

# A Catholic Case for Public Health

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## Introduction

*“A man was going down from Jerusalem to Jericho, and fell into the hands of robbers who stripped him, beat him, and went away, leaving him half dead. Now by chance a priest was going down that road; and when he saw him, he passed by on the other side. So likewise a Levite, when he came to the place and saw him, passed by on the other side. But a Samaritan while traveling came near him; and when he saw him, he was moved with pity. He went to him and bandaged his wounds, having poured oil and wine on them. Then he put him on his own animal, brought him to an inn, and took care of him. The next day he took out two denarii, gave them to the innkeeper, and said, ‘Take care of him; and when I come back, I will repay you whatever more you spend.’ Which of these three, do you think was a neighbor to the man who fell into the hands of the robbers?” He said, “The one who showed him mercy.” Jesus said to him, “Go and do likewise.” (Luke 10:30-37)*

There are few stories in the Christian imagination more powerful than Luke’s Good Samaritan. And there are few injunctions more clearly lived out by the Catholic Church than going and likewise caring for the sick and suffering. The work done to care for the sick has a rich history in the church and is grounded in the desire to participate in the healing ministry of Christ. In this essay I intend, however, to show that there is an unexplored case to be made for the church’s activity in public health, or population health. Although

complementary in many ways, I intentionally juxtapose medicine and public health as ways to “go and do likewise” in order to emphasize the latter’s potential for fruitful ministry.

The distinction is not always perfect, but medicine focuses on treating individual patients who are already ill while public health focuses on preventing illness at the population level. The difference is not clean because physicians also attempt to prevent disease at the individual level or work with populations; and public health

attempts to bring communities from states of illness to health or work with individuals.<sup>1</sup> But the primary tasks persist. While medicine and public health obviously work together, in a context of limited resources—as health services always are—choices must be made about where to place emphasis. The tension between prevention and cure is unresolved in civil society,<sup>2</sup> and I believe the Catholic community should feel greater tension than it does with regard to where it places its resources.

As a relatively new discipline, public health often finds itself pushing against the established medical order, especially in the American context. First, medicine emphasizes disease diagnosis and treatment at the individual level while public health focuses on the population level. Therefore, medicine fits much more easily with the individualism and libertarian ethos of the United States. Second, the effects of medicine are more immediate and visible, with patients literally rising up from a hospital bed and walking home. Public health often requires long-term thinking and its effects are often the absence of an illness. With this, medicine has the advantage of tapping into our established empiricism and our growing need for immediacy. Third, medicine is increasingly dependent on technology, while public health employs behavioral, environmental, and policy changes that have less reliance on the newest advance. Once again, medicine wins in a society that believes salvation comes with the next discovery. Finally, medicine requires highly trained clinicians who create an almost-priestly class, with

knowledge and abilities upon which the faithful depend. Public health professionals, while professionally trained, do not have the same social status as physicians. Therefore, medicine has a more respected voice in the public square.

It may seem like I am presenting a facile dichotomy, but it is important to understand why medicine so dominates the public's imagination when it comes to use of health resources. It follows, of course, that because a large majority of resources are placed into medical care, a large majority of ethical and moral thinking, both within and outside of the church, has been directed toward it as well. Medical ethics, which arose from the tragedy of Nazi experiments during World War II, has decades of dedicated study while public health ethics is just building its foundations.<sup>3</sup>

