Concentrated Burdens: How Self-Interest and Partisanship Shape Opinion on Opioid Treatment Policy

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October 26, 2018

Abstract

When does self-interest overwhelm partisan predispositions in forming opinions on contentious public policies? Using data from a nationally representative survey sample, we show how these two factors interact in shaping public opinion on opioid treatment policy. Moreover, we use two experiments to test how the allocation of the funding and spatial burdens inherent in treatment policy alter policy preferences. We find that a redistributive framework of funding opioid treatment receives widespread political support, including from partisan groups traditionally opposed to redistribution. Moreover, self-interest based on objective need for these policies and income can overwhelm the partisan predispositions of people who are cross-pressured when forming opinions on opioid treatment policy. However, respondents across the political spectrum exhibit consistent opposition to the implementation of policy when treatment clinics are proposed near their home. These results highlight how partisanship and self-interest interact in the formation of preferences on public policy with concentrated burdens.

Keywords: political science, public policy, public opinion, opioids, addiction, redistribution, NIMBYism

For comments, suggestions, and advice, we thank Justin Phillips, Melissa Sands, and participants at the Local Political Economy pre-conference at APSA in 2018. We appreciate the research assistance of Cody Edgerly, Aaron Henry, and Claudia Scott, and funding from Time-sharing Experiments for the Social Sciences (TESS). All mistakes, however, are our own.

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When does self-interest motivate people to shed their partisan ties when forming opinion on public policy? Much of political science has downplayed the role of self-interest in the formation of public opinion (Kinder and Kiewiet, 1981; Sears and Funk, 1991). Especially when it comes to economic self-interest, people often form opinions counter to what political scientists assume would be their rational, self-interested preferences (e.g., Campbell et al., 1960; Gelman, 2008). Often, instead, researchers note the primacy of partisanship and ideology in American politics (Green, Palmquist, and Schickler, 2002).

The ongoing opioid overdose crisis presents a policy challenge with particularly dire stakes, opening the possibility for intense self-interest that potentially could outweigh partisan factors in the formation of policy preferences. Each day, nearly 200 Americans die from a drug overdose, making overdose the leading cause of death for Americans under age 50 (Katz, 2017; Sanger-Katz, 2018). Despite the acuity of this crisis, policymakers have faced difficulty in appropriating and allocating the funding public health experts believe is necessary to combat the epidemic (Daley and Fortier, 2018; Pugh, 2017; Saloner and Barry, 2018). The construction of addiction treatment infrastructure presents further difficulties as nearby residents often fear that these clinics will deteriorate public safety, decrease property values, and diminish overall quality of life (Banker, 2017; Bohner, 2017; Rector, 2017).

Public policy to confront this crisis may activate self-interest because of the high stakes for policy beneficiaries. For instance, direct policy benefits may galvanize constituencies to protect those policies, as found in the policy feedback of social programs (e.g., Campbell, 2005; Mettler, 2005). Likewise, direct policy costs may provoke opposition due to financial self-interest, such as wealthy homeowners opposing high property taxes (Sears and Citrin, 1982). Concentrated burdens may be not only financial, but also spatial, provoking location-based self-interest typified by NIMBY (‘Not In My Backyard’) opposition (e.g., Altshuler and Luberooff, 2003; Hankinson, 2018; Schively, 2007; Stokes, 2016).

The political geography of the crisis presents a new opportunity for understanding how public opinion forms when self-interest and ideology conflict. Preferences for drug treatment
policy have historically cleaved along partisan lines: Democrats are ordinarily more supportive of treatment programs than Republicans (Meier, 1994). This support for policy has mirrored the historic concentration of drug crises in urban, liberal-leaning environments. In contrast, the current opioid crisis affects not only urban areas, but also rural, whiter, less wealthy, and more conservative parts of the United States (Jalal et al., 2018; Keyes et al., 2014). Thus, the people most affected by today’s crisis — and likely to benefit from treatment policy — are much more likely to be conservative than in past drug crises. Furthermore, those benefitting from the presence of nearby treatment clinics will most directly bear the costs feared to accompany clinics. As a result, given the geographic breadth of the epidemic, voters’ self-interest — based on their income, context, and location — might contradict their partisan identities when forming preferences on opioid treatment policies. This represents an instance of cross-pressuring in which partisanship and self-interest might counteract one another in the formation of policy preferences, depending on the circumstances or identity primed (Klar, 2013; Chong, Citrin, and Conley, 2001).

