HEALTHY, WEALTHY, AND WISE?

THE LINK BETWEEN IDEOLOGY AND HEALTH IN AMERICA

A Thesis

Presented to the Faculty of the Graduate School

of Cornell University

In Partial Fulfillment of the Requirements for the Degree of

Master of Science

by

Rachel Elizabeth Reichenbach

May 2007

ABSTRACT

The purpose of this study is to explore the relationship between ideological beliefs and individual self-reported health in America between the years 1993 and 2004. A distinction between particular ideologies and ruling ideology is made. Particular ideologies are created by social interaction as a product of history and are used as tools for categorizing and structuring observations, experiences, ideas, and action. Individuals need the structures provided by particular ideologies both to understand and to act upon their world. A ruling ideology develops when those in power knit together multiple particular ideologies to create a unified system of thought that presents an easily accepted and internalized set of normative behaviors, thought-patterns, and ideals, in order to protect their social position.

Preliminary data analysis revealed that the majority of Americans believe they have good health. These results aided in the development of several research questions. If ideology is as pervasive as suggested by the literature, then is there anything about the current ideologies that precipitate widespread belief by individuals that they have good health? Could ideology give a cohesive worldview to individuals, thus reducing their stress of being outside the norm? Or, could ideology provide individuals with normative prescriptions for behaviors that are good for their health, such as reducing smoking and binge-drinking? Do the benefits of a cohesive worldview or of behavioral health norms outweigh the consequences of the possible false consciousness that may result simultaneously?

Four propositions suggesting connections between ideology and self-reported health are evaluated using binary logistic regression analyses and data from 1993 through 2004 contained in the General Social Survey. I predicted that respondents

who had internalized the dominant particular ideologies or ruling ideology of the era would have better health than those who adhered to a different paradigm. Health is measured as poor or good perceptions of self-health.

The findings of the analyses show moderate support for three out of four of my propositions. Economic and social ideological beliefs have a significant relationship with self-reported health net of demographic controls and material indicators. Using a composite scale to give more breadth to the measurement, religious ideology is also seen as a predictor of self-reported health. The fourth proposition concerning ruling ideology found little support using this dataset. Despite the support garnered for psychosocial theory through the significance of the variables indicating particular ideology, support for neo-materialist theory was also revealed. In fact, the material indicators showed the strongest and most robust relationships with health status. In many cases, they overwhelmed the other variables.   However, in contradiction to epidemiological research, health behaviors do not contribute to explaining to self-reported health. The limitations of the study and the implications of the results in light of the research questions are discussed at length in the conclusion.

BIOGRAPHICAL SKETCH

Rachel Reichenbach was born on October 31st 1982 to Bruce Robert Reichenbach and Sharon Harvie Reichenbach. Growing up in Shoreview, Minnesota, her childhood was characterized by playing outdoors and swimming in Lake Owasso with her older brother Robert Bruce Reichenbach. During her sophomore year of high-school, her parents moved to Nairobi, Kenya to teach at Daystar University. While there, Rachel attended Rosslyn Academy and has many fond memories of that period in her life. After graduating from Minnehaha Academy in Minneapolis, Minnesota in May 2000, she moved to Wheaton, Illinois to attend Wheaton College.

Rachel's time at Wheaton College afforded her many opportunities to pursue her burgeoning interests in social justice and international affairs. She spent a summer teaching in Kazakhstan and six months in Rwanda on a Human Needs and Global Resources program internship. In addition, she fulfilled her desire to see every continent through a trip to Antarctica with her father. Matriculating in 2004 with a Bachelors of Arts degree in Anthropology, Rachel moved to Ithaca, New York to commence graduate studies at Cornell University in the department of Development Sociology.

To my parents:

Your sacrificial lifestyle is a quiet but powerful testament

to the quality of your character

And

To Alvaro Nieves:

An outstanding professor and role-model of compassion

ACKNOWLEDGMENTS

Writing a thesis is an amalgamation of the support, encouragement, and advice of many people. I would like to take this opportunity to thank those involved in this process. First, I am grateful for the time and energy invested into my experience at Cornell by my committee chair Tom Hirschl. Passionate and insightful, Tom was quick to both suggest interesting new paths for my research and to encourage my progression through the program. His years of dedication to the discipline and commitment to conducting cutting-edge research are inspiring. Likewise, I would like to thank Joe Francis for his wit and wisdom while guiding me in graduate school. His breadth of knowledge on sociological methods and statistical procedures continues to impress me and I am grateful for the opportunity to have worked with him closely through this thesis and a teaching assistantship.

Professor Dan Lichter also offered invaluable comments on Chapter Three of this thesis and advised me on the construction of several variable measurements. For this, and his course providing me with stacks of background literature, I am truly grateful. Guidance from Jeff Sobal in the early stages of this thesis is also notable. Thank you for working through my theoretical questions with me and for suggesting relevant articles to jumpstart the process. Paul Eberts also offered his wise counsel and excellent readings on the theoretical aspects of this study. Finally, without the assistance of Alvaro Nieves, studying at Cornell would not have been possible. Your classes not only planted the initial seed of inquiry into quantitative methods but also taught me the value of compassion and community support in difficult times. Thank you for facilitating the pursuit of my dreams.

For graduate work to be sustainable, a strong social support system is necessary. Words cannot express my appreciation for the friendship, solidarity, and encouragement from my officemates Roanne, Andrea, Amanda, and Vongai. You

have challenged me to read more articles, debate new positions, and process contradicting realities, all of which have contributed to this work. Also, I want to thank Doug for his patience, wisdom, and tolerance of me during this process. And to the others outside the office who have significantly touched my emotional and intellectual side, to Jennifer, Behzad, Ed, Valessa and others, I thank you for your humor, distraction, and empathy.

Finally, recognizing the blessing of stability in a life full of dynamic influences and persuasions, I want to thank my family for their continual presence. To my father, who exhausted a considerable amount of effort proof-reading this thesis, thank you not only for your assistance in logically organizing this work but also for instilling in me the desire to be able to argue all sides of an issue long ago over the dinner table. Your depth of insight, breadth of interest, and constant yearning for new knowledge, has always been an inspiration. To my mother who has always been supportive if not approving, thank you for letting go and for opening my eyes to the complexity of the world around us. Last but not least, Rob, thank you for the friendship and food over the past two years. I have enjoyed spending time with you and getting to know you outside of our childhood memories.

LIST OF FIGURES

CHAPTER ONE

DEFINING IDEOLOGY

"Early to bed, and early to rise, makes a man healthy, wealthy and wise," Benjamin Franklin's main character "Father Abraham" advised the local townspeople in a 1757 publication. This essay, entitled "The Way to Wealth," concluded Franklin's twenty-five years of publication of *Poor Richard's Almanac*, a pamphlet issuing moral advice about economics, employment, personal life, and social contracts in the form of memorable maxims. Combining quasi-religious admonitions with capitalist ideals, Franklin promoted an adherence to a puritanical frugality as the way to prosper. The character-name Franklin chose for his last essay exemplified his ability to use religious undertones to add authority to his proverbs without actually quoting religious works. In this way, he facilitated the religion of secular capitalism. In sociological circles, Franklin is perhaps best known from Max Weber's 19th century discussion of him as a purveyor of secularized Protestant virtues used to uphold and justify the merciless efficiency of modern western capitalism.

Though written in an earlier era, Franklin's adages have continued relevance today, beyond the humor they invoke. The following chapters will provide evidence that suggests that religious undertones are still being used to justify and bolster the current economic system and to influence society at large. Contemporary society has seen a marriage of the religious conservatism, economic liberalism, and social traditionalism that were in their nascent state in the 18th century. More important than the simple presence of similar systems is the understanding of the how these ideologies affect the health of Americans. By following them are Americans becoming healthy, wealthy, and wise?

In sum, this study will explore various components alluded to in Franklin's 1757 maxim in order to better understand the link between health behaviors, wealth, ideology, and health. In particular, I will examine the relations between ascribing to certain behaviors deemed healthy, having high socioeconomic status, or subscribing to the dominant thought patterns commonly understood as wisdom and common sense, and a person's perceptions of his own health. To begin, however, we need to reflect on what is meant by ideology and on how, theoretically, it is understood to influence the lives of individuals in contemporary society.

THEORETICAL VIEWS OF IDEOLOGY

Ideology is commonly conceptualized as either a pluralistic way of viewing society or as a singular totalizing understanding of the world. Particular ideologies, functioning in a social setting, can affect the worldviews and actions of individuals in society, and when molded into a unified paradigm employed by those in power, can be used to elicit certain desired social behaviors and conditions. This study seeks to ascertain that critical function. But before this can be done, we need a clearer understanding of the distinction between particular ideologies and ruling ideology.

Particular Ideologies

Multiple ideologies exist in any given epoch as tools for categorizing and structuring observations, experiences, ideas, and action. Individuals need the structures provided by particular ideologies both to understand and to act upon their world. Particular ideologies are a type of structural paradigm and are not synonymous with individual perceptions. Indeed, for individual thought to be meaningful, it must be placed into socially created categories. Since particular ideologies are created by social interaction as a product of history, they are dynamic features of the social

2

environment. Frequent social interaction forces new information in front of individuals, which must either be placed within existing categories, slightly distorted to fit, or evolved into a new paradigm. Contrary to the common perception that ideologies are necessarily coercive and created under malicious intent, particular ideologies can be treated as instruments necessarily used by social groups to understand and act upon the many dimensions of their society. By simplifying and categorizing reality into coherent instrumental ideologies, social groups can organize into meaningful structures a multitude of experiences that would not otherwise have meaning. Meaning thus arises when ideas, experiences, and observations are placed into certain categories of knowledge.

Sociologist Eduardo Bonilla-Silva explains how particular ideologies are less of coercive ideas forced on the masses by the ruling elite and more of a heuristic device used by social groups to explain the world around them. He describes ideologies as consisting of "broad mental and moral frameworks or 'grids' that social groups use to make sense of the world, to decide what is right or wrong, true or false, important or unimportant" (Bonilla-Silva 2001:62). Implicit in this characterization is a value-judgment. Ideologies are not value-neutral but contain moral imperatives for normative behavior. Although particular ideologies are generally considered good because they are necessary for human understanding and knowledge consumption, ideologies can be used in deleterious ways. Ordinary citizens feel pressure to conform to the ideals presented as "natural" or normative, creating actions and thought-patterns that may subjugate certain groups.

A good example of the transition from particular ideologies to ruling ideology is found in Max Weber's seminal work, *The Protestant Ethic and the Spirit of Capitalism* (2002), which documents the role Protestantism played in the rise of the "spirit" of modern capitalism. Weber uses the term "spirit" to highlight the ideas and

normative beliefs (as opposed to strictly the material relations) that developed as part of the capitalist paradigm. These beliefs became internalized by members of society, thereby aiding the acceptance of modern capitalism into American culture. This form of capitalism is only one of several particular economic ideologies. The transition to ruling ideology happened in the 18th century when Protestantism became secularized and combined with capitalism to form an overarching understanding of the world portrayed as common-sense. The resulting ideology has components of secularized religious ideals, such as hard work, individualism, and frugality, which can be used to justify the disturbing products (rising inequality, poverty and unemployment) of the capitalist paradigm. Once these ideas were merged with political theories and used by the elites to maintain their social position, these components formed an ideational system that became dominant in mainstream America. Thus, the conglomeration of several different particular ideologies about various spheres of influence formed a ruling ideology.

Ruling Ideology

Ideologies can become coercive and dangerous when those in power knit together multiple particular ideologies to create a unified system of thought that presents an easily accepted and internalized set of normative behaviors, thought-patterns, and ideals, in order to protect their social position. A ruling ideology becomes particularly problematic when it is presented as benefiting all (through ideological discourse on the way the world "ought" to be) although it may only contribute to the social reproduction and preservation of the group that created it.

In *The German Ideology*, Marx and Engels proposed that "The ruling ideas are nothing more than the ideal expression of the dominant material relations, the dominant material relations grasped as ideas; hence of the relations which make the

4

one class the ruling one, therefore, the ideas of its dominance" (1976:67). By virtue of controlling the means of production, these owners also have the power to set a ruling system of ideas that will best serve their interests, especially that of maintaining control over the means of production. By conflating how the world *ought* to be with how the world *is*, the dominant ideology appears as neutral and can be accepted without question by members of society. Marx and Engels (1976:34) also viewed ruling ideology as a distorted concept of or abstraction from the history of human-kind that is unique to the epoch. Political scientist Michael Freeden builds on this idea, stating that, "Ultimately, ideologies are configurations of *decontested* meanings of political concepts. … In concrete terms, an ideology will link together a particular conception of human nature, a particular conception of social structure, of justice, of liberty, of authority, etc. '*This* is what liberty means, and *that* is what justice means' it asserts" (quoted in Hoover 2003:3,4). In this way, ideologies can settle contests over meanings of the role of government or economics, because their rhetoric on the "natural" state of being informs citizens that the world is *this* way and not *that* way. C. Wright Mills expands on Marx's understanding of ruling ideology by explaining how the current ruling ideology in America has come to prevail and dominate society.

> Once the basic structure of the American political economy was built, and for so long as it could be tacitly supposed that markets would expand indefinitely, the harmony of interests could and did serve well as the ideology of dominant groups, by making their interests appear identical with the interests of the community as a whole. So long as this doctrine prevails, any lower group that begins to struggle can be made to appear inharmonious, disturbing the common interest. 'The doctrine of the harmony of interests', E.H. Carr has remarked, 'thus serves as an ingenious moral device invoked, in perfect sincerity, by privileged groups in order to justify and maintain their dominant position'" (1959a:248).

The Marxist/neo-Marxist view of ruling ideology relies on the notion that this system of ideas is created and espoused by the powerful for the specific purpose of directing policies and controlling political and economic structures and practices.

Mills also reveals the identities of the owners of production by connecting powerful players in multiple spheres of influence. The powerful are not just the wealthy capitalists and corporate CEOs but also include the upper echelon of political and military elites. It is breadth of influence and strength of vertical power relationships within multiple spheres that makes a ruling ideology so pervasive and powerful in society (Mills 1959a). By appearing to serve the interests of all, ruling ideology can create a "false consciousness" for social classes, in particular for the lower class. As a result, lower classes may have a false perception of their own interests and role in society that may encourage them to adhere to a ruling ideology that does not actually benefit them. This false consciousness is perpetuated through a discourse that makes truth claims. Although the language is ideological in form, substantively it uses decontested images to advance its cause. The ideational rhetoric sets up false dichotomies forcing citizens choose between obvious patriotism or lack there of. As exemplified in the following chapter, the discourse of the current ruling ideology has co-opted ideals such as "freedom" and "liberty," creating decontested terms in the sense that everyone desires these ideals, even if their manifestations under this ideology do not benefit them (Freeden 2000:321).

At the same time, the reach of ruling ideology is not absolute and ideologies develop in opposition to the dominant ideology. Although ruling ideology, once internalized as normative and accepted as "common sense," has a strong influence on society, the thoughts and actions of subordinate groups are not always determined by this ideology. Such groups challenge the status quo with new oppositional ideologies (Bonilla-Silva 2006:10).

In light of the sociological literature on particular ideologies and ruling ideology, particular ideologies are defined as socially-created structures of ideas that govern an individual's or group's beliefs and actions. Alternatively, ruling ideology is conceptualized as a unified system of ideologies, knit together by those in power, that is widely internalized as common knowledge within a society and which implicitly or explicitly affects an individual's or group's practices and worldview. George Ritzer argues that ruling ideology is "institutionalized as public knowledge and disseminated throughout society so effectively that it becomes taken-for-granted knowledge for all social groups" (2004:1) This suggests that the ruling ideology is not floating independently but is attached and disseminated through different structures and superstructures (Freeden 2000; Mills 1959a). Since the ideas espoused by a ruling elite will change with power shifts and global influences, a ruling ideology is specific to a certain historical context and time period.

Although this recognition of elite volition in the creation of ruling ideology resembles the Marxist approach, I do however reject the necessity of a materialist base for ideology. Alternatively, ruling ideology is conceptualized as more than just a reflection of material relationships. Evidence, such as Weyrich and Dobson's discussion of the corrupting allure of prestige (see Martin, 1997:Chap. 9), suggests that the creation of ideologies may also be based on the desire for power, prestige, and maintenance of status. In addition, while ruling ideologies are understood as created by the ruling elite, elite class consciousness does not necessarily include the intent to disempower other classes. Certainly, some elites believe quite earnestly in the widespread economic, political, and social benefits of their ideals and not that these ideals and the resultant policies are just ways to "dupe" unsuspecting members of the public into maintaining the status quo. Mills stated that despite the class awareness that he witnessed as most cohesive and prevalent at the elite level, "the view that all of

7

history is due to the conspiracy of an easily located set of villains, or of heroes, is also a hurried projection from the difficult effort to understand how shifts in the structure of society open opportunities to various elites and how various elites take advantage or fail to take advantage of them" (Mills 1959:27, 30, 283). Often elites sincerely believe their policies will help the public and reduce poverty while simultaneously protecting their class interests and ideals. Yet, despite the lack of intentional injury to non-elite classes via a ruling ideology proposed by elites, false consciousness and disempowerment through a distortion of reality may still occur.

OVERVIEW

The following chapter will explore three contemporary particular ideologies by reviewing their historical trajectory, the social interactions that formed them, their current acceptance in mainstream America, and how they came together to form a unified system of ideologies called a ruling ideology. Furthermore, the effect of ideological beliefs on the health and well-being of individuals in America will be explored. The above definition suggests that ruling ideology may affect individual health through multiple mechanisms, such as by guiding their health choices and behaviors or by influencing their worldview. Preliminary data analysis revealed that the majority of Americans believe they have good health. If the ruling ideology is as pervasive as suggested by the literature, then what is there about the current ruling ideology that precipitates widespread belief in individuals that they have good health? Could it be that contemporary ideology gives a cohesive worldview to individuals, thus reducing their stress of being outside the norm? Or, could ideology provide individuals with normative prescriptions for behaviors that are good for their health, such as reducing smoking, over-eating, and drug-use? Do the benefits of a cohesive

worldview or of health behavioral norms outweigh the consequences of the possible false consciousness that may result simultaneously?

This study purports to explore the mechanisms of transmission and the effects of ideological beliefs on individual perception of health. The first chapter of this study discussed current sociological theories of ideology in an attempt to root this work in sociological literature. Building on the various conceptualizations of ideology, a working definition of particular and ruling ideology has been uniquely created for this thesis. Chapter Two will orient the reader toward important contemporary ideologies and propose a measure of ruling ideology. This contemporary ruling ideology of America is understood as a product of the interaction of economic, religious, social, and political spheres of influence since the 1960s. Four propositions are formed after tracing the historical development of the three components of contemporary ruling ideology: economic libertarianism, and religious conservatism, and social traditionalism. In Chapter Three psychological, psychosocial, physiological, material, and organizational pathways of transmission will be explored through a review of sociological and epidemiological literature. This literature suggests that the current ideology of free-market capitalism, religious conservatism, and social traditionalism has increased inequality and class divisions in America. This inequality is seen to be closely linked in a causal way to a health gradient. This study will see if similar connections can be made between the current ruling ideology and perceptions of the government, economy, society, religion, and health using data from the General Social Survey from 1993 to 2004. The link between macro and micro scale analyses is addressed by applying C. Wright Mills' concept of "sociological imagination."

The effects of ideology on health will be tested in Chapter Four via data from the General Social Survey. Of great importance is the discussion about the dependent variable and the empirically-tested link between individual perceptions of health and

9

medical observations of health. This section takes the analysis from connecting

perceptions of society and its components to biological responses. The methods used,

limitations of the data-set, a justification of the variables included in the analysis, and

my theoretical conceptualizations of the measurements are also explored. The

findings of this study are revealed in Chapter Five. These will be discussed first in

light of their bivariate properties and then through the lens of logistic regression. The

four propositions outlined in Chapter Two will be revisited in Chapter Six and paired

with implications from the findings from Chapter Five. The importance of the

connection between ruling ideology and perceptions of health will be evaluated and

the results will be used to reassess the validity of existing theory. This section will

conclude the study by noting important limitations and offering suggestions for future

research directions.

CHAPTER TWO

IDEOLOGY IN CONTEMPORARY AMERICA

Robert C. Merton cautions researchers to be careful in their attempt to knit a complete understanding of society into one all-encompassing theory. Instead he posits that many smaller theories can help us better grasp diverse milieus. Ultimately, although middle-range theories need not be derived from one grand theory, they may contribute to development and consistency of overarching theories of society. Merton defines middle-range theories as "theories that lie between the minor but necessary working hypotheses that evolve in abundance during day-to-day research and the all-inclusive systematic efforts to develop a unified theory that will explain all the observed uniformities of social behavior, social organization and social change" (Calhoun, 2002:386).

This chapter looks at the mid-range theories behind three components of the ideology that was dominant in America during the period 1993-2004: economic libertarianism, religious conservatism, and social traditionalism. After locating the social processes that gave rise to each theory and highlighting the influence of each in recent American history, I will form propositions in order to better understand what factors might affect Americans' perceptions of their own health. Additionally, since the three components overlap, some attention will be paid to a composite measure of ideology. This measure of ideology is included for theoretical reasons although in the data analysis itself it may be insignificant due to some unreliability with the measurements of its components. Thus, although it will be included in empirical models and data analysis, this measure in its current form is not assumed to be a reliable indicator of the ruling ideology and is meant for refinement in future research.

Overall, this work may lend itself to augmenting Marx's concept of a ruling ideology and its influence on mass society, but this is not the purpose or scope of the project.

THE INFLUENCE OF ECONOMIC LIBERTARIANISM ON POLITICS AND THE AMERICAN PUBLIC

This study traces the rise of the current ruling ideology from the 1960s. Yet, not all parts of this ideology developed simultaneously, and instead its advancement can be seen as a dynamic process. Although economic libertarianism was certainly present in America before the 1960s, these ideals did not become accepted as mainstream until after the 1960s, thus, this study will begin with Barry Goldwater's 1964 presidential bid. Although the dominant economic ideology of the 1950s through the 1970s was that of the interventionist economics of John Maynard Keynes, Goldwater and his supporters began to subscribe to free-market ideas of Friedrich Hayek and Milton Friedman that have come to dominate that later part of the century (Hoover 2003:207).

Events during the Great Depression and the Second World War greatly colored Keynes' economic theories. Due to the significant decline of market reliability in the 1920s and 1930s, the government was expected by the public to have increased responsibility to care for its citizens. Thus, Keynes supported an interventionist government that would regulate the economy and thereby maintain a reasonable level of employment, economic growth and stability, and a decent standard of living for its citizens. His economic models became increasingly important during the development of the 1944 Bretton-Woods Agreements, which regulated the financial and economic world order by managing exchange rates, setting guidelines for Europe's post-war reconstruction, and creating international regulatory bodies such as the World Bank and the International Monetary Fund (IMF). Although these

agreements supported an open system of trade, they also made provisions for government intervention (Hoover 2003:3).

In the decades following, government involvement in international economic issues allowed the public and private sector alike to attribute failures such as the oil crisis of 1973 and the ceding of the Panama Canal to government intervention. More and more Americans were also using the welfare system and were feeling economic pressure from rising inflation and an economic recession in the 1970s. At the same time, Nixon was giving tax breaks to the wealthy and creating controls for wages and prices. The Watergate scandal may have been the final straw as more and more Americans were increasingly disenchanted with the corruption and irresponsible management of international affairs. Policies such as "tax breaks, subsidies, and provisions for the "undeserving" … and the compromising character of political leadership in a mass democracy led to a feeling that the government had lost its moral legitimacy" (Hoover 2003:201). With the memories of the failed market during the Great Depression receding into history and the contemporary struggles the international system faced after the Second World War at the fore, the libertarian economic theories of a community of renowned economists forming the Chicago School of Economics took center stage.

Chicago School of Economics

In the 1950s, proponents of laissez-faire economics and monetarism drifted towards the University of Chicago. A number of these scholars became professors in the Department of Economics, and under the organization of Milton Friedman, began meeting on a regular basis. This close-knit group of like-minded scholars soon became known as the Chicago School of Economics and gained notoriety when some of them, including Friedman and Friedrich Hayek, won Nobel Prizes in Economics.

Although trained in Keynesian economics, these professors increasingly found Keynes's theories to be unreliable and inconsistent with the current economic trajectory. Formulating theories around the desirability of a free and unhindered market, such theorists rejected classical Keynesianism and developed a modern take on monetarism.

Friedman in particular revived the monetarist view by arguing that since government intervention and increasing the money supply are responsible for inflation, this trend could be mitigated by maintaining price stability through keeping the supply and demand for money balanced. Friedman was deeply concerned with the Federal Reserve System and the role of the government in economic affairs. Although the intent of setting up the Federal Reserve was to restrict political influence on national monetary policy, the discretionary power given to the Board of Governors and the oversight by Congress allowed for political cooption and influence (The Federal Reserve Board 2006, Bernanke 2003). Government intervention (beyond its role in setting monetary policy for the country) was less efficient than allowing the market to be regulated by private competition (Noble 2006). From his analysis of the causes of the Great Depression, Friedman argued for limitations to be placed on the Board of Governors of the Federal Reserve so that they would have fewer discretionary powers to influence the supply of money. In particular, he advocated a fixed rate of increase of the national money supply independent of economic fluctuations, a policy "which would have the advantages of simplicity, predictability, and credibility, and it would help insulate monetary policy from outside political pressures and what Friedman saw as an inherent tendency toward excessive policy activism" (Bernanke 2003:2). Although this strict rule has never been implemented, many in government have acknowledged the role the discretionary powers of the Board of Governors of the Federal Reserve played in causing the Great Depression

and have expressed a desire to limit (but not eliminate) these powers.

Friedman also established a body of theories related to monitoring and preventing accelerating inflation rates. In particular, his theories advocated control over the money supply via a central banking system. This would keep the money supply stable and thus stabilize prices and wages (Noble 2006). Friedman was also known for criticizing the government's domestic and international economic policies and arguing that a free-market was fundamental for political freedom. His work on welfare and the idea that some unemployment was inherent and beneficial in the capitalist system (natural rate of unemployment) were popular with political and social conservatives and consequently a rhetoric stressing personal freedoms and individual responsibility quickly developed around laissez-faire economics.

Another extremely important figure in the Chicago School of Economics was Friedrich Hayek, who joined the Department of Social and Moral Science at the University of Chicago in the 1950s. Although Austrian born and never allowed to teach in the Economics Department at the University of Chicago, Hayek was nonetheless an influential member of the Chicago School of Economics; his work complemented the political economy of Milton Friedman. In 1974 he was awarded the Nobel Prize in Economics, two years before Friedman received his.

Hayek espoused the laissez-faire economics common to the Chicago School Economists, arguing that the role of government in economic matters should be restricted to the maintenance of peace so as to facilitate the groundwork for a functioning market. He ardently opposed communism, socialism, and most types of collective organization. Additionally, "Hayek supplied a critique of social justice claims and a defense of common law morality, which legitimized a retreat from government regulation and welfare provision while relieving capitalist consciences" (Hoover 2003:201).

Influence of Chicago School of Economics

Although not fully formed or accepted, by the mid 1960s the ideas of the Chicago School of Economics were already influencing politics and the public alike. Citizens, including Barry Goldwater and his supporters resonated with Friedman and Hayek's economic philosophy. Indeed, Friedman even served as Goldwater's major economic advisor during the campaign (Rayack 1987:6). Despite Goldwater's defeat in the 1964 bid for presidency, his small group of like-minded supporters pushed forward in their struggle to elect a conservative president. It is widely acknowledged that the loosely-formed religious right was too weak to accomplish much at this time, thus, "the political necessity for the revival of the right was that conservative traditionalists form an alliance with advocates of free markets and individual liberty. ... Hayek was embraced as both a free market advocate and the defender of moral traditions" (Hoover 2003). Here, the rise of the New Christian Right and their focus on traditionalist social values joined with the economic libertarians who support limited government power to protect the freedom of the market.

Free-market economic ideas were not only spreading across the country via social and religious circles but also were infiltrating the government. In some ways, Friedman was fortunate that his work focused on inflation as America faced quickly rising inflation and plummeting employment after the Vietnam War and during the oil shocks induced by OPEC. President Jimmy Carter quickly realized that Keynesian economics were failing and appointed Paul Volcker, a known monetarist, to the head of the Federal Reserve. Volcker appealed to the well-respected Chicago School of Economics (including Friedman and Hayek) for advice and then implemented its monetarist suggestions of steadily increasing the money supply in the Federal Reserve System. Although America then experienced a huge recession, the inflation rates did fall substantially. Reagan's administration continued to implement monetarist policies

and follow the advice of the Chicago School economists for Federal Reserve policy. Indeed, in his 1981 inauguration speech Reagan stated, "Government is not the solution to our problem; government is the problem" (Reagan 1981). After Reagan's election the inflation rate continued to fall from 18 percent in 1979 to four percent in 1983, plunging the country further into an economic recession. Volcker and Reagan revised their monetarist strategy and the economy recovered by 1984. Despite the partial failure of monetarist strategy, Reagan still relied on Friedman's economic advice and ability to reach the public with free-market, neo-liberal ideology.

Liberty and free markets became the rallying cry for Reagan and his supporters, and these two ideas eventually merged into full-fledged pursuit of "freedom" as the heart of the ideological discourse. Work by Friedman (including two books and many articles with "free" in the title) fed the rhetoric by aligning laissez-faire economics with personal and political freedom. Government intervention was seen to invalidate individual freedom because 1) it forced society to literally pay the price for "irresponsible" individuals through taxes supporting the welfare system, 2) it led to an increase in crime and racial unrest, which hindered the ability for all Americans to lead a safe and free life, 3) it weakened the social fabric of America by leading to family breakdown and 4) concentrated power in a government that could then restrict the rights of individual citizens (Rayack 1987:9,78-100, 104). Thus, to set policy to limit government intervention, a rhetoric of protecting individual freedoms was emphasized.

Reagan's reliance on the ideas of Friedman and Hayek was not a secret. The President openly admitted he was a disciple of Hayek and that he relied on Hayek's ground-breaking book "The Road to Serfdom" and Friedman's theories for advice on his economic policies. Indeed, many passages of his *Economic Reports* were almost direct restatements of Friedman's popular economic writings (Rayack 1987:172,198).

Upon Friedman's death his colleagues commented that rarely "did anyone have such impact on his own profession and on government [as did Friedman]. Though he never served officially in the halls of power, he was around them, as an adviser and theorist" (Noble 2006). Much later Reagan acknowledged his intellectual debt to Hayek by honoring his 87th birthday with this statement, "We are all indebted to you for this advice and I think it is clear that your wise counsel is being heeded" (Hoover 2003:215).

Hayek and Friedman's intellectual legacy continued to be important to political and economic policies as evidenced by President George H.W. Bush's presentation of the Presidential Medal of Freedom to Hayek in 1991, honoring how his "work contributed so signally to the rebirth of freedom in central and eastern Europe and to the revival of ideas of economic liberty throughout the world." Some also credited Friedman in providing the economic impetus behind the Republican Revolution of 1994 as he has "remained the guiding light to American conservatives" (Jacob Viner in Noble 2006:1).