### Emphasis on Medical Care

The Catholic presence in medical care is a line stretching from the healing ministry of Jesus to the robust national and international health systems operated today.<sup>4</sup> Early Christian deacons were to provide *hospitalitas*, a term that spoke to caring for another's deepest needs, including illness. Care centers were established in a variety of forms including inns for travelers, orphanages, and homes for the aged, all in the name of *hospitalitas*. But the modern hospital system appeared in its inchoate form with the advent of monasteries. The extensive monastery system that began with St. Benedict and eventually was found throughout Europe provided the necessary stability for

caregiving, became repositories of medical knowledge, and eventually became partners with civil institutions that were started by Christian governments. Although the Reformation and the rise of the nation-state changed the overall complexion of Catholic health care in Europe, the rise of religious orders devoted to health care and the missionary activity of the church around the world were vital to an ever-increasing presence of Catholic health care. In the United States, the dedication of women religious to personal care and their subsequent professionalization through specialized training led to an impressive system of Catholic hospitals. In 1915, members of the Sisters of St. Joseph and Fr. Charles Moulinier, SJ, founded the Catholic Hospital Association. The organization was subsequently renamed the Catholic *Health Association*, but its primary emphasis is still hospital administration.

The Catholic health care system has roots in the life and ministry of Jesus, grew up with Christian Europe, and is now a major influence in the United States and around the world. Catholic hospitals serve 15% of all patients in the United States<sup>5</sup> and it can be over 50% of all hospital beds in countries with little government health infrastructure, such as the Democratic Republic of Congo. In the United States alone, Catholic hospitals annually spend nearly \$100 billion on health care delivery.<sup>6</sup> Internationally, the figures, although certainly substantial, are almost impossible to ascertain because they flow out of so many different levels of the church – parishes, schools, dioceses, and hospitals.

So what are the reasons for continued engagement in health care? The short answer is the major sources of moral reflection: Scripture, tradition, human experience, and rational reflection. There are at least 18 healing miracles in the Gospels where Jesus gave sight to the blind (Matthew 9:27-31), cured the leper (Luke 5:12-16), or enabled the lame to walk (Mark 2:1-12). But as important as the example of Jesus himself is, the mission of those he sends out into the world is just as telling. “Whenever you enter a town and its people welcome you, eat what is set before you; cure the sick who are there, and say to them, ‘The kingdom of God has come near to you.’” (Luke 10: 8-9) In Scripture, curing the sick is not just a physical reality; it is a sign of God’s kingdom. It not only heals the body, but restores the soul and welcomes the cured back into the community. It is spiritual and social restoration as well as physical healing. Medicine’s rootedness in Jesus cannot be overstated for the Christian community. It not only authenticates the ministry throughout history; it has a powerful hold on the Christian imagination. It is impossible to imagine Jesus apart from his healing ministry and it would be equally difficult to imagine the church living out the fullness of its mission without doing the same.

Tradition also plays a strong role in Catholic health care. In addition to the storied history recounted above, many documents from the magisterium have lauded ministry in health care. In 1981, the United States Catholic Conference (now the USCCB) published *Health and*

*Health Care*, a pastoral letter that expressed their “full commitment to the Catholic health care apostolate and [their] encouragement of support of professionals in the health field.”<sup>7</sup> In 1994, the Pontifical Council for Pastoral Assistance published the *Charter for Health Care Workers*, where it states the work of health care “expresses a profoundly human and Christian commitment, undertaken and carried out not only as a technical activity but also as one of dedication to and love of neighbor.”<sup>8</sup> In addition to extolling the work of health care in general the magisterium has demonstrated a significant interest in particular aspects of bioethics, especially ethical questions that surround beginning- and end-of-life issues. It is clear that the magisterium sees the work of health care as essential to bolstering a culture of life.

Human experience and rational reflection are largely interconnected when considering the Catholic role in health care. The stories in Scripture and the magisterial teaching speak to ideas that transcend any particular religious tradition. We cannot enjoy the fullness of our humanity when we are sick. Our wellbeing depends, among other things, on our health. We know this to be true from lived experience, but many scholars make rational, normative claims about the essential dimension of health.<sup>9</sup>

Participation in health care, then, is a human activity that is aimed at producing a vibrant, flourishing community. In addition, there are rational, selfish reasons to want people to be healthy rather than sick, including a healthy person’s ability to contribute to society and an economy.

