



Health Equity, Solidarity and the Common Good

Who Lives, Who Dies, Who Tells Your Story

By MEGHAN CLARK, PhD

Viewed through the lenses of Catholic social teaching and solidarity, the 2014 Ebola epidemic was a failure of both, because health equity is at the center of the Catholic understanding of health care as a basic human right of all persons, regardless of ability to pay or citizenship status.

“Health is not a consumer good but a universal right, so access to health services cannot be a privilege,” says Pope Francis.¹

Unfortunately, Catholic social teaching’s approach is radically countercultural.

In the summer of 1997, my quiet day at the beach ended abruptly when another car failed to stop at a stop sign. In that split second, my life changed forever. Memories of the car accident remain fuzzy; almost dreamlike, because I sustained a substantial head trauma. At age 16, the realities of post-concussive syndrome and learning to manage chronic illness dominated my ensuing years.

I had migraines, and I worked with a medical team to control them well enough to be able to address a vestibular problem and its vertigo. After two years of intensive vestibular rehabilitation at NYU Langone Medical Center’s Rusk Rehabilitation, I graduated from physical therapy as I graduated from college. With a stable medication regime and medical clearance to drive, I achieved a delicate balance. As I was finishing graduate school, a second concussion reminded me just how fragile that balance is — and the reality of chronic health conditions. Migraines and medication always will be a part of my life.

Paul Farmer, MD, PhD, chair of the Harvard Medical School’s Department of Global Health

and Social Medicine, is a noted medical anthropologist and co-founder of the Boston-based non-profit Partners in Health. In his book *Pathologies of Power: Health, Human Rights and the New War on the Poor*, Farmer concludes by asking: “If access to health care is considered a human right, who is considered human enough to have that right?”²

That question haunts me. I did not earn the protection of health insurance or access to world-class medical professionals. It is a painful recognition that the diagnostic equipment and therapies that were part of my care are not available in much of the world. What’s more, in much of the world, my care would not be deemed cost effective or an efficient use of resources.

Farmer’s challenge about human rights begins to illuminate the radical vision of Catholic social teaching. Illness is an area of human vulnerability that we all experience. For those with access to health care, this vulnerability is a place for further reflection on human rights and the equal humanity of those denied access to care.

THE COMMON GOOD, CLARIFIED

In the 1970s, Fr. Peter Henriot, SJ, famously quipped that Catholic social teaching was the church’s best-kept secret. In 2016, theologians and activists still lament its relative obscurity. Words like human dignity, the common good and soli-



Jon Lezinsky

ON THE COMMON GOOD

It is our responsibility, as nurses in Catholic health care, to serve and promote not only the health and well-being of our patients but all individuals in our community. We must have an intentional commitment to sharing our resources and encouraging the greatest good for those who may be marginalized — the poor, vulnerable and underserved. It is through this viewpoint that we reflect on the impact of the decisions we make each day.

Melissa D. Cullum, MercyCare

ilarity get invoked, but they always seem kind of vague and abstract.

Pope John XXIII offered the definition of the common good as “all those social conditions which favor the full development of human personality.”³ Repeated by the Second Vatican Council, it is the most widely used definition, yet it does little to help one understand and apply the common good.

A companion to the principle of human dignity, the common good provides the overarching theme for evaluating relationships in society. The common good is at once a principle and an elusive destination. All social and economic policy should be directed at it, and it is a perpetual project. Since people and societies always are limited and developing, working for the common good is always ongoing.

PARTICIPATION AND INCLUSION

Thirty years ago, the National Conference of Catholic Bishops’ pastoral letter, “Economic Justice for All,” clarified the common good in terms of participation and justice. At the minimum, “Basic justice demands the establishment of minimum levels of participation in the life of the human community for all persons.”⁴ Having defined basic justice as participation, the bishops go on to explain that “The ultimate injustice is for a person or group to be treated actively or abandoned passively as if they were nonmembers of the human race.”⁵

Such patterned and structural exclusion is

what Pope Francis calls the “throw away culture.” Writing in the apostolic exhortation *Evangelii Gaudium*, he says that we live in a world where “human beings are themselves considered consumer goods to be used and then discarded,”⁶ which the pope calls a violation of both human dignity and the common good.

“Exclusion ultimately has to do with what it means to be a part of the society in which we live; those excluded are no longer society’s underside or its fringes or its disenfranchised — they are no longer even a part of it,” he says. “The excluded are not the ‘exploited’ but the outcast, the ‘leftovers.’”⁷

Jesuit theologian David Hollenbach identifies three strategic moral priorities of the common good:⁸

- The needs of the poor take priority over the wants of the rich
- The freedom of the dominated takes priority over the liberty of the powerful
- The participation of the marginalized takes priority over the perseverance of an order that excludes them

In terms of Catholic social teaching, the common good’s three moral priorities encompass these distinctive elements:

- Attention to each person’s human dignity
- Prioritization of the poor and marginalized
- Importance of participation

Influenced by Dominican liberation theologian Gustavo Gutierrez, Farmer argues in *Pathologies of Power* for strategic moral priorities through



what he calls the epidemiological insight, noting “most often diseases themselves make a preferential option for the poor.”⁹

By defining social justice through participation and inclusion, the concept of the common good shifts to mandate not only meeting basic needs, but also to equal regard and agency of those otherwise excluded.