Using two experiments conducted on a nationally-representative sample, we test how the structure of policies funding opioid treatment and the siting of treatment clinics shape public support. We find that treatment policy funded redistributively is more popular than policy funded according to a community’s need. Leveraging the geographic breadth of our survey sample, we also test how self-interest and partisan predispositions may cross-pressure voters. While we find that Republican voters are less supportive of the redistributive funding design, this decrease in support is primarily among high income Republicans and those in communities of low need. Low income Republicans and those in high need areas, whose partisan identity contradicts their economic self-interest, form opinions more in line with their self-interest than their partisan predispositions. Additionally, our results show that the concentrated costs stemming from the physical proximity of treatment infrastructure can dominate other considerations in forming policy opinions. Regardless of partisanship, income, or need, respondents oppose opioid treatment clinics when they are proposed near
their home. Together, these results demonstrate how economic self-interest cross-pressures and may overwhelm ideological considerations when voters engage with an especially visceral policy challenge.

Research Design and Data

To test the cross-pressuring of self-interest and ideology, we conducted two survey experiments on a nationally-representative survey of 2,000 United States residents administered by NORC at the University of Chicago in August 2018. In these experiments, we described the design of a policy funding opioid treatment and a policy that would open a new treatment clinic near a respondent’s home. The order of the experiments was randomized and support for each policy was measured using a five-point scale from ‘strongly support’ to ‘strongly oppose.’

In the first experiment, we asked for respondents’ support for a $100 million state-level bill funding medication-assisted opioid addiction treatment. We manipulate the description of how the policy’s financial burden is allocated, with some respondents paying $55 in additional taxes and others paying only $5. In the first condition, the resource-based treatment, we describe the policy as funded redistributively, with those people having greater resources (a higher household income) relative to their state’s median income paying more than those people with fewer resources. In the other condition, the needs-based treatment, we describe the policy as funded instead according to people’s need, with those living in areas with a higher opioid overdose rate relative to their state’s median rate paying more than those in areas with lower overdose rates. This type of ‘user-fee’ model would better match the costs

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1 Descriptive characteristics of our survey sample are shown in Appendix A.
2 We recoded each of the support scales to a binary measure of support, taking the value 1 if respondents answered either ‘strongly support’ or ‘somewhat support’ and 0 otherwise. Full survey questions’ text is in Appendix B.
3 These dollar figures are based on the 2018 federal budget, wherein the federal government will spend $4.6 billion to fight the opioid crisis (Mulvihill, 2018). Were all $4.6 billion to be directed to treatment funding, the average payment per taxpayer would be approximately $30. We divide the $30 per person into a 1:10 ratio to emphasize the disproportionate burden sharing that different frameworks could produce.
of treatment to those who would directly benefit from the funding, a framework that has been championed for other policies with spatially concentrated benefits (e.g., Mullin, Smith, and McNamara, 2018; Smith and Gihring, 2006). The difference in respondents’ average reported support of the policy between these two conditions represents the treatment effect of funding design.

In the second experiment, we asked for respondents’ support for construction of a new opioid treatment clinic and vary the clinic’s proposed location to manipulate its cost and therefore respondents’ location-based self-interest. We describe the proposed location of the clinic as either 2 miles away (a 40-minute walk), in the far treatment, or a 1/4 mile away (a 5-minute walk), in the near treatment, from the respondent’s home. The difference in average levels of support for the treatment clinic between the two conditions represents the treatment effect of the proximity of policy infrastructure.

To better measure respondents’ self-interest based on potential benefits from opioid treatment policy, we incorporate measures of respondents’ exposure to the opioid crisis. First, we asked respondents if they personally knew anyone who had been addicted to opioids, including heroin and prescription painkillers. Second, we measure respondents’ contextual exposure to the opioid crisis by connecting their ZIP code to county-level data on opioid death rates in 2015 from the National Vital Statistics System (NVSS) provided by the Centers for Disease Control’s National Center for Health Statistics. Finally, we use additional variables from the AmeriSpeak panel’s preexisting information on respondents’ self-reported partisan identification, ideology, income, and ZIP code. We operationalize economic self-interest using information on whether a respondent had an income above their state’s median income, and whether a respondent lived in a county with an overdose rate above their state’s median overdose rate.