With increasingly expensive technology, however, health care has needed to be tempered with versions of cost-benefit analysis. Catholic health care is not immune to this challenge, but the difficulty of agreeing to a cost-benefit analysis when it comes to a human life should not be passed over quickly. Although not without its challenges, these sources point to a clear moral justification for Catholic participation in health care. However, the sources of moral reflection are less robust when it comes to public health.

### **Emergence of Public Health**

The history of public health is nearly as long as medicine, but is nowhere as storied.<sup>10</sup> Ancient Greece and Rome provide examples of efforts on food security, water potability, and sanitation, but with little knowledge of the natural history or transmissibility of diseases, there was little that could be done on a large scale to ensure the public’s health. We do not see the field of public health come into its own until the Industrial Revolution and the accompanying need for the sanitary movement which happened to be followed by the bacteriological era. The need to control disease as population densities increased was made possible largely because germ theory emerged as a way for scientists to identify pathogenic organisms. Biological advancement, accompanied by social movements to demand government action, brought public health into the modern era. And although there were individuals within the church who certainly helped advance public health

through the centuries, it would be incorrect to say that the church played a concerted effort in public health. Unlike medicine, where efforts by private institutions often precede governments, public health's original advance was most often shepherded by government action.

The rise in public health activities over the past several decades, especially in low resources settings where governments are unable to provide for public health needs, has slightly shifted that narrative. The AIDS crisis and its ability to raise awareness of related global health issues was the most significant factor in getting non-governmental organizations and faith-based organizations involved in public health. By looking briefly at the global burden of disease we might consider why public health has recently gained advocates.<sup>11</sup> When considering the top ten causes of loss of healthy life,<sup>12</sup> most of them – including diarrheal disease, cardiovascular disease, prematurity – are best solved by public health measures. We can provide antiparasitic medication to a village of children a dozen times over their childhood. Or we can provide the rotavirus vaccine and a source of potable water. We can try to treat perinatal infections with expensive medication. Or we can provide small kits to allow for clean umbilical cord care at birth. And even with historic efforts, every year we still have more people newly diagnosed with HIV in sub-Saharan Africa than new patients on anti-retroviral drugs.<sup>13</sup> In essence, we will never be able to *treat* our way out of these illnesses and into health. An analysis of the domestic

burden of disease would yield a similar conclusion.

There are examples of non-governmental actors in public health, such as Rotary International's near-heroic effort to eliminate polio through vaccination. Yet even though there are long-standing needs for water and sanitation, malaria prevention, and vaccination, very few private organizations are committed to public health in the way they have been committed to medical care. The tide is changing, but I do not believe the Catholic Church sees the full potential of embracing the work of public health. This is in part due to the existing commitments it has to medical care. But it is also because the sectors of sources for moral theology are much less obvious when it comes to public health than they are for medical care.

If a public health practitioner is looking to the Gospels to ground their work similar to resources found by doctors and nurses, he or she will be looking for quite some time. Perhaps something can be construed out of Luke 6:37-42 when Jesus calls to disciples to take the log out of their eye so that they can take the speck out of their neighbor's and they can both, therefore, avoid falling into the pit. Or perhaps Matthew 7:24-27, where the disciples are exhorted to build a house with a strong foundation so that it might withstand a future flood. Or maybe the Matthean parable of wise and foolish bridesmaids (25:1-13) conveys a message of public health, where those who are not prepared will not find the kind of life they are hoping for. But all of these examples limp

when compared to the many examples of healing found in the Gospels. Imagine how much less compelling the parable of the Good Samaritan would be if it were characterized by public health.

A man was going down from Jerusalem to Jericho, and arrived without incident. This is because Jesus provided the necessary mental health services for the men who would have otherwise beaten the man on his journey. Go and do likewise.

