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.

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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-
The vested interests in the health care system are too deep, all its “awe and wonder,” as Kant wrote. The status quo is simply too 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 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 lobbying 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 agenda 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.

ARTICLE INFORMATION
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REFERENCES