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4 This design also matches the status quo for opioid treatment policy, in which individual cities and counties with high rates of opioid use have few outside resources to which they can turn. Consequently, taxpayers in these cities and counties are increasingly forced to fund their own local treatment programs.
Results

We first assess how respondents’ characteristics determine support for opioid treatment policy using the reported support for the policies described in our survey, aggregating both experimental treatment groups for our two policy questions. These descriptive results are presented in Figure 1, broken down into subgroups by respondent characteristics along the horizontal axis. Along the vertical axis, points show the percent of respondents reporting that they would support a given policy within each subgroup along with 95% confidence intervals. The first policy outcome, support for treatment funding, is plotted as circles, while the second outcome, support for clinic construction, is plotted as triangles.

While both policies used in our survey are stylized versions of real policy, they both were moderately supported by respondents. Overall, 50% supported the funding proposal, while 46% supported the opening of a new opioid treatment clinic in their community.

![Figure 1: Policy support among respondent subgroups. Points indicate the average response across both experimental conditions, with 95%-confidence intervals.](image)

As with most social policies, partisanship and ideology divide public opinion on opioid treatment policy. Republican respondents were 22 percentage points less likely to support the proposal for funding opioid addiction treatment than Democratic respondents \((p < 0.01)\). Republicans were 25 percentage points less likely to support the construction of a treatment
Self-interest also plays a role in opinion on opioid treatment policy. 54% of our sample reported personally knowing someone who had struggled with opioid addiction. Those respondents who reported knowing someone with an opioid use issue were 9 percentage points more likely to support funding treatment policy \( (p < 0.01) \) and were 9 percentage points more likely to support construction of a treatment clinic than those who did not know someone with addiction issues \( (p < 0.01) \).

Financial Burden

We next assess the results of our first experiment, which varied the description of how the treatment policy was funded. Our results indicate that support for the treatment policy was higher when funded redistributively (the resource-based condition) than when funded based on overdose rates (the needs-based condition). Among respondents in the resource-based condition, 56% indicated they would support the policy, while among respondents in the need-based condition only 44% reported they would support the policy. This treatment effect of 12 percentage points is statistically significant \( (p < 0.01) \).

We also observed heterogeneous treatment effects, indicating a role of self-interest. First, we find strong evidence that economic self-interest measured via respondents’ income conditions their preference for redistributive opioid treatment policy. In Figure 2, we plot our treatment effect — the difference in policy support between the redistributive resource-based funding model and the needs-based funding model — along the vertical axis, with our overall effect of 12 percentage points on the left. Moving to the left-middle panel of the figure, we plot our treatment effects for the two subgroups of respondents based on their income. We observe a (null) treatment effect of 2 percentage point among those with higher than average income while we observe a much larger effect of 21 percentage points among lower income respondents. This interaction of 19 percentage points is statistically significant \( (p < 0.01) \).

\footnote{Conservatives similarly reported lower support for treatment funding (25 percentage points) and lower support for clinic construction (28 percentage points) than liberals.}
In other words, a redistributive opioid treatment policy is far more popular relative to needs-based policy among lower income individuals but not more popular among higher income individuals, indicating that financial self-interest shapes this policy preference.

![Figure 2: Funding experiment treatment effects across respondent subgroups. Points indicate the difference between the needs-based frame and resource-based frame, with 95% (thin lines) and 90% (thick lines) confidence intervals.](image)

Second, we find evidence that self-interest as measured by respondents’ potential benefit from opioid treatment policy also conditions their preference for redistributive policy. As shown in the right-middle panel of Figure 2, we observe a treatment effect of 17 percentage points for those in high-overdose areas while we observe a smaller effect of 7 percentage points for those in low-overdose areas. This interaction of approximately 9 percentage points is statistically significant ($p < 0.05$). The preference for redistributive opioid treatment policy is especially concentrated among those respondents living in areas with a higher overdose rate whose self-interest dictates that they would pay less under this redistributive funding model.

Despite self-interest, broader political identity as measured by party identification still moderates our treatment effect, as shown in the right panel of Figure 2. Among Democratic respondents, the treatment effect was 19 percentage points, while among Republicans it was
only 6 percentage points. This difference of 13 percentage points in the size of the treatment effect between the two partisan groups is statistically significant ($p < 0.01$). While resource-based redistributive policy to confront the opioid crisis was more popular among Democrats relative to policy funded via a needs-based model, this was not true among Republicans.

