4 *"Health for All"*
Medical Progress as Justice

In the first decades of the twenty-first century, the visions of medical progress I monitored in previous chapters remain intact. Medical progress as increased biomedical knowledge of the body, as taking charge of one's own health; these are important instantiations of the belief in progress in medicine. There is, however, another idea of progress, informed by research on different forms of oppression, including racism, sexism, and classism, that became increasingly prominent in discussions about how to improve human health. In the context of neoliberal policies of the 1990s, the idea that people are a product of intersecting circumstances beyond their control (re)emerged as a topic with implications for health, illness, and well-being. The related notion of progress was associated not so much with the "endless frontier" of knowledge, as Vannevar Bush described it,[1] nor with individual empowerment. Rather, it is connected with addressing powerlessness and social action to ensure that medical advances are more equitably shared.

As researchers from different fields used various tools and methods to shed additional light on long-standing health inequities, they (re)expanded the scope of the idea of progress in medicine beyond the narrow provision of care to a wide range of social and economic factors affecting health. The terminology also shifted from (narrow) medical progress to (wider) health progress, and this shift reflects a diminished role for specifically medical resources in ensuring better health. For this reason, while access to medical progress strictly speaking remains important, it is increasingly seen as only one of multiple factors determining health and illness. Some used the idea of health justice to create a new language of progress whereby any advance or forward movement should be judged according to roughly left-wing standards. The first World Health Organization (WHO) Commission

[1] See Chapter 2.

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on Social Determinants of Health, established in 2008, published a report stating that social injustice is "killing people on a grand scale" and demanded progress toward "closing the gap."[2] For other actors, however, the idea of progress is too associated with irreversible meliorative change, which has little bearing on the persistently precarious health situations they want to bring into view. Finally, various critiques analyze the assumptions underpinning progress as health justice and argue that causality between equity and health is overstated or that action to address social inequalities involves inflating the notion of health to the extent that it loses meaning. Reappearing in these analyses are both the harmony-based and pluralistic visions of progress I have traced throughout this book.

This chapter tracks debates on progress and social justice as they evolve from the post-war period, but it focuses particularly on the late 1980s onward. While the social model of health had various influential early proponents, it was in the early 1990s that the notion of addressing health justice garnered enough momentum to challenge fundamentally previous ideas of medical progress in academia and beyond. The critique of a medical marketplace, the perceived need to dismantle an autonomy-based notion of progress, and a certain sociopolitical optimism all contributed to reimagining medical progress by placing social factors beyond healthcare front and center. As in previous chapters, I monitor transnational developments pertaining to the idea of progress, but with a special emphasis on medicine. Part of the story told in this chapter is the extent to which increased knowledge of the social determinants of health is portrayed as embodying progress. But the story is, of course, incomplete without reference to how this knowledge can be channeled into action to mitigate illness. Here, the question of action proves a particularly thorny one, as despite the strong evidence for the health impacts of social inequities, attempts to make cumulative progress on these issues have been fraught. I end the chapter with a case study of the COVID-19 pandemic. While I cannot analyze these events from a distant historical perspective, they nevertheless offer a powerful illustration of the way in which several ideas discussed here play out in real time. The extent to which COVID-19

[2] Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*, Final Report (Geneva: World Health Organization, 2008), p. 26.

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revealed existing social fractures and determinants of ill health in societies that think of themselves as at the vanguard of medical progress, the realities of the global vaccine rollout; these provide further material for a vision of health as occurring in a much larger ecosystem than previously thought and corresponding ideas of progress as social justice.

4.1 Progress as Medical Access: Origins

The previous chapter scrutinized some visions of social progress achieved through global markets and driven by new technologies; many are associated with the belief that capitalism is a powerful agent of collective progress. Indeed, many neoliberal philosophies of progress frame both the advancement of science and practices of self-improvement as inherently contributing to the public good.[3] The idea of progress I pursue in what follows takes a rather different perspective. In its modern iteration, it can be traced at least to dialectical socialism and the Marxist notion that capitalism has significant costs. Here, the idea of progress is not diminished and may even be paramount – socialism, to recall, is firmly committed to future progress – but it did take on a different form. It focused on protesting injustice and oppression; ill health was not merely a random absence of health, but rather something unjust that deserved to be rectified.

Of course, the insight that humans are equal beings who experience injustices because of power dynamics, and that rectifying these amounts to progress, is not new. As Simon Griffiths observes, the most common understanding of progressivism is that progress is concerned with some form of social justice.[4] And as depicted in Chapter 1, the development of medical care has long been linked to ideas about social progress. Nineteenth-century physician Rudolf Virchow, for instance, called physicians the natural advocates (*Anwälte*) of the disadvantaged and thought that the majority of diseases were attributable to defects in society.[5] Similarly, public health reformers of the early twentieth

[3] See Bobby M. Wilson, "Social Justice and Neoliberal Discourse," *Southeastern Geographer*, 47 (1) (2007), 97–100.

[4] Simon Griffiths, "What Was Progressive in "Progressive Conservatism"?," *Political Studies Review*, 12 (2014), 29.

[5] R. Virchow, "Was die 'medicinische Reform' will," *Medicinische Reform*, 1 (1848), reproduced in *Gesammelte Abhandlungen aus dem Gebiete der*

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century referred to the "social machinery" that would allow every individual a sufficient level of health as progress.[6]

Indeed, as the successes of bacteriology and laboratory medicine were shaping ideas of progress in medicine (Chapters 2 and 3), alternative visions bound up with the socioeconomic factors affecting health were present as well. They are visible, for example, in the establishment of the WHO in 1948 and its founders' interest in social medicine. These include Belgian professor René Sand (1877–1953) and Andrija Štampar (1888–1958) from Croatia, who shared the opinion that individualized medicine was in crisis and that the Organization must tackle the environmental and social roots of illness.[7] Henry Sigerist, a Swiss medical historian who advocated for both technological and social progress, was a close friend of Štampar and had an indirect influence on the WHO's initial priorities and definition of health.[8] Sand as well thought of medicine as an art that took into account the reciprocal relations between health and living conditions. In his book *Health and Human Progress* (1936), he approvingly quoted Descartes' claim for medicine's exceptional ability to further human progress, but gave medicine a decidedly social ethos:

> We observe that nothing remains individual. Everyone borrows from the community. Production and sale, education and assistance, become collective functions calling for a rational organisation. Henceforth can medicine be anything but a social service?[9]

Sand was highly attentive to health inequalities, observing that death and disease increase down through social ranks and that narrowing the gap between the death rates of different social classes was a measure

öffentlichen Medicin und der Seuchenlehre, vol. 1 (Berlin: August Hirschwald, 1879), p. 4.

[6] See, for example, Charles-Edward A. Winslow, "The Untilled Fields of Public Health," *Science*, 51 (1306) (1920), 30.

[7] Though see Patrick Zylberman, "Fewer Parallels than Antitheses: René Sand and Andrija Stampar on Social Medicine, 1919–1955," *Social History of Medicine*, 17 (1) (2004), 77–92.

[8] S. Bok, "Rethinking the WHO Definition of Health," *International Encyclopedia of Public Health*, ed. H. K. Heggenhougen (Amsterdam: Elsevier, 2008), p. 594. See Henry E. Sigerist, *Civilization and Disease* (Chicago: University of Chicago Press, 1970 [1943]) and *Medicine and Human Welfare: The Terry Lectures* (New Haven, CT: Yale University Press, 1941).

[9] René Sand, *Health and Human Progress: An Essay in Sociological Medicine* (New York: Macmillan, 1936), pp. 3–4.

