IWH
Halle Institute for Economic Research
Member of the Leibniz Association

Discussion Papers

No. 12
August 2026

Socioeconomic Inequality in Life Expectancy: Perception and Policy Demand in the United States and Germany

Lasse J. Jessen, Sebastian Koehne, Patrick Nüß, Jens Ruhose

https://doi.org/10.18717/dpv0bb-pe22

Authors

Lasse J. Jessen
FHVD Altenholz and Kiel University
E-mail: jessen@fhvd-sh.de

Sebastian Koehne
Corresponding author
Kiel University and CESifo
E-mail: koehne@economics.uni-kiel.de

Patrick Nüß
Halle Institute for Economic Research (IWH) – Member of the Leibniz Association, Department Labour Markets, and Kiel University
E-mail: patrick.nuess@iwh-halle.de
Tel +49 345 7753 705

Jens Ruhose
Kiel University, CESifo, and IZA Institute of Labor Economics
E-mail: ruhose@economics.uni-kiel.de

The responsibility for discussion papers lies solely with the individual authors. The views expressed herein do not necessarily represent those of IWH. The papers represent preliminary work and are circulated to encourage discussion with the authors. Citation of the discussion papers should account for their provisional character; a revised version may be available directly from the authors.

Comments and suggestions on the methods and results presented are welcome.

IWH Discussion Papers are indexed in RePEc-EconPapers and in ECONIS.

Editor

Halle Institute for Economic Research (IWH) – Member of the Leibniz Association

Address: Kleine Maerkerstrasse 8
D-06108 Halle (Saale), Germany
Postal Address: P.O. Box 11 03 61
D-06017 Halle (Saale), Germany

Tel +49 345 7753 60
Fax +49 345 7753 820

www.iwh-halle.de

ISSN 2194-2188

Socioeconomic Inequality in Life Expectancy: Perception and Policy Demand in the United States and Germany*

Abstract

Using survey experiments in the United States and Germany with about 12,000 participants, we study perceptions of socioeconomic inequality in life expectancy and policy demand. Respondents overestimate the rich-poor gap in both countries, judging the life expectancy of the rich roughly accurately but placing that of the poor well below its true level. These misperceptions vary little with political orientation or other characteristics. Correcting them shifts concern but leaves policy demand largely unchanged across general, specific, and real-stakes measures. Instead, demand divides politically, sharply in the United States and much less in Germany, consistent with views about the role of government rather than the inequality itself shaping policy demand.

Keywords: health care, information treatment, socioeconomic inequality in life expectancy, survey experiment

JEL classification: D72, D83, H53, I14, I18

* This RCT was registered as AEARCTR-0009711 (Jessen et al., 2022). IRB approval was received from the Central Ethics Committee of Kiel University (ZEK-19/22, July 4, 2022). This research was supported by the German Research Foundation (DFG), project number 454799018. We thank Marie Niemann and Samanta Schmitz for excellent research assistance.

1 Introduction

One of the most fundamental aspects of human well-being is the length of life itself. It is therefore of general concern that life expectancy varies considerably by socioeconomic status.[1] In the United States, individuals in the top decile of the household income distribution outlive those in the bottom decile by about ten years (Chetty et al., 2016). Even in a country like Germany, with a universal health care system and lower economic inequality than the United States, the life-expectancy gap between the top and bottom income deciles reaches seven years (Lampert et al., 2019). These gaps have widened in recent decades, further increasing their societal importance.[2]

Despite these high stakes, evidence on how the public perceives socioeconomic inequality in life expectancy, measured as the difference in life expectancy between individuals in the top and bottom deciles of the income distribution, remains scarce. Public perceptions matter because measures addressing the life-expectancy gap typically require government action and therefore depend, at least in part, on public support. Yet little is known about how accurately people perceive the inequality, whether these perceptions translate into policy demand, and whether that demand is structured by other respondent characteristics once beliefs about the inequality are held fixed. These questions are sharpened by two features of the setting we study. First, policies that might address the gap reach well beyond health care into the social determinants of health, from economic security to working conditions, and demand may differ across policy domains. Second, we study demand for such policies in the United States and Germany, two countries with distinct health-care and welfare-state institutions. This comparison is instructive because health policy and health outcomes can be politically patterned (Ferrario & Stantcheva, 2026; Elder & O'Brian, 2026), raising the question of whether perceptions and policy demand are specific to a particular institutional setting.

We contribute to these questions by providing the first systematic analysis of how the public perceives socioeconomic inequality in life expectancy and of the policy demand attached to it. Our analysis draws on a pre-registered, large-scale survey experiment conducted between August and November 2022 in the United States and Germany—two

[1] See Marmot (2005); Mackenbach et al. (2008); Braveman et al. (2010); Chetty et al. (2016); Lampert et al. (2019).

[2] See Meara et al. (2008); Olshansky et al. (2012); National Academies of Sciences, Engineering, and Medicine and Committee on Population (2015); Bosworth et al. (2016).

high-income countries with distinct health care and welfare systems, and potentially different views about inequality, the role of government, and the appropriate policy response. In each country, we obtained nationally representative samples of roughly 6,000 adults between the ages of 18 and 70.

The survey first elicits respondents' perceptions of the life expectancy of men and women in the bottom and top deciles of the household income distribution. We then randomly assign half of the sample an information treatment that reveals the actual life-expectancy gap. After the treatment, we measure respondents' perception of the magnitude of the life-expectancy gap, their concern about it, and their demand for policies addressing the gap. Policy demand is elicited at three levels of specificity: general support for government action, top-of-mind measures respondents propose spontaneously in an open-ended question (Ferrario & Stantcheva, 2022; Haaland et al., 2025), and support for twelve specific policies spanning health care access, economic stability, living conditions, education, and working conditions. A real-stakes donation decision and an obfuscated follow-up survey two weeks later complement the stated outcomes. We additionally collect political ideology, trust in government, and a range of sociodemographic characteristics, supplementary preferences, and beliefs. The common design across two institutional settings allows us to ask not only whether correcting beliefs moves demand, but also whether the answer depends on the setting in which this question is asked.

Turning to the results, we find that respondents in both countries overestimate the inequality, on average by about five years in the United States and four years in Germany. This overestimation arises because respondents underestimate the life expectancy of the poor more than that of the rich: they place the poor roughly seven years (United States) and six years (Germany) below the true value, against two years for the rich in both countries. The pattern holds broadly across sociodemographic groups, though it is somewhat more pronounced among younger, more educated, and higher-income respondents. Political orientation is associated with perceptions in the United States, where left-leaning respondents perceive a slightly larger gap than right-leaning respondents, by about 1.7 years; in Germany, perceptions do not divide along political lines. Accurate perceptions are rare in either country: about two-thirds of respondents overestimate the gap and about one-third underestimate it, with a dispersion of individual beliefs that is

wide and that incentives for accuracy do not narrow. Society, in other words, is largely uninformed about the true extent of socioeconomic inequality in life expectancy.

Correcting these inequality beliefs causally moves perceptions and concern, but does considerably less to move policy demand. Among respondents who had underestimated the inequality, the treatment raises the perceived magnitude of the gap and the concern that it constitutes a serious problem; among those who had overestimated it, the treatment lowers both. For both perceived magnitude and concern, the treatment closes most of the control-group difference between the two groups. The pass-through to general policy demand is weaker, and demand for specific policies does not respond at all. These effects are quantitatively similar in the United States and Germany. In the follow-up survey, the treatment still separates over- and underestimators on perceived magnitude and, among attentive respondents, on concern, while the already small effect on general policy demand fades. The weak response of policy demand survives a range of further checks, including for a mismatch between the policy areas we ask about and those respondents find relevant, ceiling effects, missing trade-offs, or inattention. Because the treatment does little to move policy demand for any political group, it leaves the difference in policy demand between left- and right-leaning respondents essentially intact.

The weak pass-through from beliefs to policy demand makes the broader determinants of demand especially important. We therefore examine whether policy demand is instead structured by self-interest, attribution beliefs, sociodemographic characteristics, and political orientation, and whether these associations differ across institutional settings. Among control-group respondents in the United States, policy demand varies most strongly with political orientation, captured by left-right ideology and trust in government. By contrast, self-interest, attribution beliefs, sociodemographic characteristics, and perceptions of the inequality itself are only weakly associated with demand. This political anchoring is more pronounced in the United States than in Germany, where statutory health insurance is organized around a broadly accepted solidarity principle (Zok & Jacobs, 2023). The cross-country contrast is sharpest in health policy itself, which is the most politically divided domain in the United States, but one of the least divided domains in Germany. Although these patterns are correlational, they suggest that demand for policies addressing the life-expectancy gap is anchored less in beliefs about the inequality than in views about the role of government, and that this anchoring depends on the institutional context.

Our paper contributes to several strands of the literature. First, we contribute to the literature on information-provision experiments, surveyed by Haaland et al. (2023) and Stantcheva (2023). This literature documents that people hold biased perceptions of social inequalities and examines how correcting these beliefs affects stated preferences. The link between inequality beliefs and policy preferences varies across domains and studies, including economic inequality (Cruces et al., 2013; Kuziemko et al., 2015; Karadja et al., 2017; Hoy & Mager, 2021; Fehr et al., 2022), intergenerational mobility (Alesina et al., 2018), educational inequality (Lergetporer et al., 2020), immigration (Grigorieff et al., 2020; Haaland & Roth, 2023; Dylong & Uebelmesser, 2024), gender gaps in wages and pensions (Settele, 2022; Schuetz, 2026), and demographic change (Schuetz et al., 2023; Stumpf et al., 2026). We extend this literature to socioeconomic inequality in life expectancy, arguably one of the most consequential dimensions of inequality and one where the belief-to-demand link is a priori open, given the many policies that could plausibly address the gap. We further exploit the parallel design to show that misperceptions and their response to information are similar across the United States and Germany, while the political structuring of demand diverges.

Another contribution concerns the structure of the misperceptions, which differs from that documented for other forms of inequality. For economic inequality, the common finding is underestimation, both of the concentration of wealth (Norton & Ariely, 2011) and of the degree of income inequality within respondents' own reference groups (Hvidberg et al., 2023). Life expectancy exhibits the opposite pattern: respondents more often overestimate the rich–poor gap, because they underestimate the life expectancy of the poor more than that of the rich. Yet, misperceptions are not one-sided. Roughly one-third of respondents in each country underestimate the gap. We further show that the relationship between perceived inequality and our main outcomes is concave, implying that belief corrections should have the largest effects among respondents who most underestimate the inequality. This pattern suggests that information campaigns can achieve larger effects on perceptions and concern for inequalities the public tends to underestimate than for one, like the life-expectancy gap, that most people already overestimate.

Our findings also connect to the literature on public attitudes toward health policy. Ferrario & Stantcheva (2026) study Americans' views on health insurance and find that partisan disagreement rests less on perceptions of efficiency or equity effects of insurance

than on differing views about the proper role of government. We speak to a related mechanism, but in a different policy context and with a broader empirical scope. Rather than explaining the mechanisms of health insurance to a U.S. sample, we correct a factual belief about inequality and examine demand for policies spanning the social determinants of health across two welfare states. This allows us to ask whether correcting perceptions of a consequential health inequality changes policy demand, and whether the answer differs across welfare-state contexts. In both settings, disagreement is anchored in views about the role of government rather than in the factual perceptions we move. A related literature examines how beliefs about the health-versus-wealth trade-off shape policy demand when that trade-off is salient, as during the COVID-19 pandemic (Lesschaeve et al., 2021; Settele & Shupe, 2022). Our surveys were fielded in late 2022, after the acute phases of the pandemic had passed, and we find similar treatment effects whether or not respondents believe the pandemic affected life expectancy. The weak link between inequality beliefs and policy demand that we document therefore appears to reflect settled political attitudes rather than the heightened salience of health policy during the pandemic.

Finally, our results contribute to the public health literature on the political and social structuring of health outcomes, health behaviors, and policy attitudes. Recent work documents a widening ideological divide in health outcomes and behaviors in the United States (Elder & O'Brian, 2026) and argues that political polarization has itself become a determinant of public health (Van Bavel et al., 2024). Other studies show that public support for health-equity policies varies across social groups and is related to beliefs about the causes of health inequalities (Fuller et al., 2016; Towe et al., 2021). Consistent with this broader literature, partisanship and trust in government predict support for specific health policies (Viskupič & Wiltse, 2023; Del Ponte et al., 2024). A related observation is that partisans can perceive the same factual reality differently and respond differently to corrective information (Alesina et al., 2020). In our setting, however, the divide runs differently. Perceptions of the inequality are largely shared across the political spectrum, with at most a slight difference in the United States and none in Germany. Policy demand, by contrast, divides along political lines, and correcting beliefs does not narrow that divide. This locates the political structuring of demand less in perceptions of the inequality itself than in broader views about the role of government.

Our cross-country design further shows that this structuring is not a fixed feature of the health domain.

The remainder of the paper is organized as follows. Section 2 describes our survey and the embedded information experiment. Section 3 documents perceptions of the life expectancy of rich and poor individuals in the United States and Germany. Section 4 presents the causal effects of the information treatment on perceived magnitude, concern, and policy demand. Section 5 turns to the broader determinants of policy demand, examining correlationally how it varies with political orientation and other characteristics across the two countries. Section 6 concludes.

2 Survey and Experimental Design

We conducted large-scale population surveys in the United States and Germany to study how individuals perceive socioeconomic inequality in life expectancy, how these perceptions shape policy preferences, and what else accounts for the demand for policies addressing this inequality. Throughout the paper, we define *socioeconomic inequality in life expectancy* (or, more compactly, the *life-expectancy gap*) as the gender-averaged difference in life expectancy between individuals in the top and bottom deciles of the household income distribution.

Our design serves three purposes.[3] First, it allows us to document the level and dispersion of beliefs about life-expectancy gaps in two advanced democracies with different levels of observed inequality and different welfare-state institutions. Second, by randomly providing information about the true extent of socioeconomic inequality in life expectancy, we identify the causal effect of belief updating on concerns about this inequality and on demand for policies targeting it. Third, the design allows us to examine, in a correlational analysis, the broader determinants of demand for policies targeting the life-expectancy gap, including political ideology, trust in government, self-interest, and beliefs about the origin of the inequality, and how these determinants differ across the two institutional settings.

We targeted a sample size of 6,000 individuals in each country to ensure sufficient statistical power to analyze heterogeneous effects across the distribution of prior beliefs,

[3] Appendix Figure A-1 provides an overview of the survey structure. Appendix D provides screenshots of the survey instrument.

including both positive and negative misperceptions. In addition to belief elicitation and the information treatment, the survey collects detailed data on policy preferences, responses in a real-stakes donation decision, supplementary preferences and beliefs, and socioeconomic characteristics. A follow-up survey conducted two weeks after the main survey allows us to assess the persistence of belief updating and policy effects.

The surveys were fielded between August 15 and November 30, 2022, by the commercial survey company *Schlesinger Group*. Samples were drawn to be representative of the population aged 18–70 in terms of age, gender, geographic region, educational attainment, and (in the United States) ethnicity. The compensation per completed survey was €2 in the United States and €1.78 in Germany. The median completion time was 19.5 minutes in the United States and 17.6 minutes in Germany.[4] The large majority of respondents did not perceive the survey as politically biased.[5]

2.1 Measuring Life Expectancy Perceptions

After a series of screening questions, we ask respondents to state their perceptions of the current life expectancy at birth for women in the bottom 10% of the household income distribution, men in the bottom 10% of the household income distribution, women in the top 10% of the household income distribution, and men in the top 10% of the household income distribution. Each question appears on a different screen, and the order of the screens is randomized. We ask for gender-specific life expectancies because women on average have a much higher life expectancy than men (about five to six years in both countries). Thus, responses to gender-neutral perception questions may be influenced by different perceptions of gender ratios at different income positions.

To reduce measurement error arising from heterogeneity in perceptions of life expectancy by gender, we provide official information on the average life expectancy of women when asking about women, and likewise for men. In addition, because people are often uncertain about the distribution of income (Engelhardt & Wagener, 2018; Hoy & Mager, 2021; Bublitz, 2022; Hvidberg et al., 2023), we explicitly state the income thresholds of the bottom 10% and top 10% of the household income distribution. This design ensures that respondents evaluate a clearly defined reference group, improving both the

[4] See Appendix Figure A-2 for the distribution of response times.

[5] As might be expected for a survey addressing inequality, there is a fraction of respondents (18%) who perceived the survey to be left-wing biased. Another fraction of respondents (4%) perceived the survey to be right-wing biased.

interpretability and comparability of their responses. By providing reference points for both baseline life expectancy and income thresholds, our approach adheres to established survey methodology for eliciting perceptions of complex or unfamiliar statistical quantities (e.g., Ansolabehere et al., 2013; Roth et al., 2022).

Note that we do not ask directly about the difference in life expectancy between the bottom 10% and the top 10% for three reasons: First, a direct estimate of the socioeconomic inequality in life expectancy would not allow us to test whether misperceptions of the socioeconomic inequality in life expectancy are due to misperceptions of the life expectancy of the rich or the poor. Second, it is arguably more cognitively demanding to estimate the socioeconomic inequality in life expectancy than to estimate the life expectancy of rich and poor men and women in separate steps, with gender-specific average life expectancies being given. Third, asking directly about the difference in life expectancy might have revealed the main perception parameter of the study right at the outset. In the follow-up survey, however, we ask directly for an estimate of the difference in life expectancy between rich and poor people and without making the question specific about gender. Reassuringly, we find similar patterns in the response data.

For half of the sample, the elicitation of the life expectancy perceptions is incentivized with \$2/€2 (United States/Germany) awarded to the 100 respondents whose answers to the four perception questions come closest to the true answer.[6] Providing incentives may lead to more accurate responses, increase attention, and reduce the risk of a potential partisan bias in responses (Haaland et al., 2023; Stantcheva, 2023). However, the literature also shows that incentives usually have no effect (Stantcheva, 2023) and can sometimes lead to increased online search (Grewenig et al., 2020). Because the elicitation stage occurs early in the survey, and because the true life expectancy by income level is not readily available through an online search, we do not expect any significant differences in perceptions between incentivized and non-incentivized respondents.

After the elicitation stage, each respondent receives a screen summarizing the respondent's assessment by stating the implied gender-averaged difference in the reported life expectancy between the top 10% and the bottom 10% of the income distribution (see Appendix Figure D-16). This step ensures that all respondents are reminded of their perceived socioeconomic inequality in life expectancy.

[6] Perception accuracy is calculated based on the sum of the absolute errors across all four predictions.

2.2 Information Treatment

In the next stage of the survey, we apply an information treatment to a random half of the sample, providing treated respondents with an estimate of the true socioeconomic inequality in life expectancy. The estimate is based on Chetty et al. (2016) for the United States and Lampert et al. (2019) for Germany, who report the life expectancy of women and men at different points in the income distribution based on recent data.[7] In the United States, the true socioeconomic inequality in life expectancy is equal to 10 years. In Germany, the true socioeconomic inequality in life expectancy is slightly smaller, but still amounts to 7 years. Fewer than 4% of all treated respondents report that they find the information provided in the treatment somewhat or very untrustworthy. To increase attention, respondents are required to confirm that they have reviewed the information before they can proceed. In addition, the preceding introductory screen alerted them to the forthcoming information about the true socioeconomic inequality in life expectancy (see Appendix Figures D-17 and D-18).

2.3 Outcomes

Magnitude, Concern, and General Policy Demand.—Directly after the treatment stage, the next screen elicits respondents' subjective sense of the magnitude of the socioeconomic inequality in life expectancy, their concern about this inequality, and their general policy demand for improving the life expectancy of poor people. In particular, we ask respondents whether they think the differences in life expectancy between rich and poor people are very small, small, neither small nor large, large, or very large to capture their perceptions of the *magnitude* of the socioeconomic inequality in life expectancy. To elicit their *concern*, we ask whether they think that differences in life expectancy between rich and poor people are not a problem, a small problem, a problem, a serious problem, or a very serious problem. To assess respondents' *general policy demand*, we ask whether the government should do more to improve the life expectancy of poor people, evaluated on a 5-point Likert scale from strongly disagree to strongly agree.[8]

[7] See Appendix B for details of the calculations of socioeconomic inequality in life expectancy.

[8] We selected this formulation after piloting more neutral phrasings (e.g., whether the government should "do anything" to improve outcomes), which elicited uniformly high agreement. Wording that implies a demand for *more* action avoids this ceiling and allows for variation that the treatment could, in principle, shift. If anything, it works against the small treatment effect we document later, which is therefore unlikely to be an artifact of question wording.

We evaluate these outcomes in two ways. First, following the procedure of Kling et al. (2007), we construct a linear outcome index based on the answers to the three domains. The index is constructed as an equally weighted average of the three variables, which have been transformed into standardized z-scores by subtracting the control-group mean and dividing by the control-group standard deviation of the pooled sample of both countries. Index aggregation addresses concerns of multiple hypothesis testing by combining all outcome indicators into one measure and improves the statistical power to detect effects (Anderson, 2008; Heller et al., 2017). Second, we also examine the shares of responses in the top two response categories for each item. That is, we construct dummy variables that are one (otherwise zero) if respondents answer large or very large for the magnitude question, serious or very serious for the concern question, and agree or strongly agree for the general policy demand question. We also construct an index dummy that is one (otherwise zero) if all three dummy variables are one for a given respondent. This index dummy serves as an indicator for individuals who perceive the magnitude of socioeconomic inequality in life expectancy to be large, are concerned about the problem, and agree that the government should do more to improve the life expectancy of the poor.

Top-of-Mind Proposals.—Before eliciting support for specific policies, we ask respondents in an open-ended format to list any measures they think the government could adopt to improve the life expectancy of poor people. This question captures respondents' spontaneous, first-order views on how the life-expectancy gap might be addressed, before any particular policy is presented to them. Following Ferrario & Stantcheva (2022) and Haaland et al. (2025), we visualize the responses in a word cloud and employ a large language model to categorize them, allowing us to quantify which policy areas respondents most frequently propose. These responses serve primarily to assess whether the predefined policy measures we elicit align with respondents' own proposals. In addition, we use them to characterize how spontaneous policy proposals vary across respondents.

Specific Policy Demand.—We then assess support for a structured set of predefined policy options. Drawing on reports by the World Health Organization (2019) and the U.S. Department of Health and Human Services (2023) that identify key domains for promoting health equity, we construct 12 policy measures grouped into five areas: health care access, economic stability, living conditions, education, and working conditions. These measures are designed either to improve the health of low-income individuals or to compensate for

their disadvantaged health status. Appendix Table A-1 provides an overview of the items in English and German. Each policy is evaluated on a 5-point Likert scale ranging from strongly oppose to strongly favor. To mitigate concerns about multiple hypothesis testing and to improve the statistical power to detect effects, we construct policy indices that cover the items of each category following again the procedure of Kling et al. (2007). We also construct a specific policy demand index that combines the five area-specific indices. For standardization, we again use the control-group mean and the control-group standard deviation of the pooled sample of both countries.

Political Consequentiality and Donation Lottery.—We incorporate two design features that introduce real stakes. First, we introduce a degree of political consequentiality by informing respondents at the beginning of the specific policy questions that the aggregated support for each policy will be forwarded to the relevant legislators in their State Legislature or General Assembly (see, e.g., Lergetporer & Woessmann, 2022). Second, each respondent participates in a lottery with a chance to win \$500/€500 (United States/Germany) and is given the option to keep the money for themselves or donate part of it to charities known for supporting the poor or promoting health equity (see, e.g., Settele, 2022; Alesina et al., 2023, for similar setups).[9] Respondents make this choice before knowing if they have won, thereby attaching probabilistic financial consequences to their stated preferences.

2.4 Properties of the Analytical Sample

In total, our partner collected 6,003 completed surveys in the United States and 6,000 completed surveys in Germany. To reduce the impact of outliers, our analytical sample selects respondents with prior perceptions between the 5th and 95th percentiles of the distribution.[10] This yields an analytical sample with 5,432 observations in the United States and 5,400 observations in Germany. As shown in Appendix Tables A-2 and A-3, the samples are representative in terms of age, gender, geographic region, educational background, and ethnicity (in the United States). Notably, however, both samples contain a lower proportion of respondents with very low levels of education, which is a common

[9] Respondents in the United States choose between the charities Feeding America, Salvation Army, Patient Access Network Foundation, and American Red Cross. Respondents in Germany choose between the charities Tafel, Arbeiterwohlfahrt, Armut und Gesundheit in Deutschland, and Deutsches Rotes Kreuz.

[10] This procedure drops the respondents who expect the richest 10% to live shorter than the poorest 10% or who expect the richest 10% to live at least 37.5 (25) years longer than the poorest 10% in the United States (Germany).

tendency in samples from online opt-in panels (Malhotra & Krosnick, 2007). Appendix Tables A-4, A-5 and A-6 provide extensive summary statistics for our surveys. We can also infer from the tables that there are barely any statistically or economically significant differences between the treatment and control groups, or between the incentivized and non-incentivized samples, on a number of individual attributes.

Before eliciting perceptions of life expectancy in the main survey, we include an obfuscated attention check (see Appendix Figure D-8 for a screenshot). Overall, 62% of respondents passed this test. This level of attentiveness is comparable to that in other online surveys (see, e.g., Chopra et al., 2022), though some studies document pass rates above 90% (Alesina et al., 2018; Bottan & Perez-Truglia, 2022; Alesina et al., 2023). While some papers drop inattentive respondents from their analysis to strengthen internal validity (see, e.g., Haaland & Roth, 2020; Enke & Graeber, 2023), Stantcheva (2023) points out that dropping inattentive respondents from the analysis may affect the external validity of the estimates. To address both considerations, we generally keep inattentive respondents in the analytical sample and provide sensitivity checks of the treatment effects with respect to respondent attention.

2.5 Estimation of Information Treatment Effects

Documenting the public perception of socioeconomic inequality in life expectancy in the United States and Germany is one central innovation of our paper. A second is to examine how perceptions causally affect respondents' sense of the magnitude, their concern, and their policy demand for addressing the life expectancy of poor people. To identify these effects, we use the random information treatment to update individuals' perceptions of socioeconomic inequality in life expectancy. Importantly, we expect opposite effects of the information treatment for those who initially overestimated the socioeconomic inequality in life expectancy compared to those who initially underestimated it.[11]

We use the following regression setup to test for information treatment effects, allowing for potential asymmetries:

$$y_i = \beta_0 + \beta_1 T_i + \beta_2 T_i \times \text{Overestimated}_i + \beta_3 \,\text{Overestimated}_i + \mathbf{X}_i'\gamma + \epsilon_i. \qquad (1)$$

[11] We expect that the information treatment does not have a strong effect on those who have accurate perceptions. We verify this expectation in the results section.

In this regression, y_i refers to one of the outcomes mentioned earlier (see Section 2.3) and the index i denotes individual responses. The term T is a dummy variable that equals one if the individual belongs to the treatment group and zero otherwise. The term "Overestimated" is also a dummy variable that indicates whether the individual overestimated the socioeconomic inequality in life expectancy. The vector $\mathbf{X}$ contains the control variables summarized in Appendix Tables A-5 and A-6 to increase the precision of the estimates. Finally, ϵ_i is an idiosyncratic error term.