Although these partisan differences in drug policy preferences are perhaps not surprising, the geographical breadth of the opioid crisis might lead self-interest to cross-pressure these partisans. We test this in Figure 3, where we disaggregate our treatment effects by both individual respondents’ partisanship and income relative to the median in their state. We observe a treatment effect among low income Republicans on par with that among high income Democrats. In other words, even though their partisanship might predispose Republicans (Democrats) to oppose (support) redistributive drug treatment policy, their income-based self-interest competes with their partisanship and elevates (lowers) their support.

![Figure 3](image.png)

**Figure 3:** Funding experiment treatment effects and confidence intervals by respondents’ partisanship and income relative to the median in their state. Points indicate the difference between the needs-based frame and resource-based frame, with 95% (thin lines) and 90% (thick lines) confidence intervals.

Figure 4 shows a similar disaggregation by respondents’ partisanship and their ‘need’, as measured by the overdose rate in their county relative to the median in their state. Although
our treatment effects show little variation among Democrats by ‘need’, our observed treatment effect among Republicans in high overdose areas is more similar to that of Democrats than that of fellow Republicans in low overdose areas. In other words, self-interest from potential policy benefits overwhelms Republicans’ partisan predisposition against redistributive drug treatment policy.

![Figure 4: Funding experiment treatment effects and confidence intervals by respondents’ partisanship and county-level overdose rate relative to the median in their state. Points indicate the difference between the needs-based frame and resource-based frame, with 95% (thin lines) and 90% (thick lines) confidence intervals.](image)

**NIMBYism and Implementation of Infrastructure**

Next, we assess the results of our second experiment, which varied the proximity of the infrastructure needed to confront the opioid crisis in relation to respondents’s homes. Our results indicate broad aversion to new opioid clinics near respondents relative to clinics farther away — a NIMBY response in line with respondents’ location-based self-interest. In Figure 5 we plot the average support for the construction of a new clinic along the vertical axis, with respondents in the ‘far’ condition on the left and the ‘near’ condition on
the right. Among those respondents in the far condition, where the proposed clinic was 2 miles away, 53% indicated they would support the construction of a new clinic. In contrast, among respondents in the near condition, in which the proposed clinic was 1/4 mile away, only 38% reported they would support construction. This statistically significant ($p < 0.01$) difference of 14 percentage points, shown by the difference between the two points in Figure 5, demonstrates how the spatial proximity of infrastructure and corresponding location-based self-interest shapes opinion on implementing opioid treatment policy.

![Figure 5: Average policy support and 95%-confidence intervals.](image)

We also test how location-based self-interest interacts with respondents’ other characteristics, as NIMBY opposition to building clinics might be counteracted by ideological preferences. We find no evidence of this. Despite pronounced differences in baseline support, Republicans and Democrats were similarly sensitive to the proximity of the clinic, indicating that self-interest swamps ideological predispositions on this policy.⁶

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⁶ We also see no differences in this sensitivity to proximity by respondents’ personal or community exposure to the opioid crisis.
Conclusion

The eventual success (or failure) of government solutions to confront the growing opioid crisis relies at least in part on public opinion about opioid treatment policies. Generating a body of knowledge about which features of policy — both in terms of funding mechanisms and implementation strategies — are more widely supported is crucial in understanding opinion on opioid treatment policies and therefore the fate of the policy process on this issue. Moreover, the opioid crisis provides a novel opportunity to assess how self-interest interacts with other political considerations when people form opinions on high-stakes policies.

Using two experiments, we find considerable support for opioid treatment policies. However, the specifics of policy design matter. People consistently favor treatment policy funded redistributively. The formation of policy preferences on this issue thus bears similarity to how people form opinions on disaster relief policy, and does not parallel the formation of opinions on social problems that are more often attributed to personal responsibility. Crucially, although ideological preferences do shape the degree to which people favor redistributive funding, we also find that self-interest can cross-pressure voters, overwhelming partisan predispositions. Moreover, we find that location-based self-interest dominates partisan predispositions in the formation of opinions on siting treatment clinics.

Our results present two direct implications for the policy response to the opioid crisis. First, the popularity of policy funded redistributively suggests that policymakers have wide leeway for structuring opioid treatment legislation progressively. The stigma often associated with drug use does not inhibit support for diffusion of costs to the wider population, even among higher income populations who would bear the most financial costs. Cross-pressuring of partisans may enable policymakers to leverage self-interest among more conservative voters directly affected by the crisis to build broad coalitions of support for policy. At the same time, location-based self-interest provokes NIMBY opposition towards treatment clinics. Historically, this NIMBY behavior has led policymakers to concentrate the unwanted infrastructure of public policies in low-income and minority neighborhoods where opposition
mobilization is less likely (Bullard, 2008). The potential for concentrating needed opioid infrastructure in disadvantaged communities may lead to stark inequities in spatial burden sharing.

