Extensions for Moral Theory Research: Study 2 and Beyond

What do we suspect?

* Model Results
  + Predicting UHC change in scores
    - Condition had the expected effect (-8.7 point difference between conditions)
    - Higher deontological scores lead to increased support for UHC
  + Looking at initial and final UHC scores
    - Initial and final scores for UHC were significantly predicted by utilitarian
    - However… there is no significant difference in CHANGE for that category.
  + Other items:
    - No significant factors change in any of the other items!
* Plots
* 
  + We see exactly what we expected
* 
  + See clearly a correlation b/w initial support and utilitarianism
* 
  + See the same again with final scores
* 
  + Don’t see if for initial scores w/ deontology
* 
  + We see greater deontology leading to increased support in both high and low conditions.
* 
  + However… we see a reversed effect in the high, and a nullification of this effect in the low, based on higher utilitarianism.
* To summarize:
  + original baseline numbers of support for UHC are actually STRONGLY influenced by initial orientation towards utility
  + In the high social consensus situation, more utilitarianism = less affected by social pressure?
    - The opposite case for higher levels of deontological orientation.

Further Extensions

* Study 1 Extensions
  + Consider adding Social Security as a ‘comparison option’
    - Given that we have social security but no UHC, regardless of if it has more or less support in the public, it has more support in policy
    - Do people view SS differently given that it is something they already have… and does this change based on deontology and utilitarian reasons?
      * E.g. in Deontological theory, it is a ‘right’ that is ‘owed’
  + Can we set up a ‘trolley’ style problem to elicit support for healthcare?
    - E.g. would you support the government to provide healthcare for person X or Y
    - This hypothetical person could vary on race (stereotypical white or black), SES, or any # of factors
    - Would we see a different level of support in these cases?
      * More importantly is this support a mediational relationship justified to the subject through perception that one group deserves it for deontological reasons, and the other group does not deserve if for those same deontological reasons – or due to utility or another measure?
    - Additionally – if there is seemingly racial motivation, is this affected by social pressure/consensus?
* Since we see a supposed effect of utilitarianism and deontology – we can directly prime and effect both of these ways of thinking.
  + Utilitarian priming
    - Analytic thinking was primed by asking a short math problem prior to the presentation of the dilemma-scenario (e.g. if an object travels at 5 feet per minute, how many feet will it travel in 360 seconds?)
      * This primes significantly more utilitarian thinking.
    - Mortality Salience priming – classic Greenberg 1990 method: “Briefly describe the emotions that the thought of your own death arouses in you’ and ‘Jot down, as specifically as you can, what you think will happen to you physically as you die and once you are physically dead’
      * Reduces utilitarianism, either through mental load, or mortality salience priming an intuitive, experiential mindset.
    - “Market Mindset” priming – Utilitarianism is primed by increasing the saliency of ‘proportional thinking’ (exchanging resources in proportions, how much you gain from an investment, whether repayment is of comparable value)
      * Market mindset is primed by showing images, sometimes with captions, indicating a market exchange (utility) or a gift being provided (control)
      * Providing explicit numerical information framing the benefits and costs of UHC (relative survival, life span, infant mortality, average cost spent, chronic disease proportion, etc. – against restrictions and travel for care, or relative total increase in taxation). This information could be considered as either a pro or a con, based on what you value.
        + Would providing this information cause an even GREATER effect (for or against) when primed with market mindset?
  + “Intuitive” priming
    - Priming occurred by making salient how emotion (or reasoning) leads to ‘good decision making’ and ‘satisfying decisions’ (Capraro 2019)
      * We can prime intuition, which leads to disfavoring instrumental harm but NOT the impartial beneficence element of the utilitarianism scale.
    - Unknown how prior utilitarian priming mechanisms affect the two dimensions of utility.
* “AI Consensus” instead of Social Consensus
  + Humans believe that AI are more competent at assessing relative utility value, but worse at assessing relative hedonic value.
  + Activate hedonic/utilitarian attitudes with a brief paragraph requesting people focus on either the hedonic attributes of it (smell, luxury, spa-like vibe, etc.) or the utilitarian attributes (practicality to use, objective performance, etc.)
    - Then provide a recommendation for either ‘traditional’ private health insurance as one option, or ‘UHC’ as the other option, and we would have either a human or AI claiming to be the one that recommended it.