The coefficient β_1 gives the effect of the information treatment on the outcome variable for those who underestimated the socioeconomic inequality in life expectancy. Similarly, the linear combination $\beta_1 + \beta_2$ yields the treatment effect for those who overestimated the socioeconomic inequality in life expectancy. The coefficient β_3 reports the association between the outcome and the overestimation of socioeconomic inequality in life expectancy (with the correlation of the control variables partialled out).

Our large sample size allows us to estimate the effect of the treatment along the distribution of perceptions to study whether larger misperceptions are associated with larger adjustments in the outcomes. We do this by partitioning the misperceptions into four-year bins and interacting the specific indicator for each bin with the treatment indicator.

2.6 Follow-up Survey

Approximately two weeks after the main survey, respondents are invited to an obfuscated follow-up survey, where we again ask about their perceptions of life expectancy inequality, their concerns, and their general policy demand (see Appendix D.2 for survey details). The follow-up survey allows us to examine the persistence of treatment effects, and also allows us to consider the relevance of potential experimenter demand and attention effects in the main survey. The sample size in the follow-up survey is 3,881 in the United States and 4,914 in Germany. This corresponds to a recontact rate of 65% in the United States and 82% in Germany, which is comparable to what other studies report (Karadja et al., 2017; Roth & Wohlfart, 2020; Fehr et al., 2022). Importantly, attrition from the sample is not correlated with the treatment.

We use four measures to obfuscate the follow-up survey. First, we (truthfully) state on the first screen that the survey is part of a scientific qualification work by young researchers. Second, the topic of the survey is changed to environmental and inequality

issues. Third, the first questions in the survey are about climate change perceptions, renewable energy, and electric cars. Only after these questions are the respondents asked to state their (posterior) perceptions of socioeconomic inequality in life expectancy. More specifically, we ask for their best guess about how much longer the richest 10% live compared to the poorest 10%. This change in the wording of the perception question compared to the main survey should have led to a further obfuscation of the follow-up survey. Fourth, we also ask about other inequalities. For instance, we ask respondents about their perceptions of income inequality and about how much later the richest 10% become dependent on care compared to the poorest 10%. We then ask about their concerns about socioeconomic inequalities in life expectancy and whether the government should do more to improve the life expectancy of poor people.

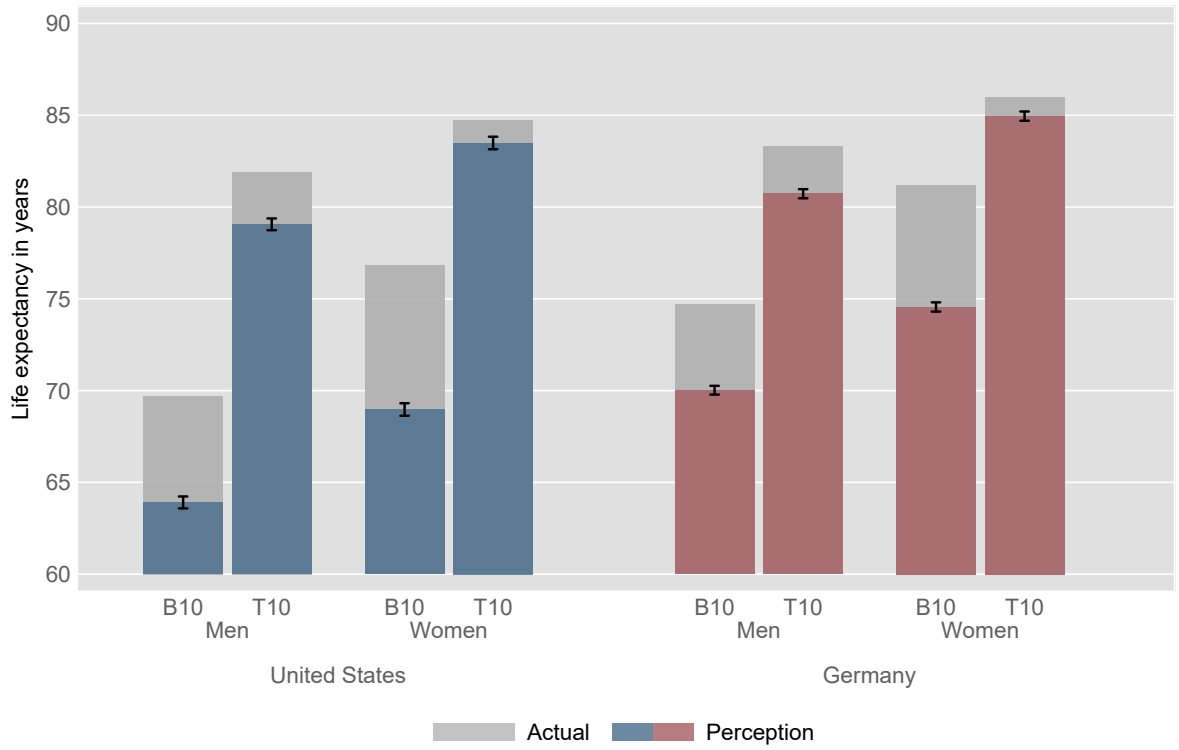
3 Perception of Socioeconomic Inequality in Life Expectancy

Figure 1 shows how people perceive life expectancy across income groups in the United States and Germany, separately for women and men. Two features stand out. Respondents in both countries substantially *overestimate* the socioeconomic inequality in life expectancy because they *underestimate* the life expectancy of low-income groups while perceiving that of high-income groups fairly accurately. As we show below, this overestimation is consistent across population groups, and unresponsive to incentives for accuracy.

In the United States, respondents believe that men in the bottom 10% of the income distribution have a life expectancy of 63.9 years, substantially below the actual value of 69.7 years. For men in the top 10%, perceptions are more accurate but still slightly underestimated (79.1 years perceived vs. 81.9 years actual). As a result, Americans overestimate the life-expectancy gap for men by about 3 years (15.2 years perceived vs. 12.2 years actual). The overestimation is even more pronounced for women, at about 6.6 years (14.5 years perceived vs. 7.9 years actual). This pattern is again driven primarily by a substantial underestimation of life expectancy in the bottom 10% (69.0 years perceived vs. 76.8 years actual), whereas life expectancy in the top 10% is only slightly underestimated (83.5 years perceived vs. 84.7 years actual).

A similar pattern emerges in Germany. Respondents overestimate the life-expectancy gap for men by 2.1 years (10.7 years perceived vs. 8.6 years actual) and for women by 5.6 years (10.4 years perceived vs. 4.8 years actual). In both countries, the systematic

Figure 1: Perceived Life Expectancy of Men and Women in the Bottom 10% and Top 10% of the Income Distribution



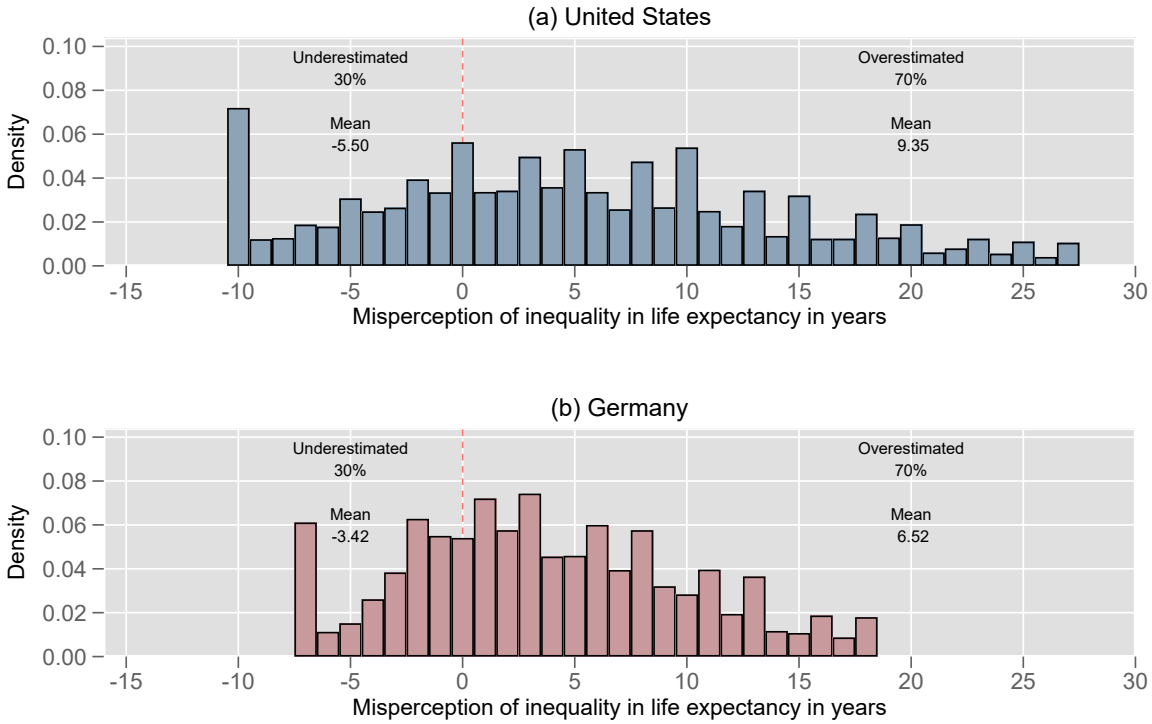
Notes: The figure shows the average perceived and actual life expectancy of men and women in the bottom 10% (B10) and the top 10% (T10) of the household income distribution for the United States and Germany. The whiskers around the averages indicate 95% confidence intervals. The actual numbers are based on Chetty et al. (2016) for the United States and Lampert et al. (2019) for Germany (see Appendix B for details). Averages can be found in Appendix Table A-7.

underestimation of life expectancy among low-income groups produces an overestimation of the gender-averaged life-expectancy gap on the order of four to five years.[12]

While the average misperception is sizable, it masks substantial dispersion in individual beliefs. Figure 2 shows the distribution of misperceptions, calculated as perceived minus actual gender-averaged life-expectancy gaps. In the United States, about one-third of respondents underestimate the gap, while roughly two-thirds overestimate it. Accurate perceptions are rare: only 3.9% of respondents report the correct life-expectancy gap, increasing to 17% if a window of ±2 years is allowed. The German distribution is similar: one-third underestimate, two-thirds overestimate, and only 2.3% report the correct gap (28% within ±2 years).

[12] The order of perception questions slightly affects misperceptions: asking about the bottom 10% first increases overestimation by 1.8 years in the United States and 1.2 years in Germany ($p < 0.001$) compared to asking about the life expectancy of the top 10% first (see Appendix Figure A-3). Question order was randomized to avoid bias, and average estimates remain similar when using only the first perception question per respondent (see Appendix Figure A-4).

Figure 2: Distribution of Misperceptions of Socioeconomic Inequality in Life Expectancy



Notes: The figure shows the distribution of misperceptions of the socioeconomic inequality in life expectancy for the United States and Germany. Misperceptions are calculated as the respondents' perceptions of gender-averaged socioeconomic inequality in life expectancy minus the actual gender-averaged socioeconomic inequality in life expectancy as obtained from Chetty et al. (2016) for the United States and Lampert et al. (2019) for Germany (see Appendix B for details).

The distribution of misperceptions is wide and ranges from −10 to +30 years in the United States and −7 to +20 years in Germany—even after excluding the outliers in the top and bottom 5% of misperceptions from the analytical sample. Notably, there is some heaping at the perception that there is no difference in life expectancy between rich and poor (corresponding to a misperception of −10 years in the United States and −7 years in Germany).[13] Randomly assigned financial incentives for accuracy do not reduce misperceptions. Even with incentives, average perceptions remain stable, respondents do not bunch around the true gap, and heaping at zero persists.[14]

Misperceptions are largely homogeneous across sociodemographic groups. Figure 3 shows that in the United States, young, educated, high-income, and left-leaning respondents exhibit somewhat larger overestimation of the life-expectancy gap, although these

[13] Response quality among respondents who perceive no difference in life expectancy is comparable to that of the other respondents: attention check pass rates are 60% versus 62% ($p = 0.355$), median response times for the four perception questions are 1.3 versus 1.2 minutes, median response times for the entire survey are 19 versus 18.5 minutes.

[14] See Appendix Figures A-3 and A-5.

differences are quantitatively small. In Germany, variation across groups is negligible. In both countries, respondents who believe the COVID-19 pandemic affected life expectancy perceive a larger life-expectancy gap. Despite these minor variations, all population segments substantially overestimate socioeconomic inequality in life expectancy.

Overall, the scarcity of accurate perceptions, the systematic overestimation across population groups, and the lack of effects from accuracy incentives indicate that the population holds biased beliefs about the socioeconomic inequality in life expectancy.

4 Perception, Concern, and Policy Demand: Causal Evidence

In this section, we study whether correcting perceptions of socioeconomic inequality in life expectancy causally affects how individuals assess its magnitude, how concerned they are about it, and the extent to which they demand government action to address it. We identify these effects by exploiting the randomized information treatment, following the empirical strategy described in Section 2.5.

4.1 Effects of Information Provision on Perception, Concern, and General Policy Demand

Figure 4 previews our main results for the United States (upper panel) and Germany (lower panel). It reports average responses on perceived magnitude, concern, and general policy demand separately for the treatment and control groups.[15] The patterns are largely similar across the two countries, which is why we describe them jointly here and return to between-country differences further below.

The information treatment shifts perceived magnitude and concern, and its effect attenuates as one moves from perceptions and concern toward general policy demand. Among respondents who initially underestimated the socioeconomic inequality in life expectancy, the treatment raises perceived magnitude, concern, and general policy demand; among those who overestimated it, the treatment lowers these outcomes. That the treatment raises these outcomes for underestimators and lowers them for overestimators is consistent with respondents updating their beliefs toward the information provided. Notably, policy demand in the control group is both high and similar among underestimators and

[15] This picture is corroborated by Appendix Figure A-7, which shows the treatment-specific shares of individuals who think that the magnitude of the socioeconomic inequality in life expectancy is large or very large, that the difference in life expectancy between rich and poor people is a serious or very serious problem, and who agree or strongly agree that the government should do more to improve the life expectancy of poor people.

Figure 3: Heterogeneity in Perceptions of Socioeconomic Inequality in Life Expectancy

Notes: The figure shows the heterogeneity of average perceptions of socioeconomic inequality in life expectancy in the United States and Germany, by sociodemographic characteristics in panel (a) and preferences and beliefs in panel (b). The shaded areas around the averages indicate 95% confidence intervals. The vertical colored lines reference the actual socioeconomic inequality in life expectancy.

overestimators, despite substantial differences in their perceived magnitude of inequality and their level of concern.

A second feature of the treatment effects is their asymmetry: on average, effects are larger in absolute value for underestimators than for overestimators across all three outcomes. This asymmetry does not reflect the size of the belief correction, since overestimators are, on average, further from the true life-expectancy gap than underestimators (Figure 2), yet their responses to the information are smaller. We examine how the treatment effects vary across finer bins of prior misperceptions further below.

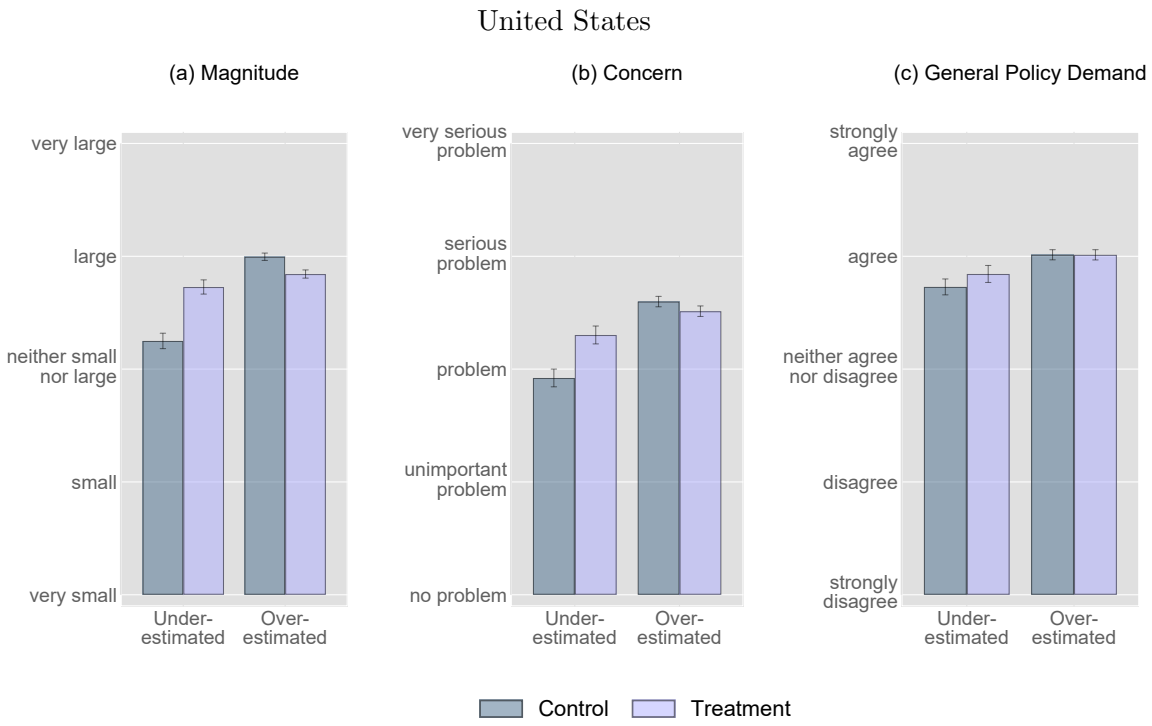
We now turn to a more structured analysis using the regression setting introduced in Section 2.5. Table 1 reports the linear (standardized) outcome specification and Table 2 the share specification, with the United States in Panel A and Germany in Panel B.[16] The estimates confirm the patterns visualized in Figure 4. For perceived magnitude and concern, the effects of the information treatment are closely comparable across the two countries; for general policy demand, the effect is somewhat weaker in the United States than in Germany, as we detail below.

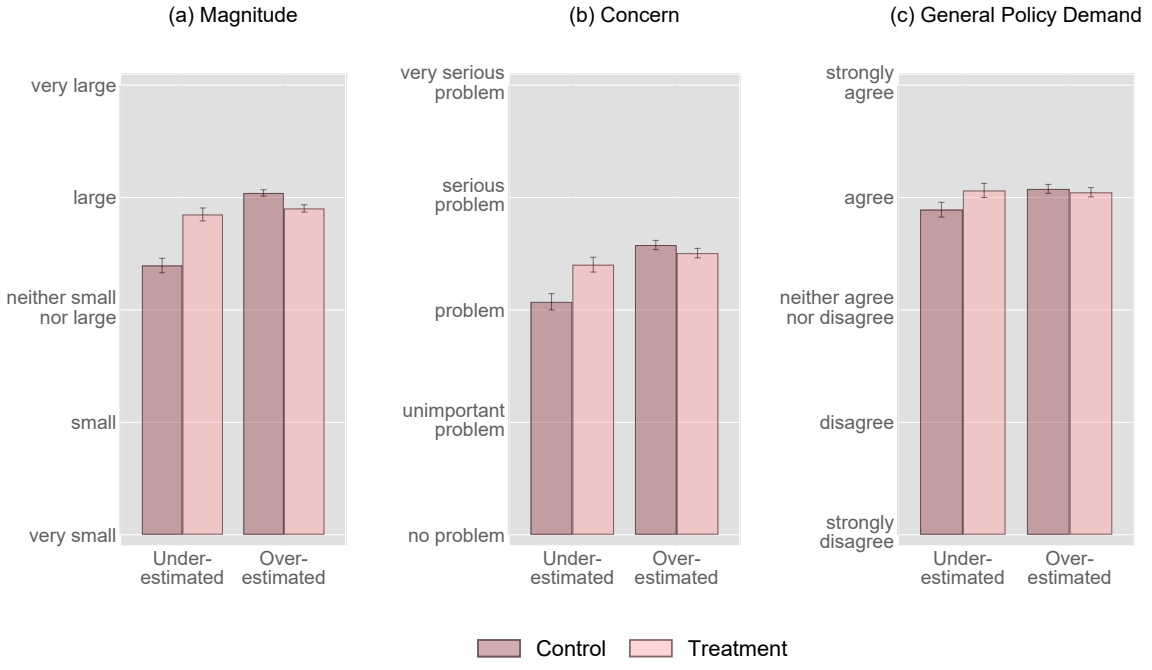
Column (1) of Table 1 reports perceived magnitude. In the United States, respondents who overestimated the inequality perceive its magnitude to be 0.79 standard deviations (SD) larger than those who underestimated it. The treatment moves the two groups in opposite directions: among underestimators, treated respondents report a 0.55 SD higher perceived magnitude than the control group, while among overestimators they report a 0.20 SD lower perceived magnitude. Together, these effects offset almost the entire control-group gap. The share specification in Panel B of Table 2 shows the same pattern: the initial gap of 34 percentage points closes once the information is provided, as the treatment raises the share perceiving the inequality as large or very large by 22 percentage points among underestimators and lowers it by 9 percentage points among overestimators. Magnitudes are closely comparable in Germany (Column (1), Panel B).

Column (2) reports concern. In the United States, the control-group gap in concern between over- and underestimators is 0.53 SD (18 percentage points) and narrows by more than 80% in both specifications once the information is provided. Germany again displays similar estimates.

[16] Appendix Tables A-8 and A-9 provide the same analysis without conditioning on the control variables. All coefficients are quantitatively very similar, which also corroborates our earlier finding that misperceptions about socioeconomic inequality in life expectancy are closely aligned across population groups (Figure 3).

Figure 4: Perceived Magnitude, Concern, and General Policy Demand by Treatment Status





Notes: The figure reports average answers to the magnitude, concern, and general policy question for respondents who received the information treatment and those who did not. The whiskers around the averages represent 95% confidence intervals.

Table 1: Information Treatment Effect on Perceived Magnitude, Concern, and General Policy Demand: Linear (Standardized) Outcome Specification

	Index components			Index
	Magnitude	Concern	Policy	
	(1)	(2)	(3)	(4)
	Panel A: United States			
Treatment	0.547***	0.331***	0.089*	0.403***
	(0.054)	(0.050)	(0.047)	(0.049)
Treatment × Overestimated	-0.748***	-0.442***	-0.118**	-0.545***
	(0.061)	(0.057)	(0.055)	(0.056)
Overestimated	0.793***	0.528***	0.177***	0.624***
	(0.045)	(0.041)	(0.039)	(0.040)
Controls	Yes	Yes	Yes	Yes
Adj. R-squared	0.152	0.230	0.280	0.293
Treatment effect for Overestimated	-0.200***	-0.111***	-0.030	-0.142***
	(0.029)	(0.029)	(0.029)	(0.028)
	Panel B: Germany			
Treatment	0.535***	0.323***	0.194***	0.438***
	(0.052)	(0.046)	(0.045)	(0.046)
Treatment × Overestimated	-0.713***	-0.404***	-0.238***	-0.564***
	(0.058)	(0.053)	(0.053)	(0.053)
Overestimated	0.733***	0.450***	0.180***	0.568***
	(0.043)	(0.040)	(0.038)	(0.039)
Controls	Yes	Yes	Yes	Yes
Adj. R-squared	0.108	0.127	0.153	0.162
Treatment effect for Overestimated	-0.177***	-0.081***	-0.044	-0.126***
	(0.026)	(0.027)	(0.028)	(0.026)

Notes: The table reports treatment effects on the outcome variable indicated in the column header for the United States in Panel A and Germany in Panel B. Outcomes are z-standardized. The index in Column (4) is an equally weighted average of z-scores of the three outcome variables. Calculation of each z-score subtracts the score's control-group mean and divides by the control-group standard deviation of the joint sample. "Treatment" indicates individuals who received the information treatment. "Overestimated" indicates individuals who overestimated the socioeconomic inequality in life expectancy. Controls: gender, age, university degree, ethnicity (US only), birthplace, parental birthplace, partner in household, children in household, income decile, employment status, occupation, region, political orientation, trust in government, belief about control over life expectancy, risk aversion, patience, altruism, health insurance status, self-assessed health status, belief about corona effect on life expectancy, certainty about perceptions, attentiveness, incentive treatment, and perception question order. $N_{US} = 5,432$ and $N_{DE} = 5,400$. Robust standard errors in parentheses. Significance levels: *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

Table 2: Information Treatment Effect on Perceived Magnitude, Concern, and General Policy Demand: Shares Outcome Specification

	Index components			Index
	Magnitude	Concern	Policy	
	(1)	(2)	(3)	(4)
	Panel A: United States			
Treatment	0.216***	0.113***	0.033	0.116***
	(0.022)	(0.022)	(0.021)	(0.021)
Treatment × Overestimated	-0.307***	-0.159***	-0.046*	-0.164***
	(0.026)	(0.027)	(0.024)	(0.025)
Overestimated	0.335***	0.178***	0.081***	0.192***
	(0.019)	(0.019)	(0.018)	(0.017)
Controls	Yes	Yes	Yes	Yes
Adj. R-squared	0.153	0.170	0.218	0.197
Treatment effect for Overestimated	-0.091***	-0.046***	-0.013	-0.048***
	(0.012)	(0.015)	(0.012)	(0.015)
Control group mean	0.736	0.464	0.721	0.399
Control group mean (Underestimated)	0.475	0.306	0.632	0.229
	Panel B: Germany			
Treatment	0.212***	0.129***	0.056***	0.138***
	(0.022)	(0.023)	(0.021)	(0.022)
Treatment × Overestimated	-0.278***	-0.159***	-0.062**	-0.159***
	(0.025)	(0.028)	(0.024)	(0.027)
Overestimated	0.312***	0.186***	0.063***	0.197***
	(0.019)	(0.020)	(0.018)	(0.019)
Controls	Yes	Yes	Yes	Yes
Adj. R-squared	0.115	0.093	0.107	0.102
Treatment effect for Overestimated	-0.066***	-0.030*	-0.007	-0.021
	(0.011)	(0.016)	(0.013)	(0.016)
Control group mean	0.785	0.472	0.760	0.406
Control group mean (Underestimated)	0.551	0.329	0.710	0.255

Notes: The table reports treatment effects on the outcome variable indicated in the column header for the United States in Panel A and Germany in Panel B. Outcomes are dummy variables for each outcome that are 1 if the response is in the two top answer categories of each item, and 0 otherwise. The index variable in Column (4) is a dummy variable that is 1 if individual answers to all three dummy outcome variables are 1, and 0 otherwise. "Treatment" indicates individuals who received the information treatment. "Overestimated" indicates individuals who overestimated the socioeconomic inequality in life expectancy. Controls: gender, age, university degree, ethnicity (US only), birthplace, parental birthplace, partner in household, children in household, income decile, employment status, occupation, region, political orientation, trust in government, belief about control over life expectancy, risk aversion, patience, altruism, health insurance status, self-assessed health status, belief about corona effect on life expectancy, certainty about perceptions, attentiveness, incentive treatment, and perception question order. $N_{US} = 5,432$ and $N_{DE} = 5,400$. Robust standard errors in parentheses. Significance levels: *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

Column (3) reports general policy demand, where both the control-group gap and the treatment effects are smaller. The gap between over- and underestimators is modest to begin with, amounting to 0.18 SD in both countries (8 percentage points in the United States and 6 in Germany). The treatment leaves overestimators essentially unaffected in both countries. Its effect on underestimators is also modest: 0.19 SD (6 percentage points) in Germany, but only 0.09 SD (3 percentage points) in the United States, where it is at most marginally significant (significant at the 10% level in the linear specification and insignificant in the share specification). Correcting beliefs thus does considerably less to move general policy demand than to move perceived magnitude or concern. The treatment effect on underestimators is somewhat weaker in the United States than in Germany, but the difference is not statistically significant ($p = 0.105$ in the linear specification and $p = 0.443$ in the share specification).