Policy responding to the opioid crisis will require large-scale public investment in treatment programs and infrastructure. On this policy issue, as on others, the allocation of a policy’s shared burdens — financially and geographically — may drive self-interest and therefore public support. As with policy solutions to other collective challenges, such as climate change (Bechtel and Scheve, 2013), when policies target benefits or concentrate costs based on a group’s income, location, or reliance on the policy, self-interest may matter for these policies’ public support. Further research is needed to understand when such concentrated burdens galvanize self-interest enough to overwhelm partisan preferences. Moreover, as policies are implemented these burdens may shift over time, provoking additional self-interest. Measuring how these tensions change opinions is crucial for understanding the longer-term viability of policy to confront the opioid crisis and halt the growing number of fatalities.
References


### Table A1: Descriptive Characteristics of AmeriSpeak Survey Sample

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<tr>
<th>Statistic</th>
<th>Mean</th>
<th>St. Dev.</th>
<th>Min</th>
<th>Max</th>
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<td>Age</td>
<td>48.399</td>
<td>16.735</td>
<td>18</td>
<td>90</td>
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<tr>
<td>% Above Median Overdose Rate</td>
<td>0.466</td>
<td>0.499</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>% Above State Median Income</td>
<td>0.511</td>
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<td>0</td>
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<tr>
<td>% Female</td>
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<td>% Democrat</td>
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<td>% Liberal</td>
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B Survey Questions

Experiment 1, evenly randomized between Needs-Based Treatment and Resource-Based Treatment
1. The [STATE] government is considering a policy to fund medication-assisted treatment programs for people with substance abuse problems across the state. The cost would be $100 million total. These programs would help people affected by the opioid crisis. It would do this by providing needed medication and follow-up that can keep them off dangerous opioids and prevent deadly overdoses. Taxpayers in [STATE] will bear the costs of this policy, divided up in the following way.

[Needs-Based Treatment]
- Taxpayers in areas with above average rates of opioid use will pay an additional $55 in taxes. In contrast, taxpayers in areas with below average rates of opioid use will pay an additional $5 in taxes.\(^7\)
- Based on your ZIP code, you live in an area with [an above/a below] average rate of opioid use.

[Resource-Based Treatment]
- Taxpayers with an above average income will pay an additional $55 in taxes. In contrast, taxpayers with a below average income will pay an additional $5 in taxes.
- Based on your income, you have [an above/a below] average level of income.

Would you support or oppose this policy?
1. Strongly support
2. Somewhat support
3. Neither support nor oppose
4. Somewhat oppose
5. Strongly oppose

Experiment 2, evenly randomized between Near Treatment and Far Treatment
2. Medication-assisted treatment clinics provide help for people with substance abuse problems. They do this by providing needed medication (such as methadone) and follow-up that can keep them off dangerous opioids and prevent deadly overdoses.

[Near Treatment]
Would you support the opening of a new medication-assisted treatment clinic for opioid addiction a 1/4 mile (5 minute walk) from your home?

[Far Treatment] Would you support the opening of a new medication-assisted treatment clinic for opioid addiction 2 miles (40 minute walk) from your home?

1. Strongly support

\(^7\) Although the assignment is based on above/below the state’s median level, we use the term ‘average’ for cognitive ease.
2. Somewhat support
3. Neither support nor oppose
4. Somewhat oppose
5. Strongly oppose

*Personal Exposure, descriptive/non-experimental question* 3. Do you personally know anyone who has ever been addicted to opioids, including prescription painkillers or heroin?
   1. Yes, me
   2. Yes, a family member
   3. Yes, a close friend
   4. Yes, an acquaintance
   5. No, I do not know anyone who has ever been addicted to opioids
C Additional Analyses

Figure A1: Clinic construction policy support and 95%-confidence intervals by respondent partisanship.

Figure A2: Clinic construction policy support and 95%-confidence intervals by respondent’s personal exposure to someone who has been addicted to opioids.
Figure A3: Clinic construction policy support and 95%-confidence intervals by respondent’s county’s overdose rate compared to median overdose rate within respondent’s state.

Figure A4: Clinic construction policy support and 95%-confidence intervals by respondent income compared to median income within respondent’s state.