Study 2 and Beyond

* Do people give utilitarian reasons to ‘disguise’ (smokescreen) their deontological beliefs?
  + E.g. If utilitarians agree that incest is a ‘victimless crime’, then the relative difference between boy/girl and boy/boy incest should be the same… but if ‘utility’ was given as a smokescreen, and deontological values hold true, perhaps they would rate boy/girl as MORE acceptable than boy/boy even though it’s claimed to be evaluated under ostensibly utilitarian values
* Moral-Intensity
  + Strongly related to recognition of moral issues/evaluations and intensions
  + Probable magnitude of harm, proximal/temporal immediacy, probability of effect all elements of moral recognition
    - Is it plausible that the differing effect of ethical perspective is based on the moral intensity of the issue?
    - E.g. There is more space for social consensus to influence perspective if people don’t feel as strong morally regarding it?
    - We would assess this empirically with direct measurements of moral intensity
  + Likewise, we can manipulate the framing of healthcare availability as something with more or less relative intensity
    - E.g. the framing that Healthcare resource distribution is ‘essentially’ moral, as there is potential to alleviate risk of illness, suffering, and absolute harm, to a greater extent than many other resources
    - Compare this to a ‘neutral’ framing of the benefits of healthcare
  + Note: We can prime subjects to think of issues in more or less moral terms (i.e. labelling their information package with the word ‘ethics’) which can increase potential for moral sensitivity (if we think that recognition of this as a moral issue is important)
    - We can DIRECTLY ask what the moral awareness is regarding the issues we’re assessing and comparing against.
* Two-Dimensional Utilitarianism: Oxford Utilitarianism Scale
  + “Defines utilitarianism as ‘greater focus on impartial maximization of well-being across different moral contexts (positive dimension) as well as giving less weight and space to values other than well-being, or moral rules that could constrain the promotion of well-being (negative dimension).”
  + Instrumental Harm axis: “The conditions upon which people find it acceptable to cause harm for a greater good”
    - E.g. in theory – taxation of others to support UHC for all
  + Impartial Benefit axis: “treating the well-being of everyone as equally important, and worth prioritizing”
    - E.g. of course we should provide UHC, as it allows for the improvement of health for the most peoples, to the greatest degree.
  + Empirical question: This split-scale form of measurement could determine and see whether the two dimensions of utility have differing impacts.
    - I suspect that impartial benefit predicts UHC support, but instrumental harm, does not? The degree of need for ‘instrumental harm’ in the form of taxation is a degree apart from killing a person and redistributing their organs, or pushing a person onto the railway.

Deontological/Utilitarian effects =/= Explicit cognizance/verbalization of reasoning.

