will be acknowledged with a letter of receipt as a record of your generosity.

With gratitude,  
[signatures of directors]

## Percentage Evidence mail solicitation

Dear Community Member,

Did you know that thousands of local residents cannot afford to see a doctor for routine visits or even urgent health problems? Did you know that such challenges remain, even with the Affordable Care Act? That's why it's critical that many of our friends and neighbors can depend upon the Ithaca Health Alliance.

Disparities in access to affordable health care are wide. Some people have insurance with low out-of-pocket costs. They don't think twice about seeing a doctor. Yet for thousands of uninsured Tompkins County residents, cost-related concerns weigh heavily.

Consider this statistic. In 2014, among working-age adults who were uninsured at some point over the previous year, 57% reported a cost-related barrier to getting the care they need (Source: Commonwealth Fund Biennial Health Insurance Survey). Cost-related barriers can include having a medical problem but not seeking care, not filling a prescription, not seeing a needed specialist, and/or skipping a recommended follow-up because of the cost. For this 57%, it's natural to hope things will get better on their own. But in the end delaying care due to cost concerns often leads to more serious illnesses with more expensive treatments and more time away from family.

Given this percentage, it's no wonder that the demand for the Ithaca Health Alliance's Free Clinic has remained high for the past four years.

The Clinic provides non-emergency health care to thousands of uninsured Tompkins County residents who, just like many other Americans, would otherwise face prohibitively high costs. We are able to do this thanks to a dedicated volunteer staff that includes physicians, registered nurses, registered dietitians, acupuncturists, chiropractors, herbalists, massage therapists, social workers and occupational therapists. We also offer employment physicals so that individuals can get or keep their jobs.

In addition to the Clinic, the Alliance provides free health education through our newsletter and community programs open to all. Topics relate to personal health as well as issues of broader concern to the community, such as healthy eating and gas drilling. We also offer financial advocacy and assistance for emergency medical and dental services through the Ithaca Health Fund.

To accomplish all this, the Alliance depends upon financial contributions from local residents like you for over half of its annual operating budget. We invite you to join us in making a tax-deductible gift. All donations will be acknowledged with a letter of receipt as a record of your generosity.

With gratitude,  
[signatures of directors]

Email Study 1 (High % Study): Body of email (subject lines are mentioned in the main text)



We all know that Obamacare did a lot to reduce the number of Americans without health insurance.

But, across the United States and right here in Tompkins County, many of our friends and neighbors remain uninsured.

Thanks to recent data collected by the Robert Wood Johnson foundation, which includes a national sample of uninsured Americans, we know a lot more about why that is.

The biggest barrier? Cost!

Indeed, [the study finds that "most of the uninsured point to the costs of health insurance as the main reason they do not have it currently."](#)

The study also finds that those without insurance believe that it's important to be insured, but when push comes to shove they simply can't afford it.

That's why it's critical that our friends and neighbors can rely upon the Ithaca Health Alliance. You already know about our Free Clinic and Health Fund. But did you also know that IHA's Ithaca Health Fund does financial advocacy work as well? Last year we helped 81 people achieve more than \$110,000 in medical debt reduction.

Many people don't know about IHA and the work we do. They also don't know that there are many uninsured people that still can't afford health insurance, even after Obamacare. Please help us spread the word to your friends, family, and neighbors about this Robert Wood Johnson study (click [here](#) to see infographics from the study!). And, as always, please stay up-to-date by joining the IHA conversation on [Facebook](#). Together, we are better.

~Your IHA team

Email Study 2 (Low % Study): Body of email (subject lines are mentioned in the main text)



A couple of weeks ago we told you about a recent survey of the uninsured in America, conducted by the Robert Wood Johnson foundation. This is a rare, but sobering, look at what it's like to be uninsured in our country today.

One of the survey's most striking findings is that, while Obamacare did a lot to reduce the number of uninsured, many remain uninsured and ["most of the uninsured point to the costs of health insurance as the main reason they do not have it currently."](#)

But what happens when they need care anyway, perhaps due to unexpected emergencies? Here the study finds that many ["cope by ... skipping care."](#)

That's why it's critical that our friends and neighbors can rely upon the Ithaca Health Alliance. Indeed, almost half of our clients last year (556 of 1208) stated that they would not have sought care for fear of medical expenses were it not for our services.