Friedman, the creator and co-leader of the Chicago School of Economics community, is often lauded as one of the most influential economists of the 20th century (Noble 2006). Publishing both popular and scholarly articles, he was able to reach a wide audience both in America and internationally. Upon Friedman's death, Alan Greenspan commented, "From a longer-term point of view, it's his academic achievements which will have lasting import. But I would not dismiss the profound impact he has already had on the American public's view" (quoted in Noble 2006:1). Above and beyond Friedman's direct influence in the political realm, his accessibility in writing created a broad readership basis that further facilitated the spread of economic libertarian ideals to all levels of society.

Although not as highly visible as Friedman, perhaps because of his Austrian citizenship, Hayek also left his mark on American society. In particular, he changed the political landscape of America significantly by the legacy of institutions that grew up around his economic ideas and that subsequently espoused these theories long after Hayek returned to his native Austria. These institutions include but are not limited to: Institute of Economic Affairs (IEA), Intercollegiate Society of Individualists, Foundation for Economic Education, American Enterprise Institute, Cato Foundation, Heritage Foundation, Mt. Pelerin Society, Atlas Foundation, and the Volker Foundation (Hoover 2003). Through these and other institutions, a network of conservative think-tanks transported free-market theories to both the public and private realm.

Implications for Health

The libertarian economic theories and calls for social freedom of Hayek and Friedman were quickly adopted as support for the political and social rhetoric of the Republican administrations and of the Republican Contract with America that structured the Congressional agenda in the 1990s. This rhetoric also influenced public opinion about the relationship between health and the economy. Although this rhetoric may have concrete links to policies that directly affect the health of individuals in America, I will focus primarily on how the rhetoric of economic ideology in the 1990s influences individual perceptions of health. Indeed, one of the reasons that Friedman's economic theories were so influential in America in the 1980s and 1990s is because "he was preaching a gospel of capitalism that fit neatly into American self-perceptions" (Noble 2006:1). The connection between perceptions of health and physical health will be assumed for this section but will be discussed in detail in Chapter Four.

A central tenet of Friedman's popular economic theories was that we cannot have political and thereby individual freedom without economic freedom (Rayack 1987:108). In addition, free market capitalism creates more opportunities for entrepreneurship through competition and without competition there is no incentive to be productive and to work hard to succeed economically. Thus, the term "healthy competition" is often employed in contemporary rhetoric. Whether or not this saying holds true medically, *health* is a widely perceived benefit of hard work and competition.

Tied closely with the idea of choice is the concept of freedom. Through conservative rhetoric, "freedom" has come to be seen as a dichotomy as either we are free or we are coerced. Therefore, the prevailing ideology supported by laissez-faire economics states that freedom is good because it leads to choices (or the perception of such) which enable individuals to be *healthier* and happier. Implicit in the economic libertarian rhetoric is that choice, in and of itself, is good because it leads to a stronger feeling of control over one's life and thus to *healthier* and happier individuals. Free-market capitalism augments good health because it gives individuals choices (or the perception of having choices). Indeed, Friedman specifically argues that "only under competitive capitalism are people free to choose" (Rayack 1987:108).

Also, free-market capitalism promotes social conservatism that is perceived as protecting family values and retarding the skyrocketing trend of the breakdown of families that destroys personal and family health. Friedman argues that it is healthier for individuals to live in neighborhoods devoid of crime, delinquency, and racism, features that, in his opinion, are fostered by the welfare state where government handouts creates dependence. By removing governmental supports and encouraging personal accountability, individuals will regain control over their lives, will feel the positive effects of the responsibility of working, will not engage in drug use and crime

because they have gainful employment and thus will be *healthier* members of society. In addition, positive neighborhood effects will encourage social cohesion and integration. Émile Durkheim's seminal work on suicide highlights the importance of integration into a community for personal health (Durkheim 1951). Drawing from the conclusions of Durkheim and Friedman, one can argue that free-market capitalism adds to social cohesion in a community thus improving the health of residents.

Finally, one last conclusion from the above discussion suggests that there may be actual physical benefits as well as the accompanying psychosocial benefits resulting from the implementation of laissez-faire economic policies. Free-market capitalism takes away government restrictions so one can choose what to do with one's money. Friedman argues that since most people will use their money beneficially, all of society will reap the rewards of economically prosperous individuals. Charitable giving is encouraged as an admirable and necessary human trait but government intervention restricts such good-will by forcing individuals to give to a particular source. Removing this coercion will actually augment the percent of charitable giving because people will give to organizations they personally support or feel connected with. Thus, free-market policies will actually improve the health and well-being of individuals because of the trickle-down effect.

Using data from the General Social Survey, I will analyze the relationship between the economic ideology explained above and individual perceptions of health. Through preliminary bivariate data analysis I have noticed that the majority of Americans report "excellent" or "good" health on a four category scale from "poor" to "excellent." Since the majority of Americans believe they have good health, I will try to find out who are the people who perceive themselves to have poor health and what are their economic beliefs. Based on the evidence of a particular economic ideology

21

prevalent during the time the data was collected (1993-2004), the following

proposition will be suggested:

Proposition 1: Respondents who believe in an economic system other than economic libertarianism will have poorer self-reported health than those who believe in a neo-liberal, free-market system.

THE INFLUENCE OF RELIGIOUS CONSERVATISM ON POLITICS AND THE AMERICAN PUBLIC

Despite the intent to separate religion and politics in the U.S. Constitution

(Article VI), religion continues to play an important role in public and private arenas

in America today. In 1905, Max Weber published his influential book, "The

Protestant Ethic and the Spirit of Capitalism," which traced the role of ascetic

Protestantism in the rise of rationalization and the "spirit" of capitalism.   As Weber

explored modern capitalism in America, he saw the same guiding social ethic as

Protestantism in Europe but observed that it was free of explicit religious doctrines.

The resultant secularized religious norms impacted Americans' perceptions of their

relationship to economic and political spheres. Weber used Ben Franklin's *Poor

Richard's Almanac*, published between 1732 and 1757, as an example of the influence

of these secularized Protestant norms.   Weber states, "One has only to re-read the

passage from Franklin, quoted at the beginning of this essay, in order to see that the

essential elements of the attitude which was there called the spirit of capitalism are the

same as what we have just shown to be the content of the Puritan worldly asceticism,

only without the religious basis, which by Franklin's time had died away" (Calhoun

2002:204). Franklin's axioms cajoled readers to work hard, be thrifty, and adhere to

the merciless efficiency of capitalism, because doing so was an "expression of virtue

and proficiency in a calling" (Calhoun 2002:194). The question remains as to whether

the same secularized Protestant ideology is dominant today or if a new ideology has

arisen. Indeed, some similarities still remain since the 1700s, such as the lasting

importance of religious values that underlie and justify economic and political

policies, but the type of religious influence has changed dramatically. The following

section will trace the rise in influence of religious conservatives, both on the political

arena and on the American public, and highlight the ruling ideology that was operative

when the dataset under analysis was collected (1993-2004).

The New Christian Right

In 1964 a small band of determined ultra-conservative Republicans felt that the

issues they cared about most were not being represented in American politics.

Organizing around a viewpoint that stressed a good versus evil bifurcation of the

world these conservatives favored a strong national defense, non-accomodationist

foreign policies in the face of communist ideals, and social traditionalism. This group

of ultra-conservatives called themselves the New Right and campaigned heavily for

Barry Goldwater (Liebman and Wuthnow 1983). Goldwater also drew support from

more moderate conservatives including Ronald Reagan, who assisted supporters by

furnishing them tickets to the 1964 Republican National Convention in San Francisco.

Nelson Rockefeller's speech was heavily booed by this contingent, signaling a

rejection that paved the way for Goldwater's nomination as the Republican Party

candidate. Although many expected the New Right to fade after Lyndon B. Johnson

won the election, the leaders were not ready to give up. They quickly joined a team of

Goldwater supporters and nascent politicians and helped to form the American

Conservative Union to maintain the progress made through campaign connections and

organization. As Morton Blackwell, a young delegate of Goldwater's 1964

presidential campaign put it, "After 1964, conservatives got tired of losing and decided

that perhaps being 'right' in the sense of being correct was not sufficient to win. Conservatives came to the understanding that we owe it to our philosophy to study how to win; that we had to be active in party structures" (Martin 1996:89). Although for a time, the New Right receded into the background, gains in financial assets, mobilization of a united front on policy matters, and an aggressive dissemination of its message through media outlets such as the Christian Broadcasting Network, greatly increased membership over the next several decades.

Discouraged with Nixon's failure in Vietnam, the moral deficiency exposed in the Watergate Scandal, Gerald Ford's pardon of Nixon, and the ceding of the Panama Canal, ultra-conservative Republicans shied away from giving Ford their full-fledged support in the 1976 presidential race. Most supported Reagan who had gained some exposure and respect from an 11th hour campaign speech for Goldwater and had since impressed conservatives with his unabashed endorsement of the conservative agenda on moral issues, the right to bear arms, and welfare reform. In a later bid for Governor of California he won more conservatives by emphasizing his similar character, "I am not a politician. I am an ordinary citizen with a deep-seated belief that much of what troubles us has been brought about by politicians...if we ordinary citizens don't run government, the government is going to run us" (Ronald Reagan 1966, quoted in Martin 1996:91). Although Reagan won several primaries, he dropped out of the race early forcing conservatives to make a tough decision between Ford, a Republican whom they did not trust, and Jimmy Carter, a religious Democrat. The tide swung towards Jimmy Carter, an intensely religious man whose moral standards many religious Americans admired. Yet, not long after he won the presidency, such regard for Carter among conservatives waned because he clearly maintained a separation of religion and politics, supported more liberal policy reforms, and failed to staunch rising inflation (See Martin 1996:168-190).

In the 1970s, the New Right linked up with the Christian Right, a group of preacher-politician-activists who sought to base the party's policy initiatives on "Biblical" standards (Utter and Storey 2001). In addition, they opposed abortion, homosexuality, feminism, and affirmative action. Leaders such as Jerry Falwell, Pat Buchanan, and Tim LaHaye and organizations such as the Moral Majority, the Christian Voice, and the Religious Roundtable became outspoken and powerful forces in the New Christian Right Movement. These organizations were direct and open when stating their purpose. The sincere attempt to link religion and politics is seen in the slogan and policies of the Christian Voice which issued "Biblical Scorecards" that gave legislators a mark based on their support of conservative issues in order to form a "Christian majority in a Christian Democracy" (Martin 1996:199).

In addition, the 1970s saw a tremendous rise in the number of conservative foundations with religious roots, some which still hold tremendous influence and power today. In 1971, Paul Weyrich founded an organization to analyze policy and provide some intellectual support for an "alternative approach" (i.e., conservative ideals) to members of Congress who did not agree with Nixon's more liberal policies. In 1973, this low-profile organization became the Heritage Foundation (Martin 1996). Even today, the Heritage Foundation continues to generate research to affect public policy on foreign and domestic issues. In particular, it supports economic libertarian polices to limit government intervention, lower taxes, and support private enterprise as a means to maintain social traditionalist values for families and communities (http://www.heritage.org, n.d.).

The Heritage Foundation established itself as an important conservative institution during the textbook wars in Kanawha County, West Virginia when it became involved at a grassroots level. Indeed, the 1970s saw a flurry of local level mobilization of conservative community leaders and other congregation members to

25

form social movements in protest of new liberal policies and organizations. This grassroots mobilization around conservative causes quickly became institutionalized into formal organizations and foundations such as The Heritage Foundation. The issues religious conservatives were most active about in the 1970s revolved around what came to be known as "family values." Religious conservatives believed that society was being continually liberalized and that they must protest these policies to retain control over their own lives and those of their children. Conservative outrage at the Equal Rights Amendment (ERA), gay rights, abortion, school textbooks, sex education in schools, banning of prayer in school, and revocation of tax exempt status for private schools spawned an era of grassroots political activism. Many leaders of the New Christian Right credit the textbook struggles of 1974-1975 in West Virginia and the 1978 IRS vs. Christian day schools conflict with lighting the fire under the religious conservative movement and uniting the political right with the religious right (Martin 1996:173). These two events in particular mobilized individuals, churches, and foundations to come together for the religious conservative cause

In summary, foundations in the 1970s provided the New Christian Right with numerous position papers to support the conservative agenda and aid leaders such as Falwell, Buchanan, and Pat Robertson in creating huge databases of supporters. These lists would become invaluable during Reagan's 1980 presidential campaign. Finally, the liaison between the religious conservatives such as Falwell and secular conservatives such as Weyrich (of the Committee for the Survival of a Free Congress, founded in 1974, and the Free Congress Foundation) who coined the phrase "moral majority" (Utter and Storey 2001), became a powerful force for building support in elite economic, social, and political spheres.

The Reagan Era

In the 1980 presidential elections, the religious right heavily supported Ronald Reagan because he stated outright that he was "born again," espoused Judeo-Christian values, was against abortions, and argued that evolution was being discredited by scientists and should be replaced with creationism in school textbooks. His long history of support from the ultra-religious conservatives meshed with his superior communication skills to help him take 44 states and 91 percent of the Electoral College votes (Martin 1996:219). Although it is likely Reagan would have won even without the support of the ultra-conservative segment, the religious right felt they had made a difference.

The influence the massive conservative foundations and religious conservative leaders had (or believed they had) on political policy was a culmination of the grassroots mobilizing and political lobbying efforts that had initially created these institutions. During Reagan's presidency the religious right grew from political lobbyists to an ideological powerhouse. Although religious conservatives received few appointments directly in the Reagan administration (in a large part due to the lack of political experience of members of the religious right), several key leaders still felt that they had access to the White House and the ear of the President himself. Indeed, in a meeting soon after taking office, President Reagan assured Jerry Falwell of this relationship by stating 'Feel free [to come see me]. That door is open" (Martin 1996:223). For the first time, the religious right felt like they were on the inside instead of being a marginalized and discounted minority. Some members of the religious right believed that the desire to maintain this influence and power politically forced them to compromise on previously staunchly defended issues. Ed Dobson, a close aide of Falwell, recounts, "I remember the first time I went to the White House with Jerry Falwell and ate at the mess hall with two key people in the President's inner

27

circle and I'm thinking, 'Wow I am sitting here at the White House' … This was heady stuff for people who, one or two years earlier, had been unnoticed and unheard of, and nobody had cared about us. … [We got] caught up in the euphoria and fail[ed] to ask, 'What's the next step?' We were carried along and seduced by success and never asked the tough questions" (Martin 1996:225-226).

The hope felt by many religious conservatives with the election of President Reagan and the inside position religious right leaders believed they gained, faltered as very little of the conservative agenda was realized in the 1980s. Reagan focused primarily on economic and international issues and seemed to have little interest fulfilling the pledges of the social agenda on which many presumed he was elected. Pat Robertson, the widely known televangelist, Southern Baptist minister (at the time), and founder of the Christian Coalition, decided to run for president in 1988, hoping to finally bring a realization of the ultra-conservative agenda to America. Robertson stated,

> The theme of my campaign was restoring the greatness of America through moral strength. I sensed in 1986, '87, '88, what has come to full flower today: a moral decline in our nation, the break-up of the American family, the rise of crime and drug addiction and abortion. . ... I was also talking about a return to faith in God and individual self-reliance. I thought we had depended too much on big government, on government programs, for the solution, and needed to go back to that sense of pioneering spirit that America had been known for. ... Many of the programs in the Contract with America were things I was enunciating in those days. So out of the seeming defeat of my campaign and the demise of what had been called the Moral Majority came an extremely effective force which I believe is the wave of the future, and which is toppling historic liberalism and will bring about a conservative era in the United States (quoted in Martin 1996:298).

Although religious conservatives put up a tough and guerilla-like fight for Robertson's nomination at the Republican National Convention, he only won a handful of primaries and conceded the race to George H. W. Bush in 1988.

Nearly three decades of focusing solely on influencing the presidency and the upper echelon had produced few victories for the religious right. Disappointed with Reagan's weak stance on abortion (via the Helms-Hyde bill), the nomination of Sandra Day O'Connor to Supreme Court Justice, the lack of endorsement for the Family Protection Act, and the failure of Robertson to get the Republican Party nomination, religious conservatives realized they needed a new strategy for influencing American society (Martin 1996).

The New Strategy

Scandals, hints of corruption, and volatile remarks decreased Falwell popularity and the Moral Majority collapsed in 1989. This decline, rising disillusionment with successive presidencies that ran on the support of conservatives but then failed to push the conservative agenda once elected, and frustrations with Congressional policies led the religious right to change their strategy for influencing politics and society. Over the next decade, the religious right shifted their focus from cajoling support from politicians to encouraging local political involvement (Utter and Storey 2001). The leaders at the time, Pat Robertson, Ralph Reed, Billy McCormack, Pat Buchanan and others, decided to move the focus of the religious conservative movement out of Washington D.C. and into local communities by designing a training manual for grassroots organizing and by encouraging supporters to run for positions on school boards, city councils, hospital boards, and county commissions.

By organizing activists in every political precinct in America, the religious right began to infiltrate local school-boards, city councils, state legislatures, and eventually was able to use this strong base to start winning seats in Congress. New campaign skills were taught and community members with little to no previous political experience were able to take important local political seats. The conservative

agenda began to be pushed through at the local level, perhaps most notably in school reforms. Paul Weyrich reviews the importance of these tactical changes, "As a result, we have lots of friends now on city councils and county boards and school boards and in state legislatures - something we never had before. This is why we can seriously talk now about fundamental changes in Washington, because you've got governors and legislators and mayors who are speaking up and advocating [conservative] positions" (quoted in Martin 1996:308).

The Republican Revolution

In 1993, the religious right capitalized on the local level support they had built. Republican politicians rallied around a set of Congressional commitments that were heavily ideological. The Contract with America, developed primarily by Newt Gingrich and Dick Armey, suggested to Americans what a Republican controlled Congress could accomplish (Sinclair 1999). "The Contract with America was itself an elaborate effort to disseminate a bundle of messages about the Republican party: policy messages, but also the message that, unlike the majority Democrats, the party was dedicated to cleaning up the "corrupt" Congress and prepared to stake its future on fulfilling its promises" (Sinclair 1999:431). Gingrich pushed his ideas into mainstream society through C-SPAN, granting many interviews, designing media kits, and creating a Republican discourse/dialect. "[I]mmense effort went into attempts to shape public perceptions of Republicans' policy proposals. … On Medicare, Republicans mounted a massive campaign, involving 'polls, focus groups, corporate coalitions, imagemakers, lobbyists, radio talk shows'" (Maraniss and Weisskopf 1996:128, quoted in Sinclair 1999:432). Even the language of the Contract was heavily infused with ideological images and euphemisms. For example, welfare reform was labeled "Personal Responsibility Act," while cutting capital gains taxes

30

and weakening environmental protections was called "Job Creation and Wage Enhancement Act." These names were actually pre-tested through focus groups in order to maximize receptivity (Sinclair 1999). The welfare reform bill unapologetically rested on conservative normative social and family values such as heterosexual marriage and committed parenting. In the early 1990s, the Contract with America became the primary mechanism to disseminate the Republican ideology to the American public, which was effectively managed through media relations.

Signed just prior to the 1994 midterm elections, the Contract with America faulted the Democratically-controlled Congress for past failures and presented a united view on political, economic, and social issues. The Contract resonated with voters, and for the first time in 50 years the Republican Party took control of both the Senate and House of Representatives in 1994. "When the GOP gained fifty-two House seats, eight Senate seats, eleven governorships, and 472 seats in state legislatures in the November 1994 elections, the Religious Right [was] flush with the knowledge that 114 members of the new House and 26 Senators had either received a perfect rating on the Christian Coalition Congressional Scorecard or were freshmen elected with the group's strong approval. An additional fifty-eight members of the 104th Congress voted for the Christian Coalition positions more than eighty-five percent of the time" (Martin 1996:340). For the first time, the religious right felt that it had influence at both the local level and national level and had an agenda that was both conservative and widely supported. By turning to the local level to garner support, the religious right had influenced both politics and society. From their perspective, the only remaining barrier was the President.

The "Republican Revolution" and subsequent transfer of power away from the Democrats greatly affected Bill Clinton's presidency. Campaigning and winning in 1992 on a moderate, centrist, social democrat ticket, Clinton promised to "end welfare

31

as we know it" and reduce the budget deficit (Zylan and Soule 2000). In practice, these two goals seemed to be simultaneously impossible as Clinton's welfare reform plan of improving social services such as job training, child care, education, and government guaranteed jobs were increasingly costly (O'Connor 2002). To combat the rising expected costs, Clinton proposed a slow phase-in stage, which angered both Democrats and Republicans. In addition, Clinton first wanted to implement health care reform so as to open access to health services for all poor people (Sinclair 1999). He hoped this safety-net would make the looming welfare reform more attractive and tolerable for low-income families and especially their children. Then, welfare reform would focus on transitioning the poor into employment, a task Clinton felt was challenging enough without the additional concern about the lack of health care benefits in such low-pay jobs (O'Connor 2002). Thus, the universal health care system would eliminate the incentive to remain jobless so as to retain Medicare benefits.

The Democrats failed to push the legislation through Congress and the Republicans filibustered as the 1994 elections neared. This resulted in the popular image that the 103rd Democrat Congress was impotent and Clinton's "health and then welfare reform" was the wrong strategy, thereby paving the way for the advancement of the Republican representatives (O'Connor 2002). Clinton's welfare reform plan was scuttled after the 1994 "Republican Revolution," where the new leadership argued that since the U.S. was experiencing a welfare crisis and not a health care crisis, the former should be the main focus of immediate policy measures (O'Connor 2002). With the failure of Clinton's health care reform plan, his welfare reform plan also lost credibility and was quickly reworked into a more Republican-favored version (seen in the Contract with America). Some saw the changes as harsh, especially the stipulation that minor mothers or mothers on welfare who have more children should not receive

benefits, and that all welfare-losers would have a life-time cap of two years on benefits received (Zuckerman 2000), but others felt this was the only way to encourage responsibility and employment. The Republican plan also gave power to the state government to decide on restrictions and time-limits, freeing Congress from any negative press associated with such measures.

Republicans felt pressure to enact the policies they had agreed upon in the Contract because they had committed to make changes in three months (Sinclair 1999). Thus, with this pressure and the ideological homogeneity built by unanimity on signing the Contract in the first place, Republicans were more assertive than they had been previously (Utter and Storey 2001). Many Republican Congressional members felt they had a mandate to carry out the terms of the Contract and that the future of the party depended on their success at this task. During this time, a rise in ideological homogeneity could be seen by the increasing voting partisanship. Until the 1982 election, less than half of votes were along party lines. The next decade saw a continuous rise in ideological polarization until over two-thirds of the votes pitted a majority of Democrats against a majority of Republicans in the 104th Congress (Sinclair 1999).   The unity of the Republican Congress also allowed Gingrich, as the new Speaker of the House, to have more power in setting the agenda and pushing the President towards this agenda. Gingrich's aim was to "transform how Americans think and talk about politics, and thereby 'transform the political alignments, institutions, and governing policies of the nation'" (Blatz and Brownstein 1996:144; Stid 1996:1 in Sinclair 1999:422). By disseminating the ruling ideology and involving Republicans at the local political level Gingrich, with the help of religious conservatives such as Buchanan and Robertson, built support for the Republican Party from the bottom up.

In 1999, the Christian Coalition broke into two organizations to counter tax evasion and political party affiliation problems of which it had been charged. Americans became disillusioned with the religious right and support began to wane as most of the promises in the Contract with America never made it through the Senate. Many leaders in the religious right, such as Paul Weyrich, believed it was time to return to evangelism and private life reforms. Sensing this disillusionment, Governor George W. Bush was less outspoken and showed less affiliation with the religious right in the early days of campaigning than was expected of the Republican presidential nominee. Yet, after his defeat in the New Hampshire primary, Bush changed strategies and aligned himself with the religious right (Utter and Storey 2001). His presidency has seen the maintenance of the ideological discourse presented in the Contract with America, particularly its fundamental beliefs on nuclear families and the power of the individual.

Implications for Health

Although this overview has traced the rise of the conservative right from the Goldwater era, arguably the New Right's most influential decade was during the years the data for this analysis were collected (1993-2004). In essence, the religious changed its focus from seeking a President who would push for conservative family values, such as restricting abortion and protecting organized religion in public schools, to waging a stealthy type of grassroots war to change such policies at a local level. Through early disappointments with supporting conservative Presidents through elections only to have their agenda toned down and pushed aside, the religious right realized that the way to change America was to change their local communities. By winning seats on school-boards, hospital boards, and local government seats, religious conservatives saw their agendas realized. This tactic more than any other, allowed the

ideals of the New Right to affect Americans (Martin 1996). As the religious right gained more influence at the local level, they were able to move up the ladder to controlling more strategic and powerful positions. For example, in 2000, religious conservatives capitalized on an opportunity to gain influence in the Presidency, but this time built upon a more solid base in local politics.

It is clear that an ideological shift has occurred in America over the past 25 years. Saunders and Abramowitz (2004:285) suggest that "as a result of an ideological realignment led by conservative Republican leaders such as Ronald Reagan and Newt Gingrich, by the mid-1990s, ideology had become a much more important motivation for participation among Republicans than among Democrats." By merging religious conservative and economic libertarian rhetoric, the religious right promoted free-market fundamentalism. They did this by presenting evidence, through research commissioned by corporations, that free-market policies were essential to guarantee American freedoms (including the freedom for school choice) and for the well-being of families and communities (i.e. they decrease crime and delinquency). By promoting laissez-faire economics, the religious right also supported the notion that economic competition is an important motivation and those who work hard will be rewarded by the market (Harvey 2005). Yet, how has the ascendancy of the religious right and its accompanying political ideology that focuses on personal responsibilities and traditional family values affected the health and well-being of Americans?

Over time the ruling ideology becomes internalized in citizens, setting the standards for normative behavior (Marx 1976). It affects what people believe, how they act, and how they view their place in the world. As the ruling ideology becomes entrenched, individuals begin to conflate their ideal and material interests. Thus, voters may support a political party because of the influence of the ruling ideology,

despite the lack of personal benefit from the proposed policies under that party (Frank 2004). The rise in free-market fundamentalism in America since the 1970s, paralleling (and supported by) the rise in the New Right, has increased inequality and class divisions in America (Banks et al. 2006, Harvey 2005). A new line of research has emerged over the past ten years that has investigated how such worldviews affect individual and societal health and well-being. Researchers from a variety of fields, including sociology, epidemiology, psychology, nutritional science, policy, and political science, have sought to tease out how human self-perceptions affect bodily processes. Their findings suggest that not only does absolute material well-being matter but also that relative social standing affects health outcomes (Marmot 2004, Kawachi et al. 1997, Wilkinson 2006). Although much research has been conducted on how social integration, community cohesiveness, and relative socioeconomic status affect health, few studies discuss the implications of ideology on health.

The conservative religious movement in America has organized around key ideological themes that implicitly (or explicitly) relate to perceptions of health. For example, religious conservatives uphold values (labeled "family values" in the conservative rhetoric) that they believe are essential to a healthy family. Explicit in conservative rhetoric is the idea that two parent families consisting of a father and mother are *healthier* for a child's development. Another common theme is sexual purity and a separation from "immoral" acts with "unsaved" people. By restricting their behavior and acquaintances, members of the religious right may perceive themselves to be *healthier* than people outside the conservative religious community. The rhetoric persists that people engaging in immoral acts are unhappy because of their rebellion against God, and were they in a "right" relationship with God, they would realize the unbounded happiness of such position. Thus, not only do religiously conservative people believe they are physically healthier because of their distance

from contagious diseases (such as STDs and AIDS) that affect humans, but also that they are mentally healthier because of their spiritual health via a relationship with God. Finally, the social safety net, social support, and cohesive world-view provided by a community of "believers" or a congregation may be interpreted as having a positive effect on heath that "non-believers" would not be able to obtain.

Based on the historical development of religious ideology in America and the current manifestation of that ideology, the following proposition will be suggested in this study:

Proposition 2: Respondents who do not espouse religious conservative beliefs and/or accompanying normative behaviors will have poorer self-reported health than those who do.

THE INFLUENCE OF SOCIAL TRADITIONALISM ON POLITICS AND THE AMERICAN PUBLIC

The rhetoric of economic libertarianism and religious conservatism on social issues has often been labeled social traditionalism (Liebman and Wuthnow 1983:16). This perspective is characterized by traditional and conservative views regarding family structure, school policy, sanctity of life and marriage, and sexual mores. Previous sections of this study have documented a number of ways social traditionalists and economic libertarians have affected government through influential people close to the President. The public has also learned of these particular ideologies through popular books and magazines, radio programming, and mailings. This section will analyze another key mechanism economic libertarians and religious conservatives used to create and publicize the social traditionalist ideology.

Interspersed through the recent history of the rise of economic libertarianism and religious conservatism documented above were brief mentions of foundations and

organizations developed to lend financial or research support to certain conservative causes. These institutions played an essential role in commissioning and disseminating information about the conservative position on specific issues to the general public and to policy-makers alike. Hoover states, "A generation of conservative politicians ... have (sic) acknowledged the critical role of these institutions in shaping their views and making conservatism politically acceptable" (2003:204). Although not all of the conservative institutions influencing public opinion and policy today began in the 1970s-1990s, many of them did. Others, such as the Hoover Institute and the American Enterprise Institute, founded in 1917 and 1943 respectively, have close ties with key economic libertarians such as Milton Friedman and Friedrich Hayek. It is clear from their mission statements that their current policy trajectory is consistent with the libertarian and conservative ideologies that dominated the 1970s-1990s. This section will discuss the agenda of some of the most influential conservative think tanks and how they influence the public and private sectors.

Despite the generic label "conservative think tanks," the target groups, agendas, and means of communication of these organizations are by no means homogenous. The overarching connection between these institutions is their use of conservative rhetoric, bolstered by either economic libertarian or religious conservative perspectives (or in some cases both). For example, the Family Research Council states, "Believing that God is the author of *life, liberty, and the family*, FRC promotes the Judeo-Christian worldview as the basis for a just, free, and stable society" (http://www.frc.org, n.d., emphasis mine). Ideas of "preserving the natural order of life" and "preserving man's natural right to freedom and liberty" through conservative policies are prevalent. Conservative organizations seek to influence public policy as well as the public. Although some groups are focused only on

38

affecting one or the other, most work at both the policy and grass-roots levels. The

following sections will discuss their different tactics for infiltrating both the

government and mainstream America.

Targeting Policy

Conservative think tanks collect and produce an enormous amount of research

about current policy debates. These briefs and articles are intended to provide policy-

makers with empirical evidence and carefully framed arguments for or against certain

issues important to the conservative agenda. For example, one influential

organization's mission statement reads: "Founded in 1973, The Heritage Foundation is

a research and educational institute – a think tank – whose mission is to formulate and

promote conservative public policies based on the principles of free enterprise, limited

government, individual freedom, traditional American values, and a strong national

defense" (http://www.heritage.org, n.d.). Other organizations, such as The National

Center for Policy Research, have similar goals. Its website states, "In 1982, we started

The National Center to provide the conservative movement with a versatile and

energetic organization capable of responding quickly and decisively to fast-breaking

issues. Today, we continue to fill this critical niche through a top-flight research and

communications operation driven by results and the bottom line"

(http://www.nationalcenter.org, n.d., n.d.). These and other organizations provide

good examples of the intent of think tanks to provide documentation and empirical

evidence to support the conservative cause in political matters.

