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REVIEW ARTICLE

# RETHINKING GLOBAL PANDEMICS THROUGH IVAN ILLICH'S CRITICAL PERSPECTIVE

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***ABSTRACT***

*Ivan Illich's theoretical framework is based on the industrialization of modern healthcare and the argument that this process deepens health inequalities. Global pandemics, such as COVID-19, have validated Illich's perspective by clearly exposing the inequalities in access to healthcare. This study aims to re-evaluate the injustices created by global pandemics in healthcare systems from Ivan Illich's critical perspective. According to Illich, the commercialization of modern healthcare transforms health needs into a profit-driven industry, neglecting genuine health requirements and limiting access to healthcare services. Using Illich's theoretical framework, this study analyzes the effects of global pandemics on health policies and discusses the necessary steps toward a more equitable healthcare system. In this context, the study explores how we can align Illich's perspective with contemporary health policies and what actions we can take to move towards a more just health future.*

**Keywords:** *Ivan illich, global pandemics, social inequality, equitable health policies*

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DERLEME MAKALESİ

# KÜRESEL PANDEMİLERİ İVAN ILLICH'İN ELEŞTİREL PERSPEKTİFİNDEN YENİDEN DÜŞÜNMEK

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***ÖZ***

*Ivan Illich'in kuramsal çerçevesi, modern sağlık hizmetlerinin endüstrileşmesi ve bu sürecin sağlık eşitsizliklerini derinleştirdiği iddiasına dayanmaktadır. COVID-19 gibi küresel pandemiler, sağlık hizmetlerine erişimdeki eşitsizlikleri açıkça görünür kılarak Illich'in perspektifini doğrulamıştır. Bu çalışma, küresel pandemilerin sağlık sistemlerinde yarattığı adaletsizlikleri Ivan Illich'in eleştirel bakış açısıyla yeniden değerlendirmeyi amaçlamaktadır. Illich'e göre, modern sağlık hizmetlerinin ticarileştirilmesi, sağlık gereksinimlerini kâr odaklı bir endüstriye dönüştürmekte; gerçek sağlık ihtiyaçlarını göz ardı ederek sağlık hizmetlerine erişimi sınırlamaktadır. Bu çalışmada, Illich'in kuramsal çerçevesinden hareketle küresel pandemilerin sağlık politikaları üzerindeki etkileri analiz edilmekte ve daha adil bir sağlık sistemi için atılması gereken adımlar tartışılmaktadır. Bu bağlamda, Illich'in yaklaşımının güncel sağlık politikalarıyla nasıl ilişkilendirilebileceği ve daha adil bir sağlık geleceğine doğru ilerlemek için hangi eylemlerin gerçekleştirilebileceği incelenmektedir.*

***Anahtar Kelimeler:*** *Ivan illich, küresel pandemiler, sosyal eşitsizlik, adil sağlık politikaları*

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## I. INTRODUCTION

Pandemics are rarely mere biomedical events; they are complex crises deeply exacerbated by social and economic determinants. The COVID-19 (SARS-CoV-2) pandemic has starkly revealed how the profit-driven structure of healthcare undermines social justice and renders the most disadvantaged groups even more vulnerable. Illich's concepts of medicalization and iatrogenesis provide a critical framework for understanding the counterproductive outcomes created by these processes.

Throughout history, pandemics have affected all segments of society, but the burden has been heavier on the poor and disadvantaged groups. Overcrowded living conditions, lack of access to adequate healthcare, and economic insecurity make these groups more vulnerable to pandemics. Ivan Illich emphasizes that the institutionalization of healthcare deepens these inequalities by ignoring the social and economic roots of health problems. Parallel to this, the commercialization of health has transformed individuals into "health consumers," where being healthy is increasingly measured by consumption and expenditures rather than genuine well-being (Kurt and Sarı 2021). Consequently, addressing global pandemics requires looking beyond biomedical issues to understand them as products of socio-economic dynamics. This study discusses how healthcare policies can be transformed into a more just, inclusive, and resilient structure in light of Illich’s critiques.

Methodologically, this study relies on a critical literature review, analyzing Illich’s concepts of medicalization, clinical, social, and cultural iatrogenesis in the context of historical and contemporary pandemics. This approach is enriched through an interdisciplinary lens to better understand how healthcare systems have further deepened social inequalities. The COVID-19 pandemic has been examined in detail, highlighting how it exposed inequalities in healthcare access and the societal impacts of these disparities, while evaluating the inadequacies of modern healthcare systems within this framework.