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of progress.[10] These sensibilities were reflected in the WHO's famous 1948 constitution, which defined health as "a state of complete physical, mental, and social well-being," thereby articulating its own version of the view that health is a holistic concept with physical, mental, and social aspects.[11]

Sand's insights coincided with contemporary scientific investigations of health inequalities and their causes. In one early study, British researcher J. W. B. Douglas and his coauthors demonstrated that the incidence of disease occurs as a gradient within all socioeconomic levels. They used their results to contest the view that class differences in health result merely from inadequate medical care for the less well-off, as well as to suggest a new view of progress that privileged a more directly sociomedical approach.[12] A post-war US study further considered the link between physical illness and what it termed "social pathologies" and emphasized the connection between health problems and social situations.[13] Several years later, anthropologist Gordon MacGregor published a study entitled "Social Determinants of Health Practices," suggesting that clusters of health problems occur among family members, as do social problems that are linked.[14] But a number of factors, including major drug discoveries and the legacies of colonization, hampered the widespread implementation of the WHO's biopsychosocial health model; for political reasons, emphasis on a social model of health had ideological implications that were quite simply unwelcome in the context of Cold War politics.[15]

[10] Ibid., p. 260.

[11] "Constitution of the World Health Organization," in *Basic Documents*, 49th ed. (Geneva: World Health Organization, 2020), https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1. On this definition, see Thomas Schramme, "Health as Complete Well-Being: The WHO Definition and Beyond," *Public Health Ethics*, 16 (3) (2023), 210–18.

[12] J. W. B. Douglas, "Social Class Differences in Health and Survival during the First Two Years of Life; the Results of a National Survey," *Population Studies*, 5 (1) (1951), 56.

[13] Zdenek Hrubec, "The Association of Health and Social Welfare Problems in Individuals and Their Families," *Milbank Memorial Fund Quarterly*, 37 (3) (1959), 251–76.

[14] Gordon McGregor, "Social Determinants of Health Practices," *American Journal of Public Health and the Nation's Health*, 51 (11) (1961), 1713.

[15] A. Irwin and E. Scali, "Action on the Social Determinants of Health: A Historical Perspective," *Global Public Health*, 2 (3) (2007), 237. Henry Sigerist, for example, was forced to leave the United States in the McCarthy era.

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An attractive and operational alternative to a full-scale socialized notion of health was increased emphasis on the fact that every person should have equal access to healthcare services.[16] In the post-war period, expenditures on healthcare were themselves often described as social progress.[17] As a rule, the focus on healthcare system reform in accordance with the requirements of justice occurred in a period that was marked by optimism that economic growth "lifted all boats" and that civil rights and social welfare policies were effectively reducing various inequalities simultaneously. By the 1970s, the belief in public healthcare and insurance policies was translated into universal access to medical care in almost all Western countries.[18] In associating the expansion of the healthcare system with progress, advocates were well aware that health was one issue for which the richest would likely be willing to accept taxation for the sake of the less well-off. Meanwhile, making the health system more accessible also constituted a goal that did not require a drastic overhaul of current medical practices. On the contrary, it offered a sufficientarian view of justice premised, not on equality as an end in itself, but rather on a sufficient threshold of health and well-being available to a maximum number of individuals. This promised improved health for low-income members of society while allowing the affluent to retain their medical privileges, including access to fashionable and expensive physicians and treatments.

4.2 Progress on Health Equity I: Primary Care and "Health for All"

The tendency to privilege a view of progress that focuses on optimizing existing resources, and distributing them more equitably, was reflected

[16] Gene Outka, "Social Justice and Equal Access to Health Care," *The Journal of Religious Ethics*, 2 (1) (1974), 11–32.

[17] See, for example, Joseph F. Follman, *Medical Care and Health Insurance: A Study in Social Progress* (Homewood, IL: R. D. Irwin, 1963) and T. R. Marmor, M. L. Barer, and R. G. Evans, "The Determinants of a Population's Health: What Can Be Done to Improve a Democratic Nation's Health Status?," in *Why Are Some People Healthy and Others Not? The Determinants of the Health of Populations*, eds. Robert G. Evans, Morris L. Barer, and Theodore R. Marmor (London and New York: Routledge, 1994), p. 220.

[18] On the exceptional U.S. case, see Ronald L. Numbers, "The Third Party: Health Insurance in America," in *The Therapeutic Revolution*: *Essays in the Social History of American Medicine*, eds. Morris J. Vogel and Charles E. Rosenberg (Philadelphia: University of Pennsylvania Press, 2017), pp. 177–200.

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in the variations of universal care for all citizens, implemented and consolidated in Western Europe, Canada, Australia, and New Zealand in the twentieth century. In a classic discussion, philosopher Bernard Williams made the case for equality in healthcare access, arguing that the provision of healthcare services should be based on health needs.[19] Trying to operationalize these and similar insights, proponents of national healthcare programs argued that healthcare is a social good that ought to be provided to all independently of income. Another philosophical influence on the idea of progress as health justice was John Rawls, whose theory of justice comprised a basic optimism about the ability of free and equal citizens to live together. Rawls did not theorize health justice; he did not think of health as something socially produced, but rather a product of random luck.[20] But while the effects of luck cannot be abolished entirely, and certain kinds of inequality are unavoidable, the negative impacts of bad luck can be softened. In an article devoted to "Medical Progress and National Health Care," philosopher Loren Lomasky observes that everyone should have access to medical technological progress and that the absence of health is rarely an indication of culpability; rather it is bad luck, and justice implies rectifying this.[21]

Given Rawls' importance to social justice theorizing, and his confident assumptions about the possibility of the lasting improvement of social institutions, several contributions subsequently refined his conception of justice to incorporate medical progress specifically.[22] Philosopher Norman Daniels, to take one prominent case, argues in his book *Just Health Care* that health and medicine have a special

[19] Bernard Williams, "The Idea of Equality," in *Problems of the Self: Philosophical Papers, 1956–1972* (Cambridge: Cambridge University Press, 1973), p. 240.

[20] John Rawls, *A Theory of Justice* (Cambridge, MA: Belknap Press, 1971); see also his *Justice as Fairness: A Restatement* (Cambridge, MA: Belknap Press, 2001) and *Political Liberalism*, expanded ed. (New York: Columbia University Press, 1996).

[21] Loren E. Lomasky, "Medical Progress and National Health Care," *Philosophy & Public Affairs*, 10 (1) (1981), 72. See also Charles Fried, "Equality and Rights in Medical Care," *Hastings Center Report*, 6 (1) (1976), 29–34.

[22] See, for example, John C. Moskop, "Rawlsian Justice and Human Right to Health Care," *Journal of Medicine and Philosophy*, 8 (1983), 329–38, as well as Lu Ann Aday and Ronald M. Andersen, "Equity of Access to Medical Care: A Conceptual and Empirical Overview," *Medical Care*, 12 (19) (1981), 4–27.

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status because they affect the equality of opportunity in society. Daniels attributes objective characteristics to health, defining it as the absence of disease and diseases as deviations from normal functioning, and he defends both a right to healthcare and the social obligation to provide adequate healthcare to all. To that end, he argues that it is necessary to make a clear distinction between health preferences and fundamental needs, as well as to acknowledge problems of bias toward identified, recognized patients as opposed to more abstract, statistical ones. Daniels thus stipulates that progress consists in the provision of the basic medical services needed to maintain, restore, or compensate for the loss of species-typical functioning – that is, health – which determines fair equality of opportunity. By confining his argument in that way, Daniels says little about how to remedy the fact that larger social injustices are reflected in his definition of health or how factors beyond medical care affect health. But by offering an account of the societal obligation to provide equal access to health services, he articulates an influential theory of progress necessary to produce a more equitable healthcare system.[23]

Despite these theoretical contributions, as well as some real increases in the availability of care based on need, rather than the ability to pay, socioeconomic inequalities in health remained. Various examples from states with universal health systems demonstrated that access to health services is not sufficient for eliminating or even reducing health disparities; in fact, in some cases, these were widening. Scientific studies on such questions were conducted against the background of an increasing sense that improved healthcare access and distribution were not sufficient to address the health needs of people at risk. This interrogation of medical progress was associated with questioning sizable expenditures on sophisticated medical technologies whose overall implications for population health were unclear. While progress through scientific medicine was a tangible reality, in countries that financed medical services for all, its diminishing marginal returns were progressively chronicled. At the global scale, many preventable and treatable health problems related to drinking water, nutritious food, and hygiene practices remained. The aim of eliminating disease through biomedical research and therapies was criticized

[23] Norman Daniels, *Just Health Care* (Cambridge: Cambridge University Press, 1985), p. 229.