The most prevalent policy issues identified in the mission statements of

conservative think tanks include limiting government intervention, encouraging

private enterprise, advancing individual liberty, promoting individual

responsibility/individualism, lowering taxes, protecting traditional values, and

maintaining a strong national defense. Often organizations will state their underlying

social agenda and or foundational beliefs, such as maintaining the integrity of the

traditional heterosexual family, and then state economic libertarian policy goals such

as restricting government power and supporting free-market ideas.   For example, the

Family Research Council (FRC) upholds traditional values such as the sanctity of life

and heterosexual marriage, but its research and policy agenda is focused on "lower

taxes, less wasteful spending, and the principles of rational and limited government"

(http://www.frc.org, n.d.). Thus, it seems that the FRC works on economic libertarian

policy issues to preserve social traditionalist ideals couched in the rhetoric of "life,

liberty, and the family." Other agencies also seek to influence policy-makers on

economic issues in order to protect traditional social values. Founded in 1976, the

Ethics and Public Policy Center focuses on limited government intervention on

economic policies such as tax breaks, health care, and retirement funds, so as to

guarantee conservative ideals (often termed "freedoms" in the rhetoric) for the family

"as the central social institution of American civilization" (http://www.eppc.org, n.d.,

n.d.).   Similarly, the Free Market Foundation, founded in 1972, seeks to "strengthen

and protect the individual and the family by supporting principles that promote

responsible citizenship, limited government, free enterprise, private property

ownership, limited taxation, and Judeo-Christian values" (http://www.freemarket.org,

n.d.). The general trend for conservative organizations is to target economic and

political policies that will ultimately guarantee social traditionalist values.

Conservative think tanks influence policy-makers by meeting with local

legislators, meeting with and sending information to state representatives, taking legal

action, and lobbying. The Free Market Foundation notes its influence on its website,

"During the Texas legislative session, Free Market consults regularly with state

government leaders to encourage and support their efforts to protect the important

40

issues that face our families" (http://www.freemarket.org, n.d.). Organizations such as the Alliance Defense Fund "provides case funding, strategy and coordination, attorney training, and litigation," for cases against traditional heterosexual marriage, religious freedom, the sanctity of life, or other conservative family values (http://www.alliancedefensefund.org, n.d.).   There is little doubt to the influence of such conservative think tanks. At the Conservative Century Dinner held in Washington DC on May 26, 1999, the keynote speaker William F. Buckley declared "what is good for the ACU [American Conservative Union] is good for America" (http://www.conservative.org, n.d.).   Conservative think tanks, such as the Free Market Foundation, the Alliance Defense Fund, and the ACU, have without a doubt greatly impacted public policy decisions over the last 40 years.

These organizations have played important roles in furthering the conservative agenda. Previously, I discussed the role the Heritage Foundation played in the school text book debates of Kanawha County West Virginia in 1974-1975, but the influence of conservative think-tanks did not stop here. As the National Center for Public Policy Research states, "In the 1980s, The National Center helped change public opinion through vocal national campaigns aimed at supporting Reagan administration initiatives concerning the USSR, arms control, Central America and human rights" (http://www.nationalcenter.org, n.d.). In the 1980s, a prominent libertarian business man who had been the Secretary of the Treasury under Nixon issued a call for "a massive corporate subsidy to 'non-egalitarian scholars and writers,' including the economic libertarian Friedrich Hayek, 'who could carry the message in books subsidized by conservative foundations'" (Diamond quoted in Hoover 215). A good example of Marx's (1976:67) theory that those who control the means of production also control the intellectual means of production, this subsidy assured that economic

libertarianism and conservative ideals quickly spread into the government and the mainstream.

Targeting Public Opinion

The influence of conservative organizations has not been limited to only politicians and public policy. Economic libertarianism and religious conservatism have also influenced the worldviews of mainstream America. In particular, these institutions have promoted their ideas via 30-second public service announcements, popular books, radio spots, websites, mailing lists, and even TV shows. The Ethics and Public Policy Center states that beyond working closely with government leaders, they also "write books that are widely read, publish articles in the popular press and in scholarly journals, and appear frequently on television and radio" (http://www.eppc.org, n.d.). By utilizing every main source of popular media, these organizations have been able to spread their ideas across America. But merely receiving information is not enough. These organizations have invested in encouraging individuals to get involved in these causes whether with local, grass-roots movements or with political lobbying in Washington D.C. For example, the Christian Coalition of America calls for people of faith "to be actively involved in shaping their government" (http://www.cc.org, n.d.), while the Cato Institute seeks for "greater involvement of the intelligent, concerned lay public in questions of policy and the proper role of government" (http://www.cato.org, n.d.). Other think tanks played major roles in influencing public opinion. For example, in the early 1990s the American Conservative Union played an important role in swaying public opinion on Clinton's national health care plan by publishing critiques, outlining other more "conservative-friendly" options, and staging a huge bus tour through the Northeast and Midwest called the National Health Care Truth Tour. This initiative created rallies

and press-conference and presented important speakers on the issue
(http://www.conservative.org, n.d.).

Implications for Health

  Conservative institutions have addressed the concern over the outcomes of a
declining civil society and meaningful engagement with politics. Indeed, the
Independent Women's Forum states that its "mission is to rebuild civil society by
advancing economic liberty, personal responsibility, and political freedom" by
pushing the conservative agenda of economic libertarianism and social traditionalism
(http://www.iwf.org, n.d.). As societies increase in complexity, it is argued that the
government is less able to manage it and its welfare should be left to market and social
forces (Reagan 1981). Poverty that is not alleviated by economic opportunities will be
cared for by concerned and active citizens. These citizens are birthed by communities
with a healthy civil society, which in conservative circles is seen as generated by
strong families. To complete the circle, "a healthy civil society protects the individual
from overwhelming state power" (Freeden 2000:42). Social traditionalists uphold the
importance of a traditional family structure and values for the well-being of the
children, family members, and ultimately the community.

  The Heritage Foundation presents a large number of studies whose conclusions
lend support to the conservative value of marriage and traditional family roles.
Married women were reported to have greater psychological well-being and less intra-
household conflict, than single or cohabiting women. In addition, women who had
social traditionalist views on gender roles within the family were more satisfied with
their husbands and less likely to divorce than women who had more liberal views and
worked outside the home. They reported that the health of infants with mothers
working outside the home was also significantly worse than infants of non-working

mothers. And they concluded that fathers who were theologically conservative were more loving to their children, more likely to maintain a consistent bedtime for their children, more likely to limit television watching, yelled less at their children, and had conservative values that contributed to happier wives, than fathers with other religious beliefs.   In addition, studies posted on their website claim other health benefits of maintaining a traditional family structure, "Intact families are more likely to provide a safe home for children. … Married mothers tend to create a better home environment for their infants. … Married fathers tend to have better psychological well-being. … Children raised in intact families have, on average, higher academic achievement, better emotional health, and fewer behavioral problems" (http://www.heritage.org, n.d., see also Wilcox 2004). Complementing the Heritage Foundation's extensive literature about the health benefits of maintaining traditional family structures and values, other conservative organizations also have noted the relationship between the two. The Alliance Defense Fund legally fights for traditional family values based on research that suggests "weakening the family harms individuals, and (sic) especially children" (http://www.alliancedefensefund.org, n.d.). Research on the relationship of health and family structure has been a powerful tool for the conservative agenda.

Conservative research suggests that family structures other than those espoused by social traditionalists are not only bad for personal and family health, but they are also bad for the health of the community. For example, the Heritage Foundation reports that, "an increase in the proportion of female-headed households in the community was associated with high rates of violent crime and drug trafficking, welfare dependency, infant mortality, high-school dropouts, and unemployment among young adults" (http://www.heritage.org, n.d.). The Alliance Defense Fund finds that "weakening the family and undermining the values that support it will ultimately destroy our society and dramatically impact religious civil liberties"

(http://www.alliancedefensefund.org, n.d.). The connection between traditional social values, individual health, family health, and community health has grown stronger in recent years with the research of many conservative think tanks. Concern for families and communities has encouraged conservatives to latch on to the popularized concept of "social capital."

Although the term "social capital" has existed for decades, sociologist Robert Putnam introduced the term to the mainstream in the 1990s and 2000s, culminating with his lauded book, "Bowling Alone" (2000). He builds off of Durkheim's thesis that community integration offers protective benefits for individual health and Mills' predictions of the decline of engagement in voluntary associations (Mills 1959:306). Testing these theories through years of empirical research in Italy and America, Putnam concludes that community involvement in the social, political, and economic issues of the surrounding area increases community and individual health. He suggests there are three main reasons why social capital may improve health.

> First, social networks furnish tangible assistance, such as money, convalescent care, and transportation, which reduces psychic and physical stress and provides a safety net. …
> Second, social networks also may reinforce healthy norms - socially isolated people are more likely to smoke, drink, overeat, and engage in other health-damaging behaviors. And socially cohesive communities are best able to organize politically to ensure first-rate medical services. …
> Finally ... social capital might actually serve as a physiological triggering mechanism, stimulating people's immune systems to fight disease and buffer stress (Putnam 2000:327).

Although Putnam did not intend for these ideas to bolster the conservative cause, certain organizations and think tanks have found his theories, often in simplified and distorted form, consistent with their agendas. Extrapolating from Putnam's argument that individuals joining civic organizations will benefit the health of the community,

conservative think tanks have asserted that strong family values will make strong families, which will lead to more civic participation, and thus better community health. Using this slight alteration to Putnam's social capital idea, conservative organizations have encouraged Americans and policy-makers to implement social traditionalist policies that will maintain traditional family structures. According to research commissioned by conservative organizations, traditional families will impede crime and delinquency while improving community health and cohesion. An increase in the number of families using materials from the conservative agendas will not only help to create more intact families but will also encourage families to become politically active in voluntary organizations. This activity will strengthen the community and improve the health of all. The social traditionalist ideology prevalent in contemporary society suggests that residents of cohesive communities, created through social traditionalist norms, are *healthier* than residents in non-politically active communities (assumed to have non-traditionalist family values). Thus, this study will examine the following related proposition:

Proposition 3: Respondents who do not have a positive perception of community cohesion will have poorer self-reported health than those who do.

A COMBINED MEASURE OF IDEOLOGY

Marx (1976) hypothesized that there was a ruling ideology for each epoch. This ideology is created and sustained by the powerful, who Marx conceptualized as those who controlled the means of production. He convincingly states, "The ideas of the ruling class are in every epoch the ruling ideas: i.e., the class which is the ruling *material* force of society is at the same time its ruling *intellectual* force" (Marx 1976: 67). We can see evidence of this hypothesis in the corporate subsidization of think tanks to create knowledge supporting the agenda of the corporate sector.

46

Mills (1959) contemporizes Marx's theory by suggesting that the powerful consist of the elite in the economic, political, and military spheres. In the history of the rise of the current ruling ideology, influential members of the economic and political spheres (the military sphere is not analyzed in this study) often worked together to put forward a unified and mutually beneficial agenda with a highly ideological discourse. A good example of this unified system of thought and the use of ideological images can be seen in the rhetoric of the Republican Contract for America. Chapter Two has shown that membership in the power elite in contemporary society is not limited to economic and political circles. Clearly, powerful members of religious and/or social circles have sought alliances with other elites in order to guarantee that their interests are included in the ideology. Religious elites such as Billy Graham and Jerry Falwell were able to obtain the ear of several Presidents. The upper echelon of all these spheres of influence has the power to create a ruling ideology because of its connections to other members of the power elite. These members of society not only control the means of production but also either already control media outlets or can co-opt them for disseminating their ideological discourse. One such means of widespread dissemination is through organizations, such as think tanks, which create and legitimize knowledge that bolsters a certain ideology.

Independently, these spheres of influence can only develop and present particular ideologies. Even with empirical evidence supporting these ideas, when issued alone, these ideas they will have little influence. The ideas of the ruling class emerge as an ideology only when they are combined into a comprehensive worldview and made to seem normative and beneficial for all members of society. Marx states, "For each new class which puts itself in the place of one ruling before it is compelled, merely in order to carry through its aim, to present its interest as the common interest of all the members of society, that is, expressed in ideal form: it has to give its ideas

the form of universality, and present them as the only rational, universally valid ones"
(1976:68). The conservative rhetoric that only by adhering to the policies of economic
libertarianism, religious conservatism, and social traditionalism will we have "the
freedom to choose" and be protecting the moral fabric of America lends weight to the
argument that the ideas presented above are indeed a cohesive ruling ideology.
Conservatives lauded adhering to the ruling ideology as patriotic and upholding the
"natural" rights of Americans delineated by the founding fathers. Although this
ideology was strong and pervasive from the 1970s to 2005, there seems to be growing
dissatisfaction with it, perhaps due to the protracted war in Iraq and to apparent misuse
of this ideology for personal and political gain by those in power, both inside and
outside of government. The Democratic take-over of Congress in 2007 suggests that
change may be underway. Sociological theory might also help us understand this part
of the process, although diverse theories offer differing explanations. Marx (1976)
argues that the current ruling ideology will persevere as long as it serves the interests
of the ruling elite, while Kuhn (1996) suggests that when it becomes so full of holes a
new paradigm will arise.

Sociological theory supports the inclusion of a metric of ruling ideology.
Unfortunately, significant disagreement exists over how this variable should be
measured. This study will create a ruling ideology variable by forming a composite of
existing measures of economic libertarianism, religious conservatism, and social
traditionalism.   Although this way of measuring ruling ideology has limitations, it
may capture some of the complex nature of the concept. Chapter Two presented
evidence that economic libertarianism, religious conservatism, and social
traditionalism are independent predictors of health but could not recount the history of
each without noting the clear overlay of ideas, movements, and the social trajectory of

the current ideologies. These three ideologies did not arise in a social vacuum but developed in response to and in support of each other.

This wedding of ideas was not mere coincidence. Leaders of all movements realized that their ideals would be more influential if they were included in the rhetoric of other elites. Paul Weyrich, founder of the Heritage Foundation and a key religious conservative leader in the 1970s and 1980s, perhaps states it best, ""We decided that the social conservatives and the economic conservatives, who were social libertarians, had to find a way to agree more than they disagreed. They had to work together on things that united them ... [Economic conservatives] supported a tax cut because they were against big government and for lower taxes. [Social conservatives] supported it because we were pro-family. ... The Heritage Foundation got on board ... and Gingrich made it a part of the official House Republican budget" (Martin 1996:330). Although the groups had different motivations, they were able to find a common ground on policy suggestions, thereby presenting a strong united front to the government and public alike.   The merging of ideologies did not just occur between economic libertarians and religious conservatives. Economic libertarians also spoke of preserving traditional values, "Not only does [big government] threaten our economic and political freedom, big government has slowed economic growth and depressed productivity, stimulated a rise in criminality and violence, weakened the family, generated racial unrest, lowered the quality of our schools, and increased poverty" (Rayack 1987:78). Sociological theory and historical evidence suggest the presence of a ruling ideology in America and that it has strains of economic libertarianism, religious conservatism, and social traditionalism. Thus, a final proposition will be examined:

Proposition 4: Respondents whose responses do not reflect the ruling ideology measured as a composite of economic libertarianism, religious conservatism, and social traditionalism, will have poorer self-reported health than those who do.

CHAPTER THREE

HEALTH AND SOCIETY

The relationship between morbidity and social class made headline news recently when the Journal of the American Medical Association published an article comparing the incidence of severe illness between Americans and the British (CNN 5/3/06). Banks et al. (2006) found that Americans' self-reported higher rates of severe health problems than the British of the same social class, despite the fact that the U.S. spends more money on health care per capita than Britain. In light of this alarming finding and its implications for societal inequality, this study attempts to tease out previously unstudied social predictors of poor health.

A gradient of morbidity and mortality between all socioeconomic levels and even within social groups has been widely observed. Research suggests that people with slightly higher socioeconomic status have lower rates of morbidity and mortality than people slightly below them (Marmot 2004, Wilkinson 1986). Thus, health inequality cannot be viewed as a dichotomy between the "rich" and the "poor" but instead must be studied as a gradated pattern of inequality. This socioeconomic gradient has also been observed in almost all illnesses (except certain types of cancers) and disease risk factors (Schnittker 2004, Adler and Ostrove 1999). The interaction between socioeconomic status and health matters not only for the physical well-being of humanity but also because this gradient can serve as an indicator of the health of the political, social, and economic environments within society. Extensive research has been conducted on the connection between health and social factors such as poverty, inequality, social class, gender and race. Researchers have pointed to links with health behaviors, unequal access to health care, environmental risk factors, genetic and demographic dispositions, material deprivation, social cohesion, relative social

51

position, social inequality, and mental health.   This chapter will serve as an introduction to and overview of the key areas of research on the relation of health and society.

When analyzing health status across a population, there are several competing theoretical models that are used explain the associations found in contemporary empirical research. Before launching into an exploration of these theories of health, a brief discussion of the unit of analysis may be useful. The greatest debate between relevant theories is whether research should focus on macro-scale societal-wide variables that suggest embedded causes of poor health or on the mechanisms of transmission from the macro-scale social factors to individual health outcomes. The route the researcher chooses will affect his methodology, conclusions, and whether his policy suggestions will target individuals or society. This research attempts to connect large scale socio-economic processes to individual health via the line of research initiated by Mills' 1959 book "The Sociological Imagination."

MILLS' "SOCIOLOGICAL IMAGINATION"

How individuals view society (and their place in society) has important consequences for perceptions of individual health. As we have seen above, the current ideology implicitly connects society and health. Contemporary ruling ideology includes the idea that a free and thus healthy economy leads to personal and political freedoms that elicit better health for individuals, that upholding Christian conservative values is good for an individual's physical, social and spiritual health, and that local participation leads to a "healthy" community.

In 1959, C. Wright Mills wrote a treatise encouraging the growth of the "sociological imagination." In using this term he sought to connect the macro to the micro and show that history and large-scale social processes affect personal biography

and vise versa. Indeed, it is as essential for the sociologist to understand the structural forces influencing an individual's place in society as it is to look at his or her personal decisions and ascriptive traits.   In Millsian tradition, this study will also seek to place contemporary societal and ideological trends in the context of the historical development of America.

Mills challenges sociologists to ask three questions when conducting their research. They are: "1) What is the structure of this particular society as a whole? What are its essential components, and how are they related to one another? …2) Where does this society stand in human history? …3) What varieties of men and women now prevail in this society" (Mills 1959:6,7). This research has attempted to be faithful to Mills call for imaginative awareness at the intersection of the macro and micro by seeking answers to these questions. The first question is addressed in Chapters One and Two, which respectively deal with the ideological views within U.S. and with the three components of this ruling ideology: economic libertarianism, religious conservatism, and social traditionalism. Chapter Two locates the analyzed decade of data in the history of the U.S. and the development of the current ruling ideology. Finally, the remaining chapters will serve to describe the attributes of modern Americans, particularly in terms of beliefs, perceptions, class position, and health.

The idea of the sociological imagination not only guides the way we conceptualize the problem but also how we go about suggesting potential remedies. Mills distinguishes between "troubles" and "issues" suggesting that the former "occur within the character of the individual" (1959:8) and thus need an individual solution such as personal behavior modification. On the other hand, "issues" "transcend these local environments" (Mills, 1959:8) and are seen as social ills due to structural failings. These issues can only be addressed by looking at the inadequacies of the

broader institutions in society instead of the personal character of affected individuals. In short, the unit of analysis for this study is the individual but since there is enough evidence that poor health is not just an individual trouble, I will suggest some structural level issues that may be leading to poor individual health in America. This level of focus does not negate the importance of studies that focus on an individual's responsibility for lifestyle choices or behaviors that may affect his or her own personal health, but suggests that there is more at play than simply personal agency.

Finally, Mills' discussion of self-awareness is relevant to this study on ideology. Following the ideas of Marx on false consciousness, Mills argues that, "The sociological imagination enables its possessor to understand the larger historical scene in terms of its meaning for the inner life and the external career of a variety of individuals. It enables him to take into account how individuals, in the welter of their daily experience, often become falsely conscious of their social positions" (Mills 1959:5). This study posits the potential for a false consciousness among ideologically-adhering Americans. Using the tools of the sociological imagination, this study will take into consideration the interaction between structural and historical processes and individual experience.

THEORIES OF HEALTH AND RELATED FACTORS

Most epidemiological research on health has adhered to a biological model that focuses on relatively proximate measures such as health behaviors, genetics, and self-selection. Despite S. Leonard Syme's elucidation that the best research on health behaviors of the past fifty years can still only account for forty percent of the variance in specific illnesses (such as heart disease), the biological model remains the definitive model for epidemiology (Singh-Manoux 2005). This model has greatly influenced policy, resulting in specifically targeted interventions on lifestyle choices and health

behaviors. Yet the increasingly steeper health gradient suggests that macro-level social factors may play an important role in the trend of declining health across society (Banks et al. 2006).

Renowned epidemiologists Michael Marmot, Ichiro Kawachi, and Bruce Link have challenged the individual unit of analysis in an attempt to explain why a socio-economic gradient persists when measuring health and mortality, despite the improvement across society of mediating risk factors such as nutrition, cleanliness, immunizations, and preventative medicines. Their main argument is that physiological responses to inequality between social classes have an enormous impact on the health of humans (Daniels et al. 2000). In support of this focus on macro-level variables, sociologists such as Ellen Idler and James House, and, have joined forces with epidemiologists, including Syme, Marmot, Kawachi, Link and Richard Wilkinson, Peggy McDonough, Bruce P. Kennedy, to create the new field of social-epidemiology.

In their pursuit of merging sociology and epidemiology, these researchers root their work in classical sociological theory. Certainly, the association between macro-level social processes and well-being is not a novel concept as classical sociologists such as Durkheim, Marx, and Veblen all theorized on the matter. Despite its limitations in the field of evolutionary psychology (Marmot 2004:169), Durkheim's research on suicide uncovered some key effects of social organization (integration or disintegration) on the health of individuals. He thought that social factors were an irreducible part of mortality and focused his work on why a population had that level of illness, not why the individual developed a certain trait (Phelan et al. 2004). Social epidemiologists suggest that although all individuals experience stress and difficulties, Durkheim's work reveals that individuals with stronger social ties weathered these challenges better (Marmot 2004:167). Despite Marx's bifurcation of social classes

and focus on material processes in society, his contributions on ownership, alienation, and control over economic and social decision-making processes are relevant to health. One such acknowledgement of the impact of inequality can be found in *Wage, Labour and Capital*, where Marx states, "A house may be large or small; as long as the surrounding houses are equally small it satisfies all social demands for a dwelling. But if a palace arises beside the little house, the little house shrinks to a hovel… the dweller will feel more and more uncomfortable, dissatisfied and cramped within its four walls" (quoted in Marmot and Wilkinson 2001:234). This research can be seen as an extension of classical sociological theories and an attempt to test the continued relevance of such theories in contemporary society.

Thorston Veblen's "Theory of the Leisure Class" (in Ritzer 2000:323-349), where he discusses conspicuous consumption, has become an integral component of the argument that relative deprivation and social comparisons matter greatly (Marmot 2004, Kawachi 1997, Wilkinson 1996, 2000). The conspicuous consumption and display of wealth at the top of the hierarchy provides a painfully obvious separation between that rung of the social gradient ladder and even the next step down. People are unhappy because, unless they are literally at the top, there will always be someone above them and something more they want to obtain so as to give off the impression that they have "made it" (Marmot 2004:86). Veblen's idea of conspicuous consumption has become a key theoretical underpinning of the social-psychological side of the debate. Studies suggest that individuals do not compare their well-being with those at the same socioeconomic level, but naturally compare to those above them, perhaps because of the tendency towards conspicuous consumption for higher socioeconomic classes (Wilkinson 1997, Davidson et al. 2006).

Link and Phelan (1995) produced a formative document for the socio-psychological model of health, which discussed (what they term) "the fundamental

causes of social inequality" in relation to mortality. They subsequently test the hypothesis that socioeconomic status, as a multifaceted variable encompassing resources such as money, education, prestige, neighborhood effect, and social ties, will be strongly associated with mortality no matter what the mechanism of transmission (Phelan et al. 2004). Finding support for their hypothesis, they conclude that socioeconomic status (SES) is a fundamental cause for poor health regardless of proximate risk factors. Going one step further, they suggest that the wealthy remain at the top of the health gradient because they have access to and utilize resources that mitigate the possibilities of illness. Many other researchers have retested this thesis or added a new component, such as race, and have similarly concluded that SES, not health behaviors or life stressors, is the primary factor in explaining the inequality of health outcomes (Lantz et al. 1998, Roy 2004, Hayward et al. 2000, Kawachi et al. 1997, Kaplan et al. 1996). Wilkinson (1997, 1996) argues that relative social standing is a more powerful predictor of health than is material deprivation (above a certain basic needs threshold) and ties his own extensive international research on the psychosocial model with that of Kawachi et al. (1997), who has produced empirical evidence linking SES as a measure of social cohesion to mortality.

ENTERING THE MECHANISM DEBATE

Despite the empirical evidence for the relationship between SES and morbidity, the question remains, how exactly does inequality in social class standing affect physical well-being? Is there a difference between the way the physical environment and the social environment impact morbidity? Do social constructions affect health through biophysical, social, or psychological mechanisms? In other words, is there a direct cause-effect relationship between social factors and disease or do proximate risk factors play an intermediate role? We will examine three prevalent

57

hypotheses that are often seen as independent but with more theoretical examination

may actually be complementary explanations of transmission (Etner and Grzywacz

2003, Adler and Ostrove 1999). The current literature offers three directions: 1)

socioeconomic position is a correlate of health behavior and lifestyle choices that

directly impact health; 2) inequality in SES produces the biophysical response of

anxiety of stress that physically impacts the body; 3) inequality in SES leads to

differential access to resources and benefits such as diet, health care, and social

support that affect all aspects (physical, mental, social) of health.

Biological and Behavioral Models

Although epidemiologists and behavioral scientists may admit the presence of

an association between SES and health, it is treated as correlate and not as a causal

variable (Phelan et al. 2004). Several mediating pathways are identified that focus

research on the specific biological or developmental variables that result from material

deprivation early in life and then continue to manifest themselves in health outcomes

over the life-course. If material deprivation persists through adulthood, these

variables have a "cumulative dose-response relationship with health" (Singh-Manoux

2005:2277). Socioeconomic status plays a role in this model only as an indication of

the life-course path of material deprivation. The focus remains on the micro-level and

looks at why individuals with low material well-being exhibit risky health behaviors

such as smoking, excessive alcohol use, and poor eating habits.

Another key focus of epidemiological research is the importance of genetics

and social selection. Empirical evidence is used to support the hypothesis that those in

low socioeconomic positions were genetically predisposed to certain illnesses. These

illnesses restrict upward mobility in class status or move individuals into lower classes

(Dohrenwend 1992). For example, when analyzing the relationship between smoking

and health, it is possible that a selection effect and not a causal effect is being

measured, because those genetically predisposed to certain illnesses would have died

before entering the survey year (Zimmer et al. 2000). Thus, selection processes are

seen by some to account for the consistent association between SES and health

Physiological Models

Physiological responses to environmental, economic, and social conditions are

beginning to be explored under the new field of social epidemiology. The

predominant paradigm is that low control, low social position, and social exclusion

lead to chronic stress, which wreaks havoc on the human endocrine and autonomic

nervous system (Roy 2004, Marmot 2004:274). This link between social factors and

position has been tested through early experiments on paupers in England, which

revealed greatly enlarged adrenal glands presumably due to chronic stress (Marmot

2004), current medical research (Hayward et al. 2000, Adler et al. 1999), and through

analogies to stress reactions in primates (Wilkinson 1996, Sapolsky 1998). In

addition, Eisenberger et al. (2004) find that the same section of the brain is activated

for both physical pain and social exclusion, which suggests there may be similar

physiologic outcomes (in Marmot 2004:283). All studies reported that low SES leads

to the observance of higher quantities of stress-induced hormones in the respondent.

Marmot (2004:272-282; 112-116) has a lengthy discussion of the biology of

stress. He suggests that the consistent release of epinephrine (adrenaline),

norepinephrine, and cortisol into the body raises the basal level of hormone secretion

and creates severe health problems. For example, increased cortisol levels raise

blood-sugar and if chronically raised can lead to diabetes and increased allostatic load.

Feedback mechanisms are blunted with constant use, dulling responses to short-term

emergencies and raising blood pressure levels. The activation of the sympathetic

nervous system also raises blood pressure, dampens the immune system, and if activated long-enough, can increase one's risk for a heart attack or stroke (see also Roy 2004, Phelan et al. 2004).

Social Model

Another perspective on the causal chain of social causes leading to health outcomes is rooted in the social capital literature. Although this concept has become tautological in its popularized form, the foundations of the idea (i.e., Bourdieu's two part conceptualization) can be considered theoretically useful as a heuristic tool if not an explanatory mechanism (Portes 1998, 2000, Carpiano 2006, Morrow 1999).

Bourdieu's theory suggests that the amount of social capital one can possess depends on "1) the size of network connections that the individual "can effectively mobilize" and 2) the amount and type(s) of capital (e.g., economic, cultural, or symbolic) possessed by each of those to whom he or she is related" (Bourdieu 1986:249 in Carpiano 2006). Thus "structural antecedents" such as SES (Link and Phelan 1995) and its correlates of residency length (Kasarda and Janowitz 1974, Sampson 1988), gender (McDonough et al. 1999), and race (Hayward et al. 2000) have implications for the form and strength of social networks that can be created. Social cohesion (i.e., trust, reciprocity, and shared values) is measured in differing degrees and forms because of the "structural antecedents" of neighborhoods and the social networks within. Thus, characteristics of low SES areas such as highly mobile residency may limit the social ties that can be built among residents. Not only does individual behavior (i.e., the choice to remain in the neighborhood) affect community attachment but the choices of others in the community (i.e., high mobility) will affect an individuals' ability to make social ties (Sampson 1988). Social capital is formed when people engaging in social cohesion take advantage of the resources (i.e., money,

power, social support, and protection) these networks provide them. Key resources gained are social support, social leverage, informal social control, and neighborhood organization participation. Thus, social capital (i.e., the collective resources emanating from social networks that are actually used for action) is dependent on the amount of social cohesion (networks, norms, and values), which ultimately rests on "fundamental causes" and the array of resources they encompass (Phelan et al. 2004, Carpiano 2006).

Bourdieu also theorized that the attainment of capital is an intentional process; that is, individuals seek out different kinds of capital with the knowledge that later on it will accrue benefits. Social, economic, and cultural capital are interlinked systems essential to human development. Because of this linkage, social capital (i.e., access to resources) relies on the individual's possession of material capital (i.e., money) and cultural capital (i.e., education, social ties, family values) (Portes 1998, 2000). Thus, different combinations of cultural (Granovetter's weak and strong ties and values transmitted by families) and material capital will produce different types of social capital, otherwise referred to as differential resources (job opportunities vs. help moving). In sum, a person's intentionally created networks give rise to the availability of resources (social capital), which if taken advantage of, can benefit the individual by providing material, ideological, and informational assets (Link and Phelan 1995, Phelan et al. 2004, Carpiano 2006).

Bourdieu's "cultural capital" has been explored by other theorists, who suggest that the strength and diversity of ties are more important than the number of friends and acquaintances (Granovetter 1973, 1983, Morrow 1999, Kasarda and Janowitz 1974). Indeed, one limitation of analyzing the impact of social networks seen in the sociological literature is that large datasets offer inadequate measures of social ties that are based on quantity, not quality (Morrow 1999). Granovetter (1973)

hypothesized that individuals with diverse social ties (meaning low-density, weak *and bridging* ties with "acquaintances") will be better off than individuals with non-diverse social ties (meaning high-density, strong ties with "close friends"). Opportunities for new resources, ideologies, and information are uniquely available to the individual through weak bridging ties because of the diversity and lack of overlap between groups. Within-group communication tends to be insular and friends of friends typically share the same resource network, whereas between-group communication offers new viewpoints and friends of friends do not overlap, thus opening up new resources markets.