The common good in Catholic social teaching directly contrasts with utilitarianism. Forms of utilitarianism often place human dignity and the common good in competition, seeking the greatest good for the greatest number. This leads to a particular priority on efficiency and risks reducing individual persons to abstract statistics.

In Catholic social teaching, the whole is greater than the part or mere sum of the parts. As Pope Francis explains, “It is the convergence of peoples who, within the universal order, maintain their own individuality; it is the sum total of persons within a society which pursues the common good, which truly has a place for everyone.”¹⁰

HEALTH EQUITY AND THE COMMON GOOD

At its core, health care ethics is not about persons and communities. Pope Francis eloquently summarizes, “There is no human life more sacred than another, just as there is no human life qualitatively more significant than another. The credibility of a health care system is not measured solely by efficiency, but above all by the attention and love given to the person, whose life is always sacred and inviolable.”¹¹

In April 2016, I had the privilege of participating in a Kellogg Institute program called “From Aid to Accompaniment” at the University of Notre Dame. Led by Farmer, scholars and practitioners focused on global health equity. One constant topic of conversation was the 2014 Ebola outbreak in West Africa. According to the Centers for Disease Control and Prevention, this, the largest Ebola outbreak in history, claimed 11,325 lives out of an estimated 28,652 total cases (15,261 confirmed).¹²

Ebola is a pathogen surrounded by fear and fascination. Often, Ebola’s high mortality rate is simply accepted as a given, so the focus becomes containment, not treatment. However, Farmer and his colleagues strongly disagree with this approach. Poverty, not the pathogen, is the crux of the problem, they maintain. The legacy of colonialism and

conflict, as well as persistent underdevelopment in public systems, create the perfect storm for a pathogen like Ebola.

Farmer discussed his experience in Liberia during the epidemic and lamented the lack of global interest in the ravaged communities. Liberia, Sierra Leone and Guinea had a high death rate from Ebola because they lack what Farmer labels the 4 S’s: staff, stuff, space and systems. Staff, equipment (protective gear and IV fluids), safe clinical spaces and public health systems with adequate resources still are desperately needed but, as yet, have not been deemed a development priority in those countries. Emergency response focuses on the crisis at hand; however, the deeper long-term need is in building health systems in the developing world.

At issue is a lack of health equity, of investment in building public health structures. This is, fundamentally, a matter of the common good.

Farmer and others in the global health equity movement issue a profound challenge to visions of development that simply assume low resource contexts will remain such, and, therefore, goals are reduced accordingly. He challenges global health to envision quality care for all and work towards building the necessary health systems. Recently, the University of Global Health Equity opened in Rwanda, seeking to develop new teaching meth-

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ods to equip health care professionals in resource constrained settings.¹³ Examining Farmer’s challenge to prevailing assumptions about Ebola within the context of the common good moves the question of health equity front and center.

From the perspective of Catholic social teaching, cultivating the virtue of solidarity is the next step. Together we must practice respect for equal human rights and work for health equity so that “a firm and persevering determination to commit oneself to the common good” of all emerges.¹⁴ The common good is present “in a community of

solidarity among active, equal agents,” explains Hollenbach, and “when these relationships form reciprocal ties among equals, the solidarity achieved is itself a good that cannot otherwise exist.”¹⁵

At Notre Dame, Farmer spoke to a packed audience of students.

“Do you know what was my brilliant idea to bring people into this important problem?” he asked. “Ebola: The Musical.”

The room erupted in laughter.

“You laugh,” he responded, “but shouldn’t we use our best minds and creativity to make addressing Ebola as immediate and important, as say, getting tickets to the musical ‘Hamilton?’”¹⁶

Questions of legacy and narratives are overriding themes in “Hamilton.” In the concluding musical number, General George Washington laments, wishing he had understood that “you have no control, who lives, who dies, who tells your story.”¹⁷

On one level, there is a deep truth contained in that verse: the inherently relational aspect of human existence. We are always in communities, we are shaped by them, and ultimately others will tell our stories — or not. Power and privilege always have been significant influences of whose stories get told.

Thus, the challenge of Washington’s lament: What of the community? Whose stories do we prioritize and choose to tell?

Will scores of Ebola survivors and victims ever make the list?

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NOTES

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