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for its inability to improve health equity within countries and between countries themselves. British physician and public health officer N. R. E. Fendall captured this mood early on when he wrote in 1972:

> If I were asked to compose an epitaph on the twentieth century, it would read "Brilliant in its scientific discoveries, superb in its technical breakthroughs, but woefully inept in its application of knowledge to those most in need." […] [T]he "implementation gap" must be closed.[24]

Progress, essentially, was being inequitably distributed. Part of the necessary reorientation involved acknowledging that medical knowledge did not need to be pursued without end. In fact, there was already enough specialist knowledge, as well as resources and qualified personnel, to improve people's health. Rather, what was required was a conception of medical progress that took into account not just formal equality, but rather a thicker, more substantive kind of equity, in order to make sure that communities facing barriers were able to benefit from medical progress. Only by including different background circumstances influencing health, and allocating resources accordingly, would it be possible to make real progress. A crucial corollary of this insight is that the entire scientific-medical community should recalibrate its priorities in a utilitarian fashion to ensure that medical progress is felt by the greatest possible number of people.[25]

In the late 1970s, the WHO became a vocal proponent of this way of thinking, and its concern with health equity underpinned a vision of progress based on the philosophy of primary healthcare. In 1978, the Alma-Ata conference sought to define the provision of primary healthcare for all, that is, basic healthcare with a spectrum of societal services, as the nearest thing approximating measurable medical progress.[26] The meeting concluded with the famous slogan, "Health for All

[24] N. R. Fendall, "Auxiliaries and Primary Medical Care," *Bulletin of the New York Academy of Medicine*, 48 (10) (1972), 1291–300.

[25] See M. Manciaux and T. M. Fliedner, "World Health: A Mobilizing Utopia?," in eds. S. W. A. Gunn et al., *Understanding the Global Dimensions of Health* (Boston: Springer, 2005), p. 79.

[26] "Declaration of Alma-Ata," International Conference on Primary Health Care, Alma-Ata, USSR, September 6–12, 1978 available at *World Health Organization*, www.who.int/teams/social-determinants-of-health/declaration-of-alma-ata. See Kenneth W. Newell, "Selective Primary Health Care: The Counter Revolution," *Social Science and Medicine*, 26 (9) (1988), 903–6 and

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by the Year 2000"; even when commuted into "primary health care for all," it provided a singularly ambitious vision of medical progress centered on fighting health inequities by addressing social inequities more broadly. In 1981, Halfdan Mahler, a Danish physician and WHO Director-General from 1973 to 1988, reemphasized the links between progress and health justice when he wrote that a minimal level of health is essential and that health and social awareness must go hand in hand, progressively reinforcing one another. "Health for all," he noted, depends on continued progress both in medical care and in public health. But the kinds of medical services Mahler had in mind went beyond more conventional medical problems such as insufficient numbers of doctors, hospital beds, or drugs, to include the elimination of malnutrition, bad drinking water, and insalubrious housing. Health for all, Mahler wrote, is a holistic concept calling for efforts in agriculture, industry, education, housing, and communications, as much as in medicine. And he emphasized the shifting locus of health progress by observing that actions undertaken outside the health sector can affect health to a much greater extent than those within it.[27] By privileging comprehensive primary care accessible to all, over specialist care accessible to the few, the WHO ethos reimagined the stage for an idea of health progress that advocated community-based – rather than hospital-based – health and care.[28] It also channeled, once again, the idea of a disease-free future, based on harmonious progress in different spheres of life; the development of a country, the WHO Executive Board wrote, has to proceed harmoniously "any positive result in one field will be beneficial in others, just as any deficiency in one sphere will inevitably retard progress in the others."[29]

Susan B. Rifkin, "Alma Ata after 40 Years: Primary Health Care and Health for All – from Consensus to Complexity," *BMJ Global Health*, 2018, 3 (3), e001188.

[27] Halfdan Mahler, "The Meaning of 'Health for All by the Year 2000'," *World Health Forum*, 2 (1) (1981), excerpted in "Voices from the Past," *American Journal of Public Health*, 106 (1) (2016), 36–38.

[28] See Dave A. Chokshi, Louise Cohen, "Progress in Primary Care – From Alma-Ata to Astana," *Journal of the American Medical Association*, 320 (19) (2018), 1965–66.

[29] WHO Executive Board, *Organizational Study on "Methods of Promoting the Development of Basic Health Services,"* Report of the Working Group (Geneva: World Health Organization, 1973), p. 19.

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4.3 Progress on Health Equity II: Upstream Determinants of Health

At roughly the same time that this WHO agenda was being developed, epidemiologist John B. McKinlay introduced the term "upstream determinants" in a contribution committed to reorienting the location of progress in health. McKinlay uses the analogy of a physician so busy helping struggling patients as they float downstream that they do not have the opportunity to look up and see what pushed them into the river in the first place. In a direct response to the "lifestyle approach" (see Chapter 3), McKinlay and like-minded colleagues attempted to reorient public opinion from downstream health problems to more pressing upstream ones. He observed that his approach:

> highlights the fact that a clear majority of our resources and activities in the health field are devoted to what I term "downstream endeavors" in the form of superficial, categorical tinkering – in response to almost perennial shifts from one health issue to the next, without really solving anything.[30]

McKinlay concluded that fighting the battle downstream was based on a misguided idea of progress that was not only futile but also led to exhaustion and disillusionment. Focusing attention upstream, on the contrary, would reveal the different actors – including interest groups and corporations – that push people into the river and then erect healthcare structures downstream to address the same health needs they have been complicit in creating. McKinlay, therefore, provides a critical reading of the dominant views of medical progress of his day, while also emphasizing the complexities and social nature of health.

McKinlay's research was largely sympathetic to the interventions of British physician and epidemiologist Thomas McKeown (1912–1988) who argues that twentieth-century trends toward financing high-tech curative medicine were a misguided diversion of resources away from prevention-oriented health programs.[31] Writing during decades in

[30] John B. McKinlay, "A Case for Refocusing Upstream: The Political Economy of Illness," *Interdisciplinary Association for Population Health Science Occasional Classics*, 1 (2019 [1975]), p. 1. The title echoes M. Mankoff, ed., *The Poverty of Progress: The Political Economy of American Social Problems* (New York: Holt, Reinhart and Winston, 1972), cited by McKinlay.

[31] On McKeown's impact see James Colgrave, "The McKeown Thesis: A Historical Controversy and Its Enduring Influence," *American Journal of Public Health*, 92 (5) (2002), 725–29.

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which formal access to healthcare – for example via Britain's National Health Service – was firmly established, McKeown's research further resonates with the idea that there are significant determinants of health beyond medical care narrowly understood. In particular, he challenged existing medical progress narratives that portray steady increases in life expectancy in the Global North as of the nineteenth century as attributable to technological interventions and biomedical research.[32] McKeown acknowledges the enormous improvements that occurred but links health progress to better standards of living, nutrition, and hygiene.[33] In his examples, McKeown conclusively shows that many of the most serious diseases had all but disappeared in England and Wales before relevant scientific medical knowledge and related innovations were available. While certain aspects of his thesis have been discredited – public health measures such as vaccination and access to clean water played a bigger role than he acknowledged – his challenge to previous understandings of medical progress still holds today. As public health historian Simon Szreter observes, McKeown effectively demonstrated that the advances we associate with clinical and hospital medicine played only a minor role in the historic decline in mortality levels.[34] The long-term outcome of McKeown's research, then, was to highlight the existence of an alternative progress narrative, whereby social conditions broadly construed had the power to effect meaningful and long-term improvements in health. Eventually, his analysis became foundational for the nascent field of population health, which focused on the social determinants of health, including early childhood care, education, employment, discrimination, poverty, housing, environmental hazards, and the like.