Contrary to popular discourse, Granovetter (1973, 1983) hypothesizes that social systems lacking in weak ties will be characterized by a lack of scientific progress, social cohesion, and access to resources. Building on Durkheim's theory of the division of labor, Granovetter suggests weak ties actually reduce alienation and anomie on the macro level because they help individuals connect to needed resources. On the micro level, diverse social ties allowing for role specialization are integral to the social construction of individualism and thus the construction of identity. Empirical findings on this theoretical position have important implications for the access to resources that ultimately affect health and well-being. For example, Granovetter (1983:204) finds that "the social structure faced by children of lower socioeconomic backgrounds does not encourage the complex role set that would, in turn, facilitate the development of 'intellectual flexibility and self-direction'" (Coser 1975:258). Low SES populations may have weak ties but often they are within-group friends of friends and not bridging acquaintances (Stack 1974). Cohen et al. (1997) suggest that numerous weak ties to different groups (i.e., work, family, friends, or community groups) are associated with a decrease in illness transmission.

Dohrenwend et al. (1992) find SES-based limitations on access to resources increased stress which predicted depression, substance abuse, and antisocial personality.

The question remains, why do low SES populations have less diverse social networks? Could limits such as time, money, geographic mobility, status group play a part? Why does this shortage seem to affect them more than a high SES population with few non-intimate contacts? Portes (1998) suggests that other resources available to high SES populations such as money, status, and education can mitigate the losses of certain benefits from a lack of weak ties, so that the loss of social capital in one form can be compensated for by other forms although with different outcomes. Finally, even Granovetter (1983) concedes that strong ties also have an important but different role in well-being. Research has shown that while weak ties are important for expanding knowledge, resources, and social mobility, strong ties are integral to having a social support network in times of need (Stack 1974, Portes 1998).

Weaknesses still exist in the social cohesion theory. Future research initiatives must analyze the variation in access and resources within a community. Access to resources cannot be assumed to be available in all forms and equal amounts to all members of the group, nor can it be assumed to always have a positive effect on each member or collectively (Carpiano 2006). Despite popular conceptions of the benefits of social capital based on Putnam's work, negative outcomes exist, including community closure that excludes outsiders, excess claims on group members, too much social control that restricts individual freedoms (see Eckstein 2001), and social pressure to maintain the status quo or maladaptive norms (Stack 1974, Bourgois 1995).

Combinations

As suggested at the commencement of this section, the above theories are not necessarily exclusive (Ettner and Grzywacz 2003, Fremont and Bird 1999). Space should be opened within the current literature to explore connections between health and social, biological, and ecological mechanisms. Future research can start with an integrated interpretive probabilistic model where social factors are hypothesized to first affect our senses (we feel insulted, shamed, stressed) and then our bio-physical system (discrimination, relative social status, chronic stress). We react on two levels: 1) feelings and psychological interpretations which may impact our health behaviors (binge drinking, social smoking), and 2) biophysical responses of releasing hormones. Short and long term health outcomes can be seen from this model because although one incident may trigger an immediately deleterious biophysical change (i.e., cancerous cell mutation), the probability of maladaptive changes in the body increases as social, biological, and environmental insults accumulate.

Gaps in the Research

Although a significant body of research on the relationship between self-perceptions of social hierarchy and health exists (Marmot 2004, Kawachi et al. 1997, Wilkinson 2006), few studies have analyzed how the internalized views of the role of government and the market affect health outcomes. Literature suggests that ideology plays an important role in the maintenance and reproduction of social stratification, especially at the macro-structural level (Domhoff 2002, Mills 1959). As discussed at the outset of this chapter, macro-social processes intimately affect individual biography and world views. In concordance, this study looks more closely at how certain economic, religious, and social paradigms affect perceptions of health.

The following chapters will examine the propositions laid out in Chapter Two in order to better understand the relationships between contemporary economic, religious, and social ideologies and health outcomes and how they may be mediated by demographic and material factors.   These propositions will serve as indicators of the future directions health research should explore. It is my hope also that the way these factors are conceptualized and tested will open future doors on refining measurements and variable validity.

CHAPTER FOUR

METHODOLOGY

DESCRIPTION OF THE DATA

In this study, the 2004 General Social Survey (GSS) (Davis et al. 2005) results are used to examine the relationship between self-reported health and the particular ideologies of economic libertarianism, religious conservatism, and social traditionalism, as well as a measure of ruling ideology, all net of demographic and material controls. This data set was chosen because it is a nationally representative, reoccurring cross-sectional sample of the English-speaking, non-institutionalized population over 18 years old. Also, social science research frequently uses the GSS because researchers have respect for the integrity of the data collection (Schnittker 2004). The most recent wave of GSS data (2004) are analyzed and compared to the data from 1993-1996. For 2004, the data were weighted for the over-sample of Blacks using the provided weight "wt2004nr," as recommended in Appendix A of the GSS (Davis et al. 2005). For this particular study, indicators of health insurance, objective medical reports, personal assets, and wealth measures would be useful to include, but such variables are not available in the GSS data set. Despite the limitations of the array of variables, the GSS does offer a self-reported health measure generally regarded as a robust indicator of health status and many other important socio-demographic controls. Most importantly, this data set contains identical questions repeated over many years, allowing for trend comparison across years.

Unit of Observation

The GSS measures responses at an individual level, which allows this study to analyze health at the level of an individual's perception of his or her own health.

Sometimes when researchers study social capital variables or any social phenomenon, the unit of observation can become confused. Although popular media would like to extrapolate individual health to family and community health, that is not the intent of this project. Thus, the unit of observation for this study is the individual respondent; the study examines how individuals perceive the surrounding society and how this may be associated with their personal health. In addition, the unit of analysis for this study is ideological power. I analyze the effect of three particular ideologies and one measure of ruling ideology on individual health, to better understand the influence that ideology has on Americans today.

VARIABLE SELECTION

The variables chosen from the GSS fall into six categories: economic ideals, religious beliefs, social perceptions, material position, health behaviors, and socio-demographics. Their inclusion in the model rests on suggestions noted in the literature as well as social expectations indicated in sociological theory. Several independent variables have been chosen for each particular ideology in order to analyze the relative strength of possible predictors. Not all variables are expected to be significant but this study will serve as an indicator of which variables perhaps best represent a particular ideology. All continuous variables (with the exception of *Age,* which was also measured as a quadratic) were organized into quantitative categories in order to better explain the nuances of the direction of coefficients within a variable. Great care was taken to provide a theoretical base for quantifying continuous variables and collapsing categories in multi-level categorical variables. For example, research suggests that there is both an urban and rural bias in health outcomes. Thus, our measure of city size (*XNORCSIZ*) was collapsed into three categories, urban, rural, suburban, with the latter as the reference group.

DEPENDENT VARIABLE

Self-reported health is used as the dependent variable. A large body of literature exists that highlights the robust nature of self-reported health in measurement and outcome. Subjective measures of personal health have been employed as valid indicators of health since the 1970s, but it was not until 1982 that quantitative research revealed the association with mortality (Idler and Benyamini 1997). Mossey and Shapiro's (1982) longitudinal analysis on aging showed that medical records and self-report of medical illnesses were not as strong of predictors of survival as was respondents' self-rated general health. Researchers explain this surprising but consistently reported finding by suggesting that self-reported health captures the complex interaction of the personal pain and relative well-being index of the respondent and a doctor's diagnosis (Idler and Benyamini 1997). Thus, unlike many other measures of illness, self-reported health can be seen as measuring the progression of disease, not just its incidence. Most illness measures in large, nationally-representative data sets bifurcate responses as "have" or "don't have" a certain affliction but fail to measure the advancement or severity of the illness. Such binary measurements of occurrence of illness are limited predictors of how soon an individual will pass away (Idler and Benyamini 1997).

Several researchers have attempted to test the reliability of self-reported health by using it as a predictor for mortality or specific illness outcomes. The vast majority of these studies find that self-reported health is a robust predictor of survival, independent of medical, behavioral and/or psychosocial factors (Idler and Benyamini 1997, Marmot 2004, Zimmer et al. 2000). Significant differences in mortality between each level of the dependent variable have been reported, so that moving from excellent health to poor health increases your risk of mortality 93.5 times (McCallum et al. 1994). In addition to predicting physical health, self-perceived health has been

shown to be a strong indicator of social and mental well-being (DeForge et al. 1989).

Others suggest that self-rated health reflects family history because individuals report based on their knowledge of familial risk factors. For example, if the respondents' father died of a heart-attack at an early age, it is likely the respondent will take that into consideration when looking at his own well-being (Idler and Benyamini 1997).

Self-reported health has several known limitations, particularly in terms of comparison groups and cultural interpretations. Identifying what group respondents use as the base for their evaluation is essential to the interpretation of research findings, but consensus on this control level has not been reached. Idler and Benyamini (1997) report that respondents tend to measure themselves against those with worse health while Wilkinson (1997) suggests that individuals measure themselves against high social classes (which presumably would have better health). Relative social class standing does not appear to be a consistently significant variable since the elderly measure their well-being against others in their age cohort (Zimmer et al. 2000) For example, an older respondent may report good health which is correctly assessed when compared within the cohort but incorrect when compared to younger cohorts. Relative deprivation can confound the findings as 80 year-olds will most likely have more health problems than 20 year-olds but may give themselves the same rating of "good" as the 20 year-olds because they are comparing themselves to other octogenarians. The degree of variation in the findings suggests that future theoretical and empirical health research should examine measurement and control groups, with a particular focus on the social categories of age, race, gender, class, education level, and household size. These variables may play an important role in interpretation as independently they all carry significantly different mortality risks (Zimmer et al. 2000, DeForge et al. 1989).

The paucity of research on the cultural interpretations of self-reported health is a second significant limitation for studies including certain sub-populations. Although Idler and Benyamini (1997) found a consistency of outcomes despite differences in dialects within the English language, other studies of self-rated health suggest that there are significant differences between language groups (Angel and Guarnaccia 1989, Appels et al. 1996). For example, an English speaking Hispanic subsection was seen to report on this measure differently than non-English speaking Hispanics (Angel and Guarnaccia 1989). Zimmer et al. (2000) report that other studies have shown that self-reported health is dependent on many socio-demographic factors, including age, sex, and education. Thus, knowing the normative level of health for a society is integral to interpreting the results of studies measuring self-reported health.

Third, self-perception of health can also be a causal variable of health. Individuals who feel they have poor health may be less likely to take care of themselves, which may lead to the self-fulfilling prophecy of even poorer health. This finding has important implications for older age-cohorts who reach an age where lack of self-care can result in serious illness or death. Research has shown that perceptions of good health in elderly respondents are a causal variable for positive self-care attention, net of chronic illnesses and psychosocial factors (Idler and Benyamini 1997).

Despite these limitations, self-reported health is believed to be a consistent and robust measure of respondents' health that captures small changes in health status more accurately than physician exams. Idler and Benyamini (1997) conclude that "the global rating represents an irreplaceable dimension of health status and in fact that an individual's health status cannot be assessed without it" (34). This compelling statement encourages the continued use of self-reported health but does not limit the possibility of additional ways to measure other aspects of well-being. Current self-

reported health research provides impetus for further examination of other self-assessments (i.e., social standing, trust, and sense of community) to determine if they are also robust measures.

The original question measuring self-reported health in the GSS asked the respondent the following, "Would you say your own health, in general, is excellent, good, fair, or poor?" (Davis et al. 2005). The previously documented gradient, where mortality decreases with each increment, allowed for the use of ordinal regression in order to determine the nuances between the four response categories (McCallum et al. 1994). Unfortunately, the paucity of cases reporting poor health did not allow for the completion of this technique as the outcome variable must have enough responses in each category to provide adequate degrees of freedom for testing. Thus, the dependent variable was dichotomized into "good health" and "poor health," by combining the categories "excellent" and "good" and the categories "fair" and "poor," and logistic regression was used to understand the changes between categories. The distribution before and after this decision are shown in Table 1, Table 2, and Figure 1. It is expected that the incremental relationship will still exist between the two groups so that those with good health will have a lower mortality rate when compared with the poor health group.

Table 1: Original Breakdown of Self-Reported Health in the U.S.; 1993-96, 2004, All Years

Categories	93-96		2004		All Years	
Excellent	1715	31.30%	429	32%	2144	31.41%
Good	2695	47.50%	651	48.50%	3346	49.03%
Fair	911	16.60%	218	16.20%	1129	16.54%
Poor	253	4.60%	44	3.30%	297	4.35%
N	5484	100%	1341	100%	6825	100.00%

Table 2: Grouped Self-Reported Health in the U.S.; 1993-96, 2004, All Years

Categories	93-96		2004		All Years	
Good	4410	78.80%	1080	80.50%	5490	80.44%
Poor	1164	21.20%	262	19.50%	1426	20.89%
N	5484	100%	1341	100%	6825	100.00%
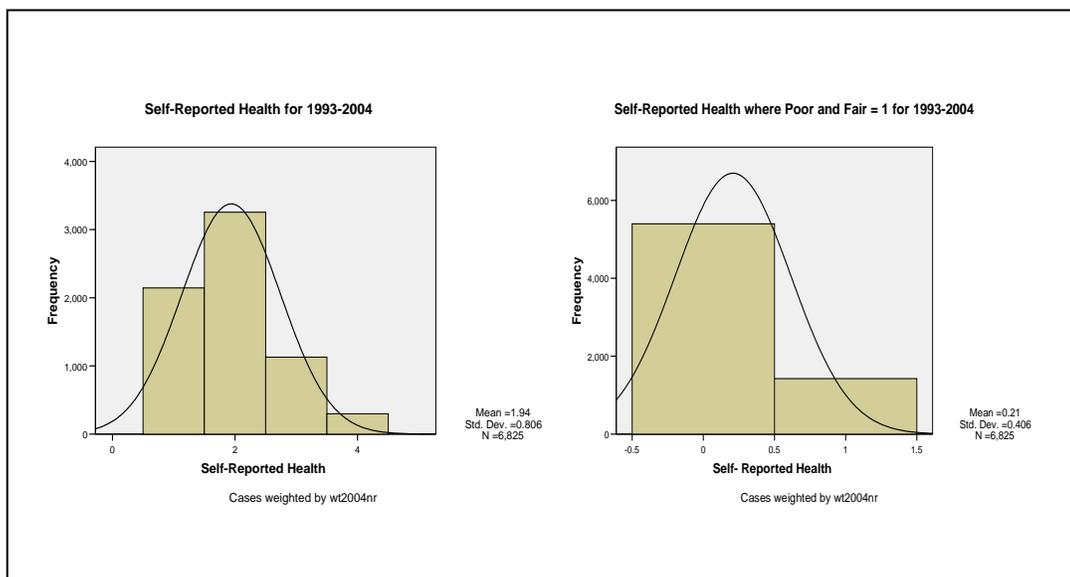
Figure 1: Distribution of the Original and Grouped Dependent Variable for 1993-2004

INDEPENDENT VARIABLES

Although significant research on the relationship between self perceptions of social hierarchy and health exists (Marmot 2004, Kawachi et al. 1997, Wilkinson 2006), few studies have analyzed how internalized views of the ideological role of economics, religion, and social perceptions affect health outcomes. The following section discusses how the measures for these views were created using data from the GSS. How each variable was measured or constructed remains constant for all analyses across all years in this study.

Economic Libertarianism

In order to measure ideological views of economic ideals, this research uses two variables *Helpnot* and *Eqwlth.* The variable *Helpnot* measures peoples' views on the role of the federal government versus the role of individuals and private businesses in solving problems in America. The GSS question reads: "Some people think that the government in Washington is trying to do too many things that should be left to individuals and private businesses. Others disagree and think that the government should do even more to solve our country's problems. Still others have opinions somewhere in between. Where would you place yourself on this scale, or haven't you made up your mind on this?" (Davis et al. 2005). Answers ranged on a five point scale from strongly agreeing that the government should do more (1) to strongly agreeing that the government is doing too much (5) (See Table 3). The original range of answers was collapsed into a three point scale by combining categories 1 and 2 (strongly agree and agree) and categories 4 and 5 (disagree and strongly disagree) (See Table 4). Category 3 is understood as having a neutral opinion on the matter and the GSS response for this category states, "I agree with both answers." Since the outcome variable is poor health and the propositions predict that the lack of adherence to the ruling ideology is related to poor health, the level within each variable that is most likely to match with the ruling ideology will be used as the reference group. The coding of the reference category for the following ideological variables will follow the same pattern for all years studied. Thus, for the variable *Helpnot*, responses indicating a belief that the individuals and private businesses are responsible for solving problems in America will be used as the reference group.

Table 3: Original Distribution of *Helpnot* (Should Govt Do More or Less?)

	Frequency	Percent
Govt Do More	306	13.5
2	310	13.7
Agree With Both	849	37.5
4	408	18.0
Govt Does Too Much	390	17.2
Total	2,263	100.0

Table 4: Recoded Distribution of *Helpnot* (Should Govt Do More or Less?)

	Frequency	Percent
Govt Should Help	616	27.2
No Opinion	849	37.5
Govt Shouldn't Help	798	35.2
Total	2,263	100.0

The use of the variable *Helpnot* to measure economic libertarian ideals is appropriate. Conservative think tanks broadcast their adherence to individualism and the importance of limiting government involvement in social issues. For example, the website from the American Conservative Union states, "We believe that it is the responsibility of the individual citizen, whenever his inherent rights are threatened from within or without, to join together with other individuals to protect these rights, or, when they have been temporarily lost, to regain them" (http://www.conservative.org, n.d.). Thus, it is not the role of the government to solve problems in America but the responsibility of individual citizens.

The second indicator of economic ideology, *Eqwlth,* measures peoples' views on how much the government should be involved in reducing income differences between the rich and the poor. The actual GSS question states, "Some people think that the government in Washington ought to reduce the income differences between the rich and the poor, perhaps by raising the taxes of wealthy families or by giving

income assistance to the poor. Others think that the government should not concern itself with reducing this income difference between the rich and the poor. Here is a card with a scale from 1 to 7. Think of a score of 1 as meaning that the government ought to reduce the income differences between rich and poor, and a score of 7 meaning that the government should not concern itself with reducing income differences. What score between 1 and 7 comes closest to the way you feel?" (Davis et al. 2005). As highlighted in Table 5, respondents' answers ranged from strongly agreeing that the government should do something to reduce the income differences between rich and poor (1) to strongly agreeing that the government should not concern itself with decreasing income differences (7). Table 6 reveals how this scale was subsequently reduced to three categories where 1 and 2 (strongly disagree and disagree) and 6 and 7 (agree and strongly agree) were grouped at the extremes and 3 through 5 were considered neutral responses. By grouping these variables in this way, the measure captures those respondents with the most extreme or ardent beliefs about market practices. Ideology tends to simplify by dichotomizing world-views and adding in non-neutral rhetoric. Thus, economic libertarian ideology polarizes beliefs by suggesting that the respondent is either for free-market policies or against them. Following the rationale for using the least ideological level as the reference group, the response indicating that the government should be less involved in reducing income differences in America was used as the reference level.

Table 5: Original Distribution of *Eqwlth* (Should Govt Reduce Income Differences?)

	Frequency	Percent
GOVT REDUCE DIFF	386	17.1
2	222	9.8
3	388	17.1
4	452	20.0
5	298	13.2
6	194	8.6
NO GOVT ACTION	324	14.3
Total	2,263	100.0

Table 6: Recoded Distribution of *Eqwlth* (Should Govt Reduce Income Differences?)

	Frequency	Percent
Govt Should Reduce	608	26.9
Neutral	1,137	50.2
Govt Shoudn't Reduce	518	22.9
Total	2,263	100.0

These two economic measures were also combined to create a composite variable that serves as an indicator of how strongly the respondent adheres to free market ideology. Free market ideology purports that markets, not government intervention, should be the regulating force in society. Anti-interventionists may oppose social welfare policies such as welfare, corporate or wealth taxes, and the redistribution of wealth by intrusive government programs, while supporting the private sector, supply-side economics, and the idea that "rising tides lift all boats." Responses on the free market scale ranged from 0 (the government should be involved in social policy) to 4 (the government should not be involved in social policy/anti-interventionist) and category 4 was used as the reference group (See Figure 2).
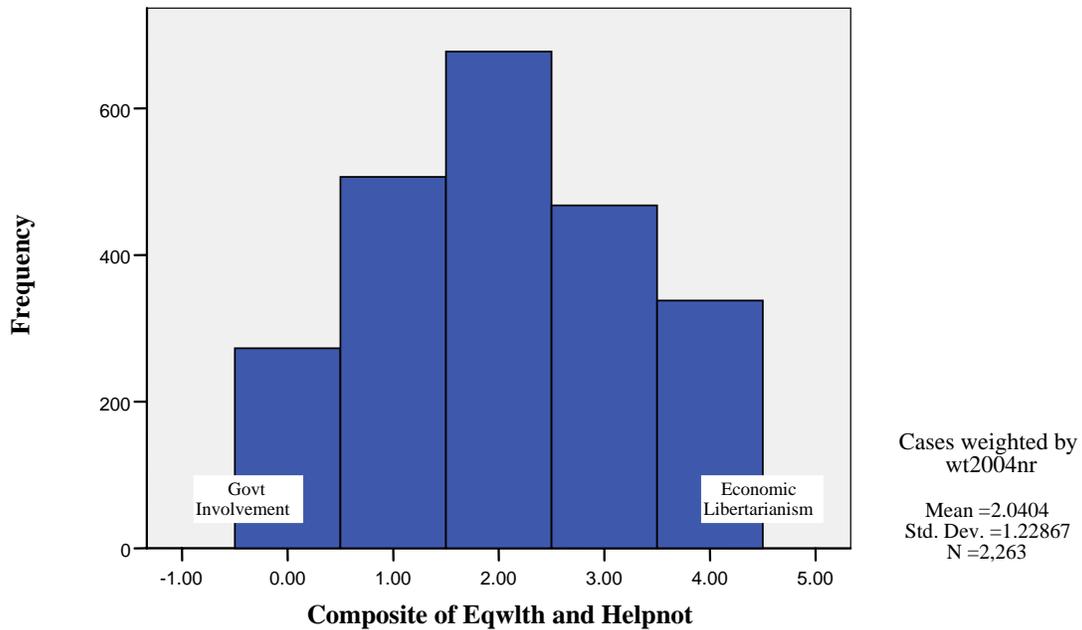
Figure 2: Distribution of Economic Summated Scale, All Years

Religious Participation

Recent research has suggested that those who attend a religious service at least once a week have a 40-46 percent lower risk of dying than those who go less frequently (Koenig et al. 1999, that bridge et al. 1997). Yet, some studies have suggested the connection between religion and mortality is spurious and that other variables correlated with religion should be analyzed. For example, religion has been seen to exert social control on health behaviors such as smoking and drinking that can lead to health problems (Dupre et al. 2006). Studies have also suggested that church attendees tend to be more obese than the surrounding population, particularly in the South (Kim et al. 2003).

Health research based on a "social capital" thesis has led other researchers to conclude that religion provides social support and a cohesive world view. This social safety net is seen to have positive effects on health, especially in times of crises (Granovetter 1983, Portes 1998). Research shows that resource availability also increases because of social ties, so that church attendees have better psychosocial health. Religion and religious social support supposedly nurture individuals and increase their self-esteem and sense of mastery (Appels et al. 1996). Thus, researchers claim that religion and social capital are highly correlated and only one measure should be included in the model. Yet, others suggest no suitable correlate has been found and current studies do not completely explain the relationship between religion and health (Dupre et al. 2006). McDonough et al. (1999) suggest that the strength of findings vary by age, gender, and race. Thus, my study introduces demographic controls while posing religion against measures of social cohesion, social support, and health behavior as suggested by current literature, as well as adding additional potential correlates to the model. Correlation matrices were created and the religion variables were not collinear with the social capital variables.

Using the available variables from the GSS, three measures of religiosity are obtained. Since previous research has acknowledged the importance of measuring religious attendance, this measure will be included and measured as a quantitative variable with three categories (Dupre et al. 2006). It is conceptualized as an indicator of not only religious behavior (i.e., physically going to religious services) but also as an indicator of strength of religious affiliation as presumably, those who attend church frequently would have stronger religious commitments than those who rarely attend. The GSS asks respondents, "How often do you attend religious services" and allows for the following responses, "Never, less than once a year, about once or twice a year, several times a year, about once a month, nearly every week, every week, several

times a week." The original distribution of this variable can be seen in Table 7. For clarity, the variable *Attend* has been regrouped into three categories that are evident in Table 8. These categories are "attend regularly (at least once a week)," "attend infrequently (less than once a week but more than a once per year)," and "attend rarely or never (once per year or less)." As church attendance is a behavior encouraged by religious conservative doctrine, "attend regularly" will be used as the reference level.

Table 7: Original Distribution of *Attend* (How Often Respondent Attends Religious Services)

	Frequency	Percent
NEVER	331	14.6
LT ONCE A YEAR	202	8.9
ONCE A YEAR	341	15.1
SEVRL TIMES A YR	307	13.5
ONCE A MONTH	155	6.8
2-3X A MONTH	207	9.1
NRLY EVERY WEEK	135	5.9
EVERY WEEK	411	18.1
MORE THN ONCE WK	177	7.8
Total	2,263	100.0

Table 8: Recoded Distribution of *Attend* (How Often Respondent Attends Religious Services)

	Frequency	Percent
Attend rarely/never	873	38.6
Attend infrequently	802	35.5
Regularly attend	587	25.9
Total	2,263	100.0

A major contribution of this research is the analysis of the connection between ideology and health outcomes. In particular, this study focuses on the role religious conservatives have played in pushing forward a conservative ideology. Thus, a measure of the fundamentalism or liberalism of the respondent's religion was also

included in the study. The variable *Fund* (stated in the GSS as

"Fundamentalism/Liberalism of Respondent's Religion") was retained in its original

three category form, of "fundamentalist," "moderate," and "liberal."

"Fundamentalist," the category most likely to espouse the ideology and thus have

good health, will be used for reference.

Table 9: Distribution of *Fund* (How Fundamentalist is Respondent Currently?)

	Frequency	Percent
Liberal	611	27.0
Moderate	901	39.8
Fundamentalist	751	33.2
Total	2,263	100.0

As a supplemental measure of strength of religious belief, the variable *Reliten*

was included in the analysis. The question asks for a self-analysis of the strength of a

respondent's religious adherence, rated on a three category scale from strong to not

religious. This scale was left in its original form with "strongly religious" used for

reference. By using three different measures to conceptualize religiosity, I hope to

capture the complicated dynamics of ideology and religious belief.

Table 10: Original Distribution of *Reliten* (Strength of Religious Affiliation)

	Frequency	Percent
STRONG	837	37.0
NOT VERY STRONG	947	41.9
SOMEWHAT STRONG	223	9.9
NO RELIGION	255	11.3
Total	2,263	100.0

Table 11: Recoded Distribution of *Reliten* (Strength of Religious Affiliation)

	Frequency	Percent
Not religious	255	11.3
Not strongly religious	1,171	51.7
Strongly Religious	837	37.0
Total	2,263	100.0

Finally, a composite measure of religiosity was created as a scale from 0 (not strongly religious) to 6 (strongly religious) (See Figure 3). By combining all measures of religious adherence in this study, this scale can provide a better understanding of the cohesiveness of respondents' views on religion. For example, respondents who received a score of 6 on the composite scale consistently marked highly religious responses.
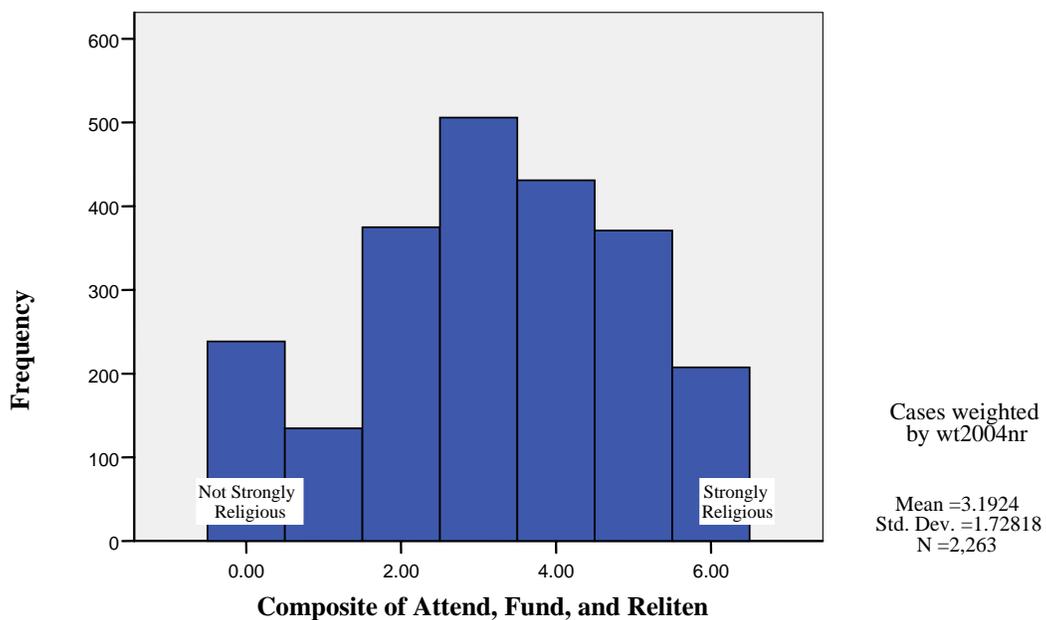
Figure 3: Distribution of Religious Summated Scale, All Years

Perceptions of Society

Research shows that a diverse social network can improve social mobility at large while providing a sense of security and support at a personal level (Granovetter 1973, 1983, Stack 1974, Portes 1998). Yet the development of broad networks can be hindered by negative perceptions of the surrounding environment and people,

followed by reluctance to get involved in the surrounding community. This study

attempts to measure the importance of perceptions of society on health outcomes by

using responses to the following GSS questions: "Do you think most people would try

to take advantage of you if they got a chance or would they try to be fair?" (*Fair*)

"Generally speaking, would you say that most people can be trusted or that you can't

be too careful in life?" (*Trust*) "Would you say that most of the time people try to be

helpful, or that they are mostly just looking out for themselves?" (*Helpful*) (Davis et

al. 2005). Table 12 highlights the frequency distribution for each variable. For each of

these binary variables, the response group suggesting positive perceptions of society

was used as the reference level. For example, the response categories for *Fair* are

"Try to be helpful," "Just look out for themselves," with the former used as the

reference level. Likewise for *Trust* and *Fair*, whose response categories were "Would

take advantage of you;" "would try to be fair," and "people can be trusted;" "you can't

be too careful in life" respectively, the former was used as the reference level.