The index specifications in Column (4) of both tables corroborate the results. They summarize the three preceding columns in a single measure and reproduce the same structure: a positive control-group gap between over- and underestimators, a positive treatment effect for underestimators, and a negative one for overestimators, with the two effects together offsetting most of the baseline gap.

So far, the analysis has divided respondents into those who under- and overestimated the life-expectancy gap. To examine how the treatment effects vary with the size of the prior misperception, Figure 5 groups misperceptions into four-year bins and interacts each bin indicator with the treatment indicator. The figure plots predicted values and 95% confidence intervals for each outcome across bins, separately for the treatment and control groups. The predictions are conditional on the full set of control variables (see Table 1). In both countries, the control-group profiles reveal a concave relationship between prior misperceptions and outcomes: perceived magnitude, concern, and general policy demand rise with the perceived life-expectancy gap, but at a decreasing rate. This concavity is pronounced for perceived magnitude, weaker for concern, and slight for general policy demand, whose control-group profile is comparatively flat across the distribution.

The treatment effects scale with the size of the prior misperception. For perceived magnitude and concern, the treatment raises outcomes among respondents who underestimated the life-expectancy gap and lowers them among those who overestimated it, by more the further the prior lies from the true value. The treatment and control pro-

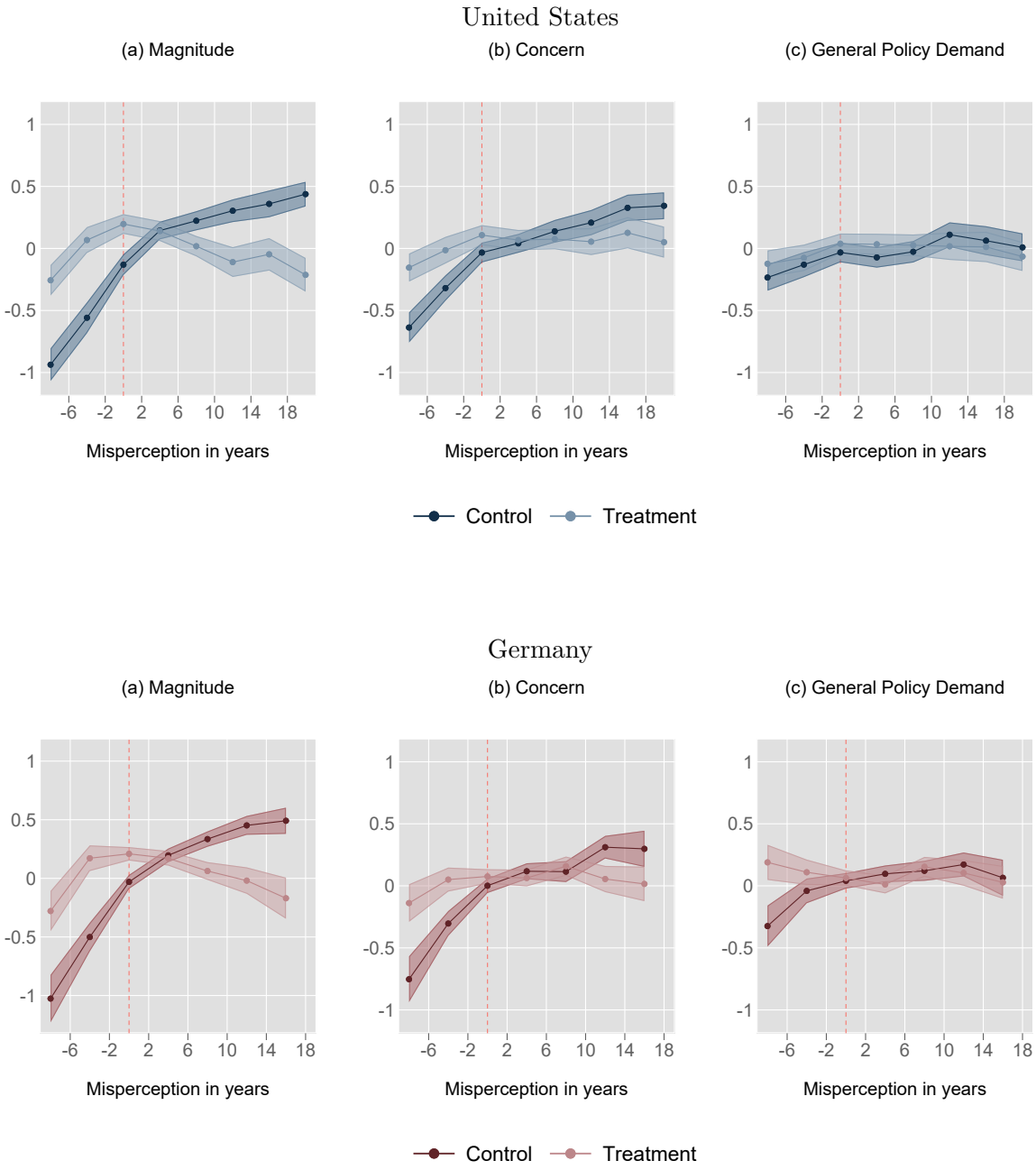
files cross near a misperception of zero, and the treatment profile is flatter, as larger prior errors are associated with larger revisions. For general policy demand, the same logic applies but the magnitudes are small. Because the control-group profile rises only weakly, there is little gradient for the treatment to flatten: the treatment and control profiles largely coincide across the distribution, separating only among respondents who substantially underestimated the life-expectancy gap, where the treatment raises demand modestly. Belief updating thus translates into substantive changes in perceived magnitude and concern, but only minor changes in general policy demand, concentrated among the most pronounced underestimators.

Taken together, the figure, the regressions, and the binned profiles point to three regularities. The treatment effects are opposite in sign for under- and overestimators, and larger for underestimators on average. They attenuate across outcomes, from perceived magnitude to concern to general policy demand. And the pass-through to general policy demand is modest, detectable mainly among respondents who substantially underestimated the true life-expectancy gap. Correcting beliefs therefore moves how respondents perceive and assess the inequality more than it moves their demand for policy to address it.

4.2 Effects of Information Provision on Specific Policy Demand

We now move from general policy demand to demand for the specific policies introduced in Section 2.3. The 12 measures span the five areas identified from the World Health Organization (2019) and U.S. Department of Health and Human Services (2023) reports. Specifically, in the area of health care access we ask respondents how they feel about (i) establishing a universal health insurance and an equal-access health care system that is independent of income or employment status, (ii) expanding medical care in rural areas despite low profitability, and (iii) abolishing deductibles and co-payments for medical services and medication for individuals with low incomes. Regarding economic stability, we ask the respondents about their opinion on (i) more redistribution of income from rich to poor people (e.g., through more generous social benefits for the poor, financed by higher taxes for the rich), (ii) increasing spending on employment and training programs for the unemployed, and (iii) raising the federal minimum wage. On living conditions, we ask about (i) higher investments to improve living conditions in disadvantaged neighborhoods

Figure 5: Perceived Magnitude, Concern, and General Policy Demand by Treatment Status along the Distribution of Misperceptions



Notes: The figure reports predicted average responses to the magnitude, concern, and general policy questions for respondents who received the information treatment and those who did not along the distribution of misperceptions. Predictions are based on four-year misperception bins where the indicator for each bin is interacted with the treatment indicator. All predictions are conditional on the full set of control variables (see Table 1). Dependent variable in each prediction is the z-standardized outcome. Calculation of each z-score subtracts the score's control-group mean and divides by the control-group standard deviation.

(e.g., by improving air quality, local public transport or public safety) and (ii) higher taxes on unhealthy food, alcohol, and cigarettes. With respect to education, we ask about (i) increasing public funding of child-care centers and schools in disadvantaged neighborhoods and (ii) expanding education on health-conscious living across all schools. Finally, regarding working conditions, we ask about (i) stricter regulation of workplace safety (e.g., through higher safety requirements or lower limits for noise and air pollution at the workplace) and (ii) enabling an early retirement without deductions for individuals with physically demanding jobs.

Unlike the general policy question studied above, these measures ask respondents to evaluate concrete interventions, providing a complementary test of whether corrected beliefs move policy demand. Table 3 reports the treatment effects on the five area indices and the combined index. There is no significant effect of the information treatment on any policy area or on the combined index, in either country. The coefficients are uniformly small: the effect on the combined index is 0.019 SD in the United States and 0.021 SD in Germany, and no area shows a systematic effect. The absence of an effect holds for underestimators and overestimators alike. Correcting beliefs about the life-expectancy gap thus leaves demand for concrete policies unchanged.

4.3 Robustness and Interpretation of the Treatment Effects

Having established that correcting misperceptions moves perceived magnitude and concern but does considerably less to move policy demand, we now ask whether either finding could be an artifact of our design. For the limited responsiveness of policy demand, we consider whether it reflects a mismatch between the policies we elicit and those respondents find relevant, whether it reflects ceiling effects or neglected trade-offs, and whether it is masked by inattention. For the effects on perceived magnitude and concern, we consider whether they reflect experimenter demand or priming rather than genuine belief updating. We then examine whether responsiveness is concentrated in particular subgroups or moderated by specific beliefs. Across these checks, the effects on perceived magnitude and concern prove robust and persist over time, while the limited pass-through to policy demand proves equally robust, indicating that updating beliefs about the inequality translates only weakly into demand for policies addressing it.

Table 3: Information Treatment Effect on Demand for Specific Policies

	Index components					Index
	Health	Economic	Living	Education	Working	
	(1)	(2)	(3)	(4)	(5)	(6)
	Panel A: United States					
Treatment	0.050	0.069	0.001	-0.046	-0.002	0.019
	(0.048)	(0.044)	(0.048)	(0.048)	(0.048)	(0.046)
Treatment × Overestimated	-0.014	-0.070	0.018	0.051	0.012	-0.001
	(0.056)	(0.052)	(0.056)	(0.056)	(0.057)	(0.053)
Overestimated	0.084**	0.085**	0.106***	0.086**	0.069*	0.112***
	(0.039)	(0.037)	(0.039)	(0.039)	(0.040)	(0.037)
Controls	Yes	Yes	Yes	Yes	Yes	Yes
Adj. R-squared	0.347	0.383	0.217	0.258	0.208	0.411
Treatment effect for Overestimated	0.036	-0.000	0.019	0.005	0.011	0.018
	(0.028)	(0.027)	(0.029)	(0.028)	(0.030)	(0.027)
	Panel B: Germany					
Treatment	0.048	0.013	-0.041	-0.010	0.070	0.021
	(0.041)	(0.040)	(0.046)	(0.045)	(0.046)	(0.039)
Treatment × Overestimated	-0.064	-0.040	0.037	0.001	-0.095*	-0.042
	(0.048)	(0.048)	(0.054)	(0.053)	(0.054)	(0.046)
Overestimated	0.050	0.038	-0.011	0.042	0.096**	0.056*
	(0.035)	(0.034)	(0.038)	(0.039)	(0.039)	(0.034)
Controls	Yes	Yes	Yes	Yes	Yes	Yes
Adj. R-squared	0.143	0.207	0.152	0.167	0.122	0.243
Treatment effect for Overestimated	-0.016	-0.027	-0.005	-0.009	-0.025	-0.021
	(0.026)	(0.026)	(0.029)	(0.028)	(0.028)	(0.024)

Notes: The table reports treatment effects on the outcome index indicated in the column header for the United States in Panel A and Germany in Panel B. Each index is an equally weighted average of z-scores of the underlying outcome variables (see Appendix Table A-1). Calculation of each z-score subtracts the score's control-group mean and divides by the control-group standard deviation of the joint sample. The index in Column (6) is an equally weighted average of all index components. "Treatment" indicates individuals who received the information treatment. "Overestimated" indicates individuals who overestimated the socioeconomic inequality in life expectancy. Controls: gender, age, university degree, ethnicity (US only), birthplace, parental birthplace, partner in household, children in household, income decile, employment status, occupation, region, political orientation, trust in government, belief about control over life expectancy, risk aversion, patience, altruism, health insurance status, self-assessed health status, belief about corona effect on life expectancy, certainty about perceptions, attentiveness, incentive treatment, and perception question order. $N_{US} = 5,432$ and $N_{DE} = 5,400$. Robust standard errors in parentheses. Significance levels: *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

Classification of Top-of-Mind Proposals. We first examine whether our elicited policy domains capture the kinds of interventions respondents spontaneously associate with the life-expectancy gap. This matters because the five policy areas above were constructed from agency reports rather than from respondents' own views. If respondents primarily had different interventions in mind, the limited treatment effects on specific policy demand could partly reflect a mismatch between the policies we ask about and the policies respondents see as relevant. To assess this possibility, we use the open-ended question described in Section 2.3, which asks respondents, before any specific policy is presented, to list measures the government could adopt to improve the life expectancy of poor people.

Following Haaland et al. (2025), we classify each response using a large language model, recording whether it proposes a measure in each of the five predefined areas (health care access, economic stability, living conditions, education, working conditions), in an additional *other* category, or in no area if no policy is proposed.[17] Unlike the raw responses, this classification records whether a respondent mentions a given domain at least once, allowing us to quantify how often each area is proposed.

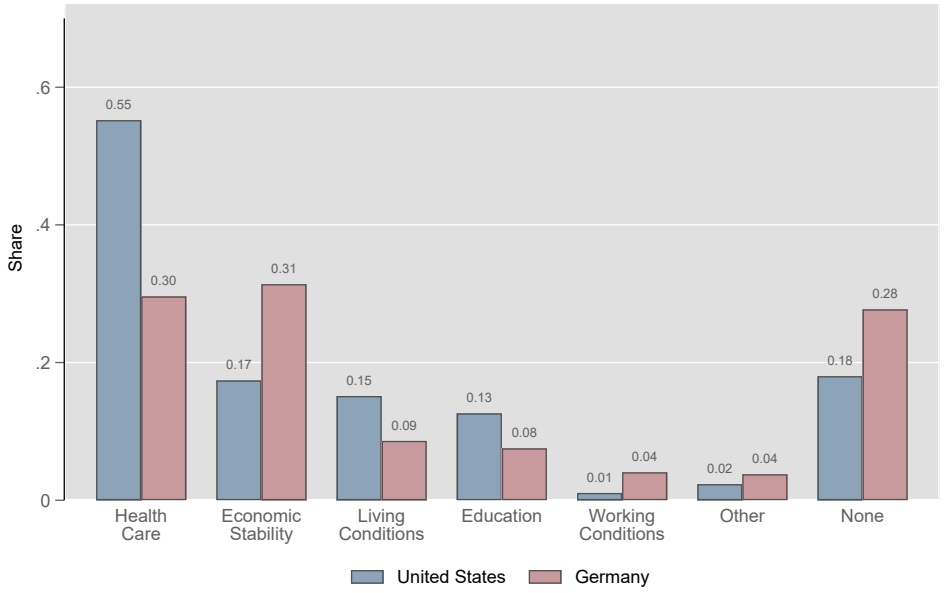
Figure 6 reports the share of respondents in the control group whose answers mention each policy area in the United States and Germany.[18] The predefined areas account for the large majority of proposals. In the United States, health care access is mentioned most often, by more than half of respondents, ahead of all other areas. In Germany, health care access and economic stability are proposed with roughly similar frequency. In both countries, respondents also propose measures relating to living conditions and education, while working conditions are mentioned less frequently. Proposals falling outside the five areas, or naming no policy, are a minority.

Overall, the proposals respondents raise on their own fall predominantly within the five policy areas we elicit. This makes it unlikely that the absence of treatment effects on specific policy demand reflects a mismatch between the policies we ask about and those respondents see as relevant.

[17] Appendix C provides details on the classification procedure. Appendix Figure A-12 summarizes the responses in word clouds for each country. In both countries, the most salient responses relate to *health care access*, with terms such as "health care," "health insurance," "medical care," and "access" appearing prominently.

[18] Note that we do not find effects of the information provision on the number of cloud items mentioned. Nor is there a difference between treatment and control regarding the share of each of the categories. The survey response time does also not differ between treatment and control respondents.

Figure 6: Share of Respondents Mentioning a Specific Policy Area



Notes: The figure reports shares of respondents in the control group mentioning policy measures from one of the specific policy areas (health care, economic stability, living conditions, education or working conditions), from any other policy area, or making no suggestions at all.

Ceiling Effects and Trade-Offs. One potential explanation for the modest treatment effects on policy demand is that baseline support for improving the life expectancy of low-income groups is already high, leaving little room for adjustment. Such a ceiling effect would be consistent with a literature in psychology arguing that some domains, such as health, are treated as sacred and thus shielded from trade-offs with more secular values, such as money, consumption, or employment (Tetlock et al., 2000; Hanselmann & Tanner, 2008).[19] A related concern is that, even where health is not treated as sacred, respondents may not fully account for the economic trade-offs the policies entail, despite our attempt to make them transparent, and therefore express support irrespective of their beliefs about the inequality.[20]

Several patterns speak against ceiling effects or insufficiently salient trade-offs as main drivers of the muted response of policy demand. First, baseline support is lower in the United States than in Germany, leaving more room for treatment-induced movement. Yet, if anything, the effects on general policy demand are somewhat weaker in the United States

[19] Recent survey evidence from the COVID-19 pandemic illustrates this mechanism by showing that many people favored shutdown policies even at high economic costs (Lesschaeve et al., 2021; Settele & Shupe, 2022).

[20] To remind respondents of potential costs, they were shown the following instruction: *When answering, please always bear in mind that implementing the respective measure may tie up financial means and other public resources, which are then no longer available in other areas.*

than in Germany. Second, we exploit variation across the 12 specific policy measures, which differ both in baseline support rates (ranging from 48% to 86%) and in the salience of economic trade-offs. Some policies involve explicit fiscal or distributional trade-offs, such as financing redistribution through higher taxes on the rich or imposing higher taxes on unhealthy food, alcohol, and cigarettes, while others leave such trade-offs less salient. If ceiling effects or neglected trade-offs drove the weak treatment response, effects should be larger for policies with lower baseline support or more salient costs. Appendix Table A-10 reports regressions of policy support, measured as the share of respondents who favor or strongly favor each policy, on the information treatment, with columns ordered by control-group support rates. Baseline support is lowest for higher taxes on unhealthy consumption, expanded employment programs, and greater income redistribution, leaving ample scope for movement. Nevertheless, we find no statistically significant treatment effects for these policies or for any other measure. Nor do the effects vary systematically with the presumed salience of the trade-off each policy entails. The absence of these patterns suggests that ceiling effects and insufficiently salient economic trade-offs are unlikely to be main sources of the limited elasticity of policy demand. Instead, corrected beliefs about the life-expectancy gap appear to have limited pass-through to policy views even when support is moderate and policy costs are relatively explicit.

Attention. In our sample, 38% of respondents fail the attention check. If the information treatment operates through active information processing, its effect should be attenuated among inattentive respondents. Consistent with this prediction, Appendix Table A-11 documents stronger treatment effects on perceived magnitude and concern among attentive respondents in both countries. In the United States, treatment effects on general policy demand remain small and do not differ meaningfully by attention status. In Germany, the treatment effect on general policy demand among attentive respondents reaches 0.27 SD and is statistically significant, but remains small in comparison to those on perceived magnitude and concern. Hence, limited attention is unlikely to explain the modest responsiveness of policy demand.

Experimenter Demand, Social Desirability Bias, and Priming. A standard concern in information experiments is that treatment effects reflect experimenter demand, social-desirability bias, or short-lived priming rather than genuine belief updating (Haaland

et al., 2023; Stantcheva, 2023). While recent evidence suggests that such concerns are generally limited (de Quidt et al., 2018; Mummolo & Peterson, 2019), two features of our design address them. First, the treatment effects on perceived magnitude and concern persist. In the obfuscated follow-up survey two weeks after the main survey, the treatment still moves perceived magnitude in both countries and, among attentive respondents, still separates the concern of over- and underestimators (Appendix Table A-12). General policy demand shows a similar pattern as in the main survey: the treatment effect remains small and becomes statistically insignificant in both countries. That the main-survey results persist in a disguised follow-up survey points to genuine belief updating. Second, the donation decision in the main survey provides a private, incentivized measure less exposed to experimenter demand and other desirability pressures. The treatment leaves donations unchanged (Appendix Table A-13), so the limited responsiveness of demand extends to a real-stakes, incentivized choice.

Heterogeneity. A natural question is whether treatment effects are concentrated in specific population groups for whom inequality perceptions are more strongly associated with policy demand in the control group. We therefore examine heterogeneity by sociodemographic characteristics, including gender, age, education, income, employment status, occupation, insurance status, and self-assessed health (Appendix Figures A-8 to A-11). In the control group, the association between misperceptions and policy demand is modest across all subgroups. Correspondingly, treatment effect heterogeneity is limited and effects rarely exceed 0.25 SD among respondents who underestimated inequality. Among respondents who overestimated inequality, treatment effects on policy demand are generally absent across subgroups.

We also examine heterogeneity by political ideology, trust in government, economic preferences, and attribution beliefs. Among respondents who underestimated inequality, treatment effects on general policy demand are detectable primarily among centrist and left-leaning individuals and among those with higher trust in government. Effects are largely absent among right-leaning respondents and those with low trust. While these patterns are consistent with findings from related information experiments (e.g., Alesina et al., 2018; Lergetporer et al., 2020; Fehr et al., 2022), effect sizes remain small for general

policy demand and are negligible for specific policy demand. Finally, heterogeneity by economic preferences and attribution beliefs is limited and imprecisely estimated.

That the treatment response varies with political ideology and trust in government, while varying little with other characteristics, anticipates their role as principal correlates of the *level* of policy demand, which we examine in Section 5.

Perception Certainty and Pandemic Beliefs. We finally consider two beliefs that might condition how respondents process the information. Approximately 30% of respondents report being uncertain about whether they correctly stated the life expectancy of rich and poor individuals. If information provision primarily affects respondents who held firm but incorrect prior beliefs, treatment effects should be weaker among those who report uncertainty. While point estimates for treatment effects on general policy demand are directionally consistent with this prediction, differences between certain and uncertain respondents remain small and statistically insignificant (Appendix Figures A-8 and A-9). Separately, because the survey was conducted in the aftermath of the COVID-19 pandemic, respondents who perceived our pre-pandemic benchmark information as outdated might respond differently. We therefore elicit whether respondents believe COVID-19 changed life expectancy among the poorest and richest 10%. A majority of 55% of respondents report perceived changes for the poor, and a smaller share of 25% of respondents for the rich. While respondents who believe the pandemic affected life expectancy exhibit larger baseline misperceptions (Figure 3), their treatment effects are similar to those of other respondents (Appendix Figures A-8 and A-9). Therefore, neither belief moderates the treatment response.

5 Political Divides in Policy Demand

The preceding section shows that correcting misperceptions about socioeconomic inequality in life expectancy meaningfully affects perceived magnitude and concern, but only weakly (if at all) affects policy demand. This raises a broader question: how does demand for policies addressing the life-expectancy gap vary across individuals? To answer it, we examine how policy demand differs with respondents' political orientation, self-interest considerations, attribution beliefs, and further sociodemographic characteristics. Unlike the experimental analysis above, this exercise is descriptive rather than causal,

and aims to characterize which respondent characteristics are most strongly associated with policy demand.

We consider three measures of policy demand, in the order they appear in the survey: general support for government action, spontaneous (top-of-mind) policy proposals, and support for specific policy measures. In the United States, political orientation, captured by left-right ideology and trust in government, is more strongly associated with demand than self-interest, attribution beliefs, or sociodemographic characteristics, across all three measures. In Germany, this pattern does not hold: the political gaps are considerably smaller and no longer stand apart from other correlates, such as self-interest.

In the main text, we present the detailed set of factors for general policy demand. For top-of-mind proposals and specific policies, we focus on political orientation and provide a more detailed analysis in Appendix Figures A-13 and A-14.

5.1 Differences in General Policy Demand

We begin with general support for government intervention, measured by agreement with the statement that the government should do more to improve the life expectancy of poor people. We consider four sets of factors. Political orientation, captured by left-right ideology and trust in government, reflects broader views about the appropriate role of the government.[21] Self-interest, captured by income, subjective health, and health insurance status, reflects how much a respondent personally stands to gain from health-equity policies. Attribution beliefs, captured by whether respondents see longevity as a matter of effort or of circumstance, reflect how much responsibility they assign to the individual. The remaining sociodemographic characteristics, including gender, age, and education, capture standard population groups.

Figure 7 reports the relevance of these factors for the United States and Germany. For each factor, it shows the difference in the share of respondents who agree or strongly agree, between two groups distinguished by the factor of interest. Each difference is reported both unconditionally and after conditioning on the full set of remaining characteristics, including perceptions of the life-expectancy gap. The unconditional difference is the raw gap between groups; the conditional difference isolates the association with the character-

[21] Trust in government may partly reflect approval of the sitting administration rather than a stable disposition toward the role of government. We therefore read the cross-country comparison of the trust gradient with this caveat in mind and note that the gradient by left-right ideology, which is less exposed to this concern, displays the same cross-country pattern.

istic of interest from those of other observed characteristics. In particular, when we report the difference by political ideology, we condition on trust in government, and conversely, so that the two concepts are not collapsed into one.[22]

In the United States, the ordering of factors is clear. General policy demand varies most with political orientation: the gaps by ideology and by trust in government each reach around 30 percentage points unconditionally and remain the largest in the figure, at roughly 20 percentage points, after conditioning. By contrast, demand varies far less with self-interest, with gaps by income, subjective health, and insurance status staying within a few percentage points throughout. Attribution beliefs matter somewhat, as respondents who see longevity as outside one's control are more supportive, but this gap also shrinks to a few percentage points once other characteristics are held fixed. The sociodemographic differences by gender, age, or education, are smaller still and nowhere near the political gaps. Hence, in the United States, demand is structured by political orientation far more than by self-interest, attribution beliefs, or sociodemographic position.