A final intervention of note for the model of progress as health justice that I want to mention here is the 1980 Black Report, published by the UK Department of Health and Social Security. The report was commissioned to investigate the effects of universal access to healthcare and found that increased access had not eliminated health disparities between classes. If individual care is what drives medical

[32] Thomas McKeown, *The Role of Medicine: Dream, Mirage, or Nemesis?* (Princeton, NJ: Princeton University Press, 1980), p. 156.
[33] Ibid., for example pp. 184–85.
[34] Simon Szreter, "The Importance of Social Intervention in Britain's Mortality Decline c. 1850–1914: A Re-interpretation of the Role of Public Health," *Society for the Social History of Medicine*, 1 (1988), p. 2.

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progress, then a universal system with virtually free treatment for all should have made huge progress in improving the health of people vulnerable to poverty and raising it to a level comparable to the health of the affluent. It had not, and as various observers have gone on to elaborate, if the progress of biomedical knowledge combined with the availability of healthcare for individuals did not result in significant health improvements, then other powerful factors must be at play.[35] The Report itself concludes that while medical care plays an important role for health, numerous other factors related to everyday life are of greater importance. And it calls for a relative improvement in living standards for people at risk of bad health, together with measures to prevent new structures and technologies from undermining their existing living conditions.[36] By raising the importance of social life and diminishing the power of medicine, this assessment had potentially radical implications for ideas of medical progress. If medical interventions narrowly speaking only have a marginal influence on health progress more broadly, why should they occupy a central place in such theories?

4.4 Progress, the Social Determinants of Health, and Health Justice

As the idea of medical progress shifted beyond the technological prowess of healthcare – indeed, actively questioned it – and beyond the notions of accessibility and participation, it opened up to a much wider constellation of social factors that were newly acknowledged as crucial for improving health. But it was following the HIV/AIDS epidemic of the 1980s that debates about progress and health as a fundamentally social matter took on a new momentum. In the early years, AIDS symbolized how the causes of illness are not simply biological but rather social and highlighted the suffering of minority groups, whether gay men or women disadvantaged by poverty. Using life expectancy as a proxy, researchers and advocates further pointed

[35] See Sean A. Valles, *Philosophy of Population Health: Philosophy for a New Public Health Era* (London and New York: Routledge, 2018).

[36] *Inequalities in Health: The Black Report*, Chapter 9, para. 9.2, available at *Socialist Health Association*, www.sochealth.co.uk/national-health-service/public-health-and-wellbeing/poverty-and-inequality/the-black-report-1980/black-report-chapter-9-policies-to-reduce-health-inequalities2-a-wider-strategy/

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out that health occurs on a gradient in every society and that health and longevity correlate with socioeconomic status.[37]

As of the 1990s, the idea that social conditions produce disease and need to be addressed in any theory of medical progress gained much wider resonance. New insights into genetics refined the knowledge of how interactions between disease and various physical, environmental, and social factors occur. There was also an increased awareness of how technologies are used to further sexism, racism, homophobia, and oppression generally.[38] The medical knowledge of different publics, including knowledge that was previously left out, for example in relation to gender and race, began circulating more widely. In keeping with the notion that new knowledge requires a new mindset, epidemiologists remarked that the widespread existence of the social gradient in health changes both the most pressing scientific questions about health and the policies needed to address the problem.[39] The missing knowledge – related to understanding how an array of social factors influences health – was associated with a more complex and nuanced framework for judging medical progress.

In the early 1990s, epidemiologist Richard Wilkinson published a piece illustrating what he termed the strong relation between a society's income distribution and the average life expectancy of its population. In it, he develops the thesis that income redistribution would have little effect on the health of wealthy people, even as the end result would be to improve the average health of the population as a whole.[40] Wilkinson's research, coming as it did at a particularly

[37] See M. G. Marmot et al. "Health Inequalities among British Civil Servants: the Whitehall II Study," *The Lancet*, 337 (8754) (1991), 1387–93 and M. G. Marmot, G. Rose, M. Shipley and P. J. Hamilton, "Employment Grade and Coronary Heart Disease in British Civil Servants," *Journal of Epidemiology and Community Health*, 32 (4) (1978), 244–49.

[38] See Sandra Harding, *Whose Science? Whose Knowledge?: Thinking from Women's Lives* (Ithaca, NY: Cornell University Press, 1991).

[39] Michael Marmot, Richard Wilkinson, eds., *Social Determinants of Health* (Oxford: Oxford University Press, 2005), p. 2. See also Anne-Emmanuelle Birn, "Making It Politic(al): Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health," *Social Medicine*, 4 (3) (2009), 166–82 and Barbara Starfield, "Are Social Determinants of Health the Same as Societal Determinants of Health?," *Health Promotion Journal of Australia*, 17 (3) (2006), 170–73.

[40] R. G. Wilkinson, "Income Distribution and Life Expectancy," *BMJ*, 34 (1992), p. 165.

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propitious moment for that type of argument, was followed by a torrent of papers on the social, economic, and political determinants of health and disease. Around that time, health progress became widely associated with tackling health inequalities head-on.[41] As one *BMJ* editorial put it, if progress is to be made, it is necessary to address the fact that rising health inequalities are a consequence of an increasingly polarized society.[42] Medical progress was now associated explicitly with political and economic social choices.[43] It was around the same time that a vision of medical progress, namely that preventable death and disability ought to be minimized, gained momentum as what has been called a "dream of social justice."[44]

In the first decades of the twenty-first century, the notion that medical progress only makes sense in relation to an ecosystemic way of thinking about health gained in popularity, and the vocabulary of the social determinants of health became increasingly widespread. In 2008, a WHO Commission acknowledged that while societies have traditionally looked to the health sector to deal with health and disease, much of the illness burden responsible for unnecessary death is largely attributable to the conditions in which people are born, grow, live, work, and age, and they termed these conditions collectively the social determinants of health. In its report, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*, the Commission concluded that social injustice is killing people on a grand scale and named health equity as a marker of progress.[45] Research contributions reflecting on these findings point to evidence suggesting we can make massive progress toward closing the health gap by improving these conditions and also note that in order to do

[41] See Tony Delamothe, "Social Inequalities in Health," *BMJ*, 303 (1991), 1046–50.

[42] George Davey Smith and Jerry Morris, "Increasing Inequalities in the Health of the Nation," *BMJ*, 309 (1994), 1453.

[43] Marshall H. Becker, "A Medical Sociologist Looks at Health Promotion," *Journal of Health and Social Behaviour*, 34 (1993), 1–6.

[44] Dan E. Beauchamp, "Public Health as Social Justice," in *New Ethics for the Public's Health*, eds. Dan E. Beauchamp and Bonnie Steinbock (Oxford: Oxford University Press, 1999), p. 105.

[45] Commission on Social Determinants of Health, *Closing the Gap in a Generation*, pp. 1, 111. See also Michael Marmot et al., "Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health," *The Lancet*, 372 (2008), 1661–69.