* Do people oppose UHC for deontological reasons?
  + E.g. Is it seen as immoral to engage in indirect ‘age based’ rationing (due to comorbidities, and less likelihood of recovery in intense care), or phrased otherwise, is it OK to let older people who have ‘had a good amount of life’ to sacrifice their healthcare resources in order to help the youth, who are MORE likely to recover from their infection?
    - ‘taxation’ in order to fund UHC, or some individuals receiving ‘less’ or ‘different’ care in order for others to have care is causing harm to some, in exchange for ‘goods’ for others (e.g. the ‘free rider’ problem) – perhaps this is deontologically unacceptable.
  + Do you believe Americans have a right to healthcare access if they are a member of the workforce, and that the government should enact programs to ensure hard-working Americans have access to healthcare (Deontology Oppose??)
  + Or perhaps a better framing “Principle of beneficence balanced against the principle of justice”
    - I think this is an EXCELLENT way of framing hypothetical deontological argument against UHC; the individual would hold the principle of justice/fairness above that of the principle of beneficence (e.g., don’t unfairly tax those to pay for healthcare for all).
    - Balances again against ‘principle of autonomy’ which gives weight to individual’s freedom to choose and determine (e.g. the right to NOT have healthcare and thus save the money). Individual freedoms can conflict with overall good, e.g., hanging out w/ friends when social isolation is recommended.
* Do people support UHC for deontological reasons?
  + Do you believe Americans have a right to healthcare access, and that the government should enact programs to ensure continued access to healthcare (Deontology Support)
* Do people oppose UHC for utilitarian reasons?
  + Can we DIRECTLY ask others if they think a transition to UHC will affect their ability to access goods and service equitably (level one), or even if they think it will be ‘equitable’, do they think with UHC their access to healthcare overall will STILL be worse than what they have?
    - E.g. asking if there isn’t enough pie to go around
    - This addresses concerns regarding personal utility – e.g. they think UHC would be bad for utilitarian reasons (their own personal utility)
  + Do people legitimately believe in “Survival of the Fittest” being best for society?
  + do you believe that more Americans would be better off if healthcare was only provided to those who work? Most of those that do not work will find it more difficult to access healthcare (Utilitarian Opposition)
* Do people support UHC for utilitarian reasons?
  + Do you believe more Americans would be better off if healthcare was provided without requiring work? Some will choose to not work, if it is not necessary for them to have healthcare (Utilitarian Support)

Directly assessing Normative Principles used to justify moral judgements (Aktas 2017).

* We can ask the subjects, after they make a choice in the ‘ethical dilemmas’ to determine what normative principle they used for judgement in the dilemma.
  + We would have to frame the individual elements as ‘dilemmas’ (e.g. present the subject as a choice-making stakeholder in a toy circumstance)
    - This dilemma could be modelled after some of the known information reflecting the various costs/benefits of UHC and other concerns.
* Uhlmann (2015) Theorized that people evaluate a person’s general moral character instead of individual actions.
  + “Thus a person who smothers a baby to save a group of fellow citizens might be judged to perform the right action from a utilitarian point of view but still be undesired as a friend because of a presumed defect in his character”
  + Alternative framing using 2 dimensional utility: I am concerned because the person has EXTREME amounts of Instrumental Harm score, even if they express generally acceptable Impartial beneficence?
* How do we determine what are the normative principles used?
  + Questions RE: grounds for judgements
    - Acting on non-moral grounds: “Moral reasons did not play an important role in my judgement”
    - Virtue-ethical principle: “Someone who intentionally harms an innocent person cannot be moral”
    - Deontology: “Intentionally harming an innocent person is against fundamental moral rules and is thus unacceptable regardless of it’s intended consequence”
    - Utilitarianism: “Moral action is what ensures the well-being of the maximum number of people”
      * Note that I think we can split this into an Instrumental Harm item, and an Impartial Beneficence item
    - Fatalism/Fate: “It is wrong to interfere with consequences that arise as a result of the natural course of events no matter what the ensuing harm is.”
  + Participants were asked to choose one of the five justifications for their choices in each of the dilemmas (order randomized!)
  + The guiding principle can also be seen as being rated, the importance of each principle from 1-5!
    - * This was what was done in the expansion, Study 3
* Can we make salient the resource limited nature of healthcare, and how it plays out between private insurance and UHC?
  + When people understand that there is an unavoidable need to choose between patients, they appear to recognize that securing the most benefit overall is both logical and ethical (Arora et al;, 2016)
  + E.g. Can we provide vignettes that illustrate what happens when there isn’t enough healthcare to go around, and that in the private sector, it’s whoever has money/job/etc., but in UHC, there are explicit choices made between who can get care (or wait time, etc.)
    - People realize that even in private care there isn’t enough to always go around, etc.