In light of these dynamics, this study argues that healthcare policies must move beyond approaches based solely on individual treatment and adopt a more holistic and just structure that considers social and economic determinants. This analysis, grounded in Illich’s theoretical framework, offers comprehensive strategies on how healthcare systems can tackle existing structural inequalities and provides significant contributions towards the development of more resilient, just, and inclusive healthcare policies.

While many analyses of the COVID-19 pandemic have focused on epidemiological and economic impacts, few have applied a critical sociological framework like that of Ivan Illich to deconstruct the systemic failures in healthcare delivery. This paper aims to fill that gap by offering a socio-critical analysis of pandemics, arguing that a renewed focus on Illich's concepts is essential for building resilient and equitable health systems.

This article will first provide a methodological approach and a historical overview of pandemics and inequality. It will then detail Illich's theoretical framework, applying it to historical and contemporary pandemics. Finally, it will synthesize these insights in a discussion to propose a re-envisioned approach to public health policy and offer concrete recommendations. Consequently, this study aims to re-evaluate the impacts of global pandemics on social inequalities in line with Ivan Illich's critical theory, analyzing the structural injustices that have deepened with the commercialization and institutionalization of modern healthcare systems.

## II. METHODOLOGY

This study employs a critical literature review methodology. The analysis is built upon a theoretical synthesis of Ivan Illich's seminal works, including *Medical Nemesis*, with historical accounts of major pandemics and contemporary analyses of the COVID-19 crisis. The literature was selected from the disciplines of sociology, public health, history, and medical ethics. The aim is not to provide an

exhaustive historical account, but to critically examine key historical and modern examples through Illich's theoretical lens to reveal underlying patterns of social iatrogenesis and health inequality. By synthesizing these diverse sources, the study seeks to deconstruct how institutionalized medical responses can paradoxically reinforce the very social disparities they intend to alleviate.

## III. HISTORICAL PERSPECTIVES ON PANDEMICS AND INEQUALITY

A global pandemic, unlike a more localized outbreak, is an infectious disease outbreak that spreads across large geographic regions, often encompassing multiple continents or even the entire world (Madhav et al., 2017). These pandemics leave indelible marks not only on populations but also on social structures and economic systems. Throughout history, major pandemics have disproportionately impacted the lives of the poor, exacerbating existing inequalities and creating additional hardships. The effects of these crises have often been felt more acutely by the most vulnerable segments of society. The COVID-19 pandemic is the most recent example of such a crisis, once again highlighting the effects of social inequalities and poverty on health outcomes.

The relationship between poverty and infectious diseases is a complex and critical issue that involves both health and social dimensions. Poverty is associated with many factors that directly affect an individual’s health. Poor individuals often live in overcrowded and unhygienic housing conditions, which increases the risk of infection. Limited access to clean water and sanitation lowers health standards, raising the likelihood of disease transmission. For instance, individuals living in poverty are often deprived of healthy food options, which weakens their immune systems and reduces their resistance to diseases. Furthermore, poor individuals tend to work in low-wage, high-risk jobs, increasing their exposure to infections and health problems (Alsan et al., 2011). This structural link between material deprivation and biological risk creates a "poverty-disease equation" that has remained fundamentally unchanged since the 19th-century industrial slums. In modern contexts, this is vividly seen in how socio-economic status dictates the "biological borders" of a person; while the wealthy can retreat into isolation, the poor are forced into the frontlines of exposure due to their reliance on daily labor and precarious housing. Thus, contemporary crises do not merely introduce new risks but rather validate and accelerate the pre-existing vulnerabilities inherent in social stratification (Kurtdaş, 2017). For example, the COVID-19 pandemic disproportionately affected low-income countries where the ability to practice social distancing and maintain proper hygiene was constrained by limited resources and overcrowded living conditions. Similarly, the Ebola outbreak in West Africa highlighted the weaknesses of healthcare infrastructure in impoverished regions, where underdeveloped health systems and inadequate access to essential services contributed to the rapid spread of the virus.

The economic impacts of pandemics are equally devastating. Global pandemics, in particular, often lead to job losses and economic downturns, further worsening the economic situation of vulnerable groups (Sahasranaman and Jensen, 2020). Crucially, the very measures designed to curb the virus, such as nationwide lockdowns, often carry a hidden social cost that falls most heavily on those at the bottom of the economic ladder. For a worker whose survival depends on daily physical presence, a standardized public health mandate can become a secondary crisis, forcing a choice between the risk of infection and the certainty of hunger (Sahasranaman and Jensen, 2020). The loss of family income and increasing debt burdens reinforce the cycle of poverty, making families more vulnerable, especially in situations where social safety nets are inadequate (Bonds et al., 2009). The destructive impact of pandemics on the poor weakens their social standing and economic power, thereby deepening social inequalities.