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so, we must deal with inequities in power, money, and resources, as social injustice itself is a threat to health. In 2012, epidemiologist Michael Marmot summed up the mood as one that acknowledges the need to "address the wider determinants of health in order to make progress."[46]

The above remarks are representative of a larger debate, namely the revitalization of the notion of progress to address the collective experience of excluded, marginalized, and oppressed members of society and to resist and challenge dominant ideas of progress. The (re)discovery of progress as social justice was driven by a reinforced concern with uncovering and documenting the web of connections that binds us together in our collective existence. Social scientists have drawn attention to the uneven and fragile nature of progress, as well as the fact that we are all connected, and that inequalities both within and across countries threaten to fundamentally damage our social fabric. In doing so, they have reimagined the core values of progress to include equality of opportunity, mutual support and care, and sustainability.[47] Such perspectives emphasize the extent to which one's place in society determines our convictions about whether progress has the potential to benefit us. They, therefore, point to the inescapably political aspects of traditionally technology-focused visions of progress, portraying them as merely one way – and not a particularly fair way – of distributing limited resources within an unequal society. They also draw attention to the ways in which a shared commitment to the progress of science and technology can serve as a surrogate for social action.[48]

Among the various critics who hold that such progress is necessary today, many of them emphasize the insufficiencies of basing an idea of progress on an abstract notion of individual autonomy and personal responsibility. Critical theorist Axel Honneth observed in 2017 that,

[46] Michael Marmot, "Fair Society, Healthy Lives," *Public Health*, 126 (2012), p. 10. See also Michael G. Marmot, "Global Action on Social Determinants of Health," *Bulletin of the World Health Organisation*, 89 (2011), p. 702.

[47] See, for example, Nancy Folbre et al., "The Multiple Directions of Social Progress: Ways Forward," in *Rethinking Society for the 21st Century*, Report of the International Panel on Social Progress, vol. 2 (Cambridge: University of Cambridge Press, 2018), p. 818.

[48] See Daniel Sarewitz, *Frontiers of Illusion: Science, Technology, and the Politics of Progress* (Philadelphia: Temple University Press, 1996).

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while up until recently the leitmotif of almost all progress was the idea of expanding individual autonomy, at present it must become collective autonomy.[49] Other contributions have linked the idea of progress to an emancipated social space and a notion of the self as driven by a concept of solidarity that involves responsibility for other people's welfare.[50] In such accounts, progress is linked to a concept of justice that takes into account the demands of equality between different social groups and generations. Not only societal progress but moral progress too has been associated with the expansion of the scope of justice and the aim of creating broadly inclusive communities. Accordingly, those who stand to gain have been vocal in promoting these conceptions of progress. Progress can, therefore, be seen as a kind of resistance, a demand on behalf of or from those who have been oppressed, or whose lives have been marked by injustice.[51]

One concrete manifestation of these philosophical sensibilities is the capabilities approach, developed by Amartya Sen and Martha Nussbaum and applied more specifically to health by Sridhar Venkatapuram, which emphasizes that being healthy has an intrinsic value, as well as increases our capacity to achieve our ends. Health, in this view, is no longer merely a primary good but rather an "actual freedom," and health justice promotes positive freedom, that is, our ability to pursue the projects that we choose. In an associated idea of progress, we can and should take measures that promote and sustain the capability to be healthy in a way that is commensurate with the equal dignity of human beings.[52] While enlarging shared perceptions of health in this way, critics also emphasized its importance among

[49] Axel Honneth, "How to Envision Social Progress Today," *Social Imaginaries*, 1 (2018), p. 165.

[50] R. C. Smith, *Society and Social Pathology: A Framework for Progress* (Cham, Switzerland: Palgrave Macmillan, 2017). See also Lea Ypi, *Global Justice and Avant-Garde Political Agency* (Oxford: Oxford University Press, 2011).

[51] See Rainer Forst, "Zum Begriff des Fortschritts," in *Vielfalt der Moderne – Ansichten der Moderne*, ed. Hans Joas (Frankfurt am Main: Fischer, 2012), p. 43. See also Rainer Forst, "The Justification of Progress and the Progress of Justification," in *Justification and Emancipation: The Critical Theory of Rainer Forst*, eds. Amy Allen and Eduardo Mendieta (State College, PA: Penn State University Press, 2019) and Marc Fleurbaey et al., *A Manifesto for Social Progress: Ideas for a Better Society* (Cambridge: Cambridge University Press, 2018).

[52] Sridhar Venkatapuram, *Health Justice: An Argument from the Capabilities Approach* (Cambridge: Polity Press, 2011), p. 8.

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social goods. Sen argued in the 2002 Tanner Lectures "Why Health Equity?" that in any discussion of social equity, illness and health must figure as major concerns.[53] His words were not devoid of political significance; on the contrary, they point to the need for a fairer society with profound policy implications concerning how we think about, fund, and organize medicine. In 2005, former International Monetary Fund economist Ken Rogoff made the political stakes explicit when he asserted that health and life expectancy will be at the center of the next big battle between socialism and capitalism.[54] Progress as justice is not inevitable, but rather actively influenced by political and economic choices.

In academic circles, a vision of progress that sought to allocate medical resources more fairly in the pursuit of health has been widely taken up. Various policy frameworks and projects concerned with framing the mandate of physicians do so in terms of their social relevance and ability to meet "societal needs."[55] The shift to an expanded vision of health is evident in how Norman Daniels, rather than produce a second edition to his book *Just Health Care*, wrote an entirely new book called *Just Health: Meeting Health Needs Fairly*, implying that healthcare is the tip of the iceberg and that health progress requires looking beyond formal medical care to social justice issues.[56] There is a widespread agreement that the best predictor of good health in affluent countries is not access to biomedical technologies but social factors including education levels and material well-being. There is also a large assortment of evidence that children who grow up in a nurturing environment and receive a good education have better health, as do adults who have fulfilling employment and support structures.

[53] Amartya Sen, "Why Health Equity?," *Health Economics*, 11 (2002), 659–66.
[54] Cited in Richard Horton, "Marx and Medicine," *The Lancet*, 390 (2017), p. 2026.
[55] See Cynthia R. Whitehead, Zubin Austin, Brian D. Hodge, "Flower Power: The Armoured Expert in the CanMEDS Competency Framework?," *Advances in Health Sciences Education*, 16 (2011), p. 686.
[56] (Cambridge: Cambridge University Press, 2007). See also Norman Daniels, "Justice, health, and health care," in *Medicine and Social Justice: Essays on the Distribution of Health Care*, eds. R. Rhodes, M. P. Battin, and A. Silvers (New York: Oxford University Press, 2002), pp. 6–23 and Norman Daniels, Bruce P. Kennedy, and Ichiro Kawachi, "Why Justice Is Good for Our Health: The Social Determinants of Health Inequalities," *Daedalus*, 128 (4) (1999), 215–51.

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Researchers have also shown that there is something about income inequality itself, as a different phenomenon from poverty, that lowers the health of both individuals and populations.[57]

These considerations have led some to contend that taking the longer view reveals a deterministic historical trend toward greater equality. For example, in their book, *The Spirit Level: Why More Equal Societies Almost Always Do Better*, Kate Pickett and Richard Wilkinson argue that this trend "runs like a river of human progress" from the first constitutional limits on autocracy through to public education and healthcare.[58] And yet, successful policies to achieve progress on these accounts have been fraught.[59] Writing in 2018, ten years after the Commission on Social Determinants of Health, a public health physician observed that social injustice remains the leading cause of bad health.[60] Despite significant evidence that the best way to improve population health is through relatively low-cost public health measures and that restricting the use of some technologies keeps healthcare costs down, research funding is overwhelmingly directed toward biomedicine.[61] If education, housing, and transportation remain important for governments across the Global North, the percentage of GDP devoted to healthcare is increasing. As a rule,

[57] R. G. Wilkinson and K. E. Pickett, "Income Inequality and Population Health: A Review and Explanation of the Evidence," *Social Science and Medicine*, 62 (2006), 1768–84.