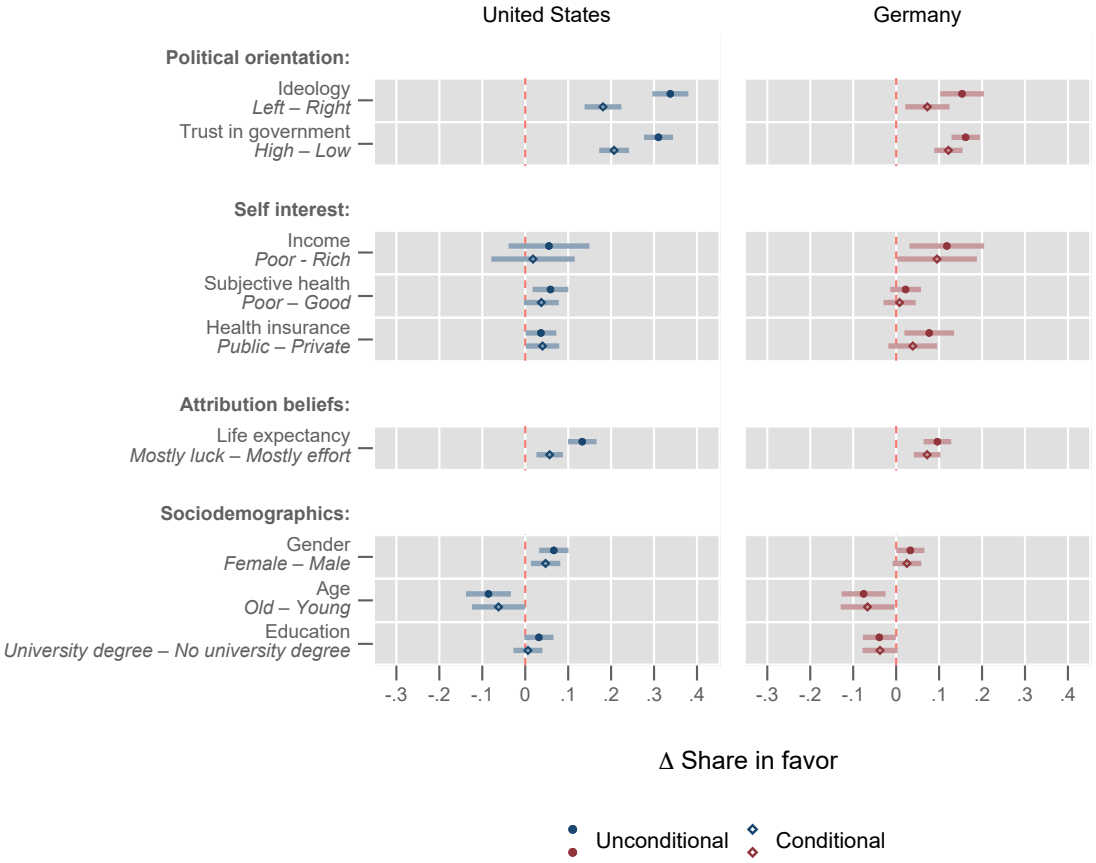
In Germany, the same factors are present but their magnitudes differ. The political gaps are roughly half as large as in the United States and they no longer stand out. The income gradient is comparable to the contrasts by ideology and trust, both unconditionally and after conditioning. Attribution beliefs also reach a similar size. Differences by gender, age, and education remain small, as in the United States. Hence, support for government action to address the life-expectancy gap is structured by political orientation in the United States to a degree that has no counterpart in Germany.

5.2 Political Differences in Top-of-Mind Proposals

The preceding analysis shows that general policy demand is structured by political orientation in the United States but much less so in Germany. We next ask whether the same holds for the policies respondents propose on their own, using the classified open-ended responses. For each policy area, we compute the difference in the share of respondents who propose a measure in that area, between left- and right-leaning respondents and between respondents with high and low trust in government.

[22] Political ideology and trust in government are correlated with $\rho = 0.219$ in the United States and $\rho = 0.174$ in Germany. Conditioning each on the other reduces the associated differences but leaves both sizable, indicating that the two capture dimensions of policy demand that are related but distinct.

Figure 7: Differences in General Policy Demand



Notes: The figure shows differences in general policy demand across population groups in the control group. For each characteristic, it plots the difference in the share of respondents who agree or strongly agree that the government should do more to improve the life expectancy of poor people, between the two groups indicated. Groups are defined as follows. Ideology: *left* if 1–4 and *right* if 7–10 on a 10-point left–right scale. Trust in government: *high* if above zero on a country-specific standardized trust index, *low* otherwise. Income: *poor* (*rich*) if in the 1st (10th) income decile. Subjective health: *poor* if self-assessed health status is poor or fair, *good* if good, very good, or excellent. Health insurance: *public* versus *private*. Attribution belief: *mostly luck* if 1–5 and *mostly effort* if 6–10 on a 10-point scale. Age: *old* if 60–70, *young* if 18–29. Gender and education are binary as labeled. Dots indicate the unconditional difference between groups; diamonds indicate the difference after conditioning on the full set of sociodemographic characteristics, preferences and beliefs (see Table 1), as well as indicators for perceived life-expectancy differences in four-year bins. Horizontal bars indicate 95% confidence intervals.

Figure 8 shows that the political structuring of proposals is specific to health policy in the United States. Left-leaning respondents are substantially more likely than right-leaning respondents to propose a health-care measure, by more than 30 percentage points unconditionally and more than 20 percentage points after conditioning on the full set of remaining characteristics, including perceptions of the life-expectancy gap. No other area shows a comparable gap. The differences by trust in government follow the same ordering across domains, with health care again being the dominant domain. Left-leaning and high-trust respondents are also less likely to propose no policy at all, indicating that they more often have a concrete measure in mind. In Germany, none of the policy areas displays a difference of comparable size, by either ideology or trust.

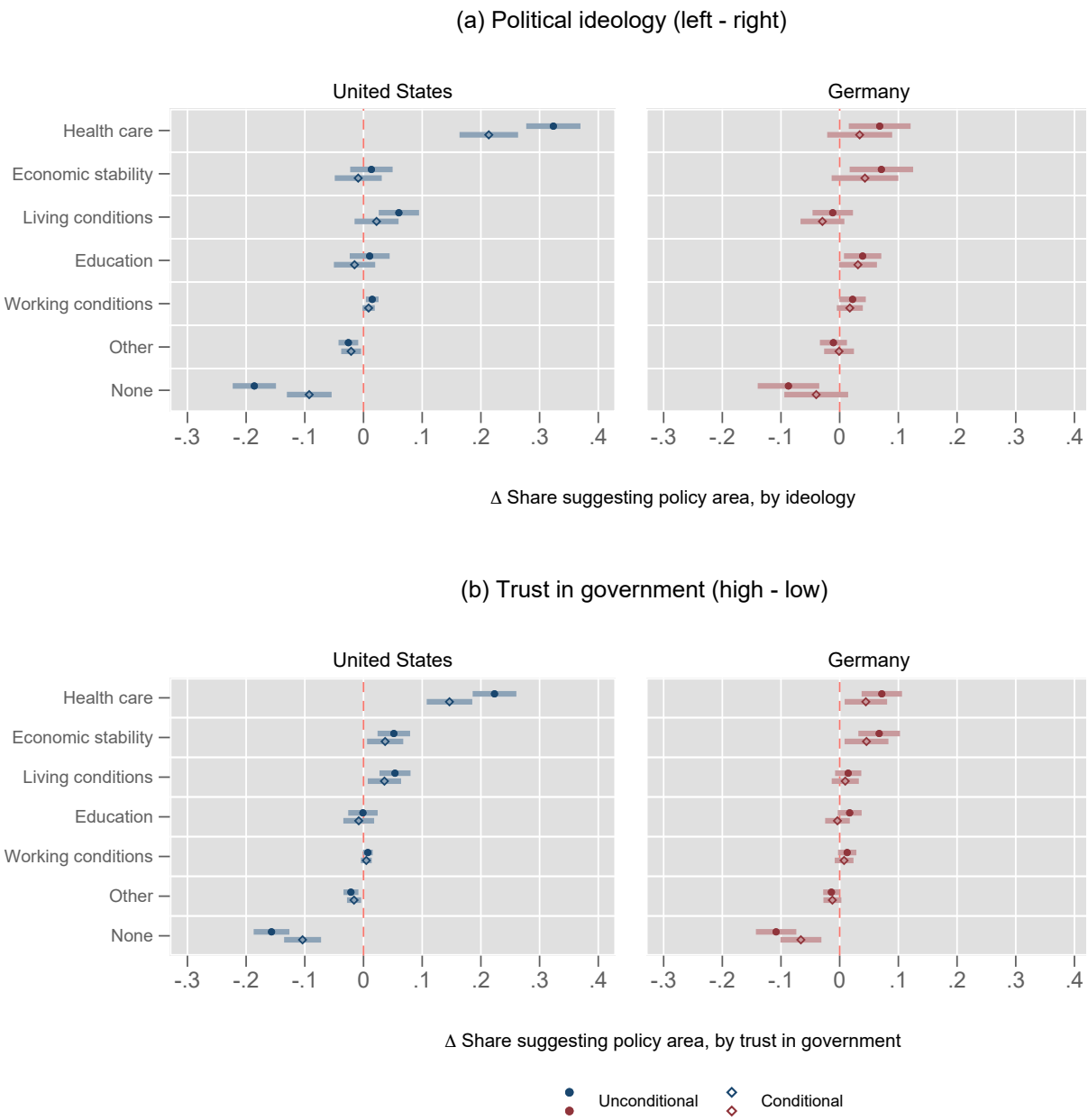
The political divide in what Americans spontaneously propose is thus concentrated on health care and is absent in Germany. We next ask whether this concentration persists once respondents evaluate a fixed set of concrete policies.

5.3 Political Differences in Specific Policy Demand

Top-of-mind proposals reveal which areas respondents spontaneously associate with the life-expectancy gap, but they do not reveal how respondents evaluate areas they do not raise on their own. We therefore turn to the specific policy indices, which record support for a fixed set of measures in each of the five areas, and compute the difference in each index between left- and right-leaning respondents, as well as between respondents with high and low trust in government. Figure 9 reports these differences in standard deviations of the pooled control group, since the specific-policy outcomes are indices rather than binary shares.

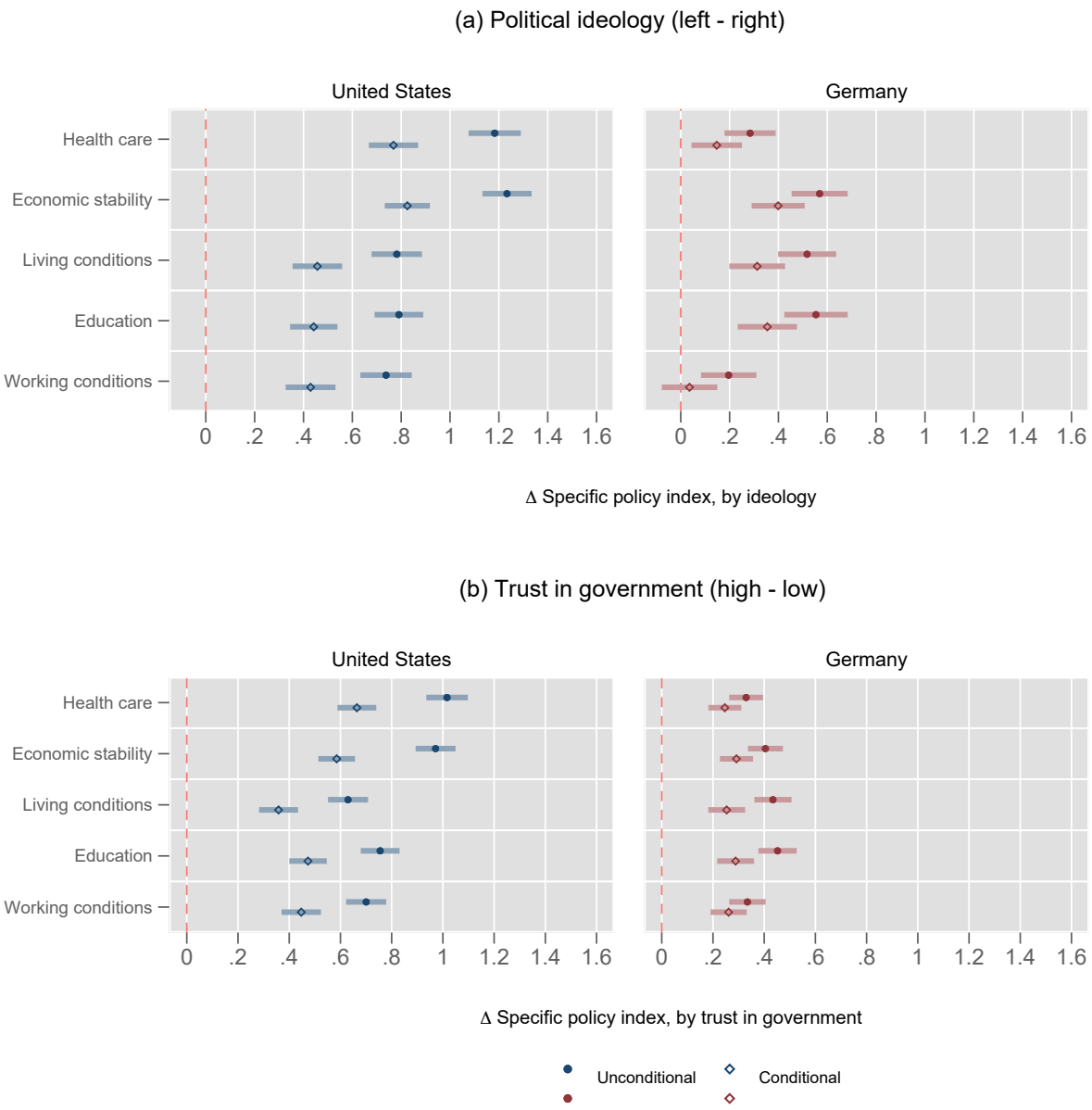
In the United States, all five areas display differences by political orientation. Differences by ideology range from about 0.7 to 1.2 standard deviations unconditionally and from roughly 0.45 to 0.8 after conditioning. Health care and economic stability show the largest differences, and living conditions, education, and working conditions smaller ones. The ordering by trust in government coincides with the ordering by ideology. Therefore, when respondents evaluate concrete measures, the political divide is no longer confined to health care, as it was among top-of-mind proposals, but extends across all five areas. The domain respondents most often raise on their own is thus not the only one over which their attitudes divide politically.

Figure 8: Political Differences in Top-of-Mind Proposals



Notes: The figure shows differences in top-of-mind policy proposals across political groups in the control group. For each policy area, it plots the difference in the share of respondents who spontaneously propose a measure in that area, between left- and right-leaning respondents in panel (a) and between respondents with high and low trust in government in panel (b). Proposals are classified from open-ended responses into five areas (health care, economic conditions, living conditions, education, working conditions), an *other* category, and *none* if no measure is proposed. Groups are defined as follows. Ideology: *left* if 1–4 and *right* if 7–10 on a 10-point left–right scale. Trust in government: *high* if above zero on a country-specific standardized trust index, *low* otherwise. Dots indicate the unconditional difference between groups; diamonds indicate the difference after conditioning on the full set of sociodemographic characteristics, preferences and beliefs (see Table 1), as well as indicators for perceived life-expectancy differences in four-year bins. Horizontal bars indicate 95% confidence intervals. Appendix Figure A-13 reports differences in top-of-mind proposals with respect to self-interest, attribution beliefs, and further sociodemographic characteristics.

Figure 9: Political Differences in Specific Policy Demand



Notes: The figure shows political differences in specific policy demand across political groups in the control group. For each of the five policy areas, it plots the difference in the specific policy index, expressed in standard deviations of the pooled control group, between left- and right-leaning respondents in panel (a) and between respondents with high and low trust in government in panel (b). Groups are defined as follows. Ideology: *left* if 1–4 and *right* if 7–10 on a 10-point left–right scale. Trust in government: *high* if above zero on a country-specific standardized trust index, *low* otherwise. Dots indicate the unconditional difference between groups; diamonds indicate the difference after conditioning on the full set of sociodemographic characteristics, preferences and beliefs (see Table 1), as well as indicators for perceived life-expectancy differences in four-year bins. Horizontal bars indicate 95% confidence intervals. Appendix Figure A-14 reports differences in specific policy demand with respect to self-interest, attribution beliefs, and further sociodemographic characteristics.

Germany stands out in two respects. First, the differences by political orientation are smaller throughout, below those in the United States in every area, both unconditionally and after conditioning. Second, the ordering across areas differs: health policy, together with working conditions, shows the smallest political differences in Germany, whereas economic stability, living conditions, and education exhibit larger ones. Health policy thus occupies opposite positions in the two countries, being the area with the largest partisan divide in the United States but one of the smallest in Germany.

5.4 Summary and Interpretation

The evidence in this section complements the experimental findings from Section 4. While the experiment shows that correcting misperceptions about socioeconomic inequality in life expectancy changes perceptions and concern but has only limited effects on policy demand, the correlational evidence here addresses a different question: which characteristics are most strongly associated with variation in policy demand across individuals. In the United States, the strongest associations across all three measures of demand are with political orientation, measured by left-right ideology and trust in government. These political associations dominate those with self-interest, attribution beliefs, or sociodemographic characteristics. In Germany, the political gradients are considerably smaller and no longer stand apart from other correlates. Political orientation thus organizes policy demand in the United States to a much larger degree than in Germany.

The role of political orientation thus appears to be country-specific. In the United States, where health policy is among the most politically divisive domains (Viskupič & Wiltse, 2023; Del Ponte et al., 2024; Elder & O'Brian, 2026), support for policies addressing the life-expectancy gap varies systematically with left-right ideology and trust in government. In Germany, where the health system is organized around a broadly accepted solidarity principle (Zok & Jacobs, 2023), political differences in support for addressing the gap are smaller. This pattern does not reflect weaker demand for government action, which is if anything somewhat higher in Germany. It suggests instead that the same policies are filtered through different political lenses across institutional settings.

Taken together, the experimental and correlational evidence support a similar interpretation. The experiment identifies a limited causal role for beliefs about the inequality, while the correlational analysis shows that demand is, especially in the United States,

associated more strongly with broader political orientations than with other personal characteristics and perceptions of the life-expectancy gap. These associations should not be read as causal, but they indicate that views about the role of government are a central organizing dimension of policy demand in this domain.

6 Conclusion

This paper studies how the public perceives socioeconomic inequality in life expectancy and how those perceptions relate to demand for policy, using pre-registered survey experiments with approximately 6,000 respondents each in the United States and Germany. Respondents in both countries substantially overestimate the rich–poor gap in life expectancy because they judge the life expectancy of high-income individuals roughly accurately but place that of low-income individuals well below its true level. These misperceptions are widely shared, varying little across sociodemographic groups or along the political spectrum, and financial incentives for accuracy do not reduce them.

Correcting these misperceptions moves how respondents perceive and assess the inequality, raising their sense of its magnitude and their concern about it, but does considerably less to move demand for policy. The pass-through to general policy demand is weak, and demand for concrete policies does not respond at all. A range of checks indicates that this limited responsiveness is not an artifact of the design. The policy areas we ask about are those respondents themselves associate with the gap, and the weak response does not reflect ceiling effects or neglected trade-offs, persists among attentive respondents and in an obfuscated two-week follow-up, and extends to a real-stakes donation decision. Correcting a factual belief about the magnitude of the life-expectancy gap thus does little to change demand for policies that would address it.

While beliefs about the inequality contribute little to policy demand, political orientation is strongly associated with it. Across several measures of demand, support varies most with left–right ideology and trust in government, and considerably less with self-interest, attribution beliefs, or perceptions of the gap itself. This political structuring is pronounced in the United States but considerably weaker in Germany, where demand for government action is, if anything, higher and divides less sharply along political lines. These patterns are correlational and cannot isolate the role of any single institutional feature, but together they point away from factual beliefs and toward views about the

role of government as the central organizing dimension of demand. Providing information about the extent of socioeconomic inequality in life expectancy may therefore raise public concern without shifting policy demand, when that demand is already embedded in broader political worldviews.

References

Alesina, A., Miano, A., & Stantcheva, S. (2020). The Polarization of Reality. *AEA Papers and Proceedings*, *110*, 324–328.

Alesina, A., Miano, A., & Stantcheva, S. (2023). Immigration and Redistribution. *Review of Economic Studies*, *90*(1), 1-39.

Alesina, A., Stantcheva, S., & Teso, E. (2018). Intergenerational Mobility and Preferences for Redistribution. *American Economic Review*, *108*(2), 521-554.

Anderson, M. L. (2008). Multiple Inference and Gender Differences in the Effects of Early Intervention: A Reevaluation of the Abecedarian, Perry Preschool, and Early Training Projects. *Journal of the American Statistical Association*, *103*(484), 1481-1495.

Ansolabehere, S., Meredith, M., & Snowberg, E. (2013). Asking about Numbers: Why and How. *Political Analysis*, *21*(1), 48–69.

Bosworth, B., Burtless, G., & Zhang, K. (2016). Later Retirement, Inequality in Old Age, and the Growing Gap in Longevity between Rich and Poor. *Economic Studies at Brookings*, *87*, 1–166.

Bottan, N. L., & Perez-Truglia, R. (2022). Choosing Your Pond: Location Choices and Relative Income. *Review of Economics and Statistics*, *104*(5), 1010-1027.

Braveman, P. A., Cubbin, C., Egerter, S., Williams, D. R., & Pamuk, E. (2010). Socioeconomic Disparities in Health in the United States: What the Patterns Tell Us. *American Journal of Public Health*, *100*(S1), S186–S196.

Bublitz, E. (2022). Misperceptions of Income Distributions: Cross-Country Evidence from a Randomized Survey Experiment. *Socio-Economic Review*, *20*(2), 435–462.

Chetty, R., Stepner, M., Abraham, S., Lin, S., Scuderi, B., Turner, N., ... Cutler, D. (2016). The Association between Income and Life Expectancy in the United States, 2001-2014. *Journal of the American Medical Association*, *315*(16), 1750-1766.

Chopra, F., Haaland, I., & Roth, C. (2022). Do People Demand Fact-Checked News? Evidence from U.S. Democrats. *Journal of Public Economics*, *205*, 104549.

Cruces, G., Perez-Truglia, R., & Tetaz, M. (2013). Biased Perceptions of Income Distribution and Preferences for Redistribution: Evidence from a Survey Experiment. *Journal of Public Economics*, *98*, 100-112.

Del Ponte, A., Gerber, A. S., & Patashnik, E. M. (2024). Polarization, the Pandemic, and Public Trust in Health System Actors. *Journal of Health Politics, Policy and Law,*, *49*(3), 375-401.

de Quidt, J., Haushofer, J., & Roth, C. (2018). Measuring and Bounding Experimenter Demand. *American Economic Review*, *108*(11), 3266-3302.

Dylong, P., & Uebelmesser, S. (2024). Biased Beliefs about Immigration and Economic Concerns: Evidence from Representative Experiments. *Journal of Economic Behavior & Organization*, *217*, 453-482.

Elder, E., & O'Brian, N. A. (2026). The Political Polarization of Health Outcomes in the USA. *Nature Human Behavior*, *forthcoming*.

Engelhardt, C., & Wagener, A. (2018). What Do Germans Think and Know about Income Inequality? A Survey Experiment. *Socio-Economic Review*, *16*(4), 743-767.

Enke, B., & Graeber, T. (2023). Cognitive Uncertainty. *Quarterly Journal of Economics*, *138*(4), 2021-2067.

Fehr, D., Mollerstrom, J., & Perez-Truglia, R. (2022). Your Place in the World: Relative Income and Global Inequality. *American Economic Journal: Economic Policy*, *14*(4), 232-268.

Ferrario, B., & Stantcheva, S. (2022). Eliciting People's First-Order Concerns: Text Analysis of Open-Ended Survey Questions. *AEA Papers and Proceedings*, *112*, 163-169.

Ferrario, B., & Stantcheva, S. (2026). How Americans Think about Health Care and Insurance. *Tax Policy and the Economy*, *40*, 109-169.

Fuller, D., Neudorf, J., Bermedo-Carrasco, S., & Neudorf, C. (2016). Classifying the Population by Socioeconomic Factors Associated with Support for Policies to Reduce Social Inequalities in Health. *Journal of Public Health*, *38*(4), 635-643.

Grewenig, E., Lergetporer, P., Werner, K., & Woessmann, L. (2020). Incentives, Search Engines, and the Elicitation of Subjective Beliefs: Evidence from Representative Online Survey Experiments. *Journal of Econometrics*, *231*(1), 304-326.

Grigorieff, A., Roth, C., & Ubfal, D. (2020). Does Information Change Attitudes Toward Immigrants? *Demography*, *57*(3), 1117-1143.

Haaland, I., & Roth, C. (2020). Labor Market Concerns and Support for Immigration. *Journal of Public Economics*, *191*, 104256.

Haaland, I., & Roth, C. (2023). Beliefs about Racial Discrimination and Support for Pro-Black Policies. *Review of Economics and Statistics*, *105*(1), 40-53.

Haaland, I., Roth, C., Stantcheva, S., & Wohlfart, J. (2025). Understanding Economic Behavior Using Open-ended Survey Data. *Journal of Economic Literature*, *63*(4), 1244–1280.

Haaland, I., Roth, C., & Wohlfart, J. (2023). Designing Information Provision Experiments. *Journal of Economic Literature*, *61*(1), 3-40.

Hanselmann, M., & Tanner, C. (2008). Taboos and Conflicts in Decision Making: Sacred Values, Decision Difficulty, and Emotions. *Judgment and Decision Making*, *3*(1), 51-63.

Heller, S. B., Shah, A. K., Guryan, J., Ludwig, J., Mullainathan, S., & Pollack, H. A. (2017). Thinking, Fast and Slow? Some Field Experiments to Reduce Crime and Dropout in Chicago. *Quarterly Journal of Economics*, *132*(1), 1-54.

Hoy, C., & Mager, F. (2021). Why Are Relatively Poor People Not More Supportive of Redistribution? Evidence from a Randomized Survey Experiment across Ten Countries. *American Economic Journal: Economic Policy*, *13*(4), 299–328.

Hvidberg, K. B., Kreiner, C. T., & Stantcheva, S. (2023). Social Positions and Fairness Views on Inequality. *Review of Economic Studies*, *90*(6), 3083-3118.

Jessen, L. J., Koehne, S., Nüß, P., & Ruhose, J. (2022). *Inequality in Life Expectancy – (Mis)Perception and Policy Demand.* AEA RCT Registry, ID AEARCTR-0009711. Retrieved from https://www.socialscienceregistry.org/trials/9711

Karadja, M., Mollerstrom, J., & Seim, D. (2017). Richer (and Holier) Than Thou? The Effect of Relative Income Improvements on Demand for Redistribution. *Review of Economics and Statistics*, *99*(2), 201-212.

Kling, J. R., Liebman, J. B., & Katz, L. F. (2007). Experimental Analysis of Neighborhood Effects. *Econometrica*, *75*(1), 83-119.

Kuziemko, I., Norton, M. I., Saez, E., & Stantcheva, S. (2015). How Elastic Are Preferences for Redistribution? Evidence from Randomized Survey Experiments. *American Economic Review*, *105*(4), 1478–1508.

Lampert, T., Hoebel, J., & Kroll, L. E. (2019). Soziale Unterschiede in der Mortalität und Lebenserwartung in Deutschland - Aktuelle Situation und Trends. *Journal of Health Monitoring*, *4*(1), 3-15.

Lergetporer, P., Werner, K., & Woessmann, L. (2020). Educational Inequality and Public Policy Preferences: Evidence from Representative Survey Experiments. *Journal of Public Economics*, *188*, 104226.

Lergetporer, P., & Woessmann, L. (2022). *Income Contingency and the Electorate's Support for Tuition.* IZA Discussion Paper No. 14991.

Lesschaeve, C., Glaurdic, J., & Mochtak, M. (2021). Health versus Wealth during the Covid-19 Pandemic. *Public Opinion Quarterly*, *85*(3), 808-835.

Mackenbach, J. P., Stirbu, I., Roskam, A.-J. R., Schaap, M. M., Menvielle, G., Leinsalu, M., & Kunst, A. E. (2008). Socioeconomic Inequalities in Health in 22 European Countries. *New England Journal of Medicine*, *358*(23), 2468–2481.

Malhotra, N., & Krosnick, J. A. (2007). The Effect of Survey Mode and Sampling on Inferences about Political Attitudes and Behavior: Comparing the 2000 and 2004 ANES to Internet Surveys with Nonprobability Samples. *Political Analysis*, *15*(3), 286–323.