Table 12: Distribution of *Fair* (People Fair or Try to Take Advantage), *Trust* (Can
People be Trusted), and *Helpful* (People Helpful or Looking Out for Selves)

Fair	Frequency	Percent
TAKE ADVANTAGE	1,001	44.2
FAIR	1,262	55.8
Total	2,263	100.0
Trust		
CAN TRUST	898	39.7
CANNOT TRUST	1,365	60.3
Total	2,263	100.0
Helpful		
HELPFUL	1,061	46.9
LOOKOUT FOR SELF	1,202	53.1
Total	2,263	100.0

Kawachi et al. have used the binary indicators *Fair*, *Trust,* and *Helpful* to measure social cohesion and its connection to both income inequality and mortality among 39 U.S. states.   They found that these variables were useful measures of a "belief in the goodwill and benign intent of others [that] facilitates collective action and mutual cooperation and therefore adds to the stock of a community's social capital" (Kawachi et al. 1997). Theoretical literature on social capital suggests that of the three indicators of social cohesion found in the GSS, social mistrust and perceived lack of fairness are expected to be the strongest predictors of poor health and may give insight into how people perceive the world around them. Similar to the composite measures for economic and religious ideology, a scale for social ideology was also computed. The distribution of responses, ranging from 0 (perception of low social cohesion) to 3 (perception of high social cohesion) can be see in Figure 4. Category 3 was used as the reference category.
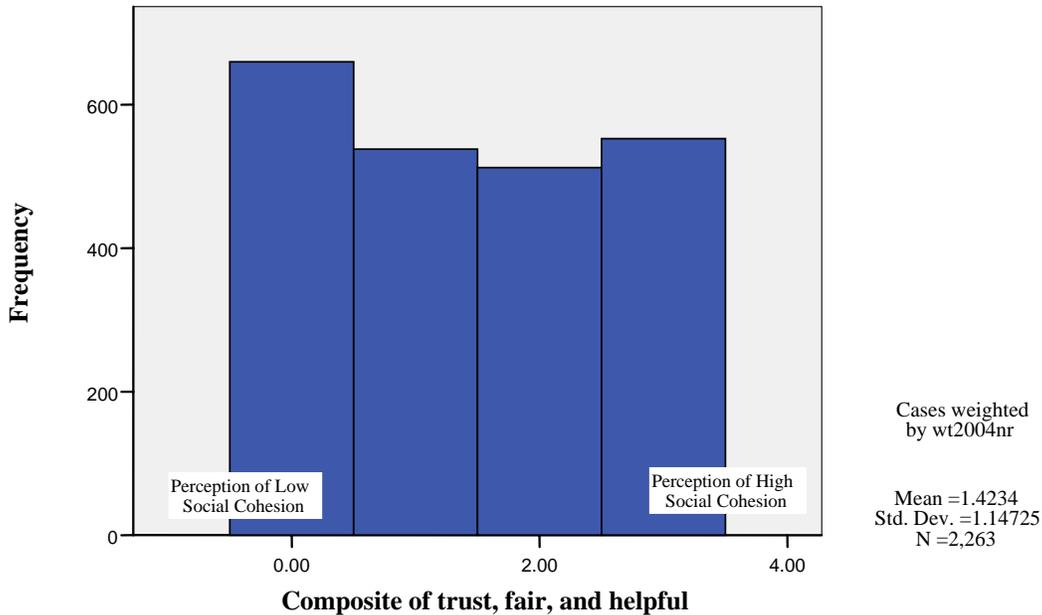
Figure 4: Distribution of Social Cohesion Summated Scale, All Years

These perceptions of social cohesion variables may also show the degree to which religious conservative and social traditionalist ideologies have been intrinsically accepted into respondents' belief systems. The religious right has built its political standing on fighting the perceived decline in family, community, and traditional values. Indeed, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) itself explicitly states the importance and intrinsic value of the nuclear family raising children. Robert Putnam's popular best-seller *Bowling Alone* (2000) highlighted the importance of maintaining civil society as the current changes in family values and work structure have precipitated a decline in community cohesion and civic engagement thereby increasing crime, fragmentation, and anomie. Thus, a relationship between respondents who adhere to free-market ideology or religious

conservatism and those who perceive their surrounding environment to be healthy would not come as a surprise. This is because these respondents may believe that their adherence to social traditionalist ideals has improved their health, the health of their family, and thereby the health of the community.

Finally, I intended to analyze civic engagement by including a measure of the number of groups and/or associations of which respondents were an active member. This variable is typically included in social capital research as a measure of how perceptions of society influence personal interaction with the community. Some suggest that it connects respondents' perceptions of the local environment and how this perception affects the degree to which they are willing to get involved. This involvement is often seen as the basis for "civil society," or the positive civic engagement of local residents. Putnam (1992; 2000) suggests that such local involvement is essential to well-functioning communities. Unfortunately, the data do not exist for the years included in the study but future research should include such measures if possible.

Ruling Ideology

The overlap among religious, social, and economic ideologies is also an important nuance that can add insight to understanding how beliefs affect all aspects of life including health outcomes. Despite measurement limitations, I included a measure of ruling ideology in the data analysis for theoretical reasons. In this study, ruling ideology is considered as a combination of the contemporary particular ideologies: economic libertarianism, religious conservatism, and social traditionalism. It is expected that there are other components to a ruling ideology that will go unmeasured in this study, but that these three components are essential building blocks of the current ruling ideology. Thus, a scale for ruling ideology has been created by

summing existing measures of economic libertarianism, religious conservatism, and social traditionalism. It is important to note that this measurement method assumes that all variables in the scale are perfectly substitutable for each other. Weighting certain particular ideologies was considered in order to mitigate this potential limitation, but it was decided that the above review of the literature did not provide conclusive evidence that any one particular ideology contributed more to the overall ruling ideology than another. Thus, an unweighted simple summated scale was maintained for this study. Figure 5 highlights that responses range from 0 (complete non-adherence to the ruling ideology) to 14 (complete adherence to the ruling ideology). The extremes of the scale were grouped in order to create a three-level quantitative variable. The third category (complete adherence to the ruling ideology) was used as the reference group.
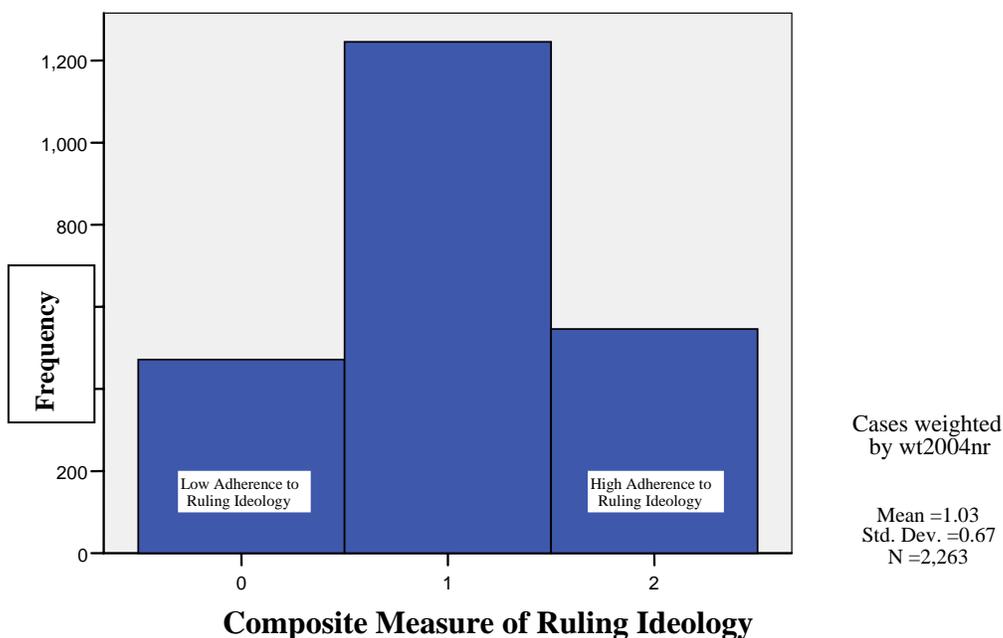
Figure 5: Distribution of Ruling Ideology Summated Scale, All Years

Material Position

Despite the rise in interest in the psychosocial hypothesis in the past decade, some researchers still argue that the importance of material position, employment, and education trumps the significance all other covariates (Rogot 1992, Lynch et al. 2000, Schnittker 2004, Mirowsky and Ross 2003, Smith and Kington 1997). A focus only on perceptions of inequality ignores the fact that humans live in a material world where mental thought cannot be artificially separated from physical needs. Individuals lacking material assets may not only suffer psychosocial consequences such as alienation and low self-worth but may do so without basic material supports (Davidson et al. 2005). Thus, the neo-materialist perspective offers a more holistic view of material and social realities and garners support through evidence of high correlations between material variables and demographics. It is essential to include variables such as *Income*, *Employment*, and *Education,* but further research must be conducted to understand their measurement and interaction with socio-demographic controls such as age, race/ethnicity, and gender (Schnittker 2004, McDonough et al. 1999, Smith and Kington 1997).

In this research, the variable *Income* measures the respondents' answers to the question, "In which of these groups did your total family income, from all sources, fall last year, before taxes, that is?" (Davis et al. 2005). The responses, adjusted for inflation fell within the range "under $1000" to "$75,000+" for 1993-1996 and between "under $1000" and "$110,000+" for 2004. These ranges were divided into quartiles with the highest quartile consistently selected as the reference group. For 1993-1996, the quartiles cut-offs were as follows: under $1000-$17,499 (Quartile 1), $17,500-$29,999 (Quartile 2), $30,000-$49,000 (Quartile 3), and $50,000-$75,000+ (Quartile 4). After adjusting for inflation, the quartiles for 2004 were: less than $22,499 (Quartile 1), $22,500-$39,999 (Quartile 2), $40,000-$74,999 (Quartile 3),

$75,000+ (Quartile 4). When measured for all years combined, the rate of inflation between years prohibited the creation of a scale based on absolute wage cut-offs. Thus, the income variable was divided by quartiles to provide information of the relative income levels of respondents (See Table 13).

Table 13: Recoded Distribution of *Income*, All Years

	Frequency	Percent
Poorest Quartile	544	24.0
Second Quartile	466	20.6
Third Quartile	621	27.5
Wealthiest Quartile	632	27.9
Total	2,263	100.0

The variable *Education* was also included in the study. The literature suggests there is a significant difference between individuals who complete high school and those who do not (Schnittker 2004, Mirowsky and Ross 2003). Thus, education level was grouped into three categories as shown in Table 14: "less than 12 years of education," "12 years of education (high school graduate)," and "more than 12 years of education." "More than 12 years of education" was used as the reference group because it is predicted that respondents with more education will be healthier. Sociological literature supports this decision, as education is seen to have many social, material, and physical benefits.

Table 14: Recoded Distribution of *Education*, All Years

	Frequency	Percent
Less than 12 Years of	372	16.4
12 Years of	701	31.0
More than 12 Years	1,190	52.6
Total	2,263	100.0

Employment status was the most difficult variable to work with out of the three material indicators. There are many reasons why a respondent may not be employed full or part-time, which could potentially confound the interpretation of the category. Some reasons are temporary while others begin as short-term and then stretch indefinitely. Indeed, Ehrenreich (2005) documented white-collar workers, unemployed for over a year, who perceive themselves as "in transition" or just "job searching." They do not consider themselves "unemployed" and certainly this perception could bias their response to employment questions on the GSS. To be as succinct as possible without obscuring important information, employment status was grouped as "working part or full time," "not working (temporarily or unemployed/laid off)," "reason not to work (retired, in school, keeping house)," and "other (not specified by GSS)," with "working" used as the reference group (See Table 15).

Table 15: Recoded Distribution of *Employment*, All Years

	Frequency	Percent
Working (Part or Full)	1,504	66.4
Not Working (Temp or Unemp)	124	5.5
Reason not to work (retired, school, keeping house)	599	26.5
Other	36	1.6
Total	2,263	100.0

One limitation of these material variables is the lack of a measure of wealth or total assets (Smith and Kington 1997). A wealth variable would offer a much more inclusive and complete way to measure material deprivation at the individual or household level. Research has suggested a link between asset wealth and geography as urban dwellers are more likely to be "absolutely" poor. Rural dwellers are more likely than urbanites to have non-liquid assets such as houses and thus gain a higher

degree of economic security in day-to-day life. Yet, in the case of a crisis or sudden downturn in economic standing, the rural poor often face significant challenges in converting these assets to cash (Weber et al. 2005).   Beyond its implications for material well-being, asset wealth can also be seen as an indicator of an individual's sense of security and stability within a community.

Socio-Demographic Controls

A number of common socio-demographic controls were included in this study in order to test the significance of the included variables based on theoretical hypotheses.   Such controls (with the reference group noted by *) include *Sex* (male, female*), *Race* (white*, black, other), *Age* (18-39*, 40-59, 60-74, 74+), *Homepop* (number of residents in home: 1,2-4*, 5+), *Region* (south, all other regions*), *XNORCSIZ (*rural, suburban*, urban) and *Marital status* (married*, formerly married, never married). The actual questions from the GSS, frequency distributions, and recoding of the socio-demographic controls can be found in Appendix A. Zimmer et al. (2000) found that respondents typically compare their own health to that of their age-mates, thus ranking their own health higher than would be expected. To account for the curvilinearity expected in self-assessments of health, age was also measured as a quadratic (Appels et al 1996).   Typically marriage is seen to have a protective effect on health, particularly that of the husband. McDonough et al.'s (1999) findings support this thesis except when the wife has greater earnings than the husband. These results suggest there is a detrimental affect on husband's health with a perceived lack of status because of lower spousal earnings. This nuance is not included in the model tested below because of its complexity, but it is an important caveat to previous findings on marriage and health.

I originally created dummy variables for 1, 2, 3, 4, 5+ member households, predicting that health would worsen with increased household size. Yet, in bivariate analysis, health status was lowest for 1 person households, then 5+ with 2-4 person households fairing about equally. Thus, revision of my measurement was necessary and household size has been grouped into three categories following the above findings. *Region* was dichotomized based on examples of similar health studies (Mossey and Shapiro 1982). Geographic proximity to large towns is often studied as metro vs. non-metro. Yet, in order to measure trends mentioned in the literature about the rural poor and urban underclass, I collapsed *XNORCSIZ* into three categories using "suburban areas" as the reference group (Tickamyer and Duncan 1990, Lichter and Jensen 2001, Weber et al. 2005, Schiller 2004, Yinger 2002, Wilson 1996). Unfortunately, the measure *XNORCSIZ* was not available for the 2004 data.

Health Behaviors

Currently, public policy is geared towards an individualistic approach of the health and well-being of Americans. Programs are created to target individual health behaviors that also run counter to normative behavior as delineated by the ruling ideology. Such risky behaviors include smoking, excessive drinking, improper diet, lack of exercise, and casual sex. Conservatives suggest that if these individual deviant behaviors could be changed, the health of Americans would greatly improve. Certainly, these behaviors affect health on an individual level, but do they remain significant across society when ideological, material, social, and demographic controls are added to the equation?

Measures of smoking and drinking were available for 1993 and 1994 but not for 1996 and 2004. A scale of smoking was created to determine if the respondent currently smoked, had ever smoked, or had never smoked. Likewise, the variable

Drink is a composite variable containing three categories: "never drink alcohol," "drink alcohol in moderation," and "drink alcohol excessively/to get drunk." The original distribution of these health behavior variables and their reorganization into a scale variable can be found in Appendix B. Variables that measured how many cigarettes smoked per day and how many drinks consumed per day would have been even more useful indicators of the extent to which respondents overindulge in such behaviors. Unfortunately, the GSS does not contain such measures, nor does it record information on Body Mass Index, frequency of exercise, or dietary patterns. In addition to the limited variables available, the infrequency of use of the subset of questions on health behaviors, the relatively small population to which it was administered, and its incomplete set of measurements pose additional limitations. Thus, findings on these variables should be regarded as indicators of trends and not as a basis for policy recommendations.

THE LOGISTIC REGRESSION PROCEDURE

Since the dependent variable "self-reported health" has four non-continuous categories that are ordered, ordinary linear regression is not appropriate for this model. In particular, the assumption that the residual errors are normally distributed is erroneous if the variable is categorical. As mentioned previously, ordinal regression was originally identified as having the potential to give the clearest understanding of the differences between dependent variable categories but was unusable due to the small response size for one category. Thus, the dependent variable *Health* was dichotomized into two groups, "poor health" and "good health" (See Figure 1, Table 2) and a two-step logistic regression procedure was used to test several regression models in order to determine which variables were significant in predicting poor health.

Logistic regression measures the natural log of the odds that the dependent variable is equal to one. This can also be expressed as the natural log of the ratio of the probability that the dependent variable equals one divided by the probability it equals zero. Maximum likelihood estimation is used to estimate parameters for the model. This technique measures all possible sets of values for the parameters and chooses the one that maximizes the likelihood of the model fitting the data. To compare the fit of two different models, a ratio must be formed. Instead of employing an F-test, a ratio of the mean square due to regression and the mean square due to residuals that is used in linear regression, a chi-square test can be used to compare the two likelihoods (Dielman 2005:383-388).

The first step of this analysis used binary logistic regression to evaluate the direction of the coefficients and the strength of the odds ratios. This step helped to determine the strongest variable to represent each particular ideology in the second step. This study did not suppose that all variables included for each measure of a particular ideology would be equally useful or significant. In part, this study seeks to identify the variables that were the strongest indicators of each particular ideology. The coefficients (contained in Appendix C) should be interpreted as the relative magnitude and direction of the relationship between levels of dummy variables. A positive coefficient and significant Wald test suggests that the level present has higher log odds of the outcome variable than the reference level (Morgan and Teachman 1988).

The odds ratio is also calculated by the SPSS statistical software program. This measure uses two values of X that are exactly one unit apart and takes the ratio of the odds. This study primarily uses dummy variables to measure different levels of categorical variables. When using dummy coding, a log odds ratio can be generated through the ratio of the difference between membership in the "present" category and

93

membership in the "reference" category. The odds ratio suggests the likelihood of an event occurring, in this case the likelihood of being in the "present' category versus the "reference" category, net of other variables in the model. Odds ratio values greater than 1.0 indicate an increased likelihood in the event occurring (DeMaris 1995).

Since the majority of variables in this study were defined categorically, a significant chi-square statistic suggests that at least one of the betas in the model is non-zero but says nothing about the significance of categories of any particular variable. Variables were entered both individually and as blocks to better understand each one's strength in predictive power via analysis of the chi-square statistic.

The second step used the chi-square test and the decrease in -2log likelihood statistic to indicate improvement in fit to the data from the basic model to the additive model. Demographic controls (including *Age, Sex, Marital Status, Race, Region,* and *Household Size*) were used as a base model against which material (*Income, Employment, and Education*) and ideological indicators were measured. This method allows for the evaluation of the strength of ideology above and beyond material and demographic effects. This method forms a rigorous test because for ideological indicators to be significant they must override the undeniable strength of material and demographic controls as documented by Rogot (1992), Lynch et al. (2000), Mirowsky and Ross (2003), Schnittker (2004), and Smith and Kington (1997). A constant number of cases were maintained for all models run in the same year. This allowed for comparison of the reduction in -2 log likelihood between models in the same year while also evaluating the concurrent loss in degrees of freedom (Brooks and Manza 2004).

A key reason for using this best-fit technique is that it provides comparisons across years as well as within years. In order to do so, the same variables were included in the demographic, material, and ideological models across all years. This

led to the exclusion of several variables mentioned earlier. For example, the measure of rural-urban residence was not available for 2004 and so was excluded from the fit statistic analysis. However, it was included in the initial binary logistic regression analysis and was not found to be a significant predictor of self-reported health. Likewise, this thesis intended to test the epidemiological argument that health behaviors are the key element in determining health outcomes, by including a model containing smoking and drinking prevalence. Unfortunately, these health behavior measures were not obtained by the GSS in all years, limiting this analysis to only 1993 and 1994. Yet, this reason alone did not justify that these variables should be excluded from the fit statistic analysis suggested by Brooks and Manza (2004). Because these variables had so few cases (n=173, 1994) including them in the second fit statistics test would have reduced the n and degrees of freedom so much as to compromise the integrity of the model. Moreover, when the preliminary binary logistic regression was run, health behaviors were consistently highly insignificant for 1993 and 1994. Not only did this finding fail to support the common epidemiological hypothesis that health behaviors serve as a mechanism of transmission between socio-economic status and health and consequently, as key predictors of health outcomes but also it provided further impetuous for removing health behaviors from the fit statistic test. Health behaviors were excluded from the fit statistics test with reasonable certainty that they were not significant predictors of self-reported health, and the fit statistics model was run with a common denominator N from all other variables.

Overall, the purpose of this study is to evaluate the effects of ideology on health. Along the way, other research has suggested key intervening variables that may also influence health and hide the impact of ideology. These variables have been included in the model in order to produce the most complete understanding of the determinants health that is possible. Yet, propositions on material indicators or health

behaviors have not been postulated because the literature review has already suggested the influence and direction these intervening variables will have on health outcomes. Since the crux of this study rests on how ideology and not material wealth or health behaviors affect self-reported health, the following chapters will primarily focus on the relationship between ideology and self-reported health.

CHAPTER FIVE

FINDINGS

This chapter will review the essential findings from the data analysis

conducted using the variables delineated in the previous chapter. First, some

descriptive statistics about self-reported health and various indicators will be explored.

These relationships give us a better understanding of the direction and strength of the

relationship but do not provide causal indications. After reviewing the key

propositions of this study, the second section of this chapter discusses the results of

the binary logistic regression analysis for each year independently and for all years

combined.

BIVARIATE ANAYSIS

The descriptive statistics of most variables in this study reveal a gradient in

health status. Perhaps the most pronounced of these gradients is seen in a cross-

tabulation of income and health. When all the years studied are aggregated,

approximately 90% of those in the top income quartile report having good health

while only 62% of those in the poorest quartile report good health. Table 16 reveals

that the likelihood of reporting poor health gets smaller with each increase in income

quartile thereby following the expected gradient. The highly significant chi-square

statistic suggests that the differences between quartiles are statistically significant.

This cross-tab suggests that the poorest Americans have worse health than even the

next poorest group above them, a finding which is consistent with health and

inequality trends reported by Marmot (2004), Kawachi (1997), and Wilkinson (2005,

2006).

Table 16: Cross-tab of Self-Reported Health and *Income*, All Years

Income	Good Health	Poor Health
Poorest Quartile	61.70%	38.30%
Second Quartile	76.40%	23.60%
Third Quartile	84.30%	15.70%
Richest Quartile	89.90%	10.10%
Chi-Sq	156.362***	

The measure of educational attainment shows a similar trend across all years studied with 88% of those with more than 12 years of education reporting good health while only 54% of those with less than 12 years of education do so.   Table 17 highlights the highly significant chi-square statistic, which suggests that the differences between levels of educational attainment are very important indicators of health. The bivariate relationship between health and education suggests that education affects more than an accumulation of school-specific knowledge. Education also represents the institutionalization of social networks and normative worldviews and health behaviors.

Table 17: Cross-tab of Self-Reported Health and *Education* All Years

Educ	Good Health	Poor Health
Less than 12	54.40%	45.60%
12	76.20%	23.80%
More than 12	87.70%	12.30%
Chi-Sq	193.866***	

Finally, significant emphasis was given to the challenges of understanding comparison groups in the independent variable discussion. This is particularly important when evaluating the relative deprivation hypothesis in relation to age. The bivarate analysis shows that, as expected, as respondents age their self-reported health

status declines. Over all years analyzed, 41.5% of respondents in the oldest age group (75+) report poor health compared with 16% of those in the youngest age cohort (18-39) (See Table 18). A larger difference in self-reported poor health was expected, which may provide evidence that a relative deprivation bias exists.

Table 18: Cross-tab of Self-Reported Health and *Age*, All Years

Age	Good Health	Poor Health
18-39	83.80%	16.20%
40-59	79.50%	20.50%
60-74	68.00%	32.00%
75+	58.50%	41.50%
Chi-Sq	67.797***	

Ideological Variables

The ideological variables *Eqwlth* and *Helpnot* are positively associated with a higher probability of poor health. Over all the years combined, 28.4% of respondents believing that the government should redistribute wealth have poor health while only 14.8% of respondents with economic libertarian beliefs report poor health. Table 19 suggests that a similar trend exists for respondents who believe the government should help the poor versus people who believe individuals and private businesses should take care of that responsibility. The chi-square statistics are highly significant for both economic ideological variables providing further impetus to include them in the binary logistic regression analysis.

Table 19: Cross-tab of Self-Reported Health and *Eqwlth*, *Helpnot*, All Years

Eqwlth		Good Health	Poor Health
	Should	71.60%	28.40%
	Neutral	79.50%	20.50%
	Shouldn't	85.20%	14.80%
Chi-Sq		32.065***	
Helpnot			
	Should	72.50%	27.50%
	Neutral	78.60%	21.40%
	Shouldn't	83.50%	16.50%
Chi-Sq		25.342***	

Figure 6 highlights the cross-tab of *Health* and the Economic Composite scale. As mentioned previously, this measure is a simple summated scale of the economic indicators *Eqwlth* and *Helpnot.* According to the statistics revealed in the cross-tab, 33% of respondents who consistently reported that the government should be involved in social issues had poor health while only 15% of respondents who consistently reported that the government should not be involved in such affairs self-reported poor health. There is a clear gradient since the differences between categories are highly significant with a chi-square statistic of 44.219.
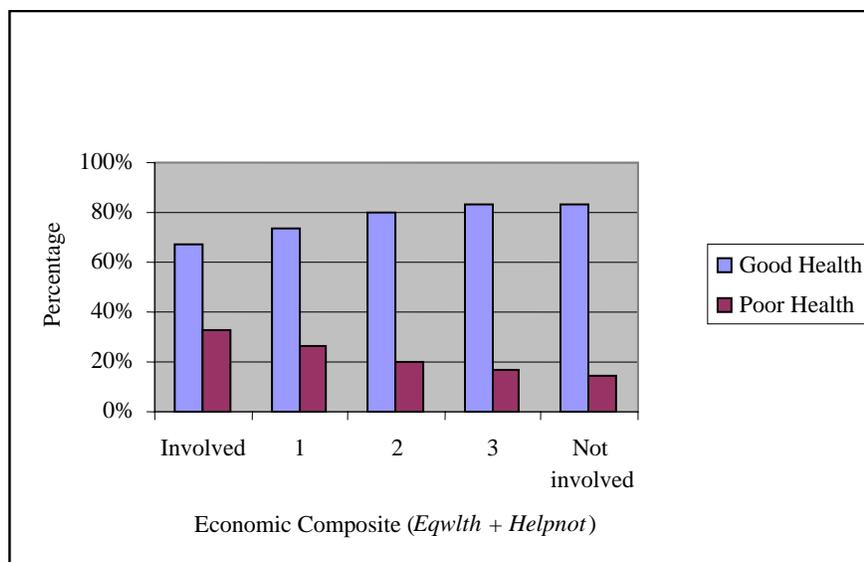
Figure 6: Cross-tab of Self-Reported Health and *Economic Composite,* All Years

The relationship between religiosity and health is significantly weaker since only the measure of fundamentalism of the respondents' religion maintains a significant chi-square across all years of the study. Despite the lack of significance, evidence of a gradient or general trend in favor of my propositions is still present. The indicator of religious attendance shows the expected pattern since only 19% of regular attendees report poor health compared to 23% of respondents who never attend. This trend generally remains for the measure of strength of religious beliefs since 21% of religious respondents report poor health while 22.5% of respondents who are not strongly religious report poor health. However, Table 20 suggests that the predicted trend does not hold for all levels of the variable because respondents who are not religious are also the least likely to report poor health. Only 17% of non-religious people reported poor health and a much higher percentage were predicted by the propositions of this thesis.

Table 20: Cross-tab of Self-Reported Health and *Attend*, *Fund*, *Reliten*, All Years

Attend		Good Health	Poor Health
	Never	77.10%	22.90%
	Infrequently	78.90%	21.10%
	Regular	80.70%	19.30%
Chi-Sq		2.84	
Fund			
	Moderate	80.70%	19.30%
	Liberal	80.20%	19.80%
	Fundamentalist	75.00%	25.00%
Chi-Sq		9.075**	
Reliten			
	Not Religious	82.90%	17.10%
	Not Strongly Religious	77.50%	22.50%
	Strong	79.10%	20.90%
Chi-Sq		3.781	

Cross-tabulations were also conducted for the religious composite variable and self-reported health.   The religious composite variable is a simple summated scale of the three individual religious variables and may give an indication of the overall consistency of reported religiosity. However, there was no clear gradient, and the chi-square statistic was not significant when measured across all years of observation.
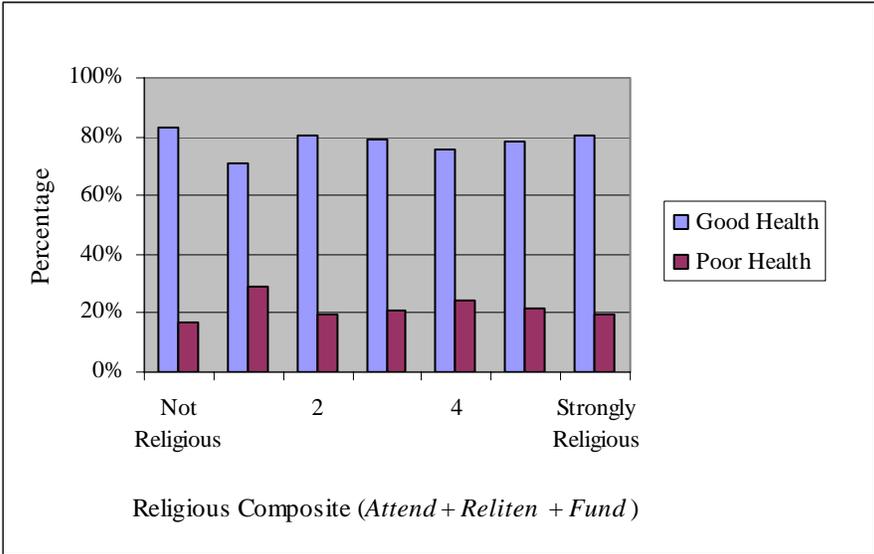
Figure 7: Cross-tab of Self-Reported Health and *Religious Composite,* All Years

The third particular ideological belief measured in this study is the perception of social cohesion. As predicted, Table 21 shows that a negative community perception was clearly related to perceived poor health. For all years, 25% of respondents who indicated they did not trust people in general reported poor health, compared to 15% of those who reported they felt they could trust people. Likewise, 26% of respondents who felt most people would try to take advantage of them if they could, reported poor health, while 18% of those who felt most people would be fair reported poor health. Although the chi-square statistic for *Trust* and *Fair* was highly

significant, the chi-square statistic for *Helpful* never reached significance when all the years of the study were aggregated. These findings provide initial evidence for the proposition that perceptions of the surrounding environment matter because people with negative community perceptions report poorer health. In addition, the variables *Trust* and *Fair,* as indicators of social cohesion, are more closely associated with a higher probability of poor health than is the variable *Helpful,* as was predicted in the literature review.

