**Understanding the Morality/Ethics Behind Support/Opposition for Universal Health Care**

Theoretical Empirical Questions to Answer?

1. Why do people support or oppose UHC?
   1. Do people support or oppose UHC primarily for deontological or utilitarian reasons?
      1. Is there a general relationship between both orientations and potential scores (high/low) and support for UHC?
   2. Supporting arguments:
      1. Deontological:
         1. “Healthcare is a human right, that should not be treated as another commodity to be traded for profit in the marketplace”.
      2. Utilitarian:
         1. “Medical resources are finite and UHC is the best tool to distribute them to reach maximum health care benefits for greatest number of people” (utility for society perspective).
         2. “UHC is a ‘necessary evil’, while it is immoral to provide ‘handouts’ the improvements in general health (for those hard working Americans that get unlucky) are a worthwhile utility tradeoff.”
   3. Opposing arguments:
      1. Deontological:
         1. Concerns about excessive state power (alternatively, trust in private corporations and the “free market”).
         2. Individual liberty is more important than ‘social justice’.
         3. People only deserve health-care if they ‘contribute’ to society.
         4. Your right to healthcare doesn’t over-rule my right to own private property – e.g. society must NOT tax the population in order to finance medical care for the poor.
         5. It’s good that only people who work get healthcare – the only people who deserve healthcare are those willing to work.
      2. Utilitarian:
         1. “I personally ‘get more’ utility of using my resources in order to advance my own interests rather than having some of my resources redirected to provide utility to others”
         2. “The United States cannot provide UHC because we simply do not have the resources to do so, money spent on UHC takes away from necessary [insert utility gaining function here, e.g. military spending]”
2. Is there a relationship between political orientation and how that moderates the effect of deontological/utilitarian orientation on support for UHC?
3. Does Universal Health Care have a social consensus (positive or negative)
   1. Obvious answer would be no, since it hasn’t been implemented in the U.S.A.
      1. Important because high or low social consensus affects the relationship of moral orientation (deontology/utilitarianism) on support for UHC. This is because ‘personal judgements’ are considered unnecessary.
      2. May be a good idea to assess this using a general measure of social consensus of various tasks/schemas (as part of a pilot?)
   2. Can we directly manipulate the salience/perception of social consensus towards UHC?
      1. If so, in conditions where social consensus is manipulated to be high (in favor or opposed) should show high/low support of UHC regardless of deontology/utilitarianism.
      2. In contrast, if social consensus is seen as low (mixed support or opposition for UHC), we should see significant effects of deontology/utilitarianism?
4. Does Universal Health Care have Scientific Consensus (probably?)
   1. More importantly – What is the perceived SCIENTIFIC (not moral) consensus on UHC… is this even a plausible consideration?
      1. Perception of scientific consensus amongst the public, specifically.
5. Is the effect moderated by participants simulating development of the HBP?

Measures to Address Empirical Questions?

1. Ethical Standards of Judgement Questionnaire (ESJQ)
   1. Recently validated (2018) survey that assesses formalism and consequentialism on ethical perceptions.
   2. Two 6-item subscales, each corresponding to formalism/utilitarianism.
   3. Measures each moral aspect as it’s own unique dimension.
2. Emotional regulation (Lee & Gino 2014)
   1. Simple ‘Two-question’ procedure asking about positive/negative affect, as well as level of arousal (0-10, 5 is neutral)
   2. Participant was asked to either assess emotional suppression or emotional reappraisal as a strategy measured by directly querying participant on their own willingness to use these strategies, as well as how much emotion they would express when they made a moral judgement.
      1. This open-ended answer was coded by outside raters from (1 = no attempt to suppress, 7 = complete suppression of emotion).
      2. Emotional suppression and reappraisal encourages more utilitarian choices in ‘emotionally charged’ contexts (contexts of low social consensus?), mediated by decreased deontological inclinations!
   3. ADD MORE STUFF
3. Measures of Self Worth/Others Worth
   1. Strengths of deontological/utilitarian inclinations were related to contingencies of self-worth.
4. Perception of Social Consensus Measurement
   1. Newstrom and Ruch (1975) Consensus Scale:
      1. Asked “What is the extent to which they believed that other (students/family/friends) agreed that these behaviors were ethically good or bad”
      2. Provided a scale of items of high and low consensus, in addition to the item consensus is wished to measure.
         1. One set of items, for example:
            1. Actively benefiting from illegal actions (“Drinking a soda without paying for it”, “Calling in sick to take a day off”)
            2. Passively benefiting from illegal actions (“Not saying anything when waitress miscalculates bill in your favor”)
         2. Alternatively, providing ‘bigger picture’ items, with some of known high or low consensus
            1. High: “Slavery is Bad”
            2. Low: “Capital Punishment is Bad”
      3. Responses fall on a 5 point likert scale, ranging from “There is a great deal of disagreement” to “There is a great deal of agreement”
   2. Kobayashi 2018 Anchoring Exercise:
      1. Initially asked to rate scientists’ competence in each of these issues, and trust in scientsts’ opinions about each issue (7-point likert scale, not competent/competent, not trustworthy/trustworthy), as well as familiarty towards each of the issues (not famililar/familiar)
      2. Presented as a ‘fictitious survey’ – “In In 2013, some research institutes jointly conducted a survey of scientists’ opinions ([the scientific consensus feedback and no feedback conditions], Japanese people’ opinions [the public consensus feedback condition]) about a variety of scientific issues, with a random sample of 1,052 scientists, including those who worked in fields relevant to each issue ([the scientific consensus feedback and no feedback conditions], 2,325 ordinary Japanese people [the public consensus feedback condition]).
         1. Asked to estimate recent past levels of scientific/public (should be either that, or social) consensus on various issues (with the important ones included)
         2. Estimation was given as a percentage of (relevant scientists/their social network/general public) who would agree on various pointed statements. (e.g. Human Activity is cause of global warming, United States should adopt UHC, etc.)
         3. Then they were given either feedback on the public/scientific consensus, which was manipulated either 20% points up/down (in order to create perception of higher or lower social consensus!)
         4. Also asked to rate their surprise at the given consensus information from (not surprised/very surprised)
      3. Then they were asked to estimate CURRENT levels of scientific/public consensus
      4. Then they ranked their own agreement (strongly disagree/strongly agree)
5. Support for Universal Health Care?

Overall, we want to measure deontological/utilitarian inclinations, then put people through a social consensus exercise where consensus is manipulated either up or down, then assess support for UHC after the consensus manipulation!

* Answers the question of: What is the inherent perception of consensus ‘as is’ for UHC, what are the deontological/utilitarian leanings of people either in support or opposition to UHC (and do they interact with social consensus to affect support for UHC?)
* Does social consensus impact support for UHC?