Marmot, M. (2005). Social Determinants of Health Inequalities. *The Lancet*, *365*(9464), 1099–1104.

Meara, E. R., Richards, S., & Cutler, D. M. (2008). The Gap Gets Bigger: Changes in Mortality and Life Expectancy, by Education, 1981–2000. *Health Affairs*, *27*(2), 350–360.

Mummolo, J., & Peterson, E. (2019). Demand Effects in Survey Experiments: An Empirical Assessment. *Ameerican Political Science Review*, *113*(2), 517-529.

National Academies of Sciences, Engineering, and Medicine and Committee on Population. (2015). *The Growing Gap in Life Expectancy by Income: Implications for Federal Programs and Policy Responses*. National Academies Press.

Norton, M. I., & Ariely, D. (2011). Building a Better America—One Wealth Wuintile at a Time. *Perspectives on Psychological Science*, *6*(1), 9–12.

Olshansky, S. J., Antonucci, T., Berkman, L., Binstock, R. H., Boersch-Supan, A., Cacioppo, J. T., ... Rowe, J. (2012). Differences in Life Expectancy Due to Race and Educational Differences Are Widening, and Many May Not Catch Up. *Health Affairs*, *31*(8), 1803–1813.

Roth, C., Settele, S., & Wohlfart, J. (2022). Beliefs about public debt and the demand for government spending. *Journal of Econometrics*, *231*(1), 165–187.

Roth, C., & Wohlfart, J. (2020). How Do Expectations about the Macroeconomy Affect Personal Expectations and Behavior? *Review of Economics and Statistics*, *102*(4), 731-748.

Schuetz, J. (2026). Beliefs about the Gender Pension Gap. *European Economic Review*, *184*, 105244.

Schuetz, J., Uebelmesser, S., Baginski, R., & Aprea, C. (2023). Pension Reform Preferences in Germany: Does Information Matter? *European Journal of Political Economy*, *80*, 102476.

Settele, S. (2022). How Do Beliefs about the Gender Wage Gap Affect the Demand for Public Policy? *American Economic Journal: Economic Policy*, *14*(2), 475-508.

Settele, S., & Shupe, C. (2022). Lives or Livelihoods? Perceived Trade-Offs and Policy Views. *Economic Journal*, *132*(643), 1150-1178.

Stantcheva, S. (2023). How to Run Surveys: A Guide to Creating Your Own Identifying Variation and Revealing the Invisible. *Annual Review of Economics*, *15*, 205-234.

Stumpf, E., Schuetz, J., Uebelmesser, S., Baginski, R., & Aprea, C. (2026). Beliefs about Demographic Change: How well Are Individuals Informed? *Journal of Pension Economics & Finance*, *25*(1), 43-71.

Tetlock, P. E., Kristel, O. V., Elson, S. B., Green, M. C., & Lerner, J. S. (2000). The Psychology of the Unthinkable: Taboo Trade-offs, Forbidden Base Rates, and Heretical Counterfactuals. *Journal of Personality and Social Psychology*, *78*(5), 853-870.

Towe, V. L., May, L. W., Huang, W., Martin, L. T., Carman, K., Miller, C. E., & Chandra, A. (2021). Drivers of differential views of health equity in the u.s.: is the u.s. ready to make progress? results from the 2018 national survey of health attitudes. *BMC Public Health*, *21*, 175.

U.S. Department of Health and Human Services. (2023). *Healthy People 2030 - Social Determinants of Health.* https://health.gov/healthypeople/priority-areas/social-determinants-health. (Accessed on June 30, 2023.)

Van Bavel, J. J., Gadarian, S. K., Knowles, E. D., & Ruggeri, K. (2024). Political Polarization and Health. *Nature Medicine*, *30*, 3085-3093.

Viskupič, F., & Wiltse, D. L. (2023). Political Partisanship and Trust in Government Predict Popular Support for COVID-19 Vaccine Mandates for Various Professions and Demographic Groups: A Research Note. *American Politics Research*, *51*(2), 139-146.

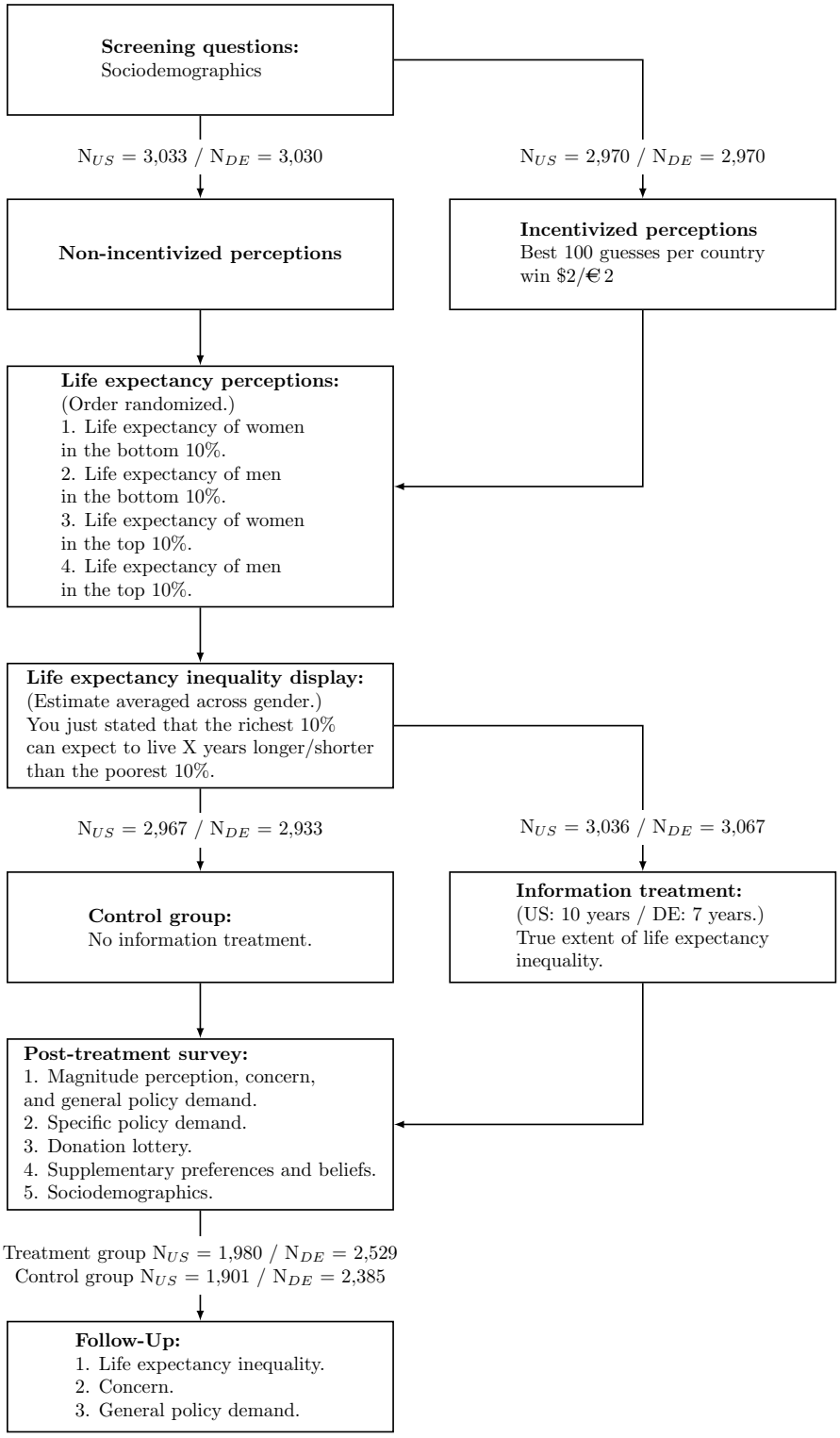
World Health Organization. (2019). *Health Equity Policy Tool - A Framework to Track Policies for Increasing Health Equity in the WHO European Region.* Meeting Report. World Health Organization Regional Office for Europe.

Zok, K., & Jacobs, K. (2023). Solidarität steht hoch im Kurs - Ergebnisse einer Repräsentativumfrage unter gesetzlich und privat Krankenversicherten. *WIdOmonitor*, *21*(1), 1-16.

Online Appendix

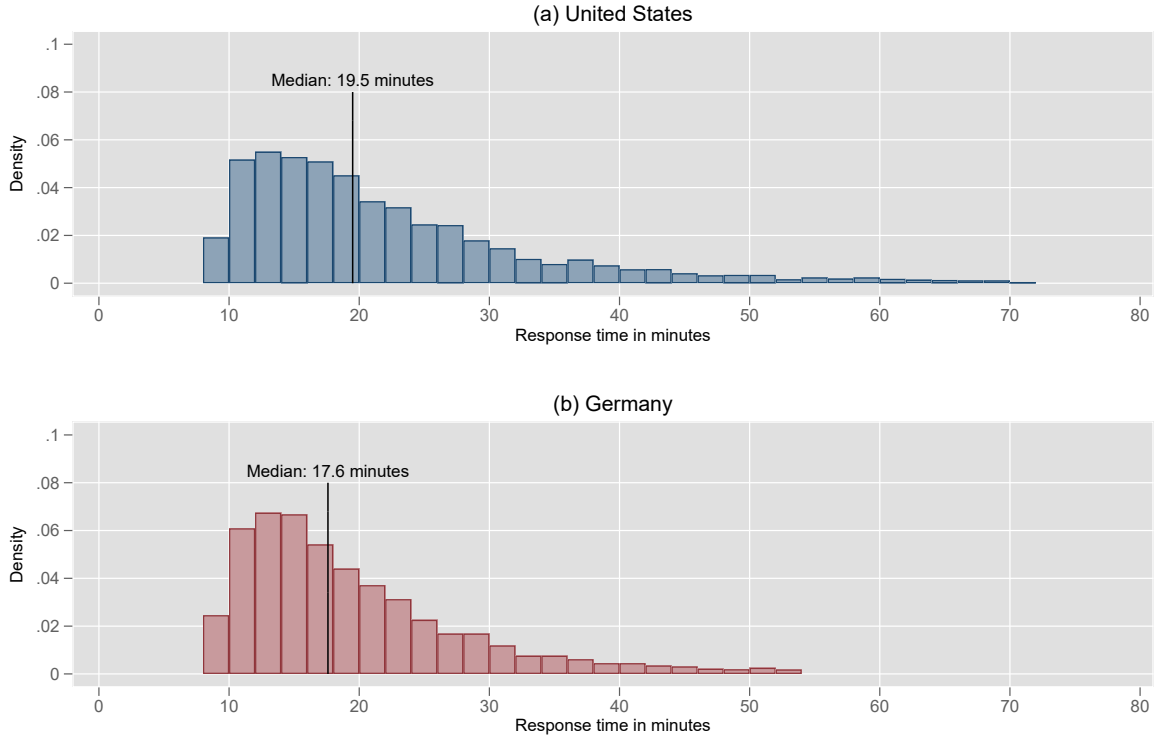
A Appendix Figures and Tables

Figure A-1: Overview of the Survey and the Information Experiment



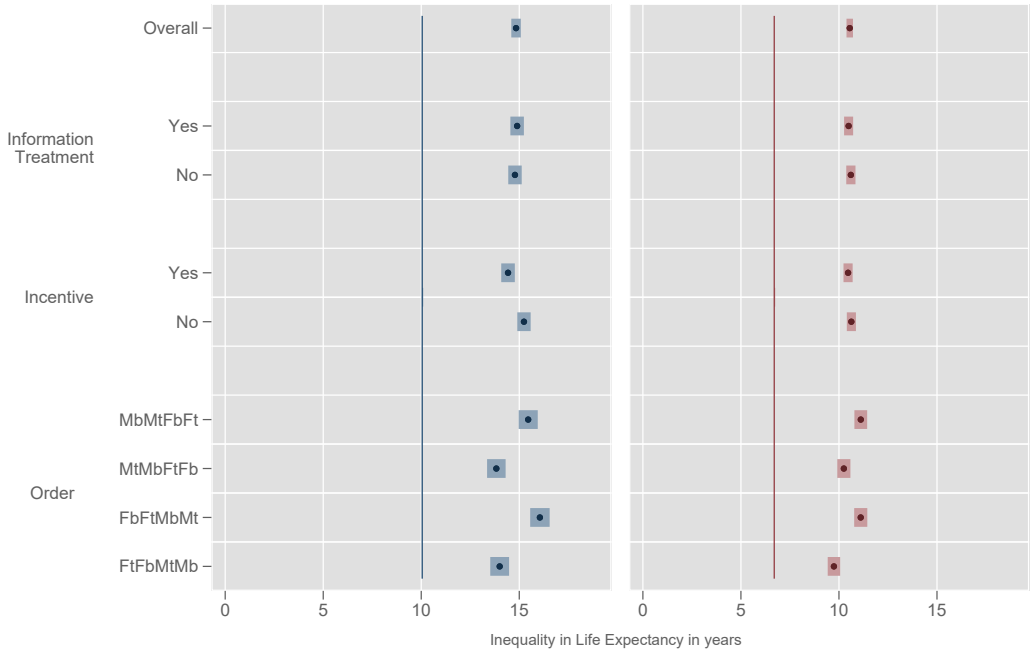
Notes: The figure shows the setup of the experiment for both countries. The planned total number of observations was 6,000 respondents in each country. Half of the sample is assigned to the treatment group.

Figure A-2: Distribution of Main Survey Response Times



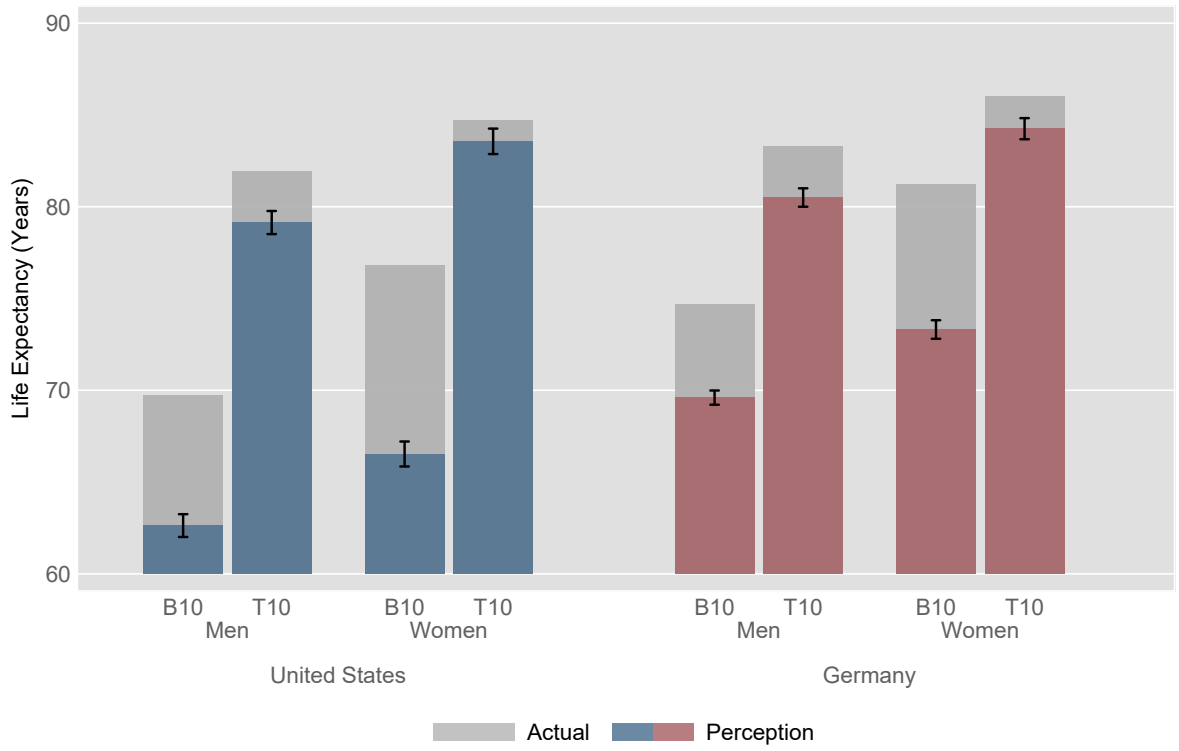
Notes: The figure shows the distribution of survey response times in the main survey. Participants with response times longer than the 95th percentile are excluded for illustrative purpose.

Figure A-3: Average Misperceptions by Treatment Groups



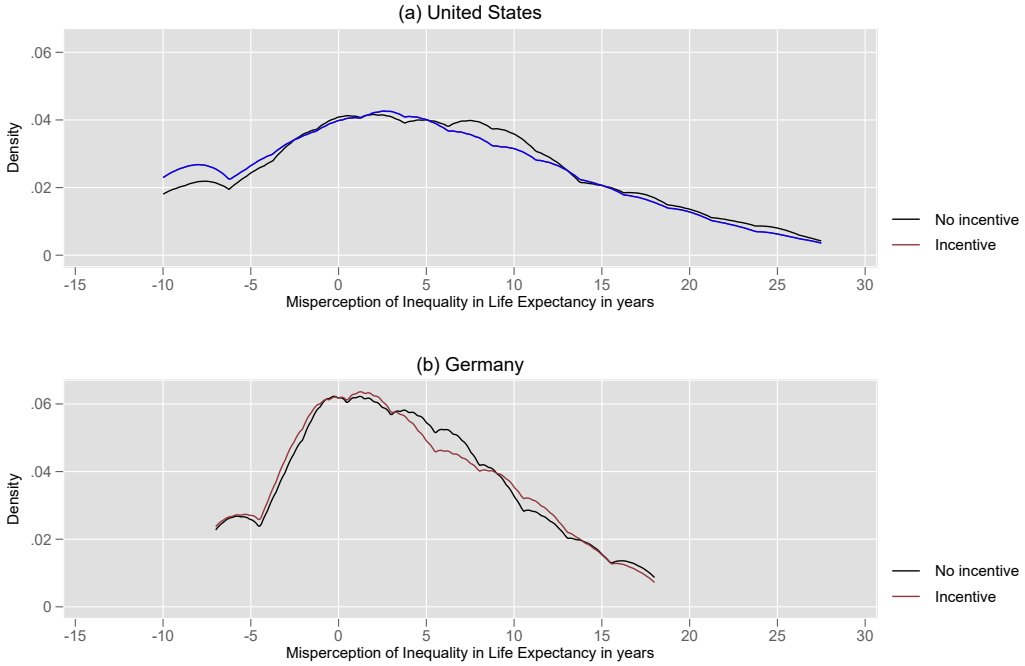
Notes: The figure shows the average perception of the socioeconomic inequality in life expectancy by different treatment groups. In the "order"-treatment, *Mb* stands for male bottom 10%, *Mt* for male top 10%, *Fb* for female bottom 10%, and *Ft* for female top 10%.

Figure A-4: Between-Subject Perceptions about Life Expectancy of Men and Women in the Bottom/Top-10%



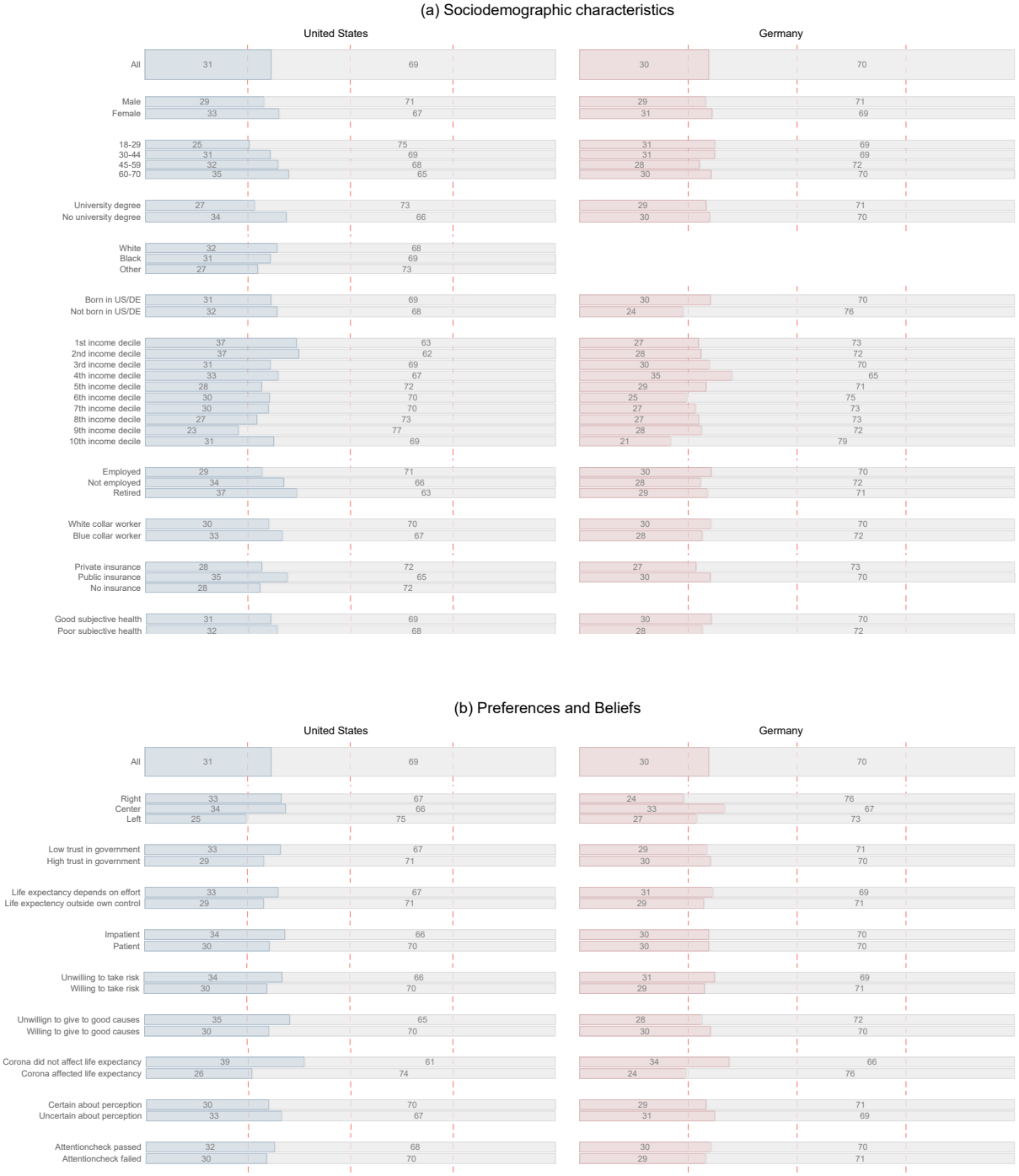
Notes: The figure shows the average perceived and actual life expectancy of men and women in the bottom 10% and the top 10% of the household income distribution when we restrict the analysis to the first perception question for each respondent. The whiskers around the averages indicate 95% confidence intervals. The actual numbers are obtained from Chetty et al. (2016) for the United States and Lampert et al. (2019) for Germany (see Appendix B for details).

Figure A-5: Kernel Density Plots of the Distribution of Misperceptions by Monetary Incentivization



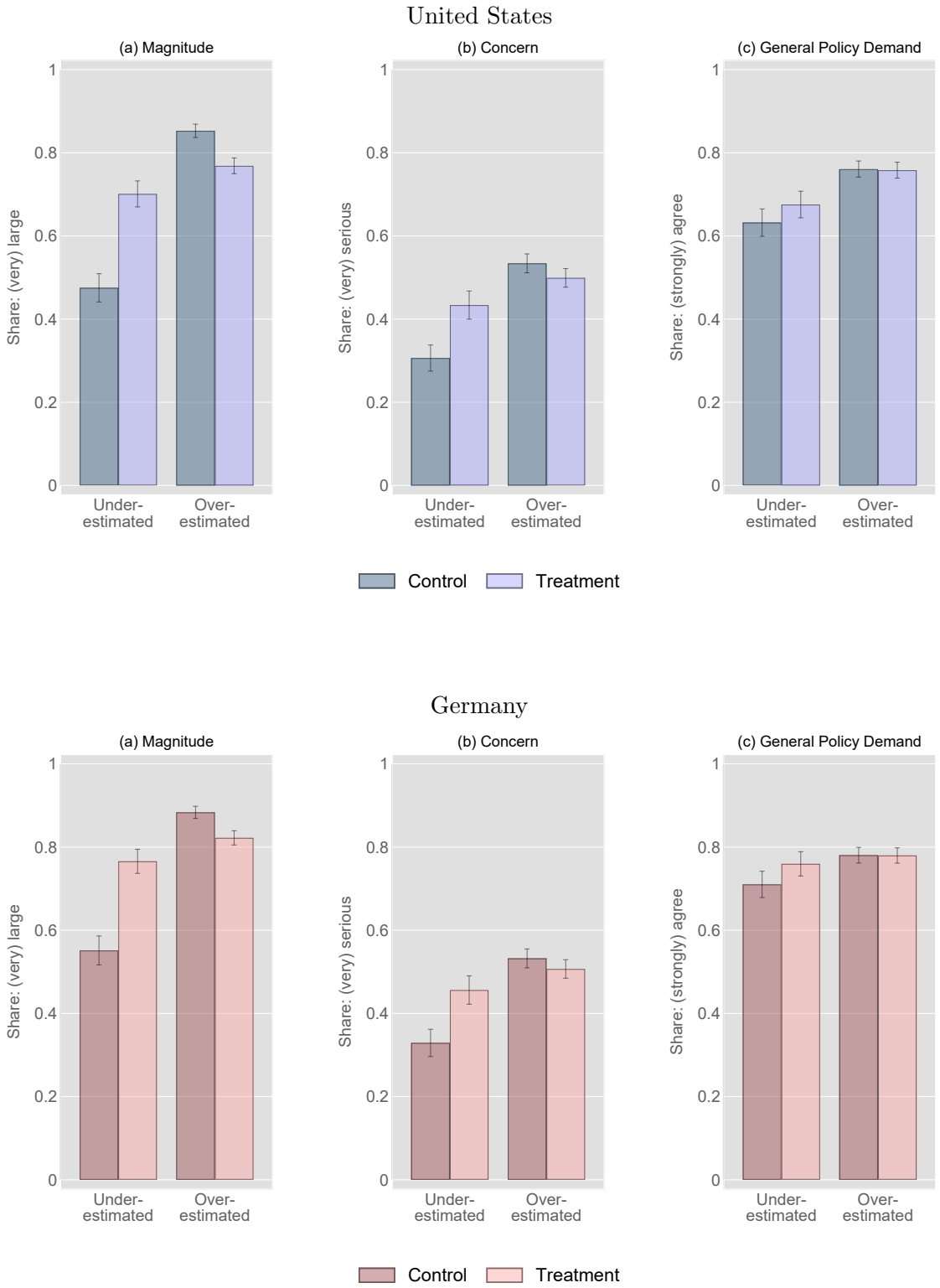
Notes: The figure shows kernel density plots of the distribution of misperception of the socioeconomic inequality of life expectancy for the United States and Germany for those who randomly received an incentive for reporting the true life expectancy and those who did not. Misperceptions are calculated by the respondents' perception about the socioeconomic inequality of life expectancy averaged across gender minus the actual average socioeconomic inequality of life expectancy as obtained from Chetty et al. (2016) for the United States and Lampert et al. (2019) for Germany (see Appendix B for details). The Kolmogorov-Smirnov test for equality of distributions is rejected in the United States ($p = 0.005$) and not rejected in Germany ($p = 0.523$).