Or

A man was going down from Jerusalem to Jericho, and was approached by a band of robbers who needed money to care for their sick families. But the man, a passing Levite, a priest, a Samaritan, and an innkeeper were all able to sit down with the robbers. They found some of them employment that carried health insurance and others they enrolled in a social safety net. Go and do likewise.

Obviously, the parables of public health do not have the same ring as the original.

The source of tradition is slightly more fruitful. The *Charter for Health Care Workers* has a section on prevention in which it states,

Safeguarding health commits the health care worker particularly in the area of prevention. Prevention

is better than cure, both because it spares the person the discomfort and suffering from the illness, and because it spares society the costs, and not only economic costs, of treatment. ... But [preventive intervention] needs a concerted effort from all sectors of a society. Prevention in this case is more than a medical-health action.<sup>14</sup>

In their statement on health care, the United States bishops also speak of “touching the social conditions that hinder the wholeness which is God’s desire for humanity” and our duty to address threats to health that are “rooted in the structures of society.”<sup>15</sup> Although always stated in the context of medical care, these statements show appreciation for the work of public health and the necessity to think more broadly than delivering medical care as a way to promote God’s desire for full human flourishing.

Human experience and rational reflection are once again considered together. If pressed, people would probably not name public health as a discipline they highly value; certainly, it would fare worse than medicine. But if we ask about the outcomes of public health measures – clean air and water, vaccinated children who don’t get sick, ability to work in a safe environment, possibility of growing old while still healthy – these are all aspects of people’s lives that they would not want to do without and are only made possible by public health efforts. If given a choice of staying healthy or getting sick and being cured, there is no doubt that

people would choose to stay healthy. If one had the choice of his or her neighbor staying healthy or the neighbor getting sick and being cured, he or she would obviously prefer the former. Many people point to the cost-savings of public health but this is not as solid an argument as one intuitively might think. The United States spends 8-9% of health expenditures on prevention,<sup>16</sup> but there is little evidence that more preventive measures would bend the cost curve downward.<sup>17</sup> Rather, the main reason for investing in prevention is its ability to give people fuller, healthier lives than they would otherwise have.

### A Necessary Investment

Once placed on Catholic health care's radar, it will not take long to embrace the need for deeper ethical reflection on public health. For example, Ron Hamel has already noted the potential of population health and the way principles of Catholic social teaching—specifically inherent dignity of all persons, solidarity, common good, stewardship, justice, and participation—provide an already strong foundation for ethical reflection. For example, regarding the common good he writes, “what we are seeing in the development of ACOs and medical homes is the creation of structures that promote the good of individuals as well as the well-being of an entire given population.”<sup>18</sup> One of the primary challenges will be how to respect the inherent dignity of the individual while giving greater consideration to the individual's social context. The triumphalism of autonomy in secular bioethics was, in my opinion,

never particularly Catholic to begin with. Therefore, Catholic scholars could easily lead the way in the shift toward balancing individual, clinical considerations with appropriate demands that come with being part of a larger society.

One example of Catholic wisdom is found in a reflection on charity and justice as they are lived out in medicine and public health. Charity has many meanings but it is most clearly illustrated in the corporal works of mercy such as feeding the hungry, clothing the naked, and visiting the sick. It is providing immediate care for those in need, much like the Good Samaritan. Justice, also a multivalent concept, is a virtue but more grounded in logic; it is ensuring each one is given his or her due. Moreover, it is often characterized as *social* justice and therefore speaks to social structures in which we are all embedded. It would be easy to characterize medicine as an act of mercy and public health as act of justice and view them as competing with one another. Yet according to the U.S. bishops, “an essential element of our religious tradition ... is that the works of mercy and the works of justice are inseparable.”<sup>19</sup> Pope Benedict XVI also writes about this inseparability quite clearly in *Caritas in veritate*.