At the societal level, the effects of pandemics are even more profound. Fear, stigma, and quarantine measures further isolate marginalized groups, weakening their position within society. Unequal access to healthcare and the withdrawal of social services exacerbate social inequalities within communities, undermining social solidarity and leading to widespread societal disruptions. In this regard, the social

impacts of pandemics extend beyond healthcare systems, threatening broader social structures and solidarity (Table 1).

**Table 1: The Impact of Pandemics on Poverty and Inequality**

| Topic | Description |
|---|---|
| **Pandemics and Poverty** | Poverty creates conditions such as overcrowded living environments, inadequate sanitation, and limited access to healthcare, all of which increase exposure to infectious diseases. Malnutrition weakens the immune system, reducing resistance to illnesses. |
| **Pandemics and Economic Effects** | Pandemics destroy livelihoods, disrupt informal economies, and deepen poverty. Individuals who rely on daily wages lose their incomes during quarantines and lockdowns. The damage to informal economies limits economic opportunities, pushing people into deeper poverty. Those without economic security struggle to access healthcare and basic needs, worsening their health outcomes. |
| **Pandemics and Exclusion** | During pandemics, fear, stigma, and quarantine measures disproportionately affect poor communities, leading to social exclusion. The loss of social capital, weakening of solidarity networks, and increased risk of exploitation make these communities more vulnerable to the negative effects of pandemics. |

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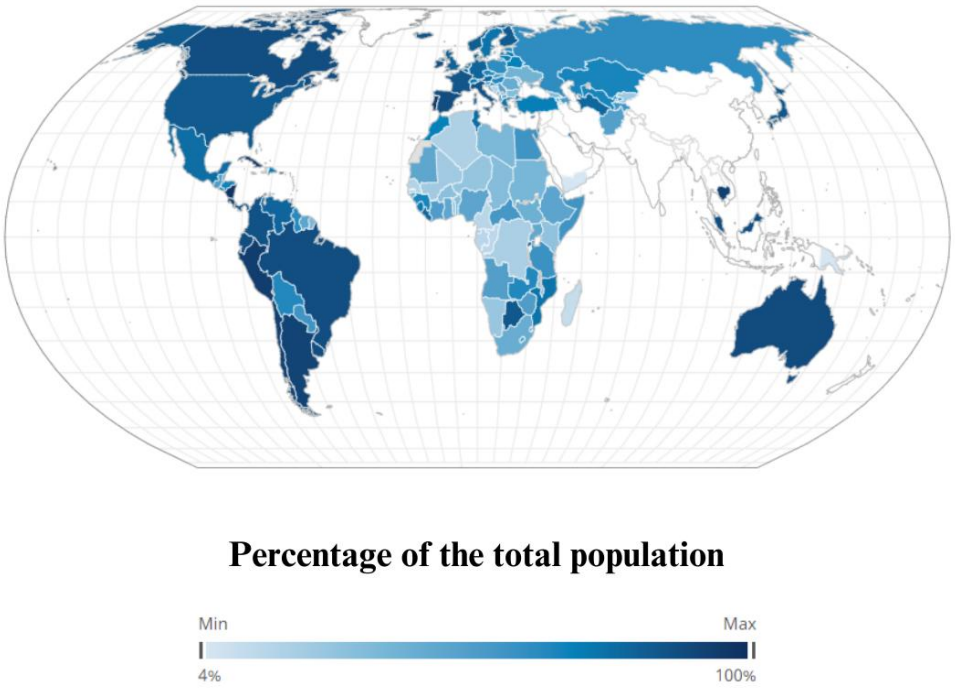
The effects of pandemics on impoverished communities have been clearly observed throughout history. The Black Death (Plague) in the 14th century wiped out approximately 30-60% of Europe's population (Sampath et al., 2021). In 1348, Europe was shaken by the Black Plague, which eliminated one-third of its population. This disease, caused by the bacterium *Yersinia pestis*, spread to humans from black rats through fleas. The plague, which had bubonic, septicemic, and pneumonic forms, caused painful swellings in the groin, legs, and armpits, usually leading to death within a few days (Slavicek, 2008). The generally accepted theory is that this pandemic started in China, spread to a Genoese colony in Crimea, and from there to Europe via trade routes. Europe’s population, which was 76 million in 1340, dropped to 50 million by 1450. Some villages were entirely wiped out, and the poor were disproportionately affected by the disease compared to the wealthy. In this way, the pandemic's impact varied significantly based on social status, with the poor generally facing higher mortality rates and greater economic devastation. In short, the Black Death (Plague) is remembered as