Figure A-6: Heterogeneity in Misperceptions about Socioeconomic Inequality in Life Expectancy, Percentages



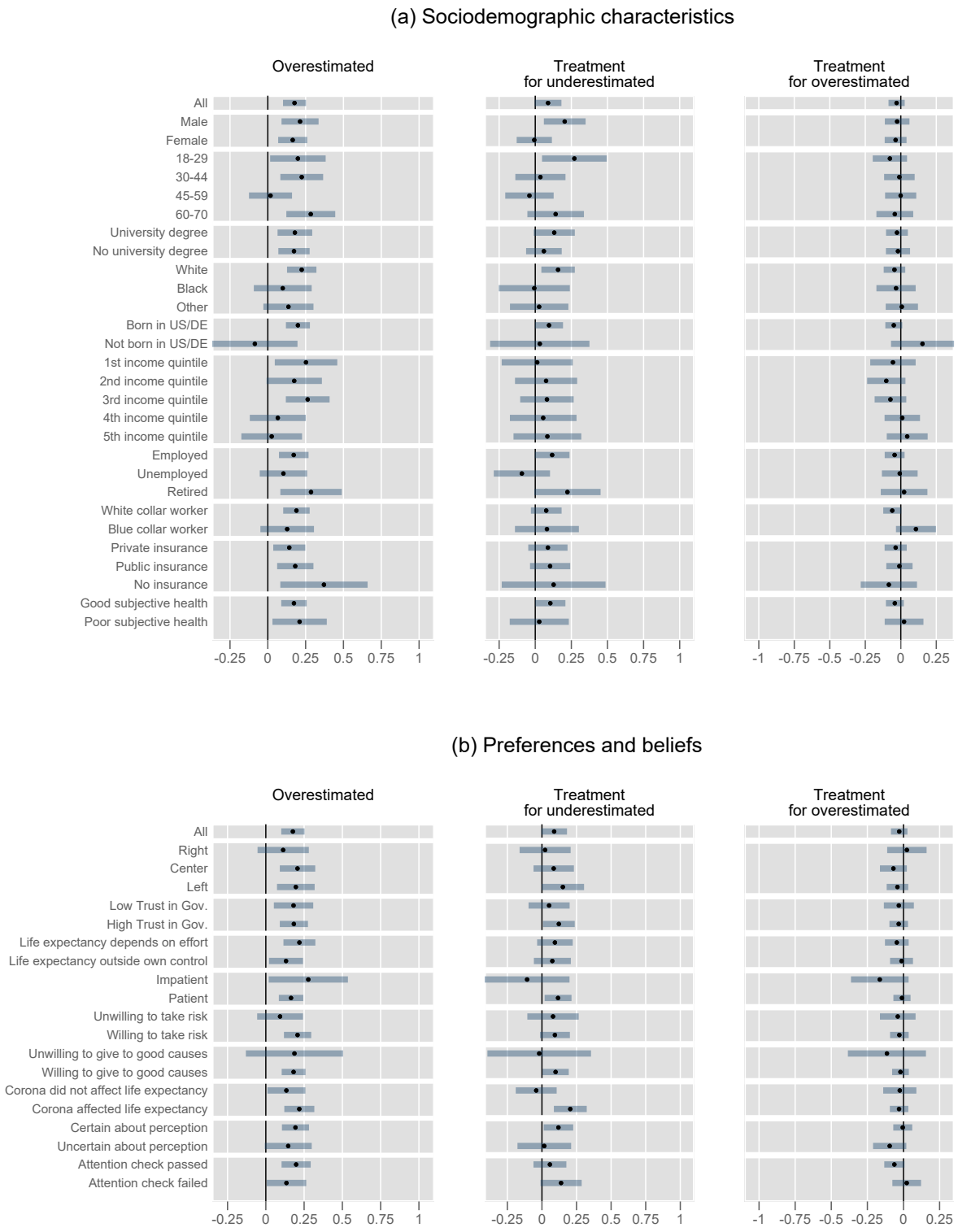
Notes: The figure shows the percentages for those who underestimated and overestimated the socioeconomic inequality in life expectancy by different individual characteristics. The actual numbers are obtained from Chetty et al. (2016) for the United States and Lampert et al. (2019) for Germany (see Appendix B for details).

Figure A-7: Perceived Magnitude, Concern, and General Policy Demand by Treatment Status - Shares



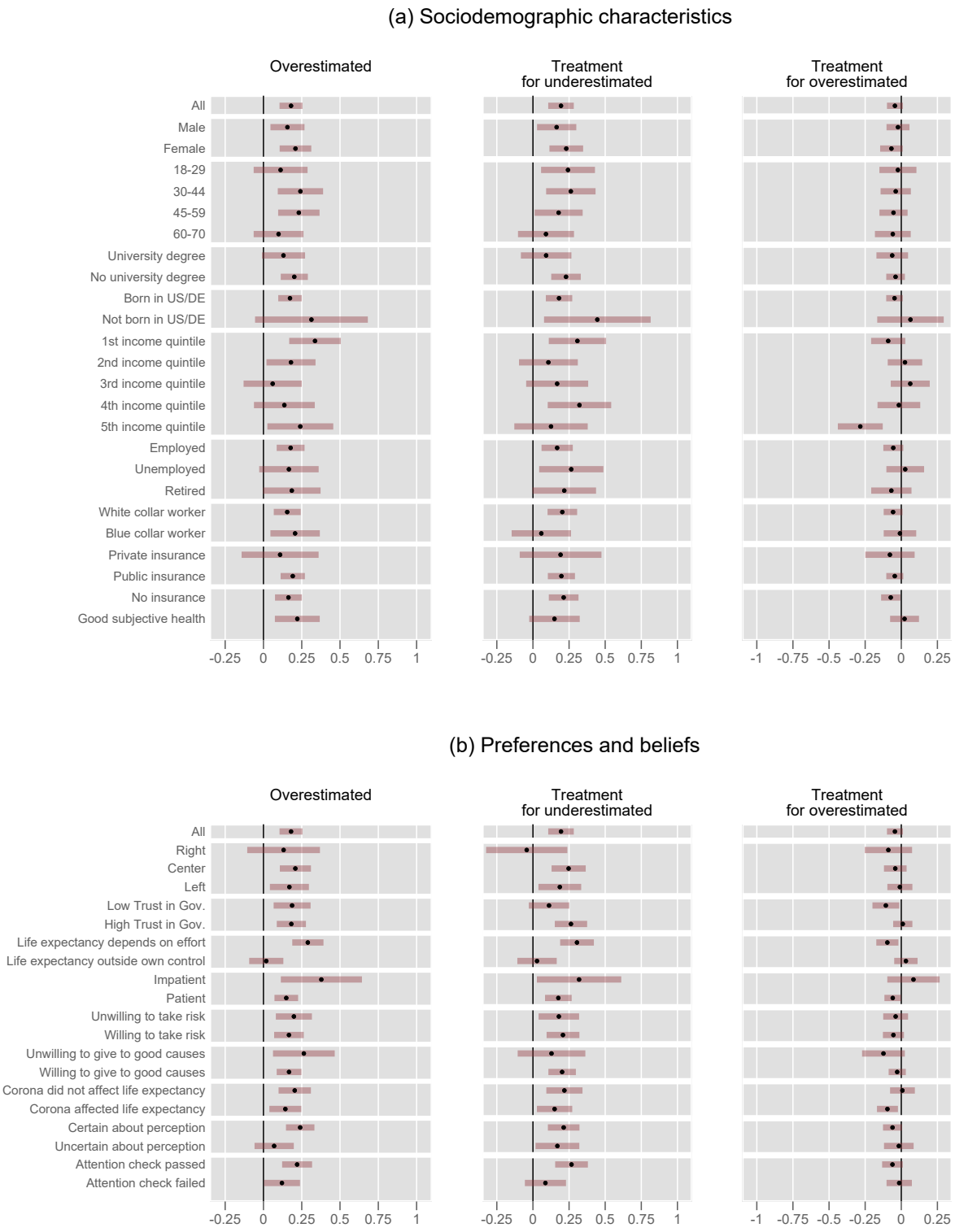
Notes: The figure reports the share of responses in the two top categories to the magnitude, concern, and general policy questions for respondents who received the information treatment and those who did not.

Figure A-8: Heterogeneity of Correlations and Treatment Effects on General Policy Demand: United States



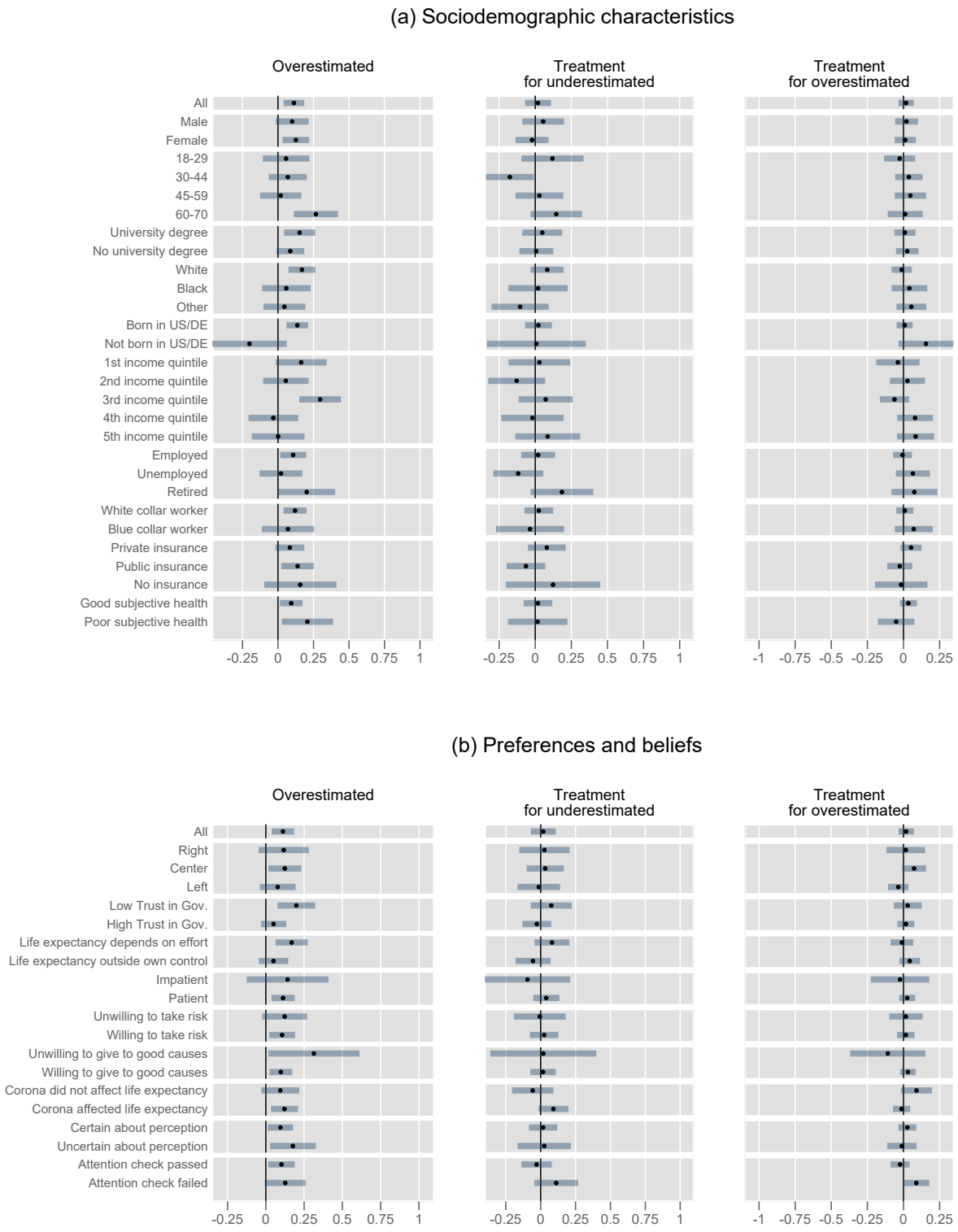
Notes: The figure shows the heterogeneity of the correlation of perceptions with general policy demand with perception of socioeconomic inequality in life expectancy and the heterogeneity of treatment effects on general policy demand for respondents who under- or overestimated inequality in life expectancy. Panel (a) shows heterogeneity with respect to sociodemographic characteristics and panel (b) with respect to preferences and beliefs. The figure presents the regression results for the United States in Table 1 for the subsamples indicated on the y-axes. The dependent variable is the z-standardized general policy demand.

Figure A-9: Heterogeneity of Correlations and Treatment Effects on General Policy Demand: Germany



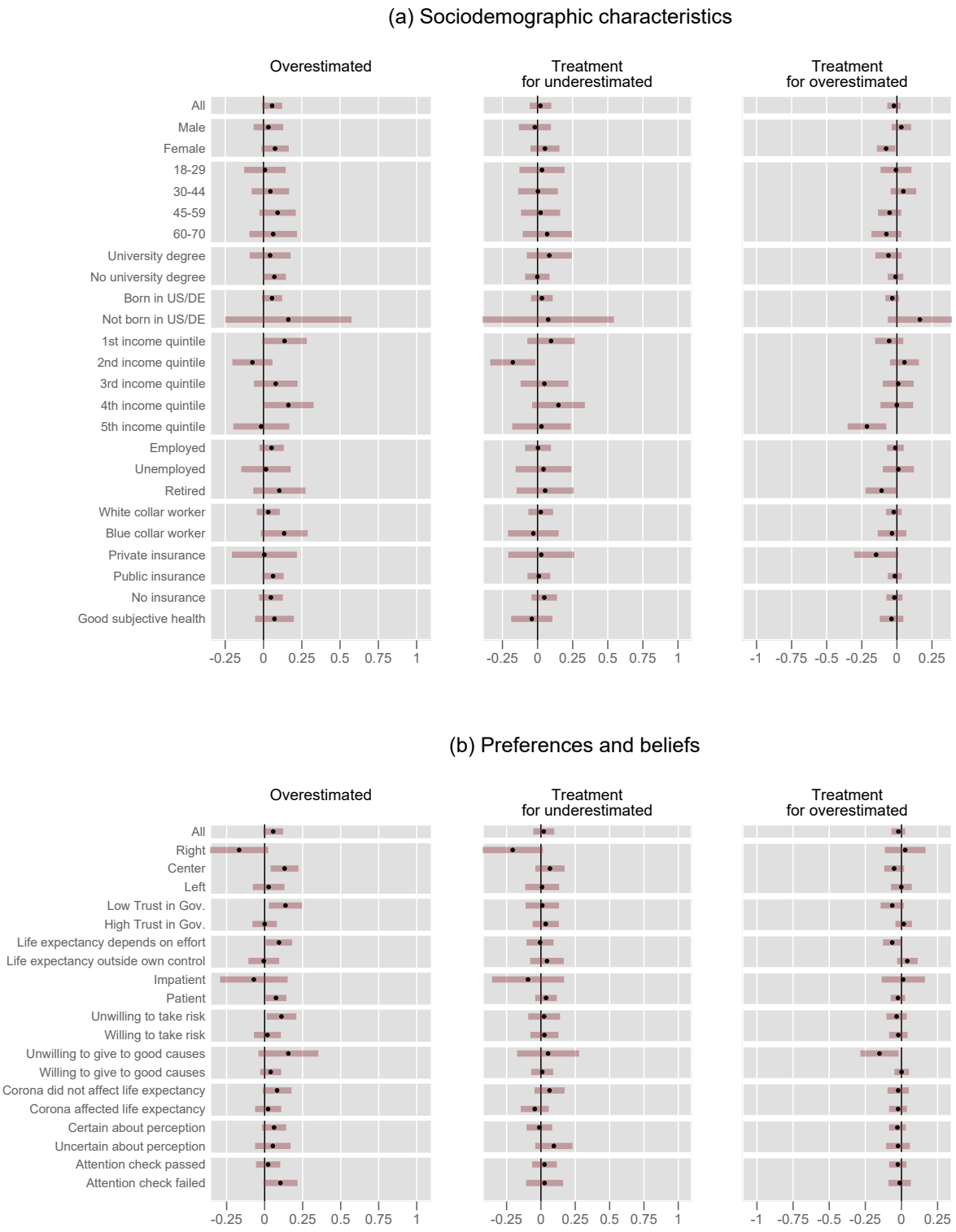
Notes: The figure shows the heterogeneity of the correlation of perceptions with general policy demand with perception of socioeconomic inequality in life expectancy and the heterogeneity of treatment effects on general policy demand for respondents who under- or overestimated inequality in life expectancy. Panel (a) shows heterogeneity with respect to sociodemographic characteristics and panel (b) with respect to preferences and beliefs. The figure presents the regression results for Germany in Table 1 for the subsamples indicated on the y-axes. The dependent variable is the z-standardized general policy demand.

Figure A-10: Heterogeneity of Correlations and Treatment Effects on Specific Policy Demand: United States



Notes: The figure shows the heterogeneity of the correlation of specific policy demand with perception of socioeconomic inequality in life expectancy and the heterogeneity of treatment effects on specific policy demand for respondents who under- or overestimated inequality in life expectancy. Panel (a) shows heterogeneity with respect to sociodemographic characteristics and panel (b) with respect to preferences and beliefs. The figure presents the regression results for the United States in Table 3 column (6) for the subsamples indicated on the y-axes. The dependent variable is the equally weighted average of all specific policy demand indices.

Figure A-11: Heterogeneity of Correlations and Treatment Effects on Specific Policy Demand: Germany



Notes: The figure shows the heterogeneity of the correlation of specific policy demand with perception of socioeconomic inequality in life expectancy and the heterogeneity of treatment effects on specific policy demand for respondents who under- or overestimated inequality in life expectancy. Panel (a) shows heterogeneity with respect to sociodemographic characteristics and panel (b) with respect to preferences and beliefs. The figure presents the regression results for Germany in Table 3 column (6) for the subsamples indicated on the y-axes. The dependent variable is the equally weighted average of all specific policy demand indices.

Figure A-12: Individual Suggestions for Specific Policies to Improve Life Expectancy of the Poor

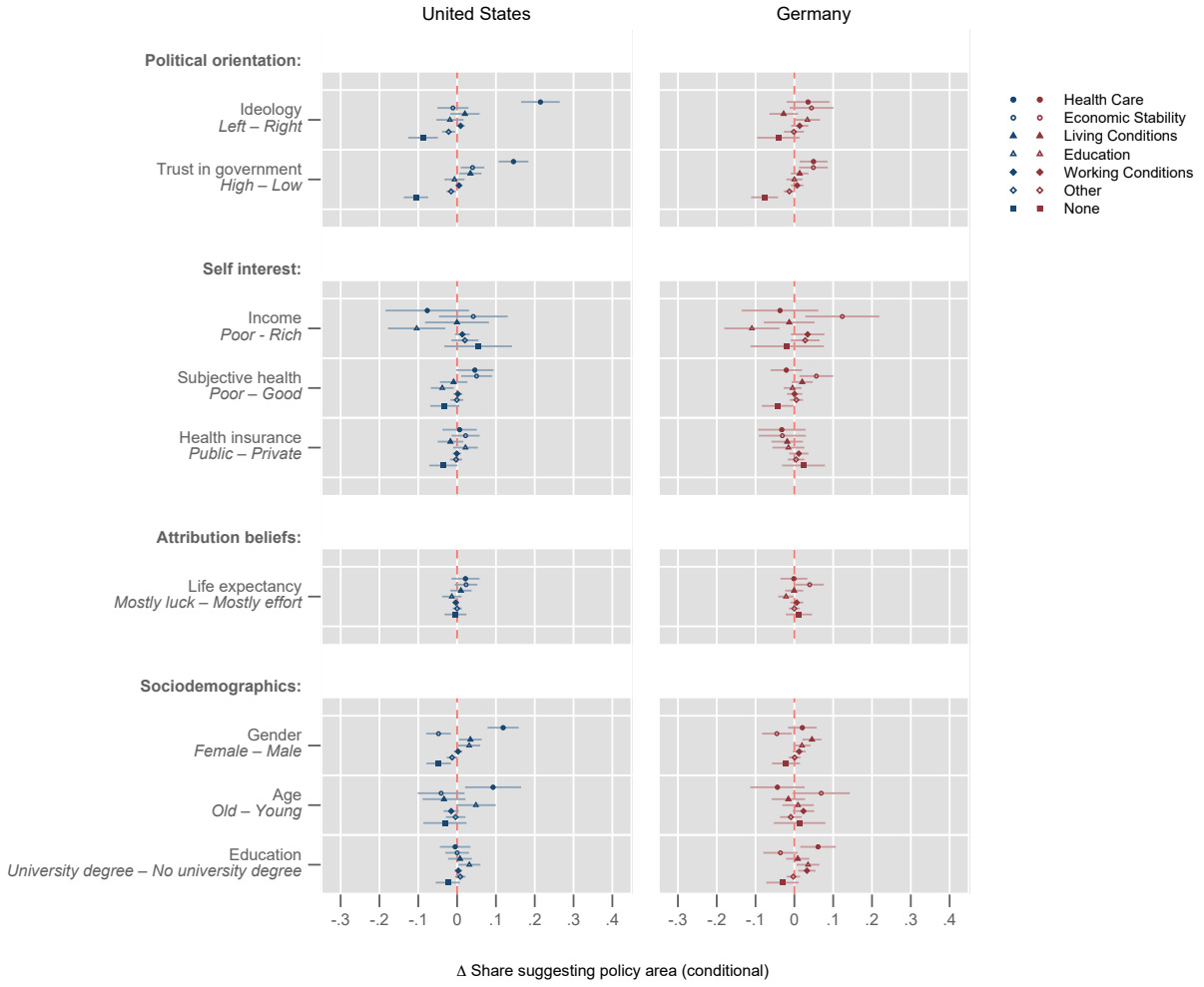
(a) United States

(b) Germany (untranslated)

(c) Germany (translated)

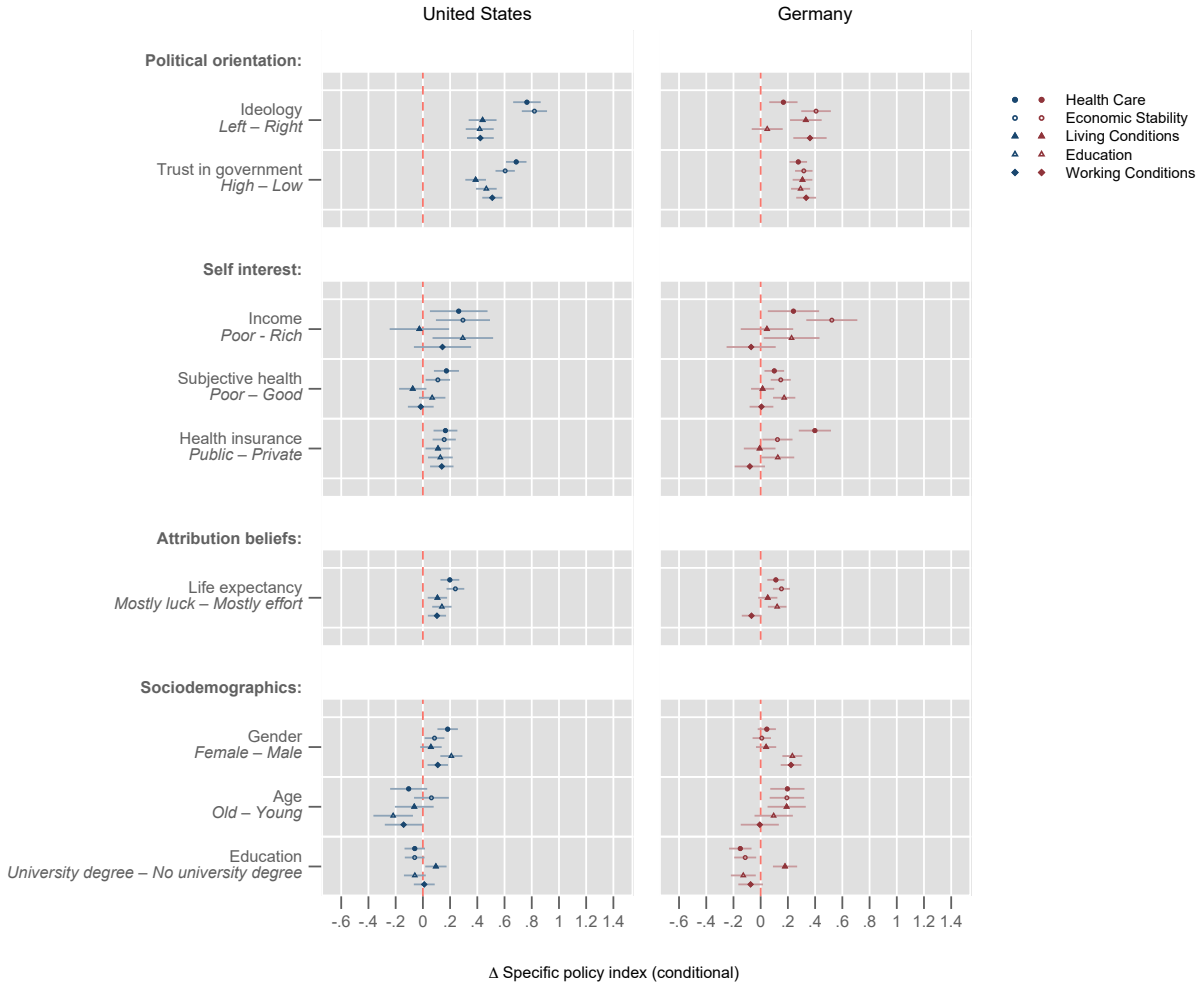
Notes: The figure presents the most frequent answers to the question of what measures the government could use to improve the life expectancy of poor people. Respondents were allowed to name as many measures as they wished. Size of the words are proportional to the frequency of mentions. We follow the approach outlined in Ferrario & Stantcheva (2022) to clean the data. To produce (c), we translated German responses into English.

Figure A-13: Differences in Top-of-Mind Proposals



Notes: The figure shows differences in top-of-mind policy proposals across population groups in the control group, for the areas of health care (solid circles), economic stability (hollow circles), living conditions (solid triangles), education (hollow triangles), working conditions (solid diamonds), other (hollow diamond), and none (solid square). For each area, it plots the difference in the share of respondents who spontaneously propose a measure in that area, between the two groups indicated. All differences are conditional on the full set of sociodemographic characteristics, preferences and beliefs (see Table 1), as well as indicators for perceived life-expectancy differences in four-year bins. Horizontal bars indicate 95% confidence intervals.

Figure A-14: Differences in Specific Policy Demand



Notes: The figure shows differences in support for specific policies across population groups in the control group, for policies from the areas of health care (solid circles), economic stability (hollow circles), living conditions (solid triangles), education (hollow triangles), working conditions (solid diamonds). For each of the five policy areas, it plots the difference in the specific policy index, expressed in standard deviations of the pooled control group, between the two groups indicated. All differences are conditional on the full set of sociodemographic characteristics, preferences and beliefs (see Table 1), as well as indicators for perceived life-expectancy differences in four-year bins. Horizontal bars indicate 95% confidence intervals.