[58] Kate Pickett and Richard Wilkinson, *The Spirit Level: Why More Equal Societies Almost Always Do Better* (London: Allen Lane, 2009), pp. 267–68.

[59] Fran E. Baum, Monique Bégin, Tanja A. J. Houweling, and Sebastian Taylor, "Changes Not for the Fainthearted: Reorienting Health Care Systems Toward Health Equity through Action on the Social Determinants of Health," *American Journal of Public Health*, 99 (11) (2009), 1967–74. See also Kumanan Rasanathan and Theresa Diaz, "Research on Health Equity in the SDG Era: The Urgent Need for Greater Focus on Implementation," *International Journal for Equity in Health*, 15 (202) (2016), https://doi.org/10.1186/s12939-016-0493-7.

[60] Kumanan Rasanathan, "10 Years after the Commission on Social Determinants of Health: Social Injustice Is Still Killing on a Grand Scale," *The Lancet*, 392 (2018), 1176–77.

[61] Editorial, "UK Life Science Research: Time to Burst the Biomedical Bubble," *The Lancet*, 392 (2018): 1227–28. See also Jon L. Wardle, Fran E. Baum, and Matthew Fisher, "The Research Commercialisation Agenda: A Concerning Development for Public Health Research," *Australian and New Zealand Journal of Public Health*, 43 (5) (2019), 407–09 and Joseph E. Davis and Ana Marta Gonzalez, eds., *To Fix or to Heal: Patient Care, Public Health, and the Limits of Biomedicine* (New York: New York University Press, 2016).

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physicians continue to treat patients as individuals with self-contained health problems, without reference to their life contexts, using what Rupa Marya and Raj Patel have termed colonial thinking.[62] As discussed in the previous chapter, the promoters of personalized/precision medicine have been challenged to explain and respond to the reality that zip codes are more predictive of health than genetic codes. At stake are differing views about what medical progress consists in and how to achieve it.

4.5 Progress as Justice: Critiques

Justice considerations for progress imply a significant recalibration of the goals of medicine. When medical progress is reframed as progress toward social justice, and based on a broad view of health that includes social factors, the repercussions are vast. Take, for example, diabetes. In its shorthand form, the research mission of the American Diabetes Association is "Science. Progress. Hope."[63] And yet, diabetes has long been a disease that reflects the anxieties and aspirations of specific historical moments, particularly with regard to race.[64] Appeals to, for example, population genetics as the crucial tool for understanding different rates of diabetes mask important factors such as poverty and racism. Making progress on diabetes, therefore, implies more than scientific understandings of different forms of the disease and their genetic origins; it also involves more than targeted campaigns to ensure better access to treatments and monitoring. Rather, progress requires understanding and addressing the racial, social, and economic factors that contribute to diabetes, including discrimination, lack of education, and limited access to nutritious food. In short, progress implies fostering social change in the name of health.

The desire to refashion societies using better health for all as a touchstone has been critiqued from various angles. First of all, it can be argued that policies designed to achieve medical progress lack precision if they attempt to address multiple social phenomena whose only

[62] Rupa Marya and Raj Patel, *Inflamed*: *Deep Medicine and the Anatomy of Injustice* (New York: Farrar, Straus and Giroux, 2021).
[63] Research Mission, American Diabetes Association, https://diabetes.org/research/research-foundation-mission-and-vision.
[64] See Arleen Marcia Tuchman, *Diabetes: A History of Race and Disease* (New Haven, CT: Yale University Press, 2020).

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point in common is that they have negative effects on health. Medical personnel have no special expertise to redress economic, class, and racial inequalities, reduce violence, and so on. For this reason, a persistent critique of using the social determinants of health as a measure of health progress is that the latter has gone beyond its natural boundaries. Addressing broader health determinants for injuries and disease inevitably requires social and political engagement and priority setting.[65] Meanwhile, a fundamental question is whether health justice is better served by narrow interventions targeting groups of individuals or communities or by broader measures aiming to reallocate the societal resources that have such a profound influence on health. Some have sought to combine this policy agenda by presenting targeted interventions and social change not as opposing choices, but rather as harmonious complements to each other. Technical, curative, and preventative measures could – at least theoretically – be integrated with far-reaching measures to improve the living conditions of people at risk of poor health by inadequate policies.[66] For example, it is possible to argue that we do not yet have a good understanding of the diverse and deep-seated health effects of racism, yet need not worry about the fact that the net health effects of reducing the social problem of racism – or poverty, or housing – will be negative.[67] At the same time, the specific mechanisms and outcomes for health are variable and poorly understood, and it is difficult to understand what to prioritize.

Second, there is a persistent difficulty related to distinguishing between causes and correlations of progress. The social determinants of health can manifest as direct causes of ill health, for example with regard to how diet affects individual biology. They can also affect health in macrosocial ways, such as when the stress of disenfranchisement causes health problems. But they can also act as what are called the causes of causes.[68] Smoking, for example, is associated with both a lower socioeconomic status and a higher risk of certain diseases than

[65] Lawrence O. Gostin and Madison Powers, "What Does Social Justice Require for the Public's Health? Public Health Ethics & Policy Imperatives," *Health Affairs*, 25 (4) (2006), 1055.
[66] James Colgrove, "The McKeown Thesis," p. 729.
[67] Y. Paradies, J. Ben, N. Denson, et al. "Racism as a Determinant of Health: A Systematic Review and Meta-Analysis," *PLoS One*, 10 (2015), e0138511.
[68] Michael Marmot and Richard G. Wilkinson, eds., *Social Determinants of Health*, 2nd ed. (Oxford: Oxford University Press, 2006 [1999]), p. 2.

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not smoking.[69] Disadvantaged members of society and minorities are also more affected by substandard healthcare. But how to be sure these are not just correlations and actual causal relationships? As Marcia Angell notes, the fact that social advantage correlates so powerfully with health makes it extremely difficult to interpret research into the effects of one on the other.[70] For this reason, it can also be difficult to compare the net outcomes of policy measures. Philosopher Frances Kamm has pointed out that policy proposals designed to address social inequality and health must compare the health we gain by improving social equality with the health resulting from economic growth that itself is associated with social inequality.[71] The importance of recognizing and intervening in the causal chains through which socioeconomic conditions directly affect health and longevity is crucial, yet highly complex.

Third, by becoming involved with redistribution and the reorganization of society, medicine becomes highly politicized. As discussed in Chapter 3, there are many things we can do to promote health through diet, exercise, and so on. MD Sally Satel has criticized a view of progress as health justice by remarking that, taken to its extreme, personal responsibility for one's own health and care becomes a quaint and even suspect notion. And she argues that while it may be politically expedient to blame ill health on oppression, alienation, or other overwhelming factors, the reality is far more complicated.[72]

If medicine is perceived as a vehicle for infinite human progress, the allocation of resources to medicine is profoundly influenced by this belief. But there is no guarantee that market forces, or even human sensibilities, conform with the requirements of social justice.[73]

[69] See also Bruce G. Link, Jo Phelan, "Social Conditions as Fundamental Causes of Disease," *Journal of Health and Social Behaviour*, Special Issue: Forty Years of Medical Sociology: The State of the Art and Directions for the Future (1995), 80–94.

[70] Marcia Angell, "Pockets of Poverty," *The Boston Review*, 25 July 2014, https://bostonreview.net/forum_response/marcia-angell-pockets-poverty/

[71] Frances M. Kamm, "Health and Equality of Opportunity," *American Journal of Bioethics*, 1 (2001), 19.

[72] Sally Satel, *PC, M.D.: How Political Correctness Is Corrupting Medicine* (New York City: Basic Books, 2000), pp. 14, 232.

