

VIEWPOINT

**Donald M. Berwick,
MD, MPP**
Institute for Healthcare
Improvement, Boston,
Massachusetts.



Viewpoint and
Editorial

The Moral Determinants of Health

The source of what the philosopher Immanuel Kant called “the moral law within” may be mysterious, but its role in the social order is not. In any nation short of dictatorship some form of moral compact, implicit or explicit, should be the basis of a just society. Without a common sense of what is “right,” groups fracture and the fragments wander. Science and knowledge can guide action; they do not cause action.

No scientific doubt exists that, mostly, circumstances outside health care nurture or impair health. Except for a few clinical preventive services, most hospitals and physician offices are repair shops, trying to correct the damage of causes collectively denoted “social determinants of health.” Marmot¹ has summarized these in 6 categories: conditions of birth and early childhood, education, work, the social circumstances of elders, a collection of elements of community resilience (such as transportation, housing, security, and a sense of community self-efficacy), and, cross-cutting all, what he calls “fairness,” which generally amounts to a sufficient redistribution of wealth and income to ensure social and economic security and basic equity. Galea² has cataloged social determinants at a somewhat finer grain, calling out, for example, gun violence, loneliness, environmental toxins, and a dozen more causes.

When the fabric of communities upon which health depends is torn, then healers are called to mend it. The moral law within insists so.

The power of these societal factors is enormous compared with the power of health care to counteract them. One common metaphor for social and health disparities is the “subway map” view of life expectancy, showing the expected life span of people who reside in the neighborhood of a train or subway stop. From midtown Manhattan to the South Bronx in New York City, life expectancy declines by 10 years: 6 months for every minute on the subway. Between the Chicago Loop and west side of the city, the difference in life expectancy is 16 years. At a population level, no existing or conceivable medical intervention comes within an order of magnitude of the effect of place on health. Marmot also estimated if the population were free of heart disease, human life expectancy would increase by 4 years,¹ barely 25% of the effect associated with living in the richer parts of Chicago instead of the poorer ones.

How do humans invest in their own vitality and longevity? The answer seems illogical. In wealthy nations, science points to social causes, but most economic investments are nowhere near those causes. Vast, expen-

sive repair shops (such as medical centers and emergency services) are hard at work, but minimal facilities are available to prevent the damage. In the US at the moment, 40 million people are hungry, almost 600 000 are homeless, 2.3 million are in prisons and jails with minimal health services (70% of whom experience mental illness or substance abuse), 40 million live in poverty, 40% of elders live in loneliness, and public transport in cities is decaying. Today, everywhere, as the murder of George Floyd and the subsequent protests make clear yet again, deep structural racism continues its chronic, destructive work. In recent weeks, people in their streets across the US, many moved perhaps by the “moral law within,” have been protesting against vast, cruel, and seemingly endless racial prejudice and inequality.

Decades of research on the true causes of ill health, a long series of pedigreed reports, and voices of public health advocacy have not changed this underinvestment in actual human well-being. Two possible sources of funds seem logically possible: either (a) raise taxes to allow governments to improve social determinants, or (b) shift some substantial fraction of health expenditures from an overbuilt, high-priced, wasteful, and frankly confiscatory system of hospitals and specialty care toward addressing social determinants instead.

Either is logically possible, but neither is politically possible, at least not so far.

Neither will happen unless and until an attack on racism and other social determinants of health is motivated by an embrace of the moral determinants of health, including, most crucially, a strong sense of social solidarity in the US. “Solidarity” would mean that individuals in the

US legitimately and properly can depend on each other for helping to secure the basic circumstances of healthy lives, no less than they depend legitimately on each other to secure the nation’s defense. If that were the moral imperative, government—the primary expression of shared responsibility—would defend and improve health just as energetically as it defends territorial integrity.

Imagine, for a moment, that the moral law within commanded shared endeavor for securing the health of communities. Imagine, further, that the healing professions together saw themselves as bearers of that news and leaders of that change. What would the physicians, nurses, and institutions of US health care insist on and help lead, as an agenda for action? A short list follows, the first-order elements of a morally guided campaign for better health.