Table A-1: Policy Questions

Item	United States	Germany
Health Care Access (HCA)		
	Some people believe that poor individuals don't get the health care services they need because they lack insurance, cannot afford them or live too far away from providers. Policies to **increase access to health care** aim to help people get the care they need. How do you personally feel about the following measures?	Einige Menschen glauben, dass arme Personen keine ausreichende Gesundheitsversorgung erhalten, weil sie keine Versicherung haben, Gesundheitsleistungen nicht bezahlen können oder zu weit entfernt von Arzten leben. Maßnahmen zur **Verbesserung des Zugangs zum Gesundheitssystem** zielen darauf ab, Menschen dabei zu helfen, eine ausreichende Versorgung zu bekommen. Wie stehen Sie persönlich zu den folgenden Maßnahmen?
HCA-1	**Abolishing deductibles and co-payments** for medical services and medication for individuals with low incomes	**Abschaffung von Selbstbeteiligungen und Zuzahlungen** für medizinische Leistungen und Medikamente für arme Personen
HCA-2	Establishing a **universal health insurance** and an **equal access health care system**, independent of income or employment status	Einrichtung einer **einheitlichen Krankenversicherung** und eines **gleichberechtigten Zugangs zum Gesundheitssystem**, unabhängig von Einkommen oder Beschäftigungsstatus (z.B. durch Zusammenlegung der gesetzlichen und privaten Krankenkassen)
HCA-3	**Expanding medical care in rural areas** despite low profitability	**Ausbau der medizinischen Versorgung im ländlichen Raum** trotz geringer Wirtschaftlichkeit
Economic Stability (ES)		
	Some people believe that poor individuals cannot afford healthy food, health care and other basic needs. Several policies therefore aim to **increase economic stability**.	Einige Menschen glauben, dass sich arme Personen eine gesunde Ernährung, ausreichende Gesundheitsversorgung und andere Grundbedürfnisse nicht leisten können. Daher zielen einige Maßnahmen darauf ab, die **wirtschaftliche Absicherung zu stärken**. Wie stehen Sie persönlich zu den folgenden Maßnahmen?
ES-1	**More redistribution of income** from rich to poor people (e.g. through more generous social benefits for the poor, financed by higher taxes for the rich)	**Stärkere Umverteilung von Einkommen** von Reich zu Arm (z.B. durch höhere Sozialleistungen für Arme, finanziert durch höhere Steuern für Reiche)
ES-2	**Increasing expenses on employment and training programs** for the unemployed	**Höhere Ausgaben zur Vermittlung und Qualifizierung** von Arbeitslosen
ES-3	**Raising the federal minimum wage**	**Erhöhung des gesetzlichen Mindestlohns**
Living Conditions (LC)		
	Some people believe that the neighborhoods people live in and the lifestyles people choose have a major impact on their health. Several policies therefore aim to **improve living conditions and promote healthy behavior.** How do you personally feel about the following measures?	Einige Menschen glauben, dass die Umgebung, in der Menschen leben, und der Lebensstil, den sie wählen, einen großen Einfluss auf die Gesundheit haben. Daher zielen einige Maßnahmen darauf ab, die **Lebensbedingungen zu verbessern** und **gesundheitsbewusstes Verhalten zu fördern.** Wie stehen Sie persönlich zu den folgenden Maßnahmen?
LC-1	Higher investments to **improve living conditions in disadvantaged neighborhoods** (e.g. by improving air quality, local public transport or public safety)	Höhere Investitionen zur **Verbesserung der Lebensbedingungen in sozialen Brennpunkten** (z.B. durch Verbesserungen der Luftqualität, des öffentlichen Nahverkehrs oder der öffentlichen Sicherheit)
LC-2	**Higher taxes on unhealthy food, alcohol, and cigarettes**	**Höhere Steuern auf ungesunde Lebensmittel, Alkohol und Zigaretten**
Education (E)		
	Some people believe that individuals with better education are likely to be healthier and live longer. Several policies therefore aim to increase **access to high-quality education**. How do you personally feel about the following measures?	Einige Menschen glauben, dass Menschen mit besserer Bildung gesünder sind und länger leben. Daher zielen einige Maßnahmen darauf ab, den **Zugang zu hochwertiger Bildung zu verbessern**. Wie stehen Sie persönlich zu den folgenden Maßnahmen?
E-1	**Increasing public funding of child-care centers and schools in disadvantaged neighborhoods**	**Höhere Investitionen in Kindertageseinrichtungen und Schulen in sozialen Brennpunkten**
E-2	**Expanding the education on health-conscious living** across all schools	**Ausweitung des Unterrichts zu gesundheitsbewusster Lebensweise** in allen Schulen
Working Conditions (WC)		
	Some people believe that poor individuals are exposed to bad working conditions that can harm their health. Several policies therefore aim to regulate **workplace safety** and **compensate the health impacts** of physically demanding jobs. How do you personally feel about the following measures?	Einige Menschen glauben, dass arme Menschen schlechten Arbeitsbedingungen ausgesetzt sind, die ihrer Gesundheit schaden können. Daher zielen einige Maßnahmen darauf ab, die **Sicherheit am Arbeitsplatz** zu regeln und die **gesundheitlichen Nachteile** von körperlicher Arbeit **zu kompensieren**. Wie stehen Sie persönlich zu den folgenden Maßnahmen
WC-1	**Stricter regulation of workplace safety** (e.g. through higher safety requirements or lower limits for noise and air pollution at the workplace)	**Stärkere Regulierung der Arbeitsplatzsicherheit** (z.B. durch höhere Sicherheitsauflagen oder niedrigere Höchstgrenzen für Lärm und Luftverschmutzung am Arbeitsplatz)
WC-2	Enabling an **early retirement** without deductions for individuals with **physically demanding jobs**	Ermöglichung eines **frühzeitigen, abschlagsfreien Rentenbeginns** für Personen mit **körperlich belastenden Berufen**

Notes: The answer categories for each item are strongly oppose, oppose, neither favor nor oppose, favor, and strongly favor. Items for each category appeared on the same screen. To avoid order effects, both the order of categories as well as the order of items is randomized.

Table A-2: Representativeness of the U.S. Sample

	(1) Survey Sample Mean	(2) Population Mean
Age		
18-29	0.23	0.24
30-44	0.29	0.29
45-59	0.29	0.28
60-70	0.20	0.19
Gender		
Male	0.47	0.50
Female	0.51	0.50
Other	0.01	.
Division		
New England	0.03	0.05
Middle Atlantic	0.14	0.13
East North Central	0.14	0.14
West North Central	0.07	0.06
South Atlantic	0.22	0.20
East South Central	0.04	0.06
West South Central	0.12	0.12
Mountain	0.08	0.07
Pacific	0.16	0.17
Ethnicity		
White	0.60	0.61
Black	0.17	0.13
Hispanic	0.14	0.18
Asian	0.07	0.06
Other	0.02	0.03
Education		
Not completed high school	0.02	0.11
High school degree / GED	0.18	0.27
Some college, no degree	0.32	0.23
2-year college degree	0.10	0.09
4-year college degree	0.25	0.20
Master's degree or higher	0.13	0.11

Notes: The table provides population shares by age group, gender, U.S. Census division, ethnicity and education in the sample ($N = 5,432$) and in the U.S. population between the ages of 18 and 70. Population measures are based on the American Community Survey 2019.

Table A-3: Representativeness of the German Sample

	(1) Survey Sample Mean	(2) Population Mean
Age		
18-29	0.19	0.20
30-44	0.28	0.29
45-59	0.33	0.32
60-70	0.20	0.19
Gender		
Male	0.50	0.51
Female	0.49	0.49
Other	0.00	.
Region		
North	0.16	0.16
East	0.19	0.19
South	0.30	0.30
West	0.35	0.35
Education		
No degree	0.01	0.04
Basic degree	0.16	0.28
Middle degree	0.40	0.26
Applied college entrance qualification	0.11	0.10
University entrance qualification	0.33	0.32

Notes: The table provides population shares by age group, gender, region, and secondary education in the sample ($N = 5,400$) and in the German population between the ages of 18 and 70. Population measures are based on the 2021 micro census by the Federal Statistical Office of Germany.

Table A-4: Summary Statistics of Outcomes

	Pooled sample			U.S. sample			German sample		
	Mean	SD	Share	Mean	SD	Share	Mean	SD	Share
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Panel A - Primary Outcomes									
Magnitude	3.81	0.84	0.76	3.77	0.89	0.74	3.85	0.79	0.78
Concern	3.41	1.04	0.47	3.39	1.10	0.46	3.43	0.97	0.47
General Policy	3.97	0.96	0.74	3.93	1.01	0.72	4.02	0.90	0.76
Panel B - Specific Policies									
Health Care									
No Copayment	4.03	1.05	0.74	3.96	1.10	0.72	4.11	0.99	0.77
Universal Insurance	4.06	1.14	0.76	3.98	1.25	0.73	4.14	1.02	0.78
Rural Care	4.20	0.83	0.84	4.18	0.86	0.84	4.22	0.79	0.85
Economic Conditions									
Redistribution	3.71	1.26	0.64	3.60	1.32	0.61	3.82	1.18	0.67
Employment Measures	3.63	1.05	0.59	3.61	1.13	0.60	3.64	0.96	0.59
Minimum Wage	4.00	1.11	0.73	3.94	1.21	0.71	4.06	1.00	0.75
Living Conditions									
Living Conditions	4.04	0.88	0.78	4.13	0.92	0.82	3.95	0.84	0.75
Consumption Taxes	3.43	1.30	0.52	3.28	1.31	0.48	3.58	1.28	0.56
Education									
Early Childhood Education	4.14	0.91	0.80	4.13	0.95	0.80	4.15	0.87	0.81
Health Education	4.24	0.83	0.85	4.25	0.81	0.86	4.24	0.84	0.83
Working Conditions									
Work Safety	4.00	0.88	0.76	4.07	0.89	0.79	3.93	0.87	0.73
Early Retirement	4.02	0.93	0.75	3.79	0.98	0.65	4.25	0.81	0.85
Panel C - Real Outcome									
Donation amount	193	167	0.87	190	170	0.85	196	164	0.89
Observations		5,331			2,690			2,641	

Notes: The table shows control-group descriptive statistics for primary outcomes, specific policies, and real outcome donation-lottery. Primary outcomes and agreement to specific policies are measured on 5-Point Likert scales. The table provides means, standard deviations, and shares of respondents selecting at least the second highest level on the scale indicated. Donations are expressed in current U.S. dollars. Euro are converted to U.S. dollars by using the average exchange rate over the sample period between August 15, 2022 and November 30, 2022 (1 U.S. dollar = 0.999 Euro).

Table A-5: Summary Statistics and Balance Check for the U.S. Sample

	(1) Full Sample mean	(2) Control mean	(3) Treatment mean	(4) Incentivized mean	(5) Unincentivized mean	(6) (2)=(3) p	(7) (4)=(5) p
Sociodemographic characteristics							
Female	0.51	0.52	0.51	0.52	0.50	0.671	0.260
Male	0.47	0.47	0.47	0.47	0.48	0.901	0.330
Age (in years)	44.33	44.30	44.36	44.35	44.31	0.872	0.937
18-29	0.23	0.23	0.23	0.22	0.23	0.865	0.506
30-44	0.29	0.29	0.28	0.29	0.28	0.511	0.698
45-59	0.29	0.28	0.29	0.29	0.28	0.307	0.570
60-70	0.20	0.20	0.20	0.20	0.20	0.555	0.699
University degree	0.48	0.47	0.49	0.49	0.47	0.135	0.039
No university degree	0.52	0.53	0.51	0.51	0.53	0.135	0.039
White	0.60	0.60	0.60	0.60	0.60	0.851	0.485
Black	0.17	0.17	0.17	0.18	0.16	0.878	0.036
Other	0.23	0.23	0.23	0.23	0.24	0.723	0.293
Born in U.S.	0.92	0.92	0.92	0.92	0.93	0.837	0.100
Not born in U.S.	0.08	0.08	0.08	0.08	0.07	0.837	0.100
Both parents born in U.S.	0.77	0.77	0.77	0.77	0.77	0.747	0.905
One or more parents not born in U.S.	0.23	0.23	0.23	0.23	0.23	0.747	0.905
Living with partner	0.48	0.48	0.48	0.47	0.49	0.686	0.157
Living without partner	0.52	0.52	0.52	0.53	0.51	0.686	0.157
Children in houshold	0.32	0.32	0.31	0.32	0.31	0.262	0.437
No children in household	0.68	0.68	0.69	0.68	0.69	0.262	0.437
Household Income (annual, in U.S. dollar)	84,539	84,234	84,839	85,109	83,957	0.740	0.528
1st income decile	0.06	0.06	0.05	0.05	0.06	0.559	0.504
2nd income decile	0.09	0.09	0.09	0.08	0.09	0.943	0.749
3rd income decile	0.10	0.10	0.11	0.10	0.11	0.434	0.260
4th income decile	0.08	0.08	0.08	0.08	0.08	0.684	0.730
5th income decile	0.14	0.14	0.14	0.15	0.14	0.800	0.589
6th income decile	0.12	0.13	0.11	0.13	0.12	0.010	0.150
7th income decile	0.12	0.11	0.12	0.11	0.12	0.966	0.108
8th income decile	0.08	0.08	0.08	0.09	0.08	0.701	0.087
9th income decile	0.09	0.09	0.10	0.09	0.09	0.282	0.998
10th income decile	0.07	0.07	0.07	0.07	0.07	0.929	0.956
Missing income information	0.05	0.05	0.05	0.05	0.05	0.469	0.527
Full-time employee	0.42	0.43	0.41	0.42	0.42	0.074	0.800
Part-time employee	0.12	0.12	0.12	0.12	0.12	0.994	0.834
Self-employed	0.10	0.10	0.11	0.10	0.11	0.806	0.495
Unemployed	0.09	0.09	0.10	0.09	0.09	0.158	0.811
Not in laborforce	0.09	0.08	0.09	0.09	0.09	0.397	0.832
Student	0.05	0.05	0.05	0.05	0.04	0.967	0.644
Retired	0.13	0.13	0.13	0.13	0.13	0.649	0.826
Northeast	0.17	0.17	0.17	0.17	0.17	0.884	0.836
Midwest	0.21	0.21	0.22	0.22	0.20	0.245	0.194
South	0.38	0.38	0.38	0.38	0.38	0.601	0.931
West	0.24	0.24	0.23	0.23	0.25	0.517	0.126
Private health insurance	0.52	0.53	0.51	0.53	0.52	0.200	0.415
Public health insurance	0.39	0.38	0.39	0.38	0.39	0.344	0.179
No health insurance	0.09	0.09	0.09	0.09	0.09	0.532	0.392
Excellent/good health	0.81	0.81	0.81	0.82	0.81	0.573	0.299
Fair/poor health	0.19	0.19	0.19	0.18	0.19	0.573	0.299
Preferences and beliefs							
Ideology: Left	0.33	0.33	0.34	0.34	0.32	0.410	0.074
Ideology: Center	0.39	0.40	0.38	0.40	0.39	0.093	0.479
Ideology: Right	0.27	0.27	0.28	0.26	0.29	0.333	0.008
High trust in Gov.	0.58	0.57	0.59	0.59	0.57	0.155	0.141
Low trust in Gov.	0.42	0.43	0.41	0.41	0.43	0.155	0.141
Life expectancy mostly outside own control	0.48	0.48	0.49	0.49	0.48	0.434	0.752
Life expectancy mostly effort	0.52	0.52	0.51	0.51	0.52	0.434	0.752
Risk attitude	6.96	6.97	6.95	6.98	6.94	0.699	0.575
Altruism	8.67	8.62	8.71	8.67	8.67	0.126	0.995
Patience	8.08	8.07	8.09	8.11	8.05	0.789	0.390
Perception of inequality in life expectancy (years)	14.84	14.78	14.89	15.24	14.43	0.659	0.001
Corona affected life expectancy	0.63	0.62	0.65	0.63	0.64	0.067	0.722
Certainty about perception of inequality	3.15	3.14	3.15	3.08	3.21	0.873	0.000
Certain	0.43	0.43	0.43	0.41	0.46	0.774	0.000
Neither certain nor uncertain	0.30	0.30	0.31	0.31	0.29	0.609	0.258
Uncertain	0.27	0.27	0.26	0.28	0.25	0.834	0.002
Trustworthiness of information	2.09		2.09	2.10	2.07		0.334
Trustworthy	0.36		0.71	0.36	0.36		0.649
Neither trustworthy nor untrustworthy	0.12		0.25	0.13	0.12		0.141
Untrustworthy	0.02		0.04	0.02	0.02		0.786
Political bias of survey	2.83	2.82	2.83	2.82	2.84	0.572	0.129
Left-biased	0.21	0.21	0.21	0.21	0.20	0.693	0.586
Unbiased	0.74	0.74	0.74	0.74	0.74	0.916	0.853
Right-biased	0.05	0.05	0.06	0.05	0.06	0.362	0.182
Attention check passed	0.64	0.64	0.64	0.64	0.64	0.805	0.929
Response time (min.)	28.30	27.71	28.88	28.41	28.19	0.177	0.797
Observations	5,432	2,690	2,742	2,737	2,695	5,432	5,432

Notes: The table shows summary statistics and balancing checks for the U.S. sample. We recoded reported annual incomes below $5000 as missing to reduce the impact of misreports. Participants with a response time of less than 9 minutes (= 50% of the median response time in the soft launch) were excluded in the data cleaning procedures of the survey company. We winsorized income and response time at the 99th percentile to reduce the impact of outliers.

Table A-6: Summary Statistics and Balance Check for the German Sample

	(1) Full Sample mean	(2) Control mean	(3) Treatment mean	(4) Incentivized mean	(5) Unincentivized mean	(6) (2)=(3) p	(7) (4)=(5) p
Sociodemographic characteristics							
Female	0.49	0.50	0.49	0.49	0.50	0.444	0.448
Male	0.50	0.50	0.51	0.51	0.50	0.392	0.431
Age (in years)	45.14	45.33	44.96	44.99	45.29	0.345	0.458
18-29	0.19	0.18	0.19	0.19	0.18	0.483	0.367
30-44	0.28	0.28	0.29	0.28	0.28	0.538	0.986
45-59	0.33	0.34	0.32	0.33	0.34	0.105	0.470
60-70	0.20	0.20	0.20	0.20	0.20	0.597	0.962
University degree	0.26	0.26	0.27	0.26	0.26	0.278	0.979
No university degree	0.74	0.74	0.73	0.74	0.74	0.278	0.979
Born in Germany	0.94	0.94	0.94	0.94	0.94	0.574	0.897
Not born in Germany	0.06	0.06	0.06	0.06	0.06	0.574	0.897
Both parents born in Germany	0.83	0.83	0.83	0.84	0.82	0.566	0.148
One or more parents not born in Germany	0.17	0.17	0.17	0.16	0.18	0.566	0.148
Living with partner	0.46	0.45	0.46	0.45	0.46	0.547	0.421
Living without partner	0.54	0.55	0.54	0.55	0.54	0.547	0.421
Children in houshold	0.28	0.26	0.30	0.28	0.28	0.005	0.912
No children in household	0.72	0.74	0.70	0.72	0.72	0.005	0.912
Household Income (annual, in Euros)	53,428	52,805	54,025	53,300	53,555	0.243	0.807
1st income decile	0.11	0.10	0.11	0.10	0.11	0.240	0.850
2nd income decile	0.11	0.12	0.10	0.11	0.11	0.128	0.451
3rd income decile	0.08	0.09	0.08	0.09	0.08	0.086	0.321
4th income decile	0.12	0.12	0.11	0.11	0.12	0.294	0.599
5th income decile	0.10	0.10	0.10	0.10	0.10	0.818	0.658
6th income decile	0.09	0.09	0.09	0.09	0.09	0.855	0.883
7th income decile	0.08	0.08	0.08	0.08	0.08	0.843	0.836
8th income decile	0.07	0.06	0.08	0.08	0.07	0.010	0.432
9th income decile	0.07	0.07	0.07	0.07	0.07	0.588	0.713
10th income decile	0.06	0.06	0.07	0.06	0.07	0.486	0.350
Missing income information	0.12	0.12	0.12	0.12	0.11	0.887	0.621
Full-time employee	0.47	0.47	0.46	0.47	0.47	0.339	0.922
Part-time employee	0.16	0.15	0.16	0.17	0.15	0.262	0.068
Self-employed	0.05	0.05	0.05	0.05	0.05	0.874	0.874
Unemployed	0.04	0.04	0.04	0.04	0.04	0.220	0.971
Not in laborforce	0.05	0.05	0.05	0.05	0.05	0.535	0.932
Student	0.08	0.08	0.08	0.08	0.08	0.514	0.579
Retired	0.16	0.15	0.16	0.15	0.17	0.405	0.147
Northeast	0.16	0.16	0.16	0.16	0.16	0.741	0.884
Midwest	0.19	0.20	0.19	0.19	0.19	0.171	0.818
South	0.30	0.30	0.30	0.29	0.31	0.983	0.125
West	0.35	0.34	0.35	0.36	0.34	0.390	0.163
Private health insurance	0.10	0.10	0.11	0.10	0.11	0.630	0.366
Public health insurance	0.90	0.90	0.89	0.90	0.89	0.630	0.366
Excellent/good health	0.71	0.72	0.71	0.71	0.72	0.225	0.245
Fair/poor health	0.29	0.28	0.29	0.29	0.28	0.225	0.245
Preferences and beliefs							
Ideology: Left	0.34	0.33	0.34	0.33	0.34	0.503	0.372
Ideology: Center	0.51	0.51	0.50	0.51	0.50	0.450	0.515
Ideology: Right	0.16	0.16	0.16	0.16	0.16	0.867	0.790
High trust in Gov.	0.55	0.55	0.55	0.55	0.54	0.950	0.615
Low trust in Gov.	0.45	0.45	0.45	0.45	0.46	0.950	0.615
Life expectancy mostly outside own control	0.43	0.43	0.42	0.43	0.43	0.449	0.739
Life expectancy mostly effort	0.57	0.57	0.58	0.57	0.57	0.449	0.739
Risk attitude	5.58	5.58	5.58	5.59	5.57	0.982	0.808
Altruism	7.35	7.35	7.35	7.34	7.36	0.903	0.812
Patience	7.55	7.51	7.58	7.60	7.50	0.199	0.082
Perception of inequality in life expectancy (years)	10.55	10.61	10.49	10.63	10.47	0.494	0.318
Corona affected life expectancy	0.49	0.47	0.51	0.48	0.50	0.005	0.115
Certainty about perception of inequality	2.99	3.02	2.97	2.95	3.04	0.119	0.001
Certain	0.35	0.35	0.34	0.33	0.36	0.493	0.017
Neither certain nor uncertain	0.33	0.34	0.32	0.32	0.34	0.223	0.285
Uncertain	0.32	0.31	0.33	0.34	0.30	0.054	0.000
Trustworthiness of information	2.07		2.07	2.08	2.07		0.786
Trustworthy	0.41		0.79	0.41	0.40		0.469
Neither trustworthy nor untrustworthy	0.09		0.18	0.09	0.08		0.168
Untrustworthy	0.02		0.03	0.01	0.02		0.642
Political bias of survey	2.88	2.88	2.87	2.89	2.86	0.588	0.032
Left-biased	0.14	0.14	0.15	0.14	0.15	0.390	0.097
Unbiased	0.83	0.83	0.82	0.83	0.82	0.374	0.295
Right-biased	0.03	0.03	0.03	0.03	0.03	0.837	0.270
Attention check passed	0.59	0.59	0.60	0.59	0.60	0.318	0.716
Response time (min.)	23.92	23.73	24.10	24.03	23.81	0.594	0.748
Observations	5,400	2,641	2,759	2,706	2,694	5,400	5,400

Notes: The table shows summary statistics and balancing checks for the German sample. We recoded reported annual incomes below $5000 as missing to reduce the impact of misreports. Participants with a response time of less than 9 minutes (= 50% of the median response time in the soft launch) were excluded in the data cleaning procedures of the survey company. We winsorized income and response time at the 99th percentile to reduce the impact of outliers.

Table A-7: Perceptions of Life Expectancy by Gender and Income

	(1) US Perceived Mean	(2) US Actual Mean	(3) DE Perceived Mean	(4) DE Actual Mean
Life Expectancy B10 Men (in years)	63.9	69.7	70.0	74.7
Life Expectancy T10 Men (in years)	79.1	81.9	80.7	83.3
Life Expectancy Difference T10-B10 Men (in years)	15.2	12.2	10.7	8.6
Life Expectancy B10 Women (in years)	69.0	76.8	74.6	81.2
Life Expectancy T10 Women (in years)	83.5	84.7	85.0	86.0
Life Expectancy Difference T10-B10 Women (in years)	14.5	7.9	10.4	4.8
Life Expectancy Difference T10-B10 Average (in years)	14.8	10.1	10.5	6.7

Notes: The table shows the average perceived and actual life expectancy of men and women in the bottom 10% and the top 10% of the household income distribution. The actual numbers are obtained from Chetty et al. (2016) for the United States and Lampert et al. (2019) for Germany (see Appendix B for details).