Moral Intensity Experimental Protocol Draft:

After providing either MORALIZED framing (high moral salience) or NON-MORALIZED framing (low moral salience), we expose to basic UHC pamphlets, and then measure difference in support

* Hypothesis: Non-moral framing will be MORE effective for attitude change in those with neutral/negative stances towards UHC (e.g. starting with a 4 or less on a 7 point scale), and less effective for those that already favor UHC
  + Corollary: Moral framing will be LESS effective for attitude change in those who are neutral/negative towards UHC, and MORE effective for those that already favor UHC.

Measure Support for … perhaps 2 items? (one of interest, one that will be seen as less moral, and one of our pre-chosen ones that seemed more moral)

To see how much ‘moral conviction’ participants have before hand, use Skitka 2005’s single item measures of moral conviction.

* “My feelings about X are a reflection of my core moral beliefs and convictions”
* “To what extent is your attitude about X a reflection of your core moral beliefs and convictions?.

Hypothetical Moral Framing Device:

* Moral (Arguments adapted from Crisp, 2017):
  + Some countries use a system for healthcare that guarantees certain minimum standards and availabilities of care to all citizens, regardless of their ability to pay. This is generally called Universal Health Care (UHC). However, simply guaranteeing UHC through law does nothing to ensure that citizens receive adequate care. Therefore, the important question arises – who will pay for UHC? The clear answer is the U.S. government.
  + The U.S. government has long promised Americans life, liberty, and the pursuit of happiness. It is impossible to reach these guaranteed rights however, unless one is in good health.
  + Additionally, while individual health is the responsibility of every citizen, it is almost an inevitability that most normal Americans will experience an injury or illness that cannot be self-solved, whether due to a lack of knowledge and skill, or due to incapacitation resulting from the injury or illness itself.
  + Good health is also unique in that it has no equivalent, if you break your iPhone, you can choose to not replace it, but generally there is no alternative to fixing a broken arm or receiving chemotherapy for cancer.
  + Furthermore, healthcare today is so complex and expensive that even hard-working Americans, with full-time jobs and good savings, not just poor people, can be excluded from access to necessary healthcare. Significant healthcare costs beyond what the average American can pay could happen to anyone, at any time.
  + Considering that America is seen by many as the land of opportunity, American citizens should demand UHC from their government. That way, everyone has access to a sufficient level of healthcare, helping to enable all Americans to pursue life, liberty, and happiness.
* Non moral (some arguments adapted from Bloom 2018)
  + Some countries use a system for healthcare that guarantees certain minimum standards and availabilities of care to all citizens, regardless of their ability to pay. This is generally called Universal Health Care (UHC). However, simply guaranteeing UHC through law does nothing to ensure that citizens receive adequate care. Therefore, the important question arises – who will pay for UHC? The clear answer is the U.S. government.
  + The U.S. government already spends a significant amount of GDP on healthcare, totaling more than 18.3% in 2022. This is in comparison to some of our peers with UHC, such as Canada (12.2%) and Japan (11%). Surprisingly, our estimated lifespans are shorter (78.5 years, vs 82.6 and 84.45, for Canada and Japan)!
  + Increased coverage of healthcare services allows for all American citizens to benefit from population-level impact changes on many current healthcare crisis today. UHC has been shown to reduce catastrophic healthcare costs, lower maternal and infant mortality, and reduce health disparities across regional and socioeconomic barriers.
  + The effects of a small-scale increase of healthcare access, through statewide Medicaid expansion have already been seen. Those who have benefited from Medicaid expansion had eliminated catastrophic medical costs, lower medical debt, reduced depression, and improved perception of their own health status, compared to those who did not benefit from Medicaid expansion.
  + Considering that America has been spending more money to get worse outcomes, American citizens should demand UHC from their government. That way, everyone can benefit from an increased life-span, and an increased quality of life.
* Control (neutral)
  + Some countries use a system for healthcare that guarantees certain minimum standards and availabilities of care to all citizens, regardless of their ability to pay. This is generally called Universal Health Care (UHC).