If we love others with charity, then first of all we are just towards them. Not only is justice not extraneous to charity, not only is it not an alternative or parallel path to charity: justice is inseparable from charity, and intrinsic to it. Justice is the primary way of

charity or, in Paul VI's words, 'the minimum measure' of it ...<sup>20</sup>

The false notions of charity as providing medical care to the uninsured and justice as working for health insurance reform are insufficient to understand their truly complex, and interdependent relationship. When a Catholic hospital provides emergency care to an uninsured patient, I find it hard to label that as "charity care." Is that care not due to him by reason of being human? Is it not the minimum measure of what should be given? Or is it from the institution's gratuity? When a Catholic hospital donates unused supplies that would have been thrown away to an institution in the global south, is that charity or justice? And if a group of doctors and nurses travel to the country where several of the hospitals' certified nursing assistants were recruited from, is that charity or justice? I would say the reflex answer from most clinicians or administrators would be that it is charity. But I am not sure that such is true and it at least deserves greater reflection. It is certainly good work that flows from loving intention, but they might more properly be considered works of justice.

Greater attention to public health has the potential to strengthen Catholic identity in health care because of public health's emphasis on the poor and vulnerable, a principle that has consistently animated Catholic health care through history. Monasteries were run as charity hospitals and missionary activity regularly brought higher quality care to areas of the world than they otherwise would have had. And when Catholic hospitals were established

in the U.S., those with wealth and social support received care at home while the poor and abandoned went to these religious institutions. Nevertheless, Catholic health care must regularly reconsider the question of what the poor need most and how the church can best respond to those needs. In my opinion, this is best done by epidemiological data on disease burden as well as prioritizing interventions that have disproportionate benefits for the poor. The option for the poor is sometimes implicit because many population-level interventions have a greater benefit for the poor and vulnerable (i.e., the wealthy would find a way to secure healthy food, vaccinate their children, and procure preventive screenings even without public health efforts). And it is sometimes explicit, such as efforts to reduce health inequities. Participation in such public health activity, therefore, could only deepen the Catholic commitment to the poor.

Further involvement in public health will likely raise difficult questions for Catholic health care. For example, at the domestic level, do the poor need specialty and tertiary care centers or do they most need community health clinics? What most effectively alleviates the burden of disease borne by the poor? And at the international level, should we model outreach on the U.S. health care system or do we need to encourage preventive medicine aimed primarily at social determinants of health? I am obviously presenting an unattractive dichotomy. The poor deserve both. Nevertheless, while large, complex health systems (even considering a large amount of 'charity'



care), might be the traditional way Catholics engage in the ministry of health care, it may not be the best way forward— theologically or epidemiologically. I don't claim to have these questions answered; I only suggest they must be asked and public health helps us do so.

Several public health measures have made for high profile challenges with the Catholic Church.<sup>21</sup> These include: harm reduction strategies such as needle exchanges; the distribution of condoms specifically for disease prevention; vaccinations, including the HPV vaccine for a sexually transmitted infection as well as vaccines originally derived from cells of aborted fetuses. Involvement in public health will not be without ethical controversy, but neither has involvement in modern medicine. Therefore, if Catholic involvement in the field increases as I suggest it should, we will need to invest as heavily in theological reflection for public health as we have with medicine.

## Conclusion

The theological resources exist for defending a greater Catholic investment in public health. Resolving the tension of investment of limited resources for medicine and public health is not *either/or* but *both/and*. Medicine is clearly an extension of the healing ministry of Jesus and has strong moral foundations, yet the emergence of public health gives us the opportunity to re-think our engagement in health care and find a different balance between the two. My hope is that it is driven by epidemiological data and

embraces theological considerations well beyond beginning- and end-of-life issues. There are nearly eight decades of life in between those moments, much of it lost to preventable illness. I believe public health and its moral demands provide the most effective means of reclaiming this loss. The pressing question is whether we have the freedom and imagination to engage it as fully as it deserves.