Many people don't know about IHA and the work we do. They also don't know that there are many uninsured people that still can't afford health insurance, even after Obamacare. Please help us spread the word to your friends, family, and neighbors about this Robert Wood Johnson study (click [here](#) to see infographics from the study!). And, as always, please stay up-to-date by joining the IHA conversation on [Facebook](#). Together, we are better.

~Your IHA team

## **Treatments, Survey Experiment**

### **Episodic Evidence**

Did you know that many people cannot afford to see a doctor for routine visits or even urgent health problems? Did you know that such challenges remain, even with the Affordable Care Act?

The fact is, disparities in access to affordable health care are wide. Some people have insurance with low out-of-pocket costs. They don't think twice about seeing a doctor. Yet for the many Americans who lack health insurance, cost-related concerns weigh heavily and prevent them from seeking medical care.

Consider the following real-life story. A 35-year-old uninsured widow starts having abdominal pain and migraines. At first, the pain is not debilitating, though taking care of her young son becomes difficult. She would love to see a doctor immediately, but she shudders to think about the potential out-of-pocket expenses for treatments and/or prescription drugs. She feels sicker and sicker each day, yet remains terrified of what will happen if she's not well enough to take care of her son. She hopes things will get better on their own. But in the end her illness gets more serious and her treatments and drugs end up costlier. Moreover, she is forced to spend more time away from her son.

### **Percentage Evidence**

Did you know that many people cannot afford to see a doctor for routine visits or even urgent health problems? Did you know that such challenges remain, even with the Affordable Care Act?

The fact is, disparities in access to affordable health care are wide. Some people have insurance with low out-of-pocket costs. They don't think twice about seeing a doctor. Yet for the many Americans who lack health insurance, cost-related concerns weigh heavily and prevent them from seeking medical care.

Consider the following. In 2014, among working-age adults who were uninsured at some point over the previous year, 57% reported a cost-related barrier to getting the care they need (Source: Commonwealth Fund Biennial Health Insurance Survey). Cost-related barriers can include having a medical problem but not seeking care, not filling a prescription, not seeing a needed specialist, and/or skipping a recommended follow-up because of the cost. For this 57%, it's natural to be terrified of the potential out-of-pocket expenses and what might happen if you're too sick to take care of loved ones. It's also natural to hope things will get better on their own. But in the end delaying care due to cost concerns often leads to more serious illnesses with more expensive treatments and more time away from family.

### **Raw Number Evidence**

Did you know that many people cannot afford to see a doctor for routine visits or even urgent health problems? Did you know that such challenges remain, even with the Affordable Care Act?

The fact is, disparities in access to affordable health care are wide. Some people have insurance with low out-of-pocket costs. They don't think twice about seeing a doctor. Yet for many Americans who lack health insurance, cost-related concerns weigh heavily and prevent them from seeking medical care.

Consider the following. In 2014, 29.5 million working-age adults who were uninsured at some point over the previous year reported a cost-related barrier to getting the care they need (Source: Commonwealth Fund Biennial Health Insurance Survey). Cost-related barriers can include having a medical problem but not seeking care, not filling a prescription, not seeing a needed specialist, and/or skipping a recommended follow-up because of the cost. For these 29.5 million folks, it's natural to be terrified of the potential out-of-pocket expenses and what might happen if you're too sick to take care of loved ones. It's also natural to hope things will get better on their own. But in the end delaying care due to cost concerns often leads to more serious illnesses with more expensive treatments and more time away from family.

### **Raw Number + Denominator Evidence**

Did you know that many people cannot afford to see a doctor for routine visits or even urgent health problems? Did you know that such challenges remain, even with the Affordable Care Act?

The fact is, disparities in access to affordable health care are wide. Some people have insurance with low out-of-pocket costs. They don't think twice about seeing a doctor. Yet for many Americans who lack health insurance, cost-related concerns weigh heavily and prevent them from seeking medical care.

Consider the following. In 2014, 29.5 million working-age adults who were uninsured (out of a total of 51.8 million) at some point over the previous year reported a cost-related barrier to getting the care they need (Source: Commonwealth Fund Biennial Health Insurance Survey). Cost-related barriers can include having a medical problem but not seeking care, not filling a prescription, not seeing a needed specialist, and/or skipping a recommended follow-up because of the cost. For these 29.5 million folks, it's natural to be terrified of the potential out-of-pocket expenses and what might happen if you're too sick to take care of loved ones. It's also natural to hope things will get better on their own. But in the end delaying care due to cost concerns often leads to more serious illnesses with more expensive treatments and more time away from family.