[73] For an argument that commonsense morality is consistent with moderate deontology, as opposed to for example consequentialism, which seeks to maximize the good for all, see Eyal Zamir, *Law, Psychology, and Morality:*

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Providing care in a society involves hard choices about which illness conditions should be prioritized in research and funding. There are tensions between providing expensive medical care to one individual and ensuring that all benefit from equal medical care. Rare diseases, diseases with expensive, labor-intensive treatments, and interventions affecting elderly people with a limited life expectancy; all these are candidates for being rethought in a system that privileges a more socially oriented view of medical progress. Daniel Callahan has gone so far as to highlight a clash between biomedical progress and equity and to argue that the very success of scientific-technological progress in medicine is a menace to progress toward health justice.[74] Others have countered that this problem can be overcome by pursuing better health through technologies and addressing health inequalities simultaneously. But seen from a historical perspective, technologies aimed at improving health equity and democratizing healthcare access consistently fail to deliver on their creators' promises.[75] Rather, it seems more honest to acknowledge that sacrifices must be made in order to provide a socialized medicine.

Such tradeoffs are visible in tensions that arise between the goals of improving the health of the entire population, of distributing health benefits fairly, and reducing health inequities.[76] New interventions, even as they are beneficial to the health of individuals, often increase inequalities in health outcomes and may conflict with the principle of distributive justice.[77] Sometimes called the dilemma of social progress, similar dilemmas occur in numerous fields beyond medicine. They can be seen, for example, when inequality between groups increases alongside social progress – for example, an overall decline in child

The Role of Loss Aversion (Oxford: Oxford University Press, 2015), p. 177 e passim.

[74] Daniel Callahan, "How Much Medical Progress Can We Afford: Equity and the Cost of Health Care," *Journal of Molecular Biology*, 319 (2002), 886, 888.

[75] See, for example, Jeremy A. Greene, *The Doctor Who Wasn't There* (Chicago: University of Chicago Press, 2022).

[76] Norman Daniels, "Reconciling Two Ethics Goals of Public Health: Reducing Health Disparities and Improving Population Health," in *Oxford Handbook of Public Health Ethics*, eds. Anna C. Mastroianni, Jeffrey P. Kahn, and Nancy E. Kass (Oxford: Oxford University Press, 2019), pp. 290–300.

[77] Jo C. Phelan and Bruce G. Link, "Fundamental Cause Theory," *Medical Sociology on the Move: New Directions in Theory*, ed. William C. Cockerham (Dordrecht: Springer, 2013), p. 119.

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mortality, though one that is distributed unevenly between different social groups. There is no easy solution to potential tensions between the fact that generalized social progress is important and the fact that all individuals within a society deserve equal respect and concern. By focusing too much on any one dimension of health – in this case, the social dimension – justice-driven visions of medical progress risk masking the conflicts between different dimensions of progress.

4.6 Medical Progress and COVID-19

COVID partout, justice nulle part

Graffiti seen in Montréal, Canada, 2020

As the critiques of progress-as-justice in medicine became more granular and articulated, this particular conception of progress took on a new urgency in the context of the COVID-19 pandemic.[78] Originating in China in 2019, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), responsible for COVID-19, is a virus that primarily affects the respiratory system, though it can touch multiple organs, including the heart, kidneys, gut, and brain. This section discusses briefly how narratives of progress played out during the emergence of this global medical event. Beyond the disease, containment policies including lockdowns, quarantines, curfews, and the use of technologies to comply with physical distancing – for example by moving to online work and schooling – affected billions of people. More specifically, I consider the early stages of the pandemic in 2020–2021 and the heated debates it occasioned about medical progress. The pandemic allowed for unprecedented collaborative scientific efforts, expedited technological advances, and a race for vaccines that embodied the hope that scientific progress can act as a magic bullet for solving health problems. At the same time, by making visible the importance of social environments for disease generally, and the deployment of scientific advances in particular, it threw narrowly scientific models

[78] Histories of COVID-19 include Jacalyn Duffin, *COVID-19: A History* (Montreal: McGill-Queens University Press, 2022) and Richard Horton, *The COVID-19 Catastrophe: What's Gone Wrong and How to Stop It Happening Again* (Cambridge: Polity Press, 2020).

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of medical progress into question.[79] The inequalities of the pandemic's effects within Western societies, and those of the vaccine rollout globally, brought the problems of the social dimensions of scientific progress into stark relief. I believe that these questions deserve analysis as a crucial moment for a clash of competing medical progress narratives, as well as shed renewed light on what medical progress as health justice entails.

Evidence from other epidemics confirms how disease outbreaks reveal preexisting problems. Epidemic disease has been called a "breaching experiment," in that it brings to light long-standing fractures and forms of suffering.[80] The COVID-19 pandemic revealed existing vulnerabilities in societies that thought of themselves as embodying a particular kind of cutting-edge, high-tech medical progress but had not invested similarly in disease prevention and public health. Particularly notable in the case of COVID-19 was the speed with which the disease destabilized and overwhelmed the healthcare systems of exceptionally wealthy and privileged societies. In doing so, it unsettled received assumptions about a particular kind of technology-intensive medicine as the locus of progress. Countries' successes in combatting the virus proceeded in a way that was to some extent decoupled from their per capita healthcare budgets and technological capacities.[81] Despite the importance of hospitals and intensive care units for treating severe cases, at times the sickest patients could not be helped by existing medical resources. Switzerland, for example, experienced the seventh highest rate of per capita deaths in November 2020 during the pandemic's second wave, as high as Iran, Russia,

[79] See Peter Strasser, "Paradoxien des medizinischen Fortschritts – kann es sein, dass die immer bessere Gesundheitsversorgung die Würde des Menschen mehr bedroht als stärkt?," *Neue Zürcher Zeitung*, June 22, 2020, www.nzz.ch/meinung/die-frage-der-wuerde-paradoxien-des-medizinischen-fortschritts-ld.1543009?reduced=true.

[80] See Luisa Enria and A. F. Tengbeh, "Ebola Wahala: Breaching Experiments in a Sierra Leonean Border Town," in *Feeling Disease: Experiencing Medicine and Illness in Modern History*, eds. R. Boddice and B. Hitzer (London: Bloomsbury, 2022), pp. 43–60 and Graham Scambler, "Covid-19 as a 'Breaching Experiment': Exposing the Fractured Society," *Health Sociology Review*, 29 (2) (2022), 140–48.

[81] Arusha Cooray, Krishna Chaitanya Vadlamannati, and Indra de Soysa, "Do Bigger Health Budgets Cushion Pandemics? An Empirical Test of COVID-19 Deaths across the World," *WIDER Working Paper*, 165 (2020), www.econstor.eu/bitstream/10419/229389/1/wp2020–165.pdf

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and Croatia.[82] Cuba was very successful at managing the early stages of the pandemic, as were Thailand and Vietnam.[83] While the United States is a global leader in biomedical science and technology, this failed to protect American society as a whole, and people at risk in particular, from COVID-19.

The pandemic also shed renewed light on the shortcomings of excessively one-dimensional forms of medical progress. For example, it revealed how illusory certain forms of progress have been because it exposed how unequally they have been shared. In particular, it put on display the extent to which inequitable social structures affect people's health both within and between different countries. US chief medical advisor Anthony Fauci referred to COVID-19 as having shone a bright light on American society's failings, in particular on the social determinants of health.[84] In a similar fashion, Michael Marmot asserted that COVID-19 had both divulged and amplified existing inequalities.[85] The virus drastically affected those whose health situation was already so precarious that illness – even a mild one – or disruption to their daily routines profoundly threatened their livelihood; elderly people living in precarious situations, people without housing or food security, and prisoners are all examples thereof.[86]

[82] See "Tracking Covid-19 Excess Deaths across Countries," *The Economist*, www.economist.com/graphic-detail/coronavirus-excess-deaths-tracker

[83] Talha Burki, "Behind Cuba's Successful Pandemic Response," *The Lancet Infectious Diseases*, 21 (4) (2021), 465–66. On Vietnam, see Tuyet-Anh T. Le et al., "Policy Responses to the COVID-19 Pandemic in Vietnam," *International Journal of Environmental Research and Public Health*, 18 (2) (2021), 559, https://doi.org/10.3390/ijerph18020559, and on Thailand Viroj Tangcharoensathien, Mary T. Bassett, Qingyue Meng, and Anne Mills, "Are Overwhelmed Health Systems an Inevitable Consequence of COVID-19? Experiences from China, Thailand, and New York State," *The BMJ*, 372 (2021), n83.