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<sup>1</sup> Another useful way of making this distinction is describing 'levels of preventions', which Mary-Jane Schneider does well in *Introduction to Public Health*. Regarding lung cancer: primary prevention (the work of public health) is to discourage smoking; second prevention is to detect cancer through screening; tertiary prevention (the work of medicine) includes medical treatment of cancer patients.

<sup>2</sup> *Prevention vs Treatment: What's the Right Balance* by Halley Faust and Paul Menzel is a recent book that documents the challenge of this issue.

<sup>3</sup> "An Ethics Framework for Public Health" by Nancy Kass is one of the first attempts to articulate a unique approach to public health ethics and it was only published in 2001. "Medicine and Public Health, Ethics and Human Rights," by Jonathan Mann in 1997 is another early attempt at distinguishing public health ethics from medical ethics.

<sup>4</sup> The entirety of this paragraph is referenced from John Padberg, S.J., "Catholic Health Care: The Mission and Ministry," Vols. 1-4 *Parameters* 1983, 1-8.

<sup>5</sup> "Fast Facts," Catholic Health Association, accessed November 22, 2012, [http://www.chausa.org/Pages/Newsroom/Fast\\_Facts/](http://www.chausa.org/Pages/Newsroom/Fast_Facts/)

<sup>6</sup> Catholic Health Association, 2012.

<sup>7</sup> United States Catholic Conference, "Health and Health Care: A Pastoral Letter of the American Catholic Bishops," Nov. 19, 1981, 3.

<sup>8</sup> The Pontifical Council for Pastoral Assistance to Health Care Workers, "The Charter for Health Care Workers," Vatican City, 1995, 1.

<sup>9</sup> In addition to Martha Nussbaum's capabilities approach, Madison Powers and Ruth Faden articulate six dimensions of well-being in their book, *Social Justice: The Moral Foundations of Public Health and Health Policy*, which is a useful framework.

<sup>10</sup> The background for this paragraph is from Chapters 2, 6, & 7 in George Rosen, *A History of Public Health*, (Baltimore: The Johns Hopkins University Press, 1993).

<sup>11</sup> There are many ways to present the data for global burden of disease, but the most widely accepted is Disability-Adjusted Life Years. I have therefore chosen that as my reference point.

<sup>12</sup> World Health Organization, "Global Burden of Disease: 2004 Update," Geneva: 2004, 43.

<sup>13</sup> UNAIDS, "2012 UNAIDS Report on the Global AIDS Epidemic," Geneva: 2012, 8 & 50.

<sup>14</sup> The Pontifical Council for Pastoral Assistance to Health Care Workers, "The Charter for Health Care Workers," Vatican City, 1995, 50-58.

<sup>15</sup> United States Catholic Conference, "Health and Health Care," 1981, 6-7.

<sup>16</sup> Miller, G., Roehrig, C., Hughes-Cromwick, P., and Lake, C., "Quantifying National Spending on Wellness and Prevention," in *Advances in Health Economics and Health Services Research: Beyond Health Insurance, Public Policy to Improve Health*, Emerald Group Publishing Limited, 19 (2008): 1.

<sup>17</sup> Louise B. Russell, "Prevention vs. Cure: An Economist's Perspective on the Right Balance," in *Prevention vs. Treatment: What's the Right Balance?*, edited by Halley S. Faust and Paul T. Menzel (Oxford: Oxford University Press, 2012), 71.

<sup>18</sup> Ron Hamel, "Catholic Identity, Ethics Need Focus in New Era," *Health Progress* 94;3 (May-June 2013), 87.

<sup>19</sup> United States Catholic Conference, "Health and Health Care," 1981, 6.

<sup>20</sup> Pope Benedict XVI, *Caritas in veritate*, 2009, 6.

<sup>21</sup> Nuala Kenny, "Cure vs. Prevention: Catholic Perspectives," In *Prevention vs. Treatment: What's the Right Balance?*, edited by Halley S. Faust and Paul T. Menzel (Oxford: Oxford University Press, 2012), 302-305.

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