Table 21: Cross-tab of Self-Reported Health and *Helpful*, *Trust*, *Fair*, All Years

Helpful		Good Health	Poor Health
	Not Helpful	77.1%	22.9%
	Helpful	80.4%	19.6%
Chi-Sq		3.669	
Trust			
	Not Trusted	74.7%	25.3%
	Trusted	84.7%	15.3%
Chi-Sq		32.309***	
Fair			
	Not Fair	74.20%	25.80%
	Fair	82.20%	17.80%
Chi-Sq		21.426***	

Cross-tabulations were also conducted for the social cohesion composite variable. This variable is a simple summated scale of the variables *Helpful, Trust,* and *Fair* and may provide a better understanding of the consistency of social ideological responses. A highly significant (Chi-square = 28.849) gradient is present in the composite scale. According to Figure 8, people who have negative perceptions of society are more likely to report poor health than respondents who have a positive perception of society.
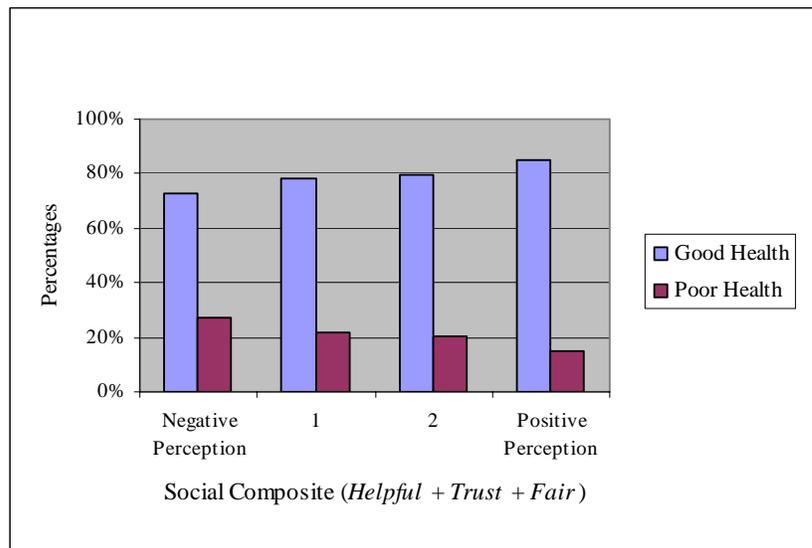
Figure 8: Cross-tab of Self-Reported Health and Social Composite, All Years

The final summated scale was created to compose a test measure of ruling ideology.   Respondents who consistently reported answers that did not correspond with the particular dominant ideologies explained in Chapter 2 were collapsed into the category "None."   Figure 9 clearly shows a health gradient for ruling ideology since respondents who consistently fail to espouse the dominant particular ideologies in their responses are more likely to report poor health than their more consistently ideological counterparts. Over all years, 27% of respondents who reported no affiliation with the dominant particular ideologies claimed poor health while 16% of respondents consistently responding affirmatively to the particular dominant ideologies reported poor health.   The high significance of the chi-square (18.497) indicates that this variable may be an important predictor of poor health and should be included in the logistic regression model.
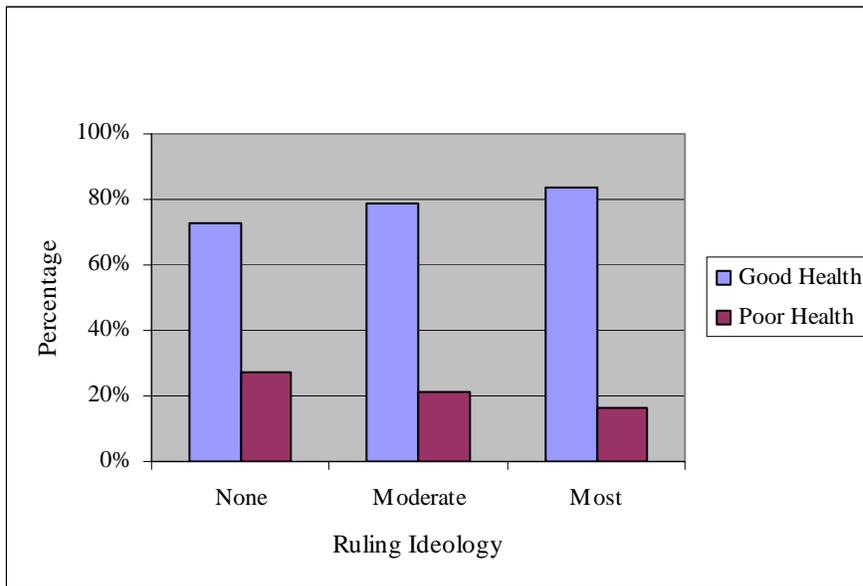
Figure 9: Cross-tab of Self-Reported Health and Ruling Ideology, All Years

Health Behaviors

The link between health behaviors and health outcomes seems irrefutable. Certainly, engaging a behavior that has proven detrimental effects on humans should negatively affect that person's health. However, the bivariate trends for two commonly used health behaviors, drinking alcohol and smoking cigarettes, show moderate to no significance for 1993 and 1994. Moreover, smoking was expected to be the more significant of the two variables; however, it is not significant in either year. The general pattern of smoking is to be expected as those who smoke report the highest percent of poor health (29%), followed by those who used to smoke (25%), and then lastly by those who never smoked (19%) (See Table 22, 1993).

The patterns for alcohol consumption are more surprising and suggest opposite trends from what was predicted based on the values espoused by the rhetoric of the dominant religious ideology. For both years studied, respondents who never drink alcohol are much more likely to report poor health than those who abstain completely

or even those who report being drunk. In addition, people who never drink were much more likely to report poor health than even those who smoke(d). Two-tailed Pearson correlations were run to detect collinearity. Collinearity was found between drinking and age and drinking and employment status.

Table 22: Cross-tab of Self-Reported Health and Health Behaviors, 1993, 1994

		1993		1994	
Drink		Good Health	Poor Health	Good Health	Poor Health
	Never Drink	67.0%	33.0%	65.4%	34.6%
	Drink	80.5%	19.5%	82.4%	17.6%
	Have Been Drunk	83.0%	17.0%	83.0%	17.0%
Chi-Sq		9.241**		6.213*	
Smoke					
	Never Smoked	81.2%	18.8%	78.2%	21.8%
	Smoked	71.1%	28.9%	75.4%	24.6%
	Did/Ever Smoke	75.0%	25.0%	78.9%	21.1%
Chi-Sq		3.806		0.206	

Surprising Results

Some of the bivariate and cross-tabulation results were surprising. For example, research has suggested a protective effect on health through marriage (McDonough 1999, Hirschl et al. 2003), yet descriptive statistics suggest that those in the "Never Married" category have the best health, followed by those in the "Married" category, and then the "Formerly Married" category. These results are highly significant, as evidenced by the chi-square statistic in Table 23. Correlation between marital status and age was found to be small and insignificant for this model. An interaction term was also formed and found to be insignificant in this model.

Table 23: Cross-tab of Self-Reported Health and *Married,* All Years

Married		Good Health	Poor Health
	Married	80.70%	19.30%
	Formerly Married	72.20%	27.80%
	Never Married	82.40%	17.60%
Chi-Sq		22.754***	

Second, the measure of employment follows the predicted trend that those who are working full-time report poor health less than their part-time counterparts. Likewise, these two groups have significantly lower rates of poor health than any other category. Yet, what is surprising about this variable is that 62.5% of respondents in the "other" category, undefined by the GSS, report poor health across all years (See Table 24). In 1993, 83% of respondents in this undefined category reported poor health. The GSS follows up on this category by asking whether the respondent has ever held a job for more than one year and the majority of respondents have. Clearly, this category needs further explanation and exploration to better understand why so many respondents in the "other" category perceive themselves to have poor health.

Table 24: Cross-tab of Self-Reported Health and *Employment*, All Years

Emp		Good Health	Poor Health
	Working	85.80%	14.20%
	Not Working	70.90%	29.10%
	Reason Not to Work	65.60%	34.40%
	Other	27.00%	73.00%
Chi-Sq		171.537***	

A third surprising result of the bivariate analyses is that there is no statistically significant difference between males and females for poor health. From the literature, females would be expected to have better health since they tend to live longer. In

addition, there is no significant difference reported between races, as evidenced in Table 26. This is a surprising result considering the amount of research documenting the relationship between race and poor health, often via mediating factors such as income or access to health care.

Table 25: Cross-tab of Self-Reported Health and *Sex*, All Years

Sex	Good Health	Poor Health
Male	77.90%	22.10%
Female	79.30%	20.70%
Chi-Sq	0.641	

Table 26: Cross-tab of Self-Reported Health and *Race*, All Years

Race	Good Health	Poor Health
White	80.2%	19.8%
Black	71.2%	28.8%
Other	70.1%	29.9%
Chi-Sq	15.759***	

Test for Collinearity

Before the logistic regression was run, correlations between all variables were computed. As expected, collinearity was present between the composite variables and the respective variables used in their creation. For example, the scale measuring the degree of economic libertarian ideology was collinear with both economic ideology variables, suggesting the role the government should play in solving problems and equalizing wealth in America. Because of these significant correlations, the composite variables will not be included in the initial logistic regression analyses but will be tested on their own model afterwards. In addition, although there was no collinear relationship found between the scale for *Ruling Ideology* and the variables that

108

composed it, a high correlation between this composite variable and the economic

ideology variables suggests that it may be wise to exclude it from the overall analysis

and place it in the secondary analysis of only the composite variable. Finally, the only

variables that were collinear out of all potentially included variables were the religious

ideology variables *Attend* and *Reliten*. Thus, only one will be analyzed in the final

model. Initially it was surprising to find no collinearity between education,

employment, and income because of the suggested overlap of these three variables in

the literature. Yet, in a large enough data set, these indicators are measuring distinct

material processes, and collinearity is not necessarily present. In analyzing

correlation matrices, pair-wise relationships between all indicator variables were

evaluated but more complex relationships were not. One limitation to this method of

determining correlations is the possibility that three-way collinear relationships may

be present but undetected. In the future, statistical techniques should be developed

and employed that will measure complex relationships that may be present in the data

(Dielman 2005:162).

LOGISTIC REGRESSION RESULTS

The two-step logistic regression procedure delineated in Chapter 4 was used

for this analysis. A unique set of respondents is measured in each year analyzed

because the GSS is not a longitudinal data set. Thus, a binary logistic regression was

first run separately for each year in order to highlight key relationships between health

and independent predictors. Through this regression sequence, consistency and

strength of individual variables could be determined, and statistics such as odds ratios

and significant differences between variable levels were created (See Appendix C).

After general trends within each year and across the four years were noted, logistic

regression was run on data from all four years in order to gain a broad picture of the decade stretching from the mid 1990s to 2004.

Next, a technique used by Brooks and Manza (2004) for evaluating the fit of the logistic regression models was employed to determine the best fit for this study. In this method, demographic controls were used as a base against which other variables and sets of variables were measured. First, material indicators were added to the model and the fit was evaluated against the base model. Subsequently, different combinations of ideological variables were entered and their improvement of fit was measured against the model containing demographic and material indicators. This design provides a very stringent test for ideological variables since they must improve the fit of the model above and beyond the documented power of material indicators.

This chapter will briefly highlight significant indicators for each model. Then the propositions presented in chapter two will be used to outline key findings using the fit statistic analysis highlighted in Brooks and Manza's 2004 article. As a quick review, the key propositions are:

Proposition 1: Respondents who believe in an economic system other than economic libertarianism will have poorer self-reported health than those who believe in a neo-liberal, free-market system.

Proposition 2: Respondents who do not espouse religious conservative beliefs and/or accompanying normative behaviors will have poorer self-reported health than those who do.

Proposition 3: Respondents who do not have a positive perception of community cohesion will have poorer self-reported health than those who do.

110

Proposition 4: Respondents whose responses do not reflect the ruling ideology measured as a composite of economic libertarianism, religious conservatism, and social traditionalism, will have poorer self-reported health than those who do.

1993 Results

Binary logistic regression analysis revealed some overwhelmingly powerful variables such as *Income.* In 1993, those in the lowest income quartile were over seven times more likely to report poor health than those in the highest quartile, while those with incomes in the second lowest income quartile were four times more likely to be ill than the wealthiest group. These preliminary findings persisted when *Income* and other material variables were included in the fit statistic analysis.

Table 27 reveals the results of Brooks and Manza's (2004) test for best fit within the 1993 sample. Demographic controls were used as a base model against which material indicators were measured. Material indicators reduced the -2 log-likelihood statistic significantly while only losing eight degrees of freedom. For 1993, the ideological variables taken together do not show an improvement over the material model because the chi-square statistic is insignificant. Models 4, 5, and 6 look at each particular ideological influence separately in order to better understand its relative strength. For the 1993 sample, it appears that all three sets of ideological measures have about equal predictive power, although the social trust variables are slightly stronger than the other two sets. Despite the relative strength of the social trust variables, none of the three sets of ideological indicators maintained their significance at the .05 level. Models 7, 8, and 9 measured specific indicators based on their continued significance when running an iterative logistic regression model to weed out insignificant indicators. Frequency of religious service attendance, the measure of

social trust, and the degree to which people believed the government should be involved in equalizing the wealth distribution, were chosen; however none significantly reduced the -2 log-likelihood in Table 27. Since the cut-off for this research is .05, none of the particular ideological propositions were supported using the 1993 data, but one could infer that the near significance of at least one of the indicators warrants these propositions more attention in future research on ideology.

Table 27: Fit Statistics for Evaluating Logistic Regression Models, 1993

Models for 1993	-2 Log-Likelihood	d.f	Reduction in LL	Reduction in d.f.	Chi-Sq Sig
Demographic Controls[a]	358.959	355			
DemC + Material	327.016	347	31.943	8	0.005
DemC + Mat + Ideology	313.991	334	13.025	13	No
DemC + Mat + Econ	323.221	343	3.795	4	No
DemC + Mat + Relig	321.748	341	5.268	6	No
DemC + Mat + Soc	322.452	344	4.564	3	No
DemC + Mat + Eqwlth	323.431	345	3.585	2	No
DemC + Mat + Attend	323.376	345	3.64	2	No
DemC + Mat + Trust	323.371	346	3.645	1	0.10

Note: Dependent variable **is** coded "1" for Poor Health and *"0"* for Good Health.
[a] Demographics include Marital status, Age, Age^2, Sex, Race, Number of persons in the household, and Region.

After evaluating the fit statistics for the logistic regression models, a final set of regression models consisting of composite variables were evaluated. This set of regressions tested variables for the consistency of the responses via a scale of ideological variables. Thus, four scales were tested: economic libertarian, religious conservative, social traditionalist, and an overall measure of ruling ideology. None of these composite scales offered a significant improvement over the model including demographic controls and material indicators (See Appendix D). However, *Ruling Ideology* was significant at the .01 level suggesting that those with a neutral view of economic libertarianism were three times more likely to report good health than

respondents with strongly libertarian beliefs. This result lends support to the fourth proposition. These scales were constructed with the hope of providing an indication of the affect of particular and ruling ideologies; however, measurement error and invalidity was suspected from the outset.

1994 Results

The subsets of questions used in this analysis were asked of significantly more respondents in 1994 (N = 506) than in 1993 (N = 367). Again, in contrast to the 1993 data where *Income* was highly significant and *Employment* moderately significant, the 1994 sample suggests the reverse. Respondents in the lowest income quartile were 2.3 times more likely to report poor health than those in the highest quartile. This was a significant reduction in probability from the 1993 sample where those in the lowest quartile were over six times more likely to report poor health. For the 1994 sample, significant differences were acknowledged between each level of *Employment* and the reference group "Working part or full time." Of particular importance was the odds ratio of the "other" group, which suggested that respondents in this category were 4.5 times more likely to be ill than those who were employed. The final material variable, *Education*, played a more significant role in the 1994 sample than in the 1993 sample. In 1994, respondents who had not graduated from high-school were twice as likely to report poor health then those working on an advanced (college) degree. Perhaps, as Schnittker (2004) suggested, the role of education was overshadowed by the relative strength of income in 1993.

In order to determine which model has the greatest reduction in -2 log-likelihood while losing the least degrees of freedom, logistic regression results were placed into a best fit statistic table. Table 28 reveals that adding material indicators to the demographic control model again significantly reduced the -2 log-likelihood

statistic while only using eight extra degrees of freedom. In contrast to the results from 1993 (Table 27), adding all the ideological variables improved the model through a significant reduction in -2 log-likelihood.

The model testing religious ideology shows a significant reduction in -2 log-likelihood, while only using two additional degrees of freedom. Furthermore, the individual indicator of particular religious ideology, *Attend,* was significant at the .05 level. These findings lend general evidence towards the support of Proposition 2 and highlight the importance of religious attendance for measuring religious ideology. No other particular ideological group showed a significant improvement over the material and demographic model. However, when the strongest ideological variables for each group were identified via step one binary logistic regression (See Appendix C), the measure of economic and social ideology were significant at the .10 level. Thus, all ideological variables showed an improvement over the fit of just the demographic control and material indicators model; however, only one variable was significant at the .05 level

Table 28: Fit Statistics for Evaluating Logistic Regression Models, 1994

Models for 1994	-2 Log-Likelihood	d.f.	Reduction in LL	Reduction in d.f.	Chi-Sq Sig
Demographic Controls[a]	664.131	494			
DemC + Material	595.195	486	68.936	8	0.005
DemC + Mat + Ideology	571.5	473	23.695	13	0.05
DemC + Mat + Econ	589.837	482	5.358	4	No
DemC + Mat + Relig	580.084	480	15.111	6	0.05
DemC + Mat + Soc	590.986	483	4.209	3	No
DemC + Mat + Eqwlth	590.197	484	4.998	2	0.10
DemC + Mat + Attend	589.034	484	6.161	2	0.05
DemC + Mat + Trust	591.867	485	3.328	1	0.10

Note: Dependent variable **is** coded "1" for Poor Health and *"0"* for Good Health.

[a] Demographics include Marital status, Age, Age^2, Sex, Race, Number of persons in the household, and Region.

Composite scales were used to analyze the consistency of respondents'
choices. None of the composite measures were significant at the .05 level (See
Appendix D). However, the religious composite scale was nearly significant at p=.10,
and respondents who were weakly religious were over 2.5 times more likely to report
poor health. Although a general gradient towards more religiosity and better health
could be seen in the odds ratios, the first category of "not religious" did not follow this
trend. Although not significant, those who were not religious were less likely to report
poor health. This surprising statistic may be a result of an extreme view of one's self
and the world. Despite the moderate support for Proposition 2, evidence to support
Proposition 4 on ruling ideology was lacking. The summated scale for *Ruling
Ideology* was not significant, even at the .10 level of significance.

1996 Results

In 1996, the GSS collected data on the specific subsets of variables in this
analysis for more individuals than any other year studied. The 1996 sample contained
almost three times as many responses (N=927) as did the 1993 or 2004 sample and
almost twice as many as the 1994 sample. Again, the material variables were
extremely strong, reducing the -2 log-likelihood 126.008 points from that of the base
demographic control model. In particular, a strong gradient in education was present
since those with the least education were four times more likely to report poor health
than those with the most education.

Table 29 reveals that adding in all the ideological variables simultaneously
reduced the -2 log-likelihood further but at a greater loss in degrees of freedom. Thus,
the ideological model was not a significant improvement over the demographic
controls and material indicators model. Moreover, none of the particular ideologies
were significant at the .05 level when all potential indicator variables were included as

a measure. This is similar to the findings from 1993 where none of the particular

ideology models consisting of multiple indicator variables were significant. However,

when single indicators were entered into the model, support can be found for two of

the three propositions of this study. Surprisingly, these variables and the particular

ideology they supported were quite different from the 1994 sample. Table 29

highlights the significance of the economic libertarian measure *Helpnot* and the social

cohesion measure *Fair*. These indicators significantly reduced the -2 log-likelihood

from the model containing demographic controls and material variables without

sacrificing too many degrees of freedom.

Using binary logistic regression, the odds ratios for these significant variables

were determined. The greatest difference in levels was seen in *Helpnot*, where

respondents who believed that the government should help the poor were almost twice

as likely to have reported poor health then respondents that thought the government

should not be as involved in social problems. The odds ratio was less dramatic for

Fair since respondents who thought that one couldn't be too careful when dealing

with other people were slightly more likely to report poor health (odds ratio = 1.4).

Table 29: Fit Statistics for Evaluating Logistic Regression Models, 1996

Models for 1996	-2 Log-Likelihood	d.f.	Reduction in LL	Reduction in d.f.	Chi-Sq Sig
Demographic Controls[a]	906.278	915			
DemC + Material	780.27	907	126.008	8	0.005
DemC + Mat + Ideology	766.903	894	13.367	13	No
DemC + Mat + Econ	773.312	903	6.958	4	No
DemC + Mat + Relig	776.413	901	3.857	6	No
DemC + Mat + Soc	776.26	904	4.01	3	No
DemC + Mat + Helpnot	773.396	905	6.874	2	0.05
DemC + Mat + Fund	778.966	905	1.304	2	No
DemC + Mat + Fair	776.325	906	3.945	1	0.05

Note: Dependent variable **is** coded "1" for Poor Health and *"0"* for Good Health.

[a] Demographics include Marital status, Age, Age^2, Sex, Race, Number of persons in the household, and Region.

Furthermore, composite scales representing each particular ideology were compared to the base demographic control model. Similar to the results of the 1994 sample, none of the models containing composite scales showed a significant improvement over the model containing only the demographic controls and material variables (See Appendix D). Similar to the 1994 results, only the religious composite scale reached near significance at p=.10. Again, proposition four was not supported by the data since *Ruling Ideology* never gained significance in the model.

2004 Results

The findings for 2004 highlight the consistent strength of the material indicators. For example, *Education,* highly significant at p=.001, showed a strong health gradient. Respondents with less than 12 years of education were over eight times more likely to be ill while those with 12 years of education were nearly three times more likely to report poor health than respondents with more than 12 years. These differences were highly significant at the .001 and .05 level (See Appendix C).

According to Table 30, the model containing the overall measure of ideology was not a significant improvement over the model containing the demographic controls and material indicators. Similarly, none of the particular ideological variables significantly reduced the -2 log-likelihood at the .05 level, although the measure of social ideology was significant at the .10 level. When these particular ideologies were deconstructed via logistic regression to reveal the strongest variable three more variables were added to the fit statistic table. Only the measure of economic libertarianism *Helpnot* yielded a significant improvement over the demographic controls and material indicators model. These results suggest that the ideological measure of whether the government or private individuals and businesses should help with the country's problems is an important predictor of health. Those who support

government involvement in America's social problems were almost five times more likely to be ill than those whose responses were consistent with the economic libertarian ideology. In addition to the significant difference between interventionists and anti-interventionists, a significant (p=.009) difference between neutral respondents and anti-interventionists is also evident (See Appendix C).

Table 30: Fit Statistics for Evaluating Logistic Regression Models, 2004

Models for 2004	-2 Log-Likelihood	d.f.	Reduction in LL	Reduction in d.f.	Chi-Sq Sig
Demographic Controls[a]	253.798	278			
DemC + Material	193.074	270	60.724	8	0.005
DemC + Mat + Ideology	177.107	257	15.967	13	No
DemC + Mat + Econ	190.752	266	2.322	4	No
DemC + Mat + Relig	186.282	264	6.792	6	No
DemC + Mat + Soc	186.113	267	6.961	3	0.10
DemC + Mat + Helpnot	186.329	268	6.745	2	0.05
DemC + Mat + Attend	189.472	268	3.602	2	No
DemC + Mat + Trust	192.126	269	0.948	1	No

Note: Dependent variable **is** coded "1" for Poor Health and *"0"* for Good Health.
[a] Demographics include Marital status, Age, Age^2, Sex, Race, Number of persons in the household, and Region.

Using the composite measures to reevaluate the four propositions presented in Chapter Two, moderate support can be found for Propositions 1 and 2. The composite scales of economic libertarianism and social conservatism were significant at the .10 level (See Appendix D). In 2004, respondents with neutral responses, as opposed to responses suggesting the government was too involved in economic affairs, were over four times more likely to report poor health. Also, similar to the composite results of 1994 and 1996, low religiosity was significantly related to poor health (odds ratio = 9.9), but the lowest religiosity category was not significantly related. Although the significance cutoff for this study is .05, this near significance suggests that theses variables should be analyzed further. Finally, Proposition 4 was not supported since *Ruling Ideology* was not significant at the .05 level of

significance.   Despite the differences in the significance of particular variables across the years 1993 through 2004, general trends can be identified. In particular, moderate support for two of the three propositions can be found in most years. The reduction in -2 log-likelihood for the specific variables measuring economic libertarianism and social perceptions was the most consistent. These variables have a significant association with health outcomes despite the power and robustness of the material factors. The final chapter will discuss the importance of these general trends, their implications, and suggested directions for future health research.

Cumulative Regression Results

After noting the particular trends for each year individually, all years were combined into a cumulative (1993-2004) dataset representing 2279 respondents. Because income had been adjusted for inflation between the 1996 sample and the 2004 sample, no single measure of income across all years existed. Instead of reverting to the adjusted income for 2004 to 1996 dollars and then recalculating quartiles for the newly combined income scale, the income quartiles for both variables were combined. Thus, although a response of number 1 in 1993-1996 does not have the same quartile cut-off as in 2004, the relative comparison of income groups is maintained. For the combined model, there are no absolute income cut-off points, and income can only be seen as a relative measure of income. Thus, respondents answering 1 in either the 1993 or 2004 data have less income than respondents answering 2, 3, or 4. As this study is measuring relative and not absolute deprivation, this combination of income quartiles without recalculating the data makes sense.

Not surprisingly, the material factors offered the strongest predictive power of poor health in the fit statistic model. This finding is congruent with the socio-economic literature that suggests SES is a fundamental cause of poor health (Phelan

and Link 2004). Binary logistic regression revealed that the poorest respondents are 2.5 times more likely to report poor health than the wealthiest respondents. *Employment* was also highly significant overall (p value of Wald Statistic = .000) and for the categories "reason not to work vs. working" and "other" vs. "working." The odds ratio for these levels of employment elucidates the importance of this variable since those who listed "other" are nearly ten times more likely to report poor health than respondents who are working, while those with a "reason not to work" are 2.1 times more likely to have poor health. Surprisingly, those who are not working have the lowest odds ratio of the three categories and are 1.9 times more likely to be in poor health than employed respondents. *Education* was the final material variable analyzed and was highly significant over all and for all levels. As predicted by the literature, a strong gradient is visible (Schnittker 2004, Mirowsky and Ross 2003). Those with less than a high-school degree are three times more likely to be ill than those with at least twelve years of school. Similarly, those with a high-school degree are almost twice as likely to be in poor health then those with more than twelve years of education.

The second step of creating a best fit table to analyze the reduction in -2 log-likelihood yielded some surprising results for the ideological indicators. As expected, the reduction in -2 log-likelihood was highly significant with the addition of the material indicators. Furthermore, there was a large decrease in -2 log-likelihood when the ideological variables were added to the material indicators and the base model of demographic controls (See Table 31). When comparing models 4, 5, and 6 it is clear that the social indicators, taken together, hold substantial predictive power. The social variables reduce the -2 log-likelihood the most and the chi-square is highly significant. The religious variables are also important indicators of self-reported health; however, the ideology variables only reach near-significance at the .10 level.

The significance of the social and religious indicators remains when the analysis is taken to the level of individual variables. The social cohesion indicators, *Fair* and *Trust,* are highly significant at the .005 level. The results lend support to Kawachi et al.'s (1997) earlier findings that perceptions of society ultimately affect health outcomes. Averaging cumulative data from 1986 through 1990, they found that social mistrust (accounting for 58% of the variance in total mortality) is associated with all-cause mortality and specific illnesses such as heart-disease and malignant cancers (Kawachi et al. 1992:1494). Similarly, this study found that people who lack trust in those around them and think that generally others would try to take advantage of them are more likely to be ill than those who had positive perceptions of the surrounding society. These findings lend support to my third proposition that an individual's positive perceptions of society have a direct relationship with his or her poor health.

The individual measure of religious ideology, *Attend,* was significant at the .05 level and provided evidence to support proposition two. When looking at the direction of the coefficients, it is clear that religious conservatism also plays a role in predicting health outcomes since fundamentalists are less likely to report poor health than liberals (See Appendix C). However, the significance of ideological indicators did not hold across the board because *Eqwlth* was only nearly significant at the .10 level. Although not significantly improving the fit of the model over demographic and material indicators, these findings are still important. Looking at the coefficients, it is clear that respondents who believed that the government should intervene to help redistribute wealth were slightly more likely to report poor health than those with an economic libertarian position on the matter.

Table 31: Fit Statistics for Evaluating Logistic Regression Models, All Years

Models for All Years	-2 Log-Likelihood	d.f.	Reduction in LL	Reduction in d.f.	Chi-Sq Sig
Demographic Controls[a]	2222.636	2267			
DemC + Material	1978.569	2259	244.067	8	0.005
DemC + Mat + Ideology	1942.186	2246	36.383	13	0.005
DemC + Mat + Econ	1970.229	2255	8.34	4	0.10
DemC + Mat + Relig	1962.679	2253	15.89	6	0.025
DemC + Mat + Soc	1963.746	2256	14.823	3	0.005
DemC + Mat + Eqwlth	1973.602	2257	4.967	2	0.10
Dem C + Mat + Attend	1971.211	2257	7.358	2	0.05
DemC + Mat + Fair	1967.746	2258	10.823	1	0.005
DemC + Mat + Trust	1969.946	2258	8.623	1	0.005

Note: Dependent variable **is** coded "1" for Poor Health and *"0"* for Good Health.

[a] Demographics include Marital status, Age, Age^2, Sex, Race, Number of persons in the household, and Region.

The final set of logistic regressions was run on the composite measures of economic, religious, social, and ruling ideology. Two of the three scales measuring particular ideologies showed a significant improvement in fit over the model containing only the demographic controls and material indicators. In particular, the social composite variable was highly significant at the .01 level and the economic composite variable was significant at the .025 level (See Appendix D). Consistent with expectations derived from the literature, the social composite variable shows a gradient since those with moderate views of society have better health than the most negative respondents but worse health than those who have the best perception of society. Respondents with very negative perceptions of society were significantly (p=.001) more likely to report poor health than those who positively perceived their surroundings. Although not significant at the .05 level, the religious composite scale was nearly significant and should be analyzed further. It is surprising, given the trend of the religious scale to be nearly significant when the other composite scales were not significant, that this scale was not more significant when aggregated over all the years. The other two scales saw a great improvement in their chi-square significance level;

however, the religious composite model remained nearly significant relatively constantly. Despite this, respondents in the second least religious group were almost twice as likely to perceive themselves to be in poor health then the most religious respondents. In contrast to the fit statistics for all other years, the composite scale for ruling ideology was significant (chi-square statistic = .03) when all years were aggregated. This is a surprising change from previous trends and must be looked at more closely.

Despite support found for the three proposed propositions in the cumulative file, the strength of the material variables (seen by their enormous chi-square statistics) overshadowed the importance of other psychosocial indicators. Thus, as Schnittker (2004) has suggested, the association between such variables and health outcomes is often thought of as explained by the robust relationship between income and health. Although the ideological variables were not as strong as the material predictors, they still showed a significant improvement in the model of best fit and may be valuable in terms of suggesting directions for new research. As stated earlier, measurement validity is extremely important and the moderate significance of variables such as religious ideology indicates that further efforts should focus on solidifying measurement validity on similar indicators of this field.

The final chapter in this study will further analyze the findings presented above. In particular it will present a broad picture of which propositions are supported and which are not. These results will be discussed in light of the historical rise of economic liberalism, religious conservatism, and social traditionalism. It is important to touch on the issue of comparison groups and how these variations may have affected the data analysis. In addition, any limitations or suggestions for future research will be reviewed.