[84] "Fauci: 'Undeniable Effects of Racism' Have Worsened Covid for U.S. Minorities," *The Guardian Online*, May 16, 2021, www.theguardian.com/world/2021/may/16/fauci-racism-covid-us-black-hispanic-native-americans-emory-university-graduation.

[85] Michael Marmot, interviewed in Stewart Paterson, "Boris Johnson Didn't Get 'Big Decisions Right' on Covid, Says Leading Epidemiologist," *Glasgow Times*, June 21, 2022, www.glasgowtimes.co.uk/news/20224923.boris-johnson-didnt-get-big-decisions-right-covid-says-leading-epidemiologist/?ref=twtrec.

[86] See, for example, Paul Webster, "COVID-19 Highlights Canada's Care Home Crisis," *The Lancet*, 397 (10270) (2021), 183 and Léa Sanchez, "Les résidents d'Ehpad représentent 44% des morts du Covid-19," *Le Monde*, December 3,

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National lockdowns designed to reduce physical interactions shed further light on the link between health and social justice considerations. For desk workers, this largely meant working from home and moving in-person activities online, effectively receiving an extra layer of protection. Other workers, for example in child care, transportation, public utilities, food and agriculture, slaughterhouses, garbage collection, and delivery services, were now identified by governments as "essential" and still required to be present in-person. Many essential jobs are poorly paid and done by people who are socioeconomically disadvantaged, including visible minorities, women, and migrants.[87] African-American and Latino communities in the United States, for example, were disproportionately affected by the disease in a striking manner, and in other OECD countries, the situation was similar.[88] Discussing why Montreal was the seventh deadliest city worldwide for COVID-19 in May 2020, a commentator noted that the reason lies in public health patterns that long predate the virus: Those infected already experience systematic inequality, poverty, and discrimination, and COVID-19 is merely making this situation more visible. In light of this reality, the idea that progress is shared in a democratic, nondiscriminatory way rings increasingly hollow.[89]

Occurring in the last year of Donald Trump's 2017–2021 presidency and directly related to the Black Lives Matter movements, one of the recurring impressions of the pandemic was that the health disparities between different social groups, and the underlying racist, classist, and sexist structures that determine those disparities, were being held up for all to see.[90] The traditional foci of medical progress

2020, www.lemonde.fr/les-decodeurs/article/2020/12/03/les-residents-d-ehpad-representent-44-des-morts-du-covid-19_6062084_4355770.html.

87 See Editorial, "The Plight of Essential Workers during the COVID-19 Pandemic," *The Lancet*, 395 (10237) (2020), 1587.

88 Isaac Chotiner, "The Interwoven Threads of Inequality and Health," *The New Yorker*, April 14, 2020, www.newyorker.com/news/q-and-a/the-coronavirus-and-the-interwoven-threads-of-inequality-and-health and Daniel Morales, "COVID 19 and Disparities Affecting Ethnic Minorities," *The Lancet*, 397 (10286) (2021), 1684–85.

89 See Colleen M. Flood et al., eds., *Vulnerable: The Law, Policy & Ethics of COVID-19* (Ottawa: University of Ottawa Press, 2020).

90 Clyde W. Yancy, "Academic Medicine and Black Lives Matter: Time for Deep Listening," *JAMA*, 324 (5) (2020), 435–36.

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on improved technology and healthcare access seemed fundamentally incomplete in light of these lived realities. In their intervention *Pandémopolitique*, Gaudillière, Izambert, and Juven draw attention to what they call the systematic health triage that has socioeconomic origins and that precedes clinical triage for COVID-19 and call for prioritizing the common good over individual decisions in the medical context. In particular, they highlight the need to replace growth as the obligatory horizon of progress, in favor of a more radically democratic concept of progress in tune with collective needs.[91] Reflecting on the import of his previous work in the context of the pandemic, Michael Marmot contemplated an idea of progress whereby the aim is not simply to restore GDP growth but to create better societies, which have both better health and narrower health inequities. And such prescriptions regarding health do not relate to medicine narrowly conceived. Rather, they concern improving the lives of children, enhancing public education and working conditions, and ensuring that everybody has the minimum income necessary to pursue healthy and sustainable behaviors.[92]

While introducing research on the AIDS epidemic, and skeptical of the desire to draw simple, historical lessons from the unanticipated outbreak of a new, lethal disease, Barbara Rosenkrantz observed that we face the recurring temptation to "celebrate linear progress and reassuringly demonstrate how evil is overwhelmed by good."[93] In the era of COVID-19, the temptation to replace the uncertainties surrounding epidemics with a simple historical story – and linear, medical progress in particular – feels ill-advised. Philosopher Bruno Latour pinpointed COVID-19 as an event that profoundly threw into question the belief in a single path of progress. He highlights instead a new collective awareness, whereby we all began to understand that each item of our daily lives – drugs, food, clothing, and means of transport – is, in fact, the subject of ongoing negotiations, and it is, therefore, possible to

[91] Jean-Paul Gaudillière, Caroline Izambert, and Pierre-André Juven, *Pandémopolitique : Réinventer la santé en commun* (Paris: La Découverte, 2021), p. 14.

[92] Michael Marmot, "Society and the Slow Burn of Inequality," *The Lancet*, 395 (10234) (2020), 1413–14. See also Jennifer Prah Ruger, "Social Justice as a Foundation for Democracy and Health," *BMJ*, 371 (2020), 4049.

[93] Barbara Gutmann Rosenkrantz, "Case Histories – An Introduction," *Social Research*, 55 (3) (1988), 399.

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change or reverse what previously seemed inevitable.[94] Against the background of climate change, and the flaws inherent in the argument that we are embarked on an irreversible path of progress, he argues that it is only by acknowledging the multidimensionality of progress that we can find a solution to the problems that face us.

4.7 Conclusion

While many people benefit from technological-scientific medical advances, disadvantaged members of society remain less well integrated into healthcare systems, less able to take advantage of their benefits because of discrimination and bias, and have poorer health when they do engage with medicine. To the extent that equity is acknowledged as a medical goal in a democratic society, it should be particularly apparent in medical priorities. The vision of medical progress as social justice has offered various scenarios, for example by emphasizing an effective and widely available – but more basic – array of medical services. Its advocates have also suggested that health and progress should be conceived much more broadly to encompass a person's roles as a family member, employee, political being, and so on. In such a view, medical progress is measured not so much by life expectancy, or survival rates, but rather in terms of the ability of persons to fulfill their various social roles and achieve their personal goals.[95] In short, progress would be measured by its impact on population health and not on individual health.

Such conceptions of progress have many real advantages for health. In Western societies where the basic health needs of different groups are not met – think, for example, of Indigenous populations in Canada – there is an urgent need to better address those who are harmed when the social dimension of medical progress gets left out. At the same time, such visions of progress are not immune to the utopianism inherent in one-dimensional views of medical progress. To the extent that they mask potential tensions between individual freedom, social justice, and scientific advances, they offer an illusory picture of a harmonious social life that would more accurately be described as a permanent compromise.

[94] Bruno Latour, "Le train du progrès n'emprunte pas qu'une seule voie," *Le Monde*, September 25, 2020, p. 29.
[95] Callahan, "How Much Medical Progress Can We Afford?," 885–90.

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