- US ratification of the basic human rights treaties and conventions of the international community. The US, alone among western democracies, has not ratified a long list of basic United Nations agreements on human rights, including the International Covenant on

**Corresponding
Author:** Donald M.
Berwick, MD, MPP,
Institute for Healthcare
Improvement, 53 State
St, 19th Floor, Boston,
MA 02109 (donberwick@gmail.com).

Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination Against Women, the Convention on the Rights of the Child, the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, and the Convention on the Rights of Persons with Disabilities.

- Realization in statute of health care as a human right in the US. The number of uninsured individuals in the US is 30 million and increasing. No other wealthy nation on earth tolerates that.
- Restoring US leadership to reverse climate change. The US is nearly alone in its withdrawal from the Paris Agreement.
- Achieving radical reform of the US criminal justice system. The US has by far the highest incarceration rate in the world, and it imprisons people of color at 5 to 7 times the rate of white persons.
- Ending policies of exclusion and achieving compassionate immigration reform. State-sponsored violence, child abuse, and family separation due to US policies remain widespread at the southern border. Congress has failed repeatedly to enact immigration reform.
- Ending hunger and homelessness in the US. These are completely addressable issues.
- Restoring order, dignity, and equity to US democratic institutions and ensuring the right of every single person's vote to count equally. Science is under attack within crucial US agencies, voter suppression tactics continue, and the Electoral College, in which the weight of a citizen's vote varies by a factor of 70 from state to state, is profoundly undemocratic.³

To many US physicians and nurses who trained for, are committed to, and are experienced in addressing health problems in individual patients, this campaign list may seem out of character. However, if the moral law within dictated that the shared goal was health, and if logic counseled that science should be the guide to investment and that the endeavor must be communal, not just individual, then the list above would be a clear and rational to-do list to get started on well-being. The agenda includes, but is by no means restricted to, ensuring care for patients with illness and disease, no matter how they acquired their health conditions. But it ranges broadly into the most toxic current social circumstances, including institutional racism, that make people—especially people of color and of lower income—become ill and injured in the first place. It is an agenda for fixing the horrors of the subway map.

No sufficient source of power exists to achieve the investments required other than discovery of the moral law within, with all its "awe and wonder," as Kant wrote. The status quo is simply too strong. The vested interests in the health care system are too deep, proud, and understandably self-righteous; the economic and lob-

bying forces of the investment community and multinational corporations are too dominant; and the political cards are too stacked against profound change.

The moral force of professional leadership can also be powerful, once grounded and mobilized. A difficult question follows: ought the health professions and their institutions take on this redirection? To use a recent vernacular, what is health care's "lane"?

Honest and compassionate people disagree about health care's proper role in improving social conditions, countering inequity, and fighting against structural racism. Some say it should remain focused on the traditional: caring for illness. Others (this author among them) believe that it is important and appropriate to expand the role of physicians and health care organizations into demanding and supporting societal reform.

The angry, despairing victims of inequity, and their supporters, marching in the streets of the US despair in part because they and their parents and their grandparents and generations before have been waiting far too long. They find no moral law in evidence, no social contract bilaterally intact. They do not believe in promises of change, because for too long people remain hungry and homeless, with the doors of justice so long closed.

What specific actions can individuals and organizations take toward the morally guided campaign sketched above? Physicians, nurses, and other health care professionals can speak out, write opinion pieces, work with community organizations devoted to the issues listed, and, most important of all, vote and ensure that colleagues vote on election days. Organizations can also act: they can contact local criminal justice authorities and develop programs to ensure proper care for incarcerated people and create paths of reentry to work and society for people leaving incarceration. They can identify needs for housing and food security in local communities, set goals for improvement, and manage progress as for any health improvement project. They can pay all staff wages sufficient for healthy living, which is far above legal minimum wages. They can lobby harder for universal health insurance coverage and US participation in human rights conventions than for the usual agendas of better reimbursement and regulatory relief. They can examine and work against implicit and structural racism. They can do whatever it takes to ensure universal voter turnout for the entire health care workforce.

Healers are called to heal. When the fabric of communities upon which health depends is torn, then healers are called to mend it. The moral law within insists so. Improving the social determinants of health will be brought at last to a boil only by the heat of the moral determinants of health.

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