CHAPTER SIX

DISCUSSION AND CONCLUSION

The overarching purpose of this study is to explore the relationship between ideological beliefs and individual self-reported health in America between the years 1993 and 2004. Three particular ideological beliefs -- economic libertarianism, religious conservatism, and social traditionalism -- were deemed both influential during this era and measurable using the General Social Survey. Since the overlap of these ideologies suggests the presence of a ruling ideology, an additive scale of these particular ideologies was also composed and included in the analysis. Four propositions were developed based on literature review and preliminary data analysis, and were subsequently evaluated through logistic regression procedures.

In order to understand the relative strength of these ideological variables, material indicators, demographic controls, and health behaviors were included in the basic logistic regression model. The addition of these indicators allows for an evaluation of several competing epidemiological theories. In sum, this study attempts to uncover determinants of health from psychosocial, material, behavioral, and ascribed spheres of influence. The findings of this study will help future researchers better understand the diverse factors that influence perceptions of health by Americans.

The final chapter revisits the four propositions outlined in Chapter Two and pairs them with the findings from Chapter Five. The implications of the supported and unsupported propositions are investigated further, and the connection between ruling ideology and perceptions of health is analyzed in light of current sociological theory. After discussing the value of this and similar research, the chapter concludes

the study by noting important limitations and offering suggestions for future research directions.

Evaluating the Propositions

Unveiled in the previous chapter, the results of this study show moderate support for three out of my four propositions. Table 32 consolidates the findings of Chapter 5 based on a .05 and .10 level of significance. It is evident that moderate support is garnered for Proposition 1, namely that ***respondents who believe in an economic system other than economic libertarianism will have poorer self-reported health than those who believe in a neo-liberal, free-market system.*** After taking into consideration demographic controls and material indicators, respondents who expressed libertarian economic views are less likely to report poor health. This finding holds true across all years except for 1993. Possibly, these findings allude to the increasing influence of libertarian economic ideology as the Republican Revolution swept America. In 1993, before the Contract with America, the Republican takeover of Congress, and the national welfare reform legislation adopted under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), respondents were no more likely to report poor health if they were economic libertarians than if they were not. Both the Contract with America and PRWORA, in their emphasis on the role of individuals in their own destiny and adherence to the ideals of free-market competition, clearly mapped to the dominant economic paradigm of the era. These major shifts in American policy and discourse paved the way for increasingly libertarian positions over the years being studied. Thus, it is not particularly surprising that the economic ideology variables are not significant in 1993 but increase in significance from 1994 onward.

Table 32: Support Found for Hypotheses at .05 and .10 Levels of Significance

	1993	1994	1996	2004	All Years
Proposition 1: Econ	No	0.10	0.05	0.05	0.10
Proposition 2: Relig	No	0.05	No	No	0.05
Proposition 3: Social	0.10	0.10	0.05	0.10	0.05
Proposition 4: Ruling Id	No	0.05	No	No	0.05

Little support for the second proposition, that ***respondents who do not espouse religious conservative beliefs and/or accompanying normative behaviors will have poorer self-reported health than those who do,*** is found using the individual best fit model. This measure only becomes significant when measured in 1994 and across all years. This indicator is also relevant under two other circumstances. First, the material indicators and demographic controls hold much sway in the analysis. Without the inclusion of these overpowering variables, religiosity gains in significance. Although one goal of this study is to compare the relative strength of indicators between ideological, material, demographic, and health behavior models, it is also important to note the absolute importance of the variables. The ideological variables, including religiosity, contribute to the model even if they are sometimes overpowered by the material indicators.

The second situation that necessitates further evaluation is the significance of religiosity when looked at as a scaled variable. Table 33 reveals that the composite scale of religiosity was nearly significant for three out of five years studied. This finding suggests that measuring degree of religious belief on a broader scale using all religious indicators allows for a more nuanced picture of the strength of belief than when only using a three category scale. One obvious problem with the religious indicators chosen for the best fit analysis is with the question asking respondents about the fundamentalism or liberalism of their religious beliefs. This question poses a false comparison in that fundamentalism is not the opposite of liberalism. Conservative

126

respondents may not want to call themselves "fundamentalist" because of the pejorative nature of that term, but do attend church at least once a week and consider their religious beliefs quite strong. Using a composite scale is a valid way of measuring religiosity and allows for more lee-way to counter potential interpretive bias.

Table 33: Support Found for Hypotheses at the .05 and .10 Levels of Significance Using the Composite Scales.

	1993	1994	1996	2004	All Years
Proposition 1: Econ	No	No	No	0.10	0.05
Proposition 2: Relig	No	0.10	No	0.10	0.10
Proposition 3: Social	No	No	No	No	0.05
Proposition 4: Ruling Id	0.10	No	No	No	0.05

The third proposition stating that ***respondents who do not have a positive perception of community cohesion will have poorer self-reported health than those who do,*** found moderate support using the individual level indicators. In one of the four years studied and in the overall analysis of all years, social indicators maintained significance at the .05 level, despite the inclusion of material indicators, and demographic controls (See Table 32). However, when the social indicators were not significant at the .05 level, as was the case in 1993, 1994 and 2004, they were significant at the .10 level. Although this level of significance fails to meet the stringent requirements of this study, the variable's near-significance suggests that it is a consistently important, if not extremely strong, predictor of self-reported health. This inference is bolstered by the findings of Kawachi et al. (1997). It is surprising then that when using a composite scale of indicators the social perceptions variable was not significant, except when measured for all years. This may be a result of the consistently strong insignificance of the variable *Helpnot*, which measured a

127

respondent's perception about the helpfulness of people around them.   This variable did not follow the trends of the other social variables and sometimes respondents who had a negative perception of society around them had better health (although never at a significant level) than those who thought people were generally helpful (see Appendix C). This contradictory finding suggests a measurement or questionnaire error with the variable. Therefore, including it in the composite scale may have diminished the effect of the other more significant social capital variables.

Despite the theoretically predicted presence of a ruling ideology based on the three dominant particular ideologies, the final proposition about the effect of ruling ideology on health outcomes only became significant at the .05 level when measured across all years (See Table 33). Proposition 4 states that r*espondents whose responses do not reflect the ruling ideology measured as a composite of economic libertarianism, religious conservatism, and social traditionalism, will have poorer self-reported health than those who do.* However, this variable may suffer from some of the measurement error mentioned previously because the ruling ideology composite summated scale includes the variables measuring the fundamentalism of religious belief and perception of helpfulness, which may contain errors. Moreover, as discussed in Chapter Four, the composite scale is suspected to be an incomplete measure of ruling ideology because of the limited variables available in the GSS. Therefore, the lack of consistently strong and positive findings for Proposition 4 do not rule out the importance of ruling ideology and its influence on health, but they do suggest that the scale should undergo further refinement. In particular, a more specific dataset with the purpose of measuring economic, religious, and social self-perceptions may offer a more accurate picture of the influence of ruling ideology on health than does the scale constructed from the variables available in the GSS.

In summary, using the individual indicators, Propositions 1 and 3 found moderate support while Proposition 2 only became relevant when using a broader scale-variable. Although support for the propositions is not consistently strong throughout all models and all years, it is possible to conclude that the particular ideological variables do matter in respect to self-reported health. Proposition 4 found little support when using a composite scale; however, limitations that may have confounded these findings have been discussed. These results encourage further discussion on the implications of these supported and unsupported propositions.

Interpretation and Implications of Findings

The findings of this study imply that particular ideologies do affect the way individuals perceive their health status. Literature reviewed in Chapter 3 revealed a divide over how ideology may affect individual health, whether through health choices and behaviors, worldview, or material success. Current epidemiological research debates the value of understanding socioeconomic (SES) position as a fundamental or proximate cause of health. Some researchers suggest that SES is a correlate of health behavior and that these lifestyle choices directly influence health status (Phelan et al. 2004). Others suggest that inequality in SES produces biophysical responses such as stress and anxiety that physically affect the well-being of the body (Marmot 2004, Roy 2004, Phelan et al. 2004, Adler et al. 1999). A third perspective is that those with better SES have more material wealth and can pay for a better standard of living than lower classes (Carpiano 2006, Schnittker 2004, Mirowsky and Ross 2003). Although this study does not measure socioeconomic standing, ideology can replace SES in the above equations. With this substitution, three key paths of transmission from ideology to health outcomes are proposed. The first is that ideology promotes normative prescriptions for behaviors that are good for their health, such as reduced smoking and

binge drinking. Second, perhaps ideology provides a cohesive worldview and acceptance into a community, thus reducing stress of being outside the norm. Third, those who adhere to the ruling ideology stand to gain more material wealth by being within and not opposed to the system.

The logistic regression models conducted on more than a decade of data provides evidence of two of the three pathways as viable mechanisms of transmission. The findings indicate that there are both a direct cause-effect relationship between social factors and disease and an intermediate role played by proximate risk factors. Since the ideological variables are significant, I can conclude that peoples' perceptions of society and their role within it affect their views on their own well-being. Yet, the significance of the material indicators in the above data analysis also suggests that intervening variables affects health. However, not all intervening mechanisms proposed in the literature were found to be significant predictors of health in the above data analysis. For example, health behaviors were not found to be key determinants of health net of socio-demographic controls.

Another implication of the findings requires revisiting sociological theory. A significant body of literature exists predicting or documenting the negative and coercive effects of ideology on individuals. In particular, Marxists critique ideology for its corrupting and manipulative power on the masses through false consciousness. Under this theoretical paradigm, lower classes subscribe to particular and ruling ideologies despite the potential lack of personal and class benefits involved. Indeed, sometimes the policies implemented under certain ideologies have serious negative consequences for the economic, social, or personal well-being of those who have internalized them. Despite this predicted effect of ideology, this study reveals that respondents who subscribe to the ideological paradigms are better off than those who do not. These findings may contribute to a revision of current sociological theory.

Several explanations of this surprising finding are possible. Perhaps false consciousness is a theoretical idea that has no empirical basis. If false consciousness is based on a materialist paradigm, a lack of material well-being would serve as an indicator of the presence of the negative aspect of the phenomenon. However, as Weber, Marmot, Wilkinson and others suggest, life seems to be more than material relations. Empirical research concludes that social relations play an important role in individual well-being (Kawachi et al. 1997, Hayward et al. 2000, Adler et al. 1999). Therefore, the exploitation of the lower classes is mitigated by the social benefits of having a cohesive worldview provided through intersecting particular ideologies.

On the other hand, despite the surprising findings of this study, false consciousness may still exist. Possibly, its effects are obscured by the lack of clarity surrounding the idea comparison groups. Chapter 3 reveals that on an international scale, the U.S. does not exhibit the lowest national mortality rates despite having the highest per capita income. If Americans compared themselves to foreigners, particularly those in countries with socialist health systems, they may realize the deleterious health effects of adhering to the current dominant ideologies. However, when compared to other individuals under the same economic and political system, the influence of false consciousness is unnoticeable. The use of a comparison group outside the system may help to reveal the potential presence and influence of false consciousness.

Value of this Research

Significant research has been undertaken on the relationship between health and social inequality (Marmot 2004, Kawachi et al. 1997, Wilkinson 2006). Likewise, researchers have suggested links between material indicators and health outcomes (Rogot 1992, Lynch et al. 2000, Schnittker 2004, Smith and Kington 1997), as well as

131

between health behaviors and health outcomes (Phelan et al. 2004). A sufficiently large body of research documenting the robust nature of self-reported health also exists (Mossey and Shapiro 1982, Idler and Benyamini 1997). However, few studies have analyzed the relationship between ideology (either particular or ruling) and self-reported health, taking into account the possible intervening effects of material indicators, demographic controls, and health behaviors. This study has set out to better understand how internalized ideological perceptions of economics, religion, and social values affect perceptions of health and ultimately health outcomes and hopefully will serve as a base for future empirical initiatives looking at the influence of ideology on well-being.

In addition to this primary goal, I have invested significant effort into rooting the variable measurements in sociological and epidemiological literature. Possible limitations surrounding self-reported health, the measure of fundamentalism, and the measure of helpfulness have already been identified and will be reviewed in the next section. Moreover, qualifications on the measurement of ruling ideology have been mentioned previously, and better specification using a different survey instrument has been called for. Thus, I hope that the way these factors have been conceptualized and tested and the potential limitations and qualifications noted will lead to future research on refining measurements and variable validity.

Qualifications and Limitations of the Study

Qualifications for specific variables in the analysis have been reviewed at length when the variable was introduced. The majority of this discussion can be found in Chapter Four on methodology. Since this study has been transparent about its potential limitations from the outset, only a brief summary is necessary here.

Although a measure of ruling ideology was included for theoretical reasons in this data analysis, it was originally identified as potentially unreliable due to the construction of its measurement. From the outset it was not assumed to be a reliable indicator of ruling ideology and I suggested that future research should seek to refine its measurement. Also, the indicators of helpfulness (social ideology) and fundamentalism (religious ideology) were called into question. Perceived helpfulness was consistently highly insignificant and had a coefficient that was opposite of the other social ideological variables, while the question on fundamentalism proposed a false comparison between the unnecessarily pejorative term "fundamentalism" and "liberalism." Conservatism, not fundamentalism, is considered to be the opposite of liberalism.

The literature on self-reported health, the dependent variable, reveals several known limitations. First, the lack of research on cultural interpretations of health status constricts the bounds of interpretation for respondents primarily identifying with a culture other than American. American residency, a requirement for this study, does not necessitate American culture assimilation, especially among recent immigrants and members of ethnic enclaves (Portes and Manning; Portes and Zhou in Grusky 2001:568-579; 597-608). A second limitation for self-reported health and thereby this study in general is the lack of research surrounding comparison groups. Contemporary research offers conflicting accounts on the topic of comparison groups. Some social scientists suggest that individuals compare their well-being to members of higher socioeconomic classes (Wilkinson 1997, Davidson et al. 2006). The relative deprivation hypothesis expresses the opposite impression of comparison groups. Robert Merton propones that an individual's concentration (reinforced by the media) on "the *most extreme sufferers* tends to fix them as a reference group against which even other sufferers can compare themselves favorably" (Calhoun 2002:387, Idler and

Benyamini 1997). A third viewpoint is that individuals usually compare themselves to members of their own age group regardless of economic status (Zimmer et al. 2000), while others suggest that individuals simply compare themselves to people "perceived as being comparable to themselves" whether in terms of race, class, gender, age or other characteristics (Calhoun 2002:387, Veblen in Ritzer 2000:335). The magnitude of the confusion over comparison groups highlighted in this analysis will hopefully spur future research in the area.

Future Research

Given the purpose of this study, its conclusions, and the limitations noted above, several suggestions for future research will be presented. In particular, variable refinement in the areas of self-reported health, religiosity, ideology, and ruling ideology is needed. Although the GSS offers a basic rubric with which one can measure personal ideology, these findings suggest that further research should employ more detailed measures of ideology to further understand how it affects personal well-being. For example, more specific questions on economic ideology would have made the interpretations of the findings more authoritative. Additionally, the presence of variables such as wealth, health insurance, and Body Mass Index in the dataset would have precipitated a more reliable test of relevant material indicators and health behaviors specifically noted in the literature. Questions on personal health variables should be asked of a large enough sample to provide the degrees of freedom needed for a broad study of society. The inclusion of these indicators in future research will contribute to building an empirical database of potential covariates.

Indeed, the paucity of previous studies empirically testing measures of contemporary ruling ideology leaves many unknowns in determining the relationship and pathways between ideology and health status. In comparison, significant research

has been conducted on the mechanisms of transmission between ideology and health. Adler and Ostrove review this literature and create a model of potential pathways by which SES influences health (See Appendix E). Social scientists should strive to explore more potential pathways from ideology to health through empirical research so that a similar model can be created out of a meta-analysis of the effects of ideology. To avoid the limitations Adler and Ostrove mention, researchers should be careful to fully explore the possibility of bidirectionality of causality, feedback loops, and interaction effects. As part of the call for a commitment to further research in the area of ideology, more attention should also be given to reworking the measure of ruling ideology created in the study by including other theoretically important variables.

Secondly, as discussed above, the contradicting results of comparison group analysis has led to confusion in interpreting health outcomes. A larger body of research needs to develop around comparison groups, testing the relative deprivation hypothesis and formulating new hypotheses, so as to find some general trends in comparison groups. These findings might alter the construction of future models testing ideology because of the potential interactions between age, race, class, and perceptions of comparison groups. Finally, further research should use time-series models to determine the direction of causality and also the importance of feedback loops. For example, a bidirectional relationship between perceived health status and level of personal care almost certainly exists. This and similar relationships can be analyzed further to learn more about the strength of each respective direction and the fundamental starting point. In sum, the study of particular and ruling ideologies has important consequences for health in America. Further refinements in survey instruments, measures, statistical techniques, and models will help to shed more light on the initial findings and trends presented in this analysis.

APPENDIX A

Demographic Questions from the General Social Survey

Marital Status:

"Are you currently married, widowed, divorced, separated, or have you never been married?"

Original Distribution of Marital Status, All Years		
	Frequency	Percent
MARRIED	1,205	53.2
WIDOWED	174	7.7
DIVORCED	356	15.7
SEPARATED	80	3.5
NEVER MARRIED	448	19.8
Total	2,263	100.0

Recoded Distribution of Marital Status, All Years		
	Frequency	Percent
Married (1)	1,205	53.2
Formerly Married (Widowed (2), Divorced (3), Seperated (4))	610	27.0
Not married (5)	448	19.8
Total	2,263	100.0

Race:

"What race do you consider yourself?"

Original Distribution of Race of Respondent, All Years		
	Frequency	Percent
WHITE	1,897	83.8
BLACK	280	12.4
OTHER	86	3.8
Total	2,263	100.0

Sex:

Interviewer coded respondent's sex

Original Distribution of Sex of Respondent, All Years		
	Frequency	Percent
MALE	1,054	46.6
FEMALE	1,209	53.4
Total	2,263	100.0

Age:

Date of birth has been recoded into actual age and is a continuous variable (See

Appendix E: Age Distributions of the General Social Survey for detailed responses)

(Davis et al. 2005).

Recoded Distribution of Age, All Years		
	Frequency	Percent
18-39	1,014	44.8
40-59	809	35.7
60-74	321	14.2
75+	119	5.3
Total	2,263	100.0

Region:

Interviewer records Region of Interview (See Statistical Abstract of the General Social

Survey for a list of states within each region) (Davis et al. 2005).

Original Distribution of Region of Interview, All Years		
	Frequency	Percent
NEW ENGLAND	111	4.9
MIDDLE ATLANTIC	281	12.4
E. NOR. CENTRAL	410	18.1
W. NOR. CENTRAL	178	7.9
SOUTH ATLANTIC	444	19.6
E. SOU. CENTRAL	172	7.6
W. SOU. CENTRAL	187	8.3
MOUNTAIN	156	6.9
PACIFIC	325	14.4
Total	2,263	100.0

Recoded Distribution of Region of Interview, All Years		
	Frequency	Percent
All Regions	1,648	72.8
South	615	27.2
Total	2,263	100.0

NORC Size of Place:

Interviewer records NORC Size of Place (See Appendix T of the General Social Survey for more information) (Davis et al. 2005).

Original Distribution of Rural-Urban Measure, 1993, 1994, 1996		
	Frequency	Percent
CITY GT 250000	313	15.7
CITY,50-250000	329	16.5
SUBURB, LRG CITY	420	21.1
SUBURB, MED CITY	297	15.0
UNINC,LRG CITY	60	3.0
UNINC,MED CITY	81	4.1
CITY,10-49999	139	7.0
TOWN GT 2500	146	7.3
SMALLER AREAS	162	8.1
OPEN COUNTRY	42	2.1
Total	1,989	100.0

Recoded Distribution of Rural-Urban Measure, 1993, 1994, 1996		
	Frequency	Percent
Suburb (control) - XNorc values 4-7	858	43.1
Rural - XNorc values -0-3	489	24.6
Urban - XNorc values 8,9	642	32.3
Total	1,989	100.0

Number of Household Members:

Interviewer records household size and composition (See Appendix D of the General

Social Survey for more information about this variable) (Davis et al. 2005).

Original Distribution of Number of Persons in Household, All Years		
	Frequency	Percent
1	508	22.4
2	798	35.3
3	361	16.0
4	372	16.4
5	141	6.2
6	55	2.4
7	23	1.0
8	5	0.2
9	1	0.0
Total	2,263	100.0

Recoded Distribution of Number of Persons in Household, All Years		
	Frequency	Percent
2-4 Persons in Household	1,531	67.7
1 Person in Household	508	22.4
5+ Persons in Household	224	9.9
Total	2,263	100.0

APPENDIX B

Health Behavior Questions from the General Social Survey

Drink:

"Do you ever have occasion to use any alcoholic beverages such as liquor, wine, or

been or are you a total abstainer?"

Original Distribution of "Ever Drink Alcoholic Beverages?" 1993-1994		
	Frequency	Percent
YES	379	70.2
NO	161	29.8
Total	540	100.0

Drunk:

"Do you sometimes drink more than you think you should?"

Original Distribution of "Ever Drink too Much?", 1993-1994		
	Frequency	Percent
YES	147	38.8
NO	232	61.2
Total	379	100.0

Recoded Distribution of Alcohol History, 1993-1994		
	Frequency	Percent
Never drink	161	29.8
Drink	232	43.0
Have gotten Drunk	147	27.2
Total	540	100.0

Smoke:

"Do you smoke?"

Original Distribution of Whether Respondent Smokes, 1993-1994		
	Frequency	Percent
YES	147	27.2
NO	393	72.8
Total	540	100.0

EvSmoke:

"Have you ever smoked regularly?"

Original Distribution of Whether Respondent Has Ever Smoked, 1993-		
	Frequency	Percent
YES	134	34.2
NO	258	65.8
Total	392	100.0

Recoded Distribution of Smoking History, All Years		
	Frequency	Percent
Never Smoked	259	48.0
Smoke	147	27.2
Did Smoke/Ever Smoked	134	24.8
Total	540	100.0

Logistic Regression Models with Coefficients, 1993, 1994, 1996, 2004, All Years

Logistic Regression Models with Coefficients for 1993					
Variable	**Category**	**Model 1**	**Model 2**	**Model 3**	**Model 4**
EqWlth	Gov. should reduce income differences vs. Gov. shouldn't	1.019*	0.618	0.700	0.798
	Neutral vs. Gov. shouldn't	0.539	0.394	0.652	0.657
Helpnot	Gov. should do more vs. Gov. shouldn't help	-0.266	-0.306	-0.099	-0.069
	Neutral vs. Gov. shouldn't help	-0.051	-0.299	-0.174	-0.23
Fund	Liberal vs.Fundamentalist	0.038	0.178	-0.130	-0.031
	Moderate vs.Fundamentalist	-0.229	-0.142	-0.408	-0.448
Attend	Never attend vs. Regularly attend	0.445	0.330	0.222	0.226
	Infrequently attend vs. Regularly attend	0.366	0.425	0.720	0.753
Reliten	Not religious vs. Strongly religious	-0.543	-0.697	-0.117	-0.287
	Not strongly religious vs. Strongly religious	-0.226	-0.098	0.156	0.21
Helpful	Just look out for self vs.Try to be helpful	0.091	0.026	0.221	0.304
Fair	Can't be too careful vs. Wouldn't take advantage	-0.319	0.008	0.253	0.135
Trust	Can't be too careful vs. Most can be trusted	.935**	0.45	0.408	0.439
Income	Less than $22.5 vs. 75+		2.21***	2.203***	2.214***
	22.5-39.9 vs. 75+		1.653**	1.526**	1.623**
	40-74.9 vs. 75+		1.462**	1.489**	1.553**
Employ	Not working vs. Working		0.517	0.669	0.687
	Reason not to work vs. Working		0.280	-0.116	-0.197
	Other vs. Working		1.191		1.186
Educ	Less than 12 vs. More than 12		0.413	0.275	0.312
	12 vs. More than 12		0.078	0.003	0.046
Marital	Formely married vs. Married			0.334	0.36
	Never married vs. Married			0.004	0.012
Age	40-59 vs. 18-39			-0.062	0.01
	60-75 vs. 18-39			-0.687	-0.374
	75+ vs. 18-39			-0.791	-0.101
AgeSq	AgeSq			0.000	0
Sex	Male vs. Female			0.419	0.487

Logistic Regression Models with Coefficients for 1993 (cont.)					
Race	Black vs. White				-0.546	-0.749
	Other vs. White				0.553	0.296
Hompop	1 vs. 2-4 persons				0.048	0.027
	5+ vs. 2-4 persons				0.284	0.289
Region	South vs. All others				-0.876*	-.843*
XNORC	Rural vs. Suburb					-0.625
	Urban vs. Suburb					-0.239
Drink	Drink vs. Never drink					-0.492
	Have gotten drunk vs. Never drink					-0.877
Smoke	Smoke vs. Never smoke					0.485
	Did/ever smoke/d vs. Never smoke					0.158
	Constant	-2.129***	-3.673***	-5.075***	-4.486***

*p<.05
**p<.01
***p<.001

	Logistic Regression Models with Coefficients for 1994				
Variable	**Category**	**Model 1**	**Model 2**	**Model 3**	**Model 4**
EqWlth	Gov. should reduce income differences vs. Gov. shouldn't	1.121***	0.823*	0.78*	-0.57
	Neutral vs. Gov. shouldn't	0.596*	0.460	0.500	-0.610
Helpnot	Gov. should do more vs. Gov. shouldn't help	0.056	-0.122	-0.079	0.589
	Neutral vs. Gov. shouldn't help	-0.071	-0.145	-0.109	1.227
Fund	Liberal vs.Fundamentalist	0.085	0.097	0.166	-0.095
	Moderate vs.Fundamentalist	-0.436	-0.373	-0.510	-0.652
Attend	Never attend vs. Regularly attend	0.526	0.494	0.572	0.844
	Infrequently attend vs. Regularly attend	-0.246	-0.037	0.083	0.413
Reliten	Not religious vs. Strongly religious	-1.239**	-1.052*	-1.040	0.361
	Not strongly religious vs. Strongly religious	-0.104	0.069	0.146	0.622
Helpful	Just look out for self vs.Try to be helpful	0.016	0.073	0.161	-0.166
Fair	Can't be too careful vs. Wouldn't take advantage	0.140	0.026	0.001	0.033
Trust	Can't be too careful vs. Most can be trusted	0.456	0.313	0.301	1.169
Income	Less than $22.5 vs. 75+		0.697*	0.945*	0.774
	22.5-39.9 vs. 75+		0.457	0.585	-0.207
	40-74.9 vs. 75+		0.088	0.180	-1.146
Employ	Not working vs. Working		0.891*	0.973*	-0.865
	Reason not to work vs. Working		1***	1.138***	1.776*
	Other vs. Working		1.423*	1.885*	0.236
Educ	Less than 12 vs. More than 12		0.869**	0.836**	0.944
	12 vs. More than 12		0.140	0.094	-0.053
Marital	Formely married vs. Married			-0.096	0.703
	Never married vs. Married			-0.613	0.794
Age	40-59 vs. 18-39			0.049	0.18
	60-75 vs. 18-39			-0.730	-1.968
	75+ vs. 18-39			-1.771	-3.31
AgeSq	AgeSq			0.000	0.001
Sex	Male vs. Female			0.440	0.97

Logistic Regression Models with Coefficients for 1994 (cont.)					
Race	Black vs. White			0.370	0.043
	Other vs. White			0.589	0.407
Hompop	1 vs. 2-4 persons			-0.435	0.013
	5+ vs. 2-4 persons				0.04
				0.114	
Region	South vs. All others			0.028	0.261
XNORC	Rural vs. Suburb				0.596
	Urban vs. Suburb				0.138
Drink	Drink vs. Never drink				0.008
	Have gotten drunk vs. Never drink				-1.002
Smoke	Smoke vs. Never smoke				-0.196
	Did/ever smoke/d vs. Never smoke				0.007
	Constant	-2.158***	-3.002***	-4.219***	-5.461***
	Chi-Sq	43.722***	108.305***	137.869***	56.122*
		0.000	0.000	0.000	0.037
	df	13	21	33	39
	-2Log likelihood	665.477	600.895	571.330	128.538
	N	506	506	506	173[a]

*p<.01
**p<.01
***p<.001
[a] Note that this model uses significantly fewer cases.