Table A-8: Information Treatment Effect on Perceived Magnitude, Concern, and General Policy Demand: Linear (Standardized) Outcome Specification, Omitting Controls

	Index components			Index
	Magnitude	Concern	Policy	
	(1)	(2)	(3)	(4)
	Panel A: United States			
Treatment	0.570***	0.366***	0.120**	0.440***
	(0.056)	(0.055)	(0.055)	(0.055)
Treatment × Overestimated	-0.752***	-0.447***	-0.120*	-0.550***
	(0.064)	(0.063)	(0.065)	(0.064)
Overestimated	0.889***	0.650***	0.297***	0.765***
	(0.046)	(0.045)	(0.044)	(0.045)
Controls	No	No	No	No
Adj. R-squared	0.080	0.045	0.011	0.059
Treatment effect for Overestimated	-0.182***	-0.082**	-0.000	-0.110***
	(0.030)	(0.032)	(0.034)	(0.032)
	Panel B: Germany			
Treatment	0.541***	0.317***	0.178***	0.432***
	(0.053)	(0.048)	(0.048)	(0.048)
Treatment × Overestimated	-0.705***	-0.386***	-0.210***	-0.542***
	(0.059)	(0.056)	(0.057)	(0.056)
Overestimated	0.770***	0.485***	0.193***	0.603***
	(0.043)	(0.041)	(0.041)	(0.040)
Controls	No	No	No	No
Adj. R-squared	0.072	0.029	0.004	0.044
Treatment effect for Overestimated	-0.164***	-0.069**	-0.031	-0.110***
	(0.026)	(0.029)	(0.031)	(0.028)

Notes: The table reports treatment effects on the outcome variable indicated in the column header for the United States in Panel A and Germany in Panel B. Outcomes are z-standardized. The index in Column (4) is an equally weighted average of z-scores of the three outcome variables. Calculation of each z-score subtracts the score's control-group mean and divides by the control-group standard deviation of the joint sample. "Treatment" indicates individuals who received the information treatment. "Overestimated" indicates individuals who overestimated the socioeconomic inequality in life expectancy. No additional controls included. $N_{US} = 5,432$ and $N_{DE} = 5,400$. Robust standard errors in parentheses. Significance levels: *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

Table A-9: Information Treatment Effect on Perceived Magnitude, Concern, and General Policy Demand: Shares Outcome Specification, Omitting Controls

	Index components			Index
	Magnitude	Concern	Policy	
	(1)	(2)	(3)	(4)
	Panel A: United States			
Treatment	0.226***	0.127***	0.043*	0.130***
	(0.024)	(0.024)	(0.023)	(0.022)
Treatment × Overestimated	-0.310***	-0.162***	-0.046*	-0.166***
	(0.027)	(0.029)	(0.027)	(0.027)
Overestimated	0.377***	0.228***	0.129***	0.246***
	(0.019)	(0.020)	(0.019)	(0.019)
Controls	No	No	No	No
Adj. R-squared	0.081	0.023	0.012	0.029
Treatment effect for Overestimated	-0.084***	-0.035**	-0.003	-0.036**
	(0.013)	(0.016)	(0.014)	(0.016)
Control Group Mean	0.736	0.464	0.721	0.399
Control group mean (Underestimated)	0.475	0.306	0.632	0.229
	Panel B: Germany			
Treatment	0.214***	0.127***	0.049**	0.135***
	(0.023)	(0.024)	(0.022)	(0.023)
Treatment × Overestimated	-0.276***	-0.153***	-0.050*	-0.151***
	(0.026)	(0.029)	(0.026)	(0.028)
Overestimated	0.332***	0.203***	0.070***	0.214***
	(0.019)	(0.020)	(0.019)	(0.019)
Controls	No	No	No	No
Adj. R-squared	0.071	0.018	0.003	0.021
Treatment effect for Overestimated	-0.061***	-0.025	-0.001	-0.016
	(0.011)	(0.016)	(0.013)	(0.016)
Control Group Mean	0.785	0.472	0.760	0.406
Control group mean (Underestimated)	0.551	0.329	0.710	0.255

Notes: The table reports treatment effects on the outcome variable indicated in the column header for the United States in Panel A and Germany in Panel B. Outcomes are dummy variables for each outcome that are 1 if the response is in the two top answer categories of each item, and 0 otherwise. The index variable in Column (4) is a dummy variable that is 1 if individual answers to all three dummy outcome variables are 1, and 0 otherwise. "Treatment" indicates individuals who received the information treatment. "Overestimated" indicates individuals who overestimated the socioeconomic inequality in life expectancy. No additional control variables included. $N_{US} = 5,432$ and $N_{DE} = 5,400$. Robust standard errors in parentheses. Significance levels: *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

Table A-10: Information Treatment Effect on Share in Favor of Specific Policies

	Consumption taxes	Employment measures	Redistri-bution	Minimum wage	No copayment	Early retirement	Work safety	Universal health care	Living conditions	Early childhood education	Rural care	Health education
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
Panel A: United States												
Treatment	0.005	0.037	0.021	0.019	0.019	0.001	-0.009	0.001	-0.028	-0.033*	-0.020	-0.027
	(0.024)	(0.023)	(0.021)	(0.020)	(0.020)	(0.023)	(0.020)	(0.019)	(0.019)	(0.019)	(0.019)	(0.019)
Treatment X Overestimated	0.011	-0.032	-0.030	-0.020	-0.005	-0.003	0.002	0.014	0.031	0.044**	0.015	0.026
	(0.028)	(0.028)	(0.025)	(0.024)	(0.024)	(0.027)	(0.024)	(0.023)	(0.022)	(0.022)	(0.022)	(0.021)
Overestimated	0.025	0.041**	0.031*	0.025	0.030*	0.036*	0.036**	-0.001	0.026*	0.014	0.044***	0.037**
	(0.020)	(0.020)	(0.018)	(0.017)	(0.017)	(0.019)	(0.017)	(0.016)	(0.015)	(0.016)	(0.016)	(0.015)
Controls	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Adj. R-ssquared	0.063	0.073	0.278	0.251	0.185	0.105	0.113	0.274	0.178	0.199	0.109	0.074
Treatment for Overestimated	0.015	0.005	-0.009	-0.001	0.015	-0.003	-0.008	0.016	0.004	0.011	-0.005	-0.001
	(0.016)	(0.015)	(0.013)	(0.013)	(0.013)	(0.015)	(0.012)	(0.012)	(0.011)	(0.011)	(0.011)	(0.010)
Control group mean	0.477	0.600	0.613	0.709	0.717	0.654	0.787	0.733	0.817	0.804	0.839	0.859
Control group mean (Underestimated)	0.444	0.552	0.557	0.669	0.680	0.614	0.745	0.708	0.774	0.771	0.794	0.820
Panel B: Germany												
Treatment	-0.004	-0.003	0.012	-0.006	-0.007	0.009	0.002	0.027	-0.031	-0.009	-0.006	-0.006
	(0.024)	(0.024)	(0.022)	(0.020)	(0.020)	(0.018)	(0.022)	(0.020)	(0.021)	(0.019)	(0.018)	(0.019)
Treatment X Overestimated	0.009	0.029	-0.024	0.010	0.005	-0.022	0.006	-0.033	0.035	0.009	0.011	0.018
	(0.029)	(0.029)	(0.027)	(0.024)	(0.024)	(0.021)	(0.026)	(0.024)	(0.025)	(0.023)	(0.021)	(0.022)
Overestimated	0.010	-0.005	0.052***	-0.006	-0.014	0.019	0.035*	0.027	-0.015	0.008	0.005	0.024
	(0.021)	(0.021)	(0.019)	(0.017)	(0.017)	(0.015)	(0.019)	(0.017)	(0.018)	(0.016)	(0.015)	(0.016)
Controls	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Adj. R-ssquared	0.062	0.048	0.137	0.118	0.078	0.060	0.062	0.081	0.099	0.092	0.044	0.083
Treatment for Overestimated	0.005	0.026*	-0.012	0.004	-0.001	-0.013	0.009	-0.006	0.005	0.000	0.006	0.012
	(0.016)	(0.016)	(0.014)	(0.013)	(0.013)	(0.011)	(0.014)	(0.013)	(0.013)	(0.012)	(0.011)	(0.011)
Control group mean	0.558	0.587	0.672	0.754	0.769	0.846	0.728	0.781	0.747	0.805	0.849	0.833
Control group mean (Underestimated)	0.543	0.582	0.633	0.760	0.778	0.831	0.701	0.761	0.752	0.793	0.841	0.813

Notes: The table reports treatment effects on support for the specific policy indicated in the column header. The dependent variables are dummy variables for each specific policy that are 1 if the response is in the two top answer categories (favor or strongly favor) and 0 otherwise. The columns are sorted in ascending order by the control group mean support rate for the policy. "Treatment" indicates individuals who received the information treatment. "Overestimated" indicates individuals who overestimated the socioeconomic inequality in life expectancy. Controls: gender, age, university degree, ethnicity (US only), birthplace, parental birthplace, partner in household, children in household, income decile, employment status, occupation, region, political orientation, trust in government, belief about control over life expectancy, risk aversion, patience, altruism, health insurance status, self-assessed health status, belief about corona effect on life expectancy, certainty about perceptions, attentiveness, incentive treatment, and perception question order. Panel (a) presents the data for the United States ($N = 5,432$) and Panel (b) for Germany ($N = 5,400$). Robust standard errors in parentheses. Significance levels: *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

Table A-11: Information Treatment Effect on Perceived Magnitude, Concern, and General Policy Demand: Attention Check Passed vs. Failed

	Index components						Index	
	Magnitude		Concern		Policy			
Attention check:	Pass	Fail	Pass	Fail	Pass	Fail	Pass	Fail
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
				Panel A: United States				
Treatment	0.595***	0.445***	0.422***	0.147*	0.058	0.139*	0.448***	0.305***
	(0.069)	(0.088)	(0.063)	(0.081)	(0.061)	(0.076)	(0.062)	(0.078)
Treatment	-0.847***	-0.544***	-0.584***	-0.179*	-0.121*	-0.116	-0.647***	-0.350***
× Overestimated	(0.077)	(0.101)	(0.072)	(0.095)	(0.070)	(0.091)	(0.071)	(0.092)
Overestimated	0.871***	0.629***	0.636***	0.317***	0.198***	0.135**	0.711***	0.450***
	(0.056)	(0.076)	(0.052)	(0.068)	(0.049)	(0.066)	(0.050)	(0.066)
Controls	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Adj. R-squared	0.159	0.137	0.246	0.204	0.308	0.228	0.311	0.259
Treatment effect	-0.251***	-0.099**	-0.162***	-0.032	-0.063*	0.022	-0.199***	-0.045
for Overestimated	(0.035)	(0.050)	(0.036)	(0.049)	(0.036)	(0.051)	(0.034)	(0.049)
				Panel B: Germany				
Treatment	0.690***	0.304***	0.442***	0.152**	0.267***	0.086	0.583***	0.226***
	(0.065)	(0.085)	(0.057)	(0.075)	(0.058)	(0.073)	(0.058)	(0.075)
Treatment	-0.876***	-0.475***	-0.546***	-0.196**	-0.328***	-0.101	-0.729***	-0.321***
× Overestimated	(0.073)	(0.095)	(0.067)	(0.086)	(0.068)	(0.085)	(0.067)	(0.085)
Overestimated	0.792***	0.649***	0.542***	0.319***	0.220***	0.121**	0.648***	0.453***
	(0.055)	(0.068)	(0.051)	(0.063)	(0.050)	(0.060)	(0.051)	(0.061)
Controls	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Adj. R-squared	0.116	0.104	0.135	0.120	0.146	0.169	0.162	0.169
Treatment effect	-0.186***	-0.170***	-0.104***	-0.044	-0.061*	-0.014	-0.146***	-0.095**
for Overestimated	(0.033)	(0.043)	(0.036)	(0.043)	(0.037)	(0.045)	(0.034)	(0.042)

Notes: The table reports treatment effects on the outcome variable indicated in the column header, in Panel (a) for the United States and in Panel (b) for Germany. Odd columns present results for the subsample that passed the attention check (United States: $N = 3,474$ and Germany: $N = 3,202$) and even columns present results for the subsample that did not pass the attention check (United States: $N = 1,948$ and Germany: $N = 2,198$). The dependent variables are z-standardized outcomes. The index is an equally weighted average of z-scores of the three outcome variables. Calculation of each z-score subtracts the score's control-group mean and divides by the control-group standard deviation of the joint sample. "Treatment" indicates individuals who received the information treatment. "Overestimated" indicates individuals who overestimated the socioeconomic inequality in life expectancy. Controls: gender, age, university degree, ethnicity (US only), birthplace, parental birthplace, partner in household, children in household, income decile, employment status, occupation, region, political orientation, trust in government, belief about control over life expectancy, risk aversion, patience, altruism, health insurance status, self-assessed health status, belief about corona effect on life expectancy, certainty about perceptions, attentiveness, incentive treatment, and perception question order. Robust standard errors in parentheses. Significance levels: *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

Table A-12: Information Treatment Effect on Perceptions, Concerns, and General Policy Demand in Follow Up Survey

	LE Gap *Years*			Concern *std.*			Policy *std.*		
Attention check:	All	Pass	Fail	All	Pass	Fail	All	Pass	Fail
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
					Panel A: United States				
Treatment	0.717*	1.054**	-0.127	0.072	0.088	0.033	-0.035	-0.081	0.071
	(0.395)	(0.454)	(0.763)	(0.060)	(0.072)	(0.110)	(0.056)	(0.068)	(0.098)
Treatment × Overestimated	-1.546***	-2.191***	0.014	-0.080	-0.175**	0.095	0.067	0.081	-0.000
	(0.472)	(0.539)	(0.919)	(0.072)	(0.086)	(0.131)	(0.067)	(0.081)	(0.119)
Overestimated	3.002***	3.274***	2.298***	0.195***	0.286***	0.036	0.031	0.061	-0.006
	(0.353)	(0.406)	(0.687)	(0.052)	(0.062)	(0.097)	(0.048)	(0.058)	(0.087)
Controls	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Adj. R-squared	0.076	0.075	0.076	0.261	0.267	0.248	0.284	0.306	0.240
Treatment effect for Overestimated	-0.829***	-1.137***	-0.113	-0.008	-0.087*	0.128*	0.032	-0.000	0.070
	(0.259)	(0.297)	(0.507)	(0.039)	(0.048)	(0.069)	(0.037)	(0.044)	(0.066)
					Panel B: Germany				
Treatment	0.366	0.490*	0.228	0.049	0.160**	-0.095	0.030	0.098	-0.064
	(0.251)	(0.290)	(0.448)	(0.052)	(0.066)	(0.085)	(0.049)	(0.063)	(0.078)
Treatment × Overestimated	-1.563***	-1.706***	-1.387***	-0.087	-0.193**	0.054	-0.008	-0.105	0.133
	(0.293)	(0.345)	(0.518)	(0.061)	(0.077)	(0.099)	(0.057)	(0.074)	(0.092)
Overestimated	2.663***	2.898***	2.391***	0.176***	0.233***	0.106	0.042	0.075	-0.008
	(0.227)	(0.274)	(0.388)	(0.043)	(0.055)	(0.069)	(0.041)	(0.054)	(0.064)
Controls	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Adj. R-squared	0.068	0.079	0.043	0.118	0.117	0.121	0.139	0.133	0.144
Treatment effect for Overestimated	-1.197***	-1.216***	-1.159***	-0.038	-0.033	-0.041	0.022	-0.008	0.068
	(0.153)	(0.186)	(0.264)	(0.032)	(0.041)	(0.052)	(0.030)	(0.039)	(0.048)

Notes: The table reports treatment effects on the outcome variable indicated in the column header in the follow-up survey two weeks after the main survey, in Panel (a) for the United States and in Panel (b) for Germany. Columns (1), (4), and (7) present results for the full follow up sample (United States: $N = 3525$, Germany: $N = 4445$), columns (2), (5), and (8) for the subsample that passed the attention check (United States: $N = 2351$, Germany: $N = 2619$), and columns (3), (6), and (9) present results for the subsample that did not pass the attention check (United States: $N = 1174$, Germany: $N = 1826$). The dependent variables are the perception of the socioeconomic inequality in life expectancy in years (winsorized at the 95th percentile) in columns (1) to (3), concern about inequality in life expectancy, standardized by the control group mean and standard deviation in the main survey, in columns (4) to (6), and general policy demand, also standardized by the control group mean and standard deviation in the main survey, in columns (7) to (9). "Treatment" indicates individuals who received the information treatment. "Overestimated" indicates individuals who overestimated the socioeconomic inequality in life expectancy. Controls: gender, age, university degree, ethnicity (US only), birthplace, parental birthplace, partner in household, children in household, income decile, employment status, occupation, region, political orientation, trust in government, belief about control over life expectancy, risk aversion, patience, altruism, health insurance status, self-assessed health status, belief about corona effect on life expectancy, certainty about perceptions, attentiveness, incentive treatment, and perception question order. Robust standard errors in parentheses. Significance levels: *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

Table A-13: Information Treatment Effect on Donation Behavior

	Yes/No	Amount	
		Value	> 0
	(1)	(2)	(3)
		Panel A: United States	
Treatment	-0.005	0.612	2.705
	(0.017)	(8.346)	(8.744)
Treatment × Overestimated	0.016	-2.005	-8.120
	(0.020)	(9.895)	(10.338)
Overestimated	-0.010	-6.305	-4.303
	(0.015)	(7.050)	(7.371)
Controls	Yes	Yes	Yes
Adj. R-squared	0.059	0.050	0.047
Treatment effect for Overestimated	0.011	-1.394	-5.415
	(0.011)	(5.326)	(5.520)
		Panel B: Germany	
Treatment	0.010	2.411	-0.347
	(0.016)	(7.757)	(8.080)
Treatment × Overestimated	-0.021	-6.107	-1.169
	(0.019)	(9.305)	(9.660)
Overestimated	0.018	14.687**	11.981*
	(0.013)	(6.747)	(7.019)
Controls	Yes	Yes	Yes
Adj. R-squared	0.079	0.073	0.046
Treatment effect for Overestimated	-0.011	-3.696	-1.517
	(0.010)	(5.146)	(5.298)

Notes: The table reports treatment effects on the outcome index indicated in the column header for the donation-lottery. Dependent variable in Column (1) is a dummy that indicates a donation to any of the charities that is strictly larger than 0. Column (2) uses the absolute amount of the donation to all charities as dependent variable, and Column (3) the absolute amount conditional on donating a positive amount. Donations are expressed in current U.S. dollars. Euro are converted to U.S. dollars by using the average exchange rate over the sample period between August 15, 2022 and November 30, 2022 (1 U.S. dollar = 0.999 Euro). "Treatment" indicates individuals who received the information treatment. "Overestimated" indicates individuals who overestimated the socioeconomic inequality in life expectancy. Controls: gender, age, university degree, ethnicity (US only), birthplace, parental birthplace, partner in household, children in household, income decile, employment status, occupation, region, political orientation, trust in government, belief about control over life expectancy, risk aversion, patience, altruism, health insurance status, self-assessed health status, belief about corona effect on life expectancy, certainty about perceptions, attentiveness, incentive treatment, and perception question order. Panel (A) presents the data for the United States ($N = 5,432$) and Panel (b) for Germany ($N = 5,400$). Robust standard errors in parentheses. Significance levels: *** $p < 0.01$, ** $p < 0.05$, * $p < 0.1$.

B Estimates of Actual Life Expectancy

In this appendix, we describe how we calculate the actual life expectancy of rich and poor people.

B.1 United States

Chetty et al. (2016) estimate socioeconomic inequality in life expectancy for the US population using tax records and social security records from 1999 to 2014. They rank individuals by their pre-tax household earnings position (relative to individuals of the same gender and age) to estimate life expectancy by income percentile and gender. We use that data to calculate the average expected age at death for the first and last ten income percentiles, by gender, to approximate the life expectancy of the bottom 10% and top 10%. Since the data sets are large enough to produce accurate estimates for each year, we rely on the results for the most recent year (2014).

Table B-1: Socioeconomic Inequality in Life Expectancy Estimates for the United States

	Men	Women	Average
	(1)	(2)	(3)
Bottom 10%	76.1	82.0	79.0
Top 10%	88.2	89.8	89.0
Δ	12.2	7.8	10.0

Notes: The table shows estimates of life expectancy at age 40 by income decile for the United States based on Chetty et al. (2016).

In the perception questions, we provide participants with the latest data on average life expectancy at birth for men and women. These values are 76.3 years for men and 81.4 years for women in 2019. The estimates of mean life expectancy at age 40 in 2014 by Chetty et al. (2016) are significantly higher than the values we provide (82.7 for men and 86.6 for women). Chetty et al. (2016) acknowledge that their estimates of life expectancy are higher than official data from the National Center for Health Statistics due to differences in the populations included in the estimations. To correct for the differences in life expectancy between the Chetty et al. (2016) data and the anchors we provide to participants, we adjust the estimates by Chetty et al. (2016) downwards by the difference in mean life expectancy in 2019 and mean life expectancy at age 40 in 2014 in the Chetty et al. (2016) data to arrive at the results shown in Table B-2.

Table B-2: Corrected Socioeconomic Inequality in Life Expectancy Estimates for the United States

	Men	Women	Average
	(1)	(2)	(3)
Bottom 10%	69.7	76.8	73.3
Top 10%	81.9	84.7	83.3
Δ	12.2	7.8	10.0

Notes: The table shows estimates for the life expectancy by income decile for the United States based on Chetty et al. (2016), corrected for the difference between mean life expectancy in 2019 and mean life expectancy at age 40 in the Chetty et al. (2016) data set for 2014.

We compare the participants' perceptions with the corrected values reported in Table B-2. Our main value of interest, which we also inform about in the information treatment, is the difference in life expectancy between the bottom 10% and the top 10%, averaging across men and women.

B.2 Germany

Lampert et al. (2019) provide the most recent data on socioeconomic inequality in life expectancy for Germany. They use data from the Socio-Economic Panel (SOEP) from 1992 to 2016 to estimate relative mortality by income group and gender in combination with official period life tables to estimate the life expectancy of each income group. Lampert et al. (2019) define income groups by net equivalence income relative to the median, differentiating between $< 60\%$, $60 - 80\%$, $80 - 100\%$, $100 - 150\%$, and $\geq 150\%$. We use SOEP Microdata from 2017 to redefine the relative income groups in terms of income percentiles. The group with $< 60\%$ of median income corresponds to the first 16 percentiles and the group with $\geq 150\%$ corresponds to the last 19 percentiles. We linearly extrapolate the life expectancy to predict life expectancy of men and women in the 5th and 95th percentile to approximate the mean life expectancy of the bottom 10% and the top 10%, respectively. Because the SOEP data is a relatively small sample, the variance of life expectancy estimates is large when the time period for the estimations is reduced to the most recent observations. Therefore, we rely on the estimates that use the entire time period from 1992 to 2016.

Table B-3: Socioeconomic Inequality in Life Expectancy Estimates for Germany

	Men	Women	Average
	(1)	(2)	(3)
Bottom 10%	71.1	78.6	74.8
Top 10%	79.7	83.4	81.6
Δ	8.6	4.8	6.7

Notes: The table shows estimates for the life expectancy by income decile for Germany based on Lampert et al. (2019).

In the perception questions, we provide participants with the latest data on average life expectancy at birth for men and women. These values are 78.6 for men and 83.4 for women. Since the mean life expectancy for the 1992-2016 period in Lampert et al. (2019) is lower (75.0 years for men and 80.8 years for women), we correct the estimates in the above table upwards by the difference in the information we provide and the mean life expectancy in the dataset used by Lampert et al. (2019) to arrive at the results shown in Table B-4.

Table B-4: Corrected Socioeconomic Inequality in Life Expectancy Estimates for Germany

	Men	Women	Average
	(1)	(2)	(3)
Bottom 10%	74.7	81.2	77.9
Top 10%	83.3	86.0	84.6
Δ	8.6	4.8	6.7

Notes: The table shows estimates for the life expectancy by income decile for Germany based on Lampert et al. (2019), corrected for the difference between current mean life expectancy and mean life expectancy in the Lampert et al. (2019) data set between 1992 and 2016.

We compare the participants' perceptions with the corrected values reported in Table B-4. Our main value of interest, which we also inform about in the information treatment, is the difference in life expectancy between the bottom 10% and the top 10%, averaging across men and women. We ask about life expectancy of the bottom 10% and the top 10% in terms of gross household income, yet the estimates from Lampert et al. (2019) are based on net equivalence income. However, we can show that adjusting the Lampert et al. (2019) results by defining income groups in terms of gross household income yields a similar difference in life expectancy between the bottom 10% and the top 10%, averaging across men and women, of 7.0 years (results not shown).

C Classification of Free-Text Responses

Respondents were asked the following open-ended question:

> *What measures can you think of that the government could use to improve the life expectancy of poor people? Please state the measures that you find most important. If you cannot think of any, please state "None".*

To analyze these responses systematically, we classify the policy areas mentioned using a large language model (GPT-4o-mini). The goal of this procedure is to identify which *policy domains* respondents refer to. Specifically, for each response we assess whether it suggests measures related to the following policy areas: health care access, economic stability, living conditions, education, working conditions, another policy area, or none. Because responses may refer to multiple domains, the classification allows several policy areas to be identified within a single answer.

The model is prompted to assign probabilities indicating whether a response refers to policies in each domain. Specifically, we used the following prompt for the U.S. sample (and a comparable prompt for the German sample):

> *Classify the following responses to the question "What measures can you think of that the government could use to improve the life expectancy of poor people? Please state the measures that you find most important. If you cannot think of any, please state "None"." by whether they suggest measures from any of the following policy areas. The areas are:*
>
> 1. *Health Care (i.e. policies aimed at improving affordability, insurance coverage, availability and access to health care. Examples are abolishing deductibles and co-payments for medical services and medication for individuals with low incomes, establishing a universal health insurance and an equal access health care system, independent of income or employment status; expanding medical care in rural areas despite low profitability; or other measures aimed at the health care system.);*
> 2. *Economic Stability (i.e. policies aimed at increasing redistribution, strengthening unemployment programs and economic opportunities, and improving benefits and incomes of poor people. Examples are more redistribution of*

income from rich to poor people (e.g. through more generous social benefits for the poor, financed by higher taxes for the rich); or increasing expenses on employment and training programs for the unemployed; or raising the federal minimum wage.);

3. *Living Conditions (i.e. policies aimed at improving the living conditions of poor people or their possibilities to live healthy lifestyles. Examples are higher investments to improve living conditions in disadvantaged neighborhoods (e.g. by improving air quality, local public transport or public safety); or higher taxes on unhealthy food, alcohol, and cigarettes.);*
4. *Education (i.e. policies aimed at improving access to education or increasing health literacy. Examples are increasing public funding of child-care centers and schools in disadvantaged neighborhoods; or expanding the education on health-conscious living across all schools.);*
5. *Working Conditions (i.e. policies affecting work safety, working conditions, or retirement conditions. Examples are stricter regulation of workplace safety (e.g. through higher safety requirements or lower limits for noise and air pollution at the workplace); or Enabling an early retirement without deductions for individuals with physically demanding jobs.);*
6. *Any Other Policy Area (i.e. policies that do not fit into the other areas above);*
7. *None (i.e. no specific policy mentioned).*

The output should only contain seven comma-separated probabilities between 0 and 100, indicating the likelihood that the response contains measures from the five policy areas, another policy area, or no policy at all. If a response suggests measures from multiple areas, indicate so by assigning a positive probability to all multiple areas mentioned.

For example, if the answer was "The government should provide universal healthcare and mandate that employers give employees 4 days of work leave per year for preventative care." and you are 95% sure that this response contains healthcare policies and 70% sure that it contains working condition policies, your answer should be "95,0,0,0,70,0,0".

For each response, the model therefore produces probabilities indicating whether the respondent mentioned policies in any of the five predefined policy areas, another policy area, or none at all. To assess the plausibility of the classification, we manually inspected a random subsample of responses and compared the model's assignments with human judgment. The classifications align closely with the content of the responses.

The examples below illustrate how the model assigns probabilities across policy areas for selected responses. The seven numbers correspond to the following categories (in order): health care access, economic stability, living conditions, education, working conditions, other policy area, and none.

Response: "socialized healthcare, better pay for lower skilled jobs, redistribute wealth from richest 10%"
Classification probabilities: 90, 70, 0, 0, 0, 0, 0

Response: "Make health insurance more affordable and accessible. Lower deductible"
Classification probabilities: 100, 0, 0, 0, 0, 0, 0

Response: "Give money and jobs to them."
Classification probabilities: 0, 100, 0, 0, 0, 0, 0

Response: "We need more homeless shelters, more government relief to the poor people, we need inflation to go away and we need more local food banks."
Classification probabilities: 0, 70, 30, 0, 0, 0, 0

Response: "More opportunities for healthier foods. Taxe breaks or incentives to grow food."
Classification probabilities: 0, 0, 70, 0, 0, 0, 0

Response: "Nan"
Classification probabilities: 0, 0, 0, 0, 0, 0, 100

In the empirical analysis, we convert these probabilities into binary indicators for each policy domain. A response is classified as mentioning a policy area if the assigned probability is at least 30 percent; higher thresholds lead to frequent misclassification.

Halle Institute for Economic Research –
Member of the Leibniz Association

Kleine Maerkerstrasse 8

D-06108 Halle (Saale), Germany

Postal Adress: P.O. Box 11 03 61

D-06017 Halle (Saale), Germany

Tel +49 345 7753 60

Fax +49 345 7753 820

www.iwh-halle.de

ISSN 2194-2188

The IWH is funded by the federal government and the German federal states.