Variable	Category	Model 1	Model 2	Model 3
	Logistic Regression Models with Coefficients for 1996			
EqWlth	Gov. should reduce income differences vs. Gov. shouldn't	0.275	-0.041	0.077
	Neutral vs. Gov. shouldn't	0.035	-0.076	0.027
Helpnot	Gov. should do more vs. Gov. shouldn't help	.663**	0.481*	0.565*
	Neutral vs. Gov. shouldn't help	0.190	0.124	0.194
Fund	Liberal vs.Fundamentalist	-0.100	-0.062	-0.116
	Moderate vs.Fundamentalist	-0.311	-0.203	-0.237
Attend	Never attend vs. Regularly attend	0.110	0.179	0.172
	Infrequently attend vs. Regularly attend	-0.001	0.235	0.212
Reliten	Not religious vs. Strongly religious	-0.543	-0.306	-0.249
	Not strongly religious vs. Strongly religious	-0.095	0.032	0.091
Helpful	Just look out for self vs.Try to be helpful	-0.235	-0.038	-0.042
Fair	Can't be too careful vs. Wouldn't take advantage	0.462*	0.330	0.346
Trust	Can't be too careful vs. Most can be trusted	0.302	-0.011	0.030
Income	Less than $22.5 vs. 75+		0.567*	0.971**
	22.5-39.9 vs. 75+		0.499	0.678*
	40-74.9 vs. 75+		0.042	0.131
Employ	Not working vs. Working		-0.007	-0.150
	Reason not to work vs. Working		0.749***	0.823***
	Other vs. Working		3.357***	3.243***
Educ	Less than 12 vs. More than 12		1.433***	1.33***
	12 vs. More than 12		0.762***	0.72***
Marital	Formely married vs. Married			-0.409
	Never married vs. Married			-0.406
Age	40-59 vs. 18-39			-0.726
	60-75 vs. 18-39			0.254
	75+ vs. 18-39			0.267
AgeSq	AgeSq			0.000
Sex	Male vs. Female			0.414*

Logistic Regression Models with Coefficients for 1996 (cont.)				
Race	Black vs. White			0.127
	Other vs. White			0.432
Hompop	1 vs. 2-4 persons			0.136
	5+ vs. 2-4 persons			-0.109
Region	South vs. All others			-0.138
XNORC	Rural vs. Suburb			
	Urban vs. Suburb			
	Constant	-1.795***	-2.822***	-2.7***
	Chi-Sq	37.266***	156.532***	181.529***
		0.000	0.000	0.000
	df	13	21	33
	-2Log likelihood	911.166	791.900	766.903
	N	927	927	927

*p<.01
**p<.01
***p<.001

Logistic Regression Models with Coefficients for 2004				
Variable	**Category**	**Model 1**	**Model 2**	**Model 3**
EqWlth	Gov. should reduce income differences vs. Gov. shouldn't	0.480	-0.205	-0.217
	Neutral vs. Gov. shouldn't	0.403	-0.113	-0.102
Helpnot	Gov. should do more vs. Gov. shouldn't help	1.566**	0.922	0.882
	Neutral vs. Gov. shouldn't help	1.252**	1.07*	1.431*
Fund	Liberal vs.Fundamentalist	-0.962	-1.015	-0.769
	Moderate vs.Fundamentalist	-0.075	0.155	0.219
Attend	Never attend vs. Regularly attend	0.190	-0.100	-0.054
	Infrequently attend vs. Regularly attend	0.457	0.373	0.430
Reliten	Not religious vs. Strongly religious	0.799	1.279	1.441
	Not strongly religious vs. Strongly religious	0.591	0.713	0.944
Helpful	Just look out for self vs.Try to be helpful	-0.886*	-0.717	-0.438
Fair	Can't be too careful vs. Wouldn't take advantage	0.508	0.551	0.709
Trust	Can't be too careful vs. Most can be trusted	0.815*	0.673	0.175
Income	Less than $22.5 vs. 75+		0.700	1.271
	22.5-39.9 vs. 75+		0.455	0.915
	40-74.9 vs. 75+		0.318	0.389
Employ	Not working vs. Working		1.935**	2.489***
	Reason not to work vs. Working		0.826**	0.629
	Other vs. Working		2.995*	3.682*
Educ	Less than 12 vs. More than 12		1.959***	1.754***
	12 vs. More than 12		0.985*	1.136*
Marital	Formely married vs. Married			-1.257
	Never married vs. Married			-0.481
Age	40-59 vs. 18-39			-1.682
	60-75 vs. 18-39			-4.832**
	75+ vs. 18-39			-5.210
AgeSq	AgeSq			0.001**
Sex	Male vs. Female			0.592

Logistic Regression Models with Coefficients for 2004 (cont.)				
Race	Black vs. White			1.67*
	Other vs. White			0.822
Hompop	1 vs. 2-4 persons			-0.339
	5+ vs. 2-4 persons			-0.374
Region	South vs. All others			-0.877
	Constant	-3.454***	-4.447***	-6.526***
	Chi-Sq	33.628***	71.705***	96.934***
		0.000	0.000	0.000
	df	13	21	33
	-2Log likelihood	240.412	202.335	177.107
	N	290	290	290

*p<.01
**p<.01
***p<.001

Variable	Category	Model 1	Model 2	Model 3
	Logistic Regression Models with Coefficients for 1993-2004			
EqWlth	Gov. should reduce income differences vs. Gov. shouldn't	0.627***	0.254	0.322
	Neutral vs. Gov. shouldn't	0.300*	0.118	0.188
Helpnot	Gov. should do more vs. Gov. shouldn't help	0.417**	0.197	0.256
	Neutral vs. Gov. shouldn't help	0.182	0.051	0.099
Fund	Liberal vs.Fundamentalist	-0.052	0.021	-0.022
	Moderate vs.Fundamentalist	-0.307*	-0.209	-0.268
Attend	Never attend vs. Regularly attend	0.316	0.305	0.315
	Infrequently attend vs. Regularly attend	0.041	0.222	0.286
Reliten	Not religious vs. Strongly religious	-0.664	-0.544*	-0.392
	Not strongly religious vs. Strongly religious	-0.055	0.077	0.135
Helpful	Just look out for self vs.Try to be helpful	-0.155	-0.066	-0.034
Fair	Can't be too careful vs. Wouldn't take advantage	0.222	0.211	0.290*
Trust	Can't be too careful vs. Most can be trusted	0.496***	0.203	0.262
Income	Less than $22.5 vs. 75+		0.883***	1.143***
	22.5-39.9 vs. 75+		0.636***	0.750***
	40-74.9 vs. 75+		0.292	0.366*
Employ	Not working vs. Working		0.615**	0.612**
	Reason not to work vs. Working		0.755***	0.671***
	Other vs. Working		2.284***	2.264***
Educ	Less than 12 vs. More than 12		1.095***	0.979***
	12 vs. More than 12		0.510***	0.462***
Marital	Formely married vs. Married			-0.223
	Never married vs. Married			-0.384
Age	40-59 vs. 18-39			0.223*
	60-75 vs. 18-39			-0.331
	75+ vs. 18-39			-0.744
AgeSq	AgeSq			0.000*
Sex	Male vs. Female			0.391

Logistic Regression Models with Coefficients for 1993-2004 (cont.)				
Race	Black vs. White			0.176
	Other vs. White			0.498
Hompop	1 vs. 2-4 persons			0.181
	5+ vs. 2-4 persons			0.129
Region	South vs. All others			-0.327*
	Constant	-2.108***	-3.071***	-3.968***
	Chi-Sq	89.323***	331.640***	385.318***
		0.000	0.000	0.000
	df	13	21	33
	-2Log likelihood	2238.181	1995.649	1942.186
	N	2279	2279	2279

*p<.01
**p<.01
***p<.001

Fit Statistic Logistic Regression Models with Coefficients for 1993-2004				
Variable	**Category**	**Model 1**	**Model 2**	**Model 3**
EqWlth	Gov. should reduce income differences vs. Gov. shouldn't			0.322
	Neutral vs. Gov. shouldn't			0.188
Helpnot	Gov. should do more vs. Gov. shouldn't help			0.256
	Neutral vs. Gov. shouldn't help			0.099
Fund	Liberal vs.Fundamentalist			-0.022
	Moderate vs.Fundamentalist			-0.268
Attend	Never attend vs. Regularly attend			0.315
	Infrequently attend vs. Regularly attend			0.286
Reliten	Not religious vs. Strongly religious			-0.392
	Not strongly religious vs. Strongly religious			0.135
Helpful	Just look out for self vs.Try to be helpful			-0.034
Fair	Can't be too careful vs. Wouldn't take advantage			0.290*
Trust	Can't be too careful vs. Most can be trusted			0.262
Income	Less than $22.5 vs. 75+		1.238***	1.143***
	22.5-39.9 vs. 75+		0.848***	0.750***
	40-74.9 vs. 75+		.405*	0.366*
Employ	Not working vs. Working		0.608**	0.612**
	Reason not to work vs. Working		0.650***	0.671***
	Other vs. Working		2.129***	2.264***
Educ	Less than 12 vs. More than 12		1.187***	0.979***
	12 vs. More than 12		0.558***	0.462***
Marital	Formely married vs. Married	.357*	-0.184	-0.223
	Never married vs. Married	0.098	-0.398*	-0.384
Age	40-59 vs. 18-39	-0.138	0.171	0.223*
	60-75 vs. 18-39	-0.155	-0.382	-0.331
	75+ vs. 18-39	-0.422	-0.747	-0.744
AgeSq	AgeSq	.000**	0	0.000*
Sex	Male vs. Female	0.182	.379**	0.391

Fit Statistic Logistic Regression Models with Coefficients for 1993-2004 (cont.)				
Race	Black vs. White	.622***	.429*	0.176
	Other vs. White	.753**	.551*	0.498
Hompop	1 vs. 2-4 persons	-0.036	0.129	0.181
	5+ vs. 2-4 persons	0.197	0.079	0.129
Region	South vs. All others	-0.083	-.267*	-0.327*
	Constant	-2.329***	-3.272***	-3.968***
	Chi-Sq	104.869***	348.935***	385.318***
		0.000	0.000	0.000
	df	12	20	33
	-2Log likelihood	2222.636	1978.569	1942.186
	N	2279	2279	2279

*p<.01
**p<.01
***p<.001

APPENDIX D

Fit Statistics for Composite Models

Fit Statistics for Evaluating Logisitic Regression Models with Composite Scales, 1993					
Models for 1993	-2 Log-Likelihood	d.f	Reduction in LL	Reduction in d.f.	Chi-Sq Sig
Demographic Controls[a]	358.959	355			
DemC + Material	327.016	347	31.943	8	0.005
DemC + Mat + Ruling ID	322.038	345	4.978	2	0.10
DemC + Mat + Econ Comp	324.521	343	2.495	4	No
DemC + Mat + Relig Comp	324.991	341	2.025	6	No
DemC + Mat + Soc Comp	322.006	344	5.01	3	No

Note: Dependent variable **is** coded "1" for Poor Health and *"0"* for Good Health.

[a] Demographics include Marital status, Age, Age^2, Sex, Race, Number of persons in the household, and Region.

Fit Statistics for Evaluating Logisitic Regression Models with Composite Scales, 1994					
Models for 1994	-2 Log-Likelihood	d.f.	Reduction in LL	Reduction in d.f.	Chi-Sq Sig
Demographic Controls[a]	664.131	494			
DemC + Material	595.195	486	68.936	8	0.005
DemC + Mat + Ruling ID	590.89	484	4.305	2	No
DemC + Mat + Econ Comp	589.594	482	5.601	4	No
DemC + Mat + Relig Comp	583.676	480	11.519	6	0.10
DemC + Mat + Soc Comp	590.052	483	5.143	3	No

| Fit Statistics for Evaluating Logisitic Regression Models with Composite Scales, 1996					
Models for 1996	-2 Log-Likelihood	d.f.	Reduction in LL	Reduction in d.f.	Chi-Sq Sig
Demographic Controls[a]	906.278	915			
DemC + Material	780.27	907	126.008	8	0.005
DemC + Mat + Ruling ID	779.183	905	1.087	2	No
DemC + Mat + Econ Comp	772.592	903	7.678	4	No
DemC + Mat + Relig Comp	772.102	901	8.168	6	No
DemC + Mat + Soc Comp	776.537	904	3.733	3	No

Fit Statistics for Evaluating Logisitic Regression Models with Composite Scales, 2004

Models for 2004	-2 Log-Likelihood	d.f.	Reduction in LL	Reduction in d.f.	Chi-Sq Sig
Demographic Controls[a]	253.798	278			
DemC + Material	193.074	270	60.724	8	0.005
DemC + Mat + Ruling ID	192.346	268	0.728	2	No
DemC + Mat + Econ Comp	184.977	266	8.097	4	0.10
DemC + Mat + Relig Comp	180.743	264	12.331	6	0.10
DemC + Mat + Soc Comp	191.476	267	1.598	3	No

Fit Statistics for Evaluating Logisitic Regression Models with Composite Scales, All Years

Models for All Years	-2 Log-Likelihood	d.f.	Reduction in LL	Reduction in d.f.	Chi-Sq Sig
Demographic Controls[a]	2222.636	2267			
DemC + Material	1978.569	2259	244.067	8	0.005
DemC + Mat + Ruling ID	1971.264	2257	7.305	2	0.03
DemC + Mat + Econ Comp	1966.759	2255	11.81	4	0.025
DemC + Mat + Relig Comp	1967.615	2253	10.954	6	0.10
DemC + Mat + Soc Comp	1965.818	2256	12.751	3	0.01

APPENDIX E

Model of the Pathways by Which SES Influences Health
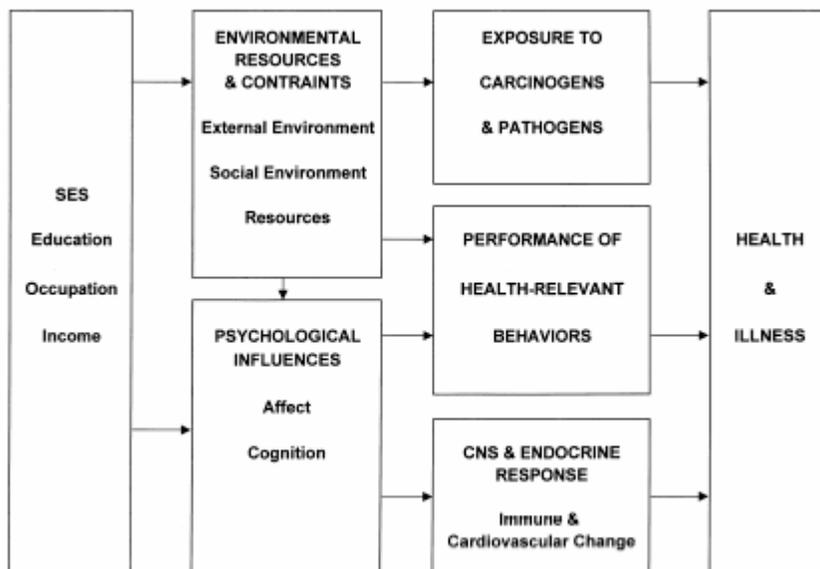
Source: Adler, Nancy E. and Joan M. Ostrove. 1999. "Socioeconomic Status and Health: What We Know and What We Don't." *Annals of the New York Academy of Sciences* 896:12.

REFERENCES

2006. "Alliance Defense Fund: About ADF." Retrieved November 9, 2006
       http://www.alliancedefensefund.org.

2006. "The American Conservative Union: Statement of Principles." Retrieved
       November 9, 2006 http://www.conservative.org.

2006. "The Cato Institute: About Cato." Retrieved November 9, 2006
       http://www.cato.org.

2006. "Christian Coalition of America: About Us." Retrieved November 9, 2006
       http://www.cc.org.

2006. "Ethics and Public Policy Center: About EPPC." Retrieved November 11, 2006
       http://www.eppc.org.

2006. "Family Research Council: About FRC." Retrieved November 9, 2006
       http://www.frc.org.

2006. "Federal Reserve System." vol. 2006: The Federal Reserve Board.

2006. "Free Market Foundation: About Us." Retrieved November 10, 2006
       http://www.freemarket.org.

2006. "The Heritage Foundation." Retrieved November 9, 2006
       http://www.heritage.org.

2006. "Independent Women's Forum." Retrieved November 9, 2006
       http://www.iwf.org.

2006. "The National Center for Public Policy Research." Retrieved November 10,
       2006 http://www.nationalcenter.org.

2006. "The U.S. Constitution." Retrieved September 4, 2006
       http://www.law.cornell.edu/constitution/constitution.articlevi.html. Cornell
       University Law School.

157

Adler, Nancy E. and Joan M. Ostrove. 1999. "Socioeconomic Status and Health: What We Know and What We Don't." *Annals of the New York Academy of Sciences* 896:3-15.

Appels, A., H. Bosma, V. Grabauskas, A. Gostautas, and F. Sturmans. 1996. "Self-rated health and mortality in a Lithuanian and a Dutch Population." *Social Science & Medicine* 42:681-689.

Banks, James, Michael Marmot, Zoe Oldfield, and James P. Smith. 2006. "Disease and Disadvantage in the United States and in England." *Journal of the American Medical Association* 295:2037-2045.

Ben-Shlomo, Yoav, Geogre Davey Smith, Martin J. Shipley, and Michael G. Marmot. 1994. "What Determines Mortality Risk in Male Former Cigarette Smokers." *American Journal of Public Health* 84:1235-1242.

Bernanke, Ben S. 2003. ""Constrained Discretion" and Monetary Policy: Remarks by Governor Ben S. Bernanke Before the Money Marketers of New York University, New York, New York." 2006. The Federal Reserve Board.

Bonilla-Silva, Eduardo. 2001. *White Supremacy and Racism in the Post-Civil Rights Era*. Boulder, CO: Lynne Rienner Publishers.

—. 2006. *Racism Without Racists: Color-Blind Racism and the Persistence of Racial Inequality in the United States*. New York: Rowman & Littlefield.

Bourgois, Phillippe. 1995. *In Search of Respect: Selling Crack in El Barrio*. New York: Cambridge University Press.

Brooks, Clem. 2002. "Religious Influence and the Politics of Family Decline Concern: Trends, Sources, and U.S. Political Behavior." *American Sociological Review* 67:191-211.

Brooks, Clem and Jeff Manza. 2004. "A GREAT DIVIDE? Religion and Political Change in U.S. National Elections, 1972-2000." *The Sociological Quarterly* 45:421-450.

Buroway, Michael. "Transition without Transformation: Russia's Involuntary Road to Capitalism."

Calhoun, Craig, Joseph Gerteis, James Moody, Steven Pfaff, Kathryn Schmidt, and Indermohan Virk. 2002. "Classical Sociological Theory." Malden, MA: Blackwell Publishers Ltd.

Carpiano, Richard M. 2006. "Toward a neighborhood resource-based theory of social capital for health: Can Bourdieu and sociology help?" *Social Science & Medicine* 62:165-175.

Chaves, Mark. 1999. "Religious Congregations and Welfare Reform: Who Will Take Advantage of "Charitable Choice?"" *American Sociological Review* 64:836-846.

Coburn, David. 2000. "Income inequality, social cohesion and the health status of populations: the role of neo-liberalism." *Social Science & Medicine* 51:135-146.

Cohen, S., W. J. Doyle, D. P. Skoner, B. S. Rabin and J. M. Gwaltney Jr. 1997. "Social ties and susceptibility to the common cold." *Journal of the American Medical Association* 277.

Davidson, Rosemary, Jenny Kitzinger, and Kate Hunt. 2006. "The wealthy get healthy, the poor get poorly? Lay perceptions of health inequalities." *Social Science & Medicine* 62:2171-2182.

Davis, James A., Tom W. Smith, and Peter V. Marsden. "GENERAL SOCIAL SURVEYS, 1972-2004 [CUMULATIVE FILE] [Computer file]. ICPSR04295-v2." Chicago, IL: National Opinion Research Center, 2005. Storrs, CT: Roper Center for Public Opinion Research, University of Connecticut/Ann Arbor, MI: Inter-university Consortium for Political and Social Research, 2006-04-05.

De Forge, Bruce R., Jeffery Sobal, and John P. Krick. 1989. "Relation of Perceived Health With Psychosocial Variables in Elderly Osteoarthritis Patients." *Psychological Reports* 64:147-156.

DeMaris, Alfred. 1999. "A Tutorial in Logistic Regression." *Journal of Marriage and Family* 57:956-968.

Dielman, Terry E. 2005. *Applied Regression Analysis*. Belmont, CA: Brooks/Cole Thomson Learning.

Dohrenwend, Bruce P., Itzhak Levav, Patrick E. Shrout, Sharon Schwartz, Guedalia Naveh, Bruce G. Link, Andrew E. Skodol, Ann Stueve. 1992. "Socioeconomic Status and Psychiatric Disorders: The Causation-Selection Issue." *Science* 255:946-952.

Domhoff, William G. 2002. *Who Rules America?: Power and Politics*. Boston: McGraw Hill.

Dupre, Matthew E., Alexis T. Franzese, and Emilio A. Parrado. 2006. "Religious Attendance and Mortality: Implications for the Black-White Mortality Crossover." *Demography* 43:141-164.

Durkheim, Émile. 1951. *Suicide, a Study in Sociology.*, Edited by J. A. a. G. S. Spaulding. Glencoe, IL: Free Press Inc.

Eckstein, Susan E. 2001. "Community as Gift-Giving: Collective Roots of Volunteerism." *American Sociological Review* 66:829-851.

Ettner, Susan and Joseph G. Grzywacz. 2003. "Socioeconomic Status and Health Among Californians: An Examination of Multiple Pathways." *American Journal of Public Health* 93:441-444.

Evans, Geoffrey. 1997. "Political ideology and popular beliefs about class and opportunity: evidence from a survey experiment." *British Journal of Sociology* 48:450-470.

Frank, Thomas. 2004. *What's the Matter with Kansas?: How Conservatives Won the Heart of the Nation*. New York: Metropolitan Books.

Franklin, Benjamin. 1757. "The Way to Wealth." edited by 12/06. http://www.get-rich-books.com/way-to-wealth/.

Freeden, Michael. 2000. "Practising Ideology and Ideological Practices." *Political Studies* 48:302-322.

Fremont, Allen M. and Chloe Bird. 1999. "Integrating Sociological and Biological Models: An Editorial." *Journal of Health and Social Behavior* 40:126-129.

Granovetter, Mark. 1983. "The Strength of Weak Ties: A Network Theory Revisited." *Sociological Theory* 1:201-233.

Harvey, David. 2005. *A Brief History of Neo-Liberalism*. New York: Oxford University Press.

Hayward, Mark D., Eileen M Crimmins, Toni P. Miles, and Yu Yang. 2000. "The Significance of Socioeconomic Status in Explaining the Racial Gap in Chronic Health Conditions." *American Sociological Review* 65:910-930.

Hirschl, Thomas A., Joyce Altobelli, and Mark R. Rank. 2003. "Does Marriage Increase the Odds of Affluence? Exploring the Life Course Probabilities." *Journal of Marriage and Family* 65:927-938.

Hoover, Kenneth R. 2003. *Economics as Ideology: Keynes, Laski, Hayek, and the Creation of Contemporary Politics*. Lanham, MD: Rowman & Littlefield Publishers.

Idler, Ellen L. and Yael Benyamini. 1997. "Self-Rated Health and Mortality: A Review of Twenty-Seven Community Studies." *Journal of Health and Social Behavior* 38:21-37.

Kaplan, G.A., E.R. Pamuk, J.W. Lynch, R.D. Cohen, and J.L. Balfour. 1996. "Inequality in income and mortality in the United States: analysis of mortality and potential pathways." *British Medical Journal* 312.

Kasarda, John D. and Morris Janowitz. 1974. "Community Attachment in Mass Society." *American Sociological Review* 39:328-339.

Kawachi, I., GA Colditz, A Ascherio, EB Rimm, E Giovannucci, MJ Stampfer and WC Willett. "A prospective study of social networks in relation to total mortality and cardiovascular disease in men in the USA." *Journal of Epidemiology and Community Health* 50:245-251.

Kawachi, Ichiro, Bruce P. Kennedy, Kimberly Lochner, and Deborah Prothrow-Stith. 1997. "Social Capital, Income Inequality, and Mortality." *American Journal of Public Health* 87:1491-1498.

Kim, K.H., J. Sobal and E. Wethington. 2003. "Religion and body weight." *International Journal of Obesity* 27:469-477.

Kuhn, Thomas S. 1996. *The Structure of Scientific Revolutions*. Chicago: University of Chicago Press.

Lantz, Paula M., James S. House, James M. Lepkowski, David Williams, Richard Mero, and Jieming Chen. 1998. "Socioeconomic Factors, Health Behaviors, and Mortality: Results from a nationally representative prospective study of US Adults." *Journal of the American Medical Association* 279:1703-1708.

Lee, Soo-Kyung and Jeffery Sobal, Edward A. Frongillo, Christine M. Olson, Wendy S. Wolfe. 2005. "Parity and Body Weight in the United States: Differences by Race and Size of Place of Residence." *Obesity Research* 13:1263-1269.

Liebman, Robert C. and Robert Wuthnow. 1983. *The New Christian Right*. New York: Aldine Publishing Company.

Link, Bruce G. and Jo Phelan. 1995. "Social Conditions as Fundamental Causes of Disease." *Journal of Health and Social Behavior* Extra Issue:80-94.

Lynch, J.W., G. Davey Smith, G.A. Kaplan, and J.S. House. 2000. "Income inequality and mortality: Importance to health of individual income, psychosocial environment, or material conditions." *British Medical Journal* 320.

Marmot, Michael. 2004. *The Status Syndrome: How Social Standing Affects Our Heath and Longevity*. New York: Times Books.

Marmot, Michael, and Richard G. Wilkinson. 2001. "Psychosocial and material pathways in the relation between income and health: a response to Lynch et al." *British Medical Journal* 322:1233-1236.

Martin, William. 1996. *With God on Our Side: The Rise of the Religious Right in America*. New York: Broadway Books.

Marx, Karl and Frederich Engels. 1976. *The German Ideology*, vol. I. Moscow: Progress Publishers.

McCallum, John, Bruce Shadbolt, and Doug Want. 1994. "Self-Rated Health and Survival: A 7-Year Follow-Up Study of Australian Elderly." *American Journal of Public Health* 84:1100-1105.

McDonough, Peggy, David R. Williams, James S. House, and Greg J. Duncan. 1999. "Gender and the Socioeconomic Gradient in Mortality." *Journal of Health and Social Behavior* 40:17-31.

Mills, C. Wright. 1959a. *The Power Elite*. New York: Oxford University Press.

—. 1959. *The Sociological Imagination*. Oxford: University Press.

Mirowsky, John and Catherine E. Ross. 2003. *Education, Social Status, and Health*. New York: Aldine de Gruyter.

Moaddel, Mansoor. 1992. "Ideology as Episodic Discourse: The Case of the Iranian Revolution." *American Sociological Review* 57:353-379.

Morgan, S. Philip and Jay D. Teachman. 1988. "Logistic Regression: Description, Examples, and Comparisons." *Journal of Marriage and Family* 50:929-936.

Morrow, Virginia. 1999. "Conceptualising social capital in relation to the well-being of children and young people: a critical review." *The Sociological Review*:744-765.

Mossey, Jana M. and Evelyn Shapiro. 1982. "Self-Rated Health: A Predictor of Mortality Among the Elderly." *American Journal of Public Health*:8.

Nicholson, Amanda, Martin Bobak, Michael Murphy, Richard Rose, and Michael Marmot. 2005. "Socio-economic influences on self-rated health in Russian men and women - life-course approach." *Social Science & Medicine* 61:2345-2354.

Noble, Holcomb B. 2006. "Milton Friedman, 94, Free-Market Theorist, Dies." Pp. 1,28 in *The New York Times*. New York.

Oakes, J. Michael and Peter H. Rossi. 2003. "The measurement of SES in health research: current practice and steps toward a new approach." *Social Science & Medicine* 56:769-784.

O'Connor, Brendon. 2002. "Policies, Principles, and Polls: Bill Clinton's Third Way Welfare Politics 1992-1996." *Australian Journal of Politics and History* 48:396-411.

Patrick, Donald L., Allen Cheadle, Diane C. Thompson, Paula Diehr, Thomas Koepsell, and Susan Kinne. 1994. "The Validity of Self-Reported Smoking: A Review and Meta-Analysis." *American Journal of Public Health* 84:1086-1093.

Phelan, Jo C., Bruce G. Link, Ana Diez-Roux, Ichiro Kawachi, Bruce Levin. 2004. ""Fundamental Causes" of Social Inequalities in Mortality: A Test of Theory." *Journal of Health and Social Behavior* 45:265-285.

Pimpare, Stephen "Book Review." *The American Review of Public Administration*, pp. 229-231.

Portes, Alejandro. 1998. "Social Capital: Its Origins and Applications to Modern Sociology." *Annual Review of Sociology* 24:1-24.

—. 2000. "The Two Meanings of Social Capital." *Sociological Forum* 15:1-12.

Portes, Alejandro and Min Zhou. 2001. "The New Second Generation: Segmented Assimilation and Its Variants." Pp. 597-608 in *Social Stratification*, edited by D. B. Grusky. Boulder, CO: Westview Press.

Portes, Alejandro and Robert D. Manning. 2001. "The Immigrant Enclave: Theory and Empirical Examples." Pp. 568-579 in *Social Stratification*, edited by D. B. Grusky. Boulder, CO: Westview Press.

Putnam, Robert D. 1992. *Making Democracy Work: Civic Traditions in Modern Italy*. Princeton, NJ: Princeton University Press.

—. 2000. *Bowling Alone: The Collapse and Revival of American Community*. New York: Simon & Schuster.

Putnam, Robert D. and John M. Bridgeland. 2004. "A Nation of Doers Needs to Do More." vol. 2006: Energize Inc.

Rayack, Elton. 1987. *Not So Free to Choose*. New York: Praeger Publishers.

Reagan, Ronald. 1981. "Inaugural Address." vol. 2006: Ronald Reagan Presidential Library.

Ritzer, George. 2000. *Classical Sociological Theory*. Boston: McGraw-Hill.

—. 2004. "Classical Sociological Theory Glossary." vol. 2006.

Rogot, Eugene, Paul D. Sorlie, and Norman J. Johnson. 1992. "Life Expectancy by Employment Status, Income, and Education in the National Longitudinal Mortality Study." *Public Health Reports* 107:457-461.

Roy, Jean-Pierre. 2004. "Socioeconomic status and health: a neurobiological perspective." *Medical Hypotheses* 62:222-227.

Sampson, Robert J. 1988. "Local Friendship Ties and Community Attachment in Mass Society: A Multilevel Systemic Model." *American Sociological Review* 53:766-779.

Saunders, Kyle L. and Alan I. Abramowitz. 2004. "Ideological Realignment and Active Partisans in the American Electorate." *American Politics Research* 32:285-309.

Schiller, Bradley. 2004. *The Economics of Poverty and Discrimination*. New York: Prentice Hall.

Schnittker, Jason. 2004. "Education and the Changing Shape of the Income Gradient in Health." *Journal of Health and Social Behavior* 45:286-305.

Siegal, Michael and Frances Aboud. 2005. "Characterizing the scope of socialization and its impact on health: A commentary on Singh-Manoux and Marmot's "Role of socialization in explaining social inequalities in health"." *Social Science & Medicine* 60:2129-2133.

Sinclair, Barbara. 1999. "Transformational Leader or Faithful Agent? Principal-Agent Theory and House Majority Party Leadership." *Legislative Studies Quarterly* XXIV:421-449.

Singh-Manoux, Archana. 2005. "Socialization & health inequalities: Some clarifications. A reply to Kendall & Li, and Siegal & Aboud." *Social Science & Medicine* 61:2277-2279.

Smith, James P. and Raynard Kington. 1997. "Demographic and Economic Correlates of Health in Old Age." *Demography* 34:159-170.

Smith, Tom W. 1987. "Classifying Protestant Denominations." Inter-university Consortium of Political and Social Research, Ann Arbor.

Stack, Carol. 1974. *All Our Kin*. New York: BasicBooks.

Tickamyer, Ann R. and Cynthia Duncan. 1990. "Poverty and Opportunity Structure in Rural America." *Annual Review of Sociology* 16:67-86.

Toner, Robin and Kate Zernike. 2006. "For Incoming Democrats, Populism Trumps Ideology." Pp. 1 in *The New York Times*. New York.

Utter, Glenn and John Storey. 2001. *The Religious Right: A Reference Handbook*. Santa Barbara, California: ABC-Clio.

Weber, Bruce, Leif Jenson, Kathleen Miller, Jane Mosley, and Monica Fisher. 2005. "A Critical Review of Rural Poverty Literature: Is There Truly a Rural Effect?" *International Regional Science Review* 28:381-414.

Weber, Max. 2002. *The Protestant Ethic and the "Spirit" of Capitalism*, Edited by P. a. G. C. W. Baehr. New York: Penguin Books.

Wilcox, W. Bradford. 2004. *Soft Patriarchs, New Men: How Christianity Shapes Fathers and Husbands*. Chicago: University of Chicago Press.

Wilkinson, Richard. 1996. "Chapter 6: A small town in the USA, wartime Britain, Eastern Europe and Japan." Pp. 113-136 in *Unhealthy Societies: The Afflictions of Inequality*.

—. 2005. *The Impact of Inequality: How to Make Sick Societies Healthier*. New York: The New Press.

Wilkinson, Richard and Kate E. Pickett. 2006. "Income inequality and population health: A review and explanation of the evidence." *Social Science & Medicine* 62:1768-1784.

Wilkinson, Richard G. 1997. "Comment: Income, Inequality, and Social Cohesion." *American Journal of Public Health* 87:1504-1506.

Wilson, William Julius. 1996. *When Work Disappears: The World of the New Urban Poor*. New York: Alfred A. Knopf Inc.

Yinger, John. 2002. "Housing Discrimination and Residential Segregation as Causes of Poverty." Pp. 359-391 in *Understanding Poverty*, edited by S. H. D. a. R. H. Haveman. New York: Russell Sage Foundation.

Zimmer, Zachary, Josefina Natividad, Hui-Sheng Lin, Napaporn Chayovan. 2000. "A Cross-national Examination of the Determinants of Self-assessed Health." *Journal of Health and Social Behavior* 41:465-481.

Zuckerman, Diana M. 2000. "The Evolution of Welfare Reform: Policy Changes and Current Knowledge." *Journal of Social Issues* 56:811-820.

—. 2000. "Welfare Reform in America: A Clash of Politics and Research." *Journal of Social Issues* 56:587-600.

Zylan, Yvonne and Sarah A. Soule. 2000. "Ending Welfare as We Know It (Again): Welfare State Retrenchment, 1989-1995." *Social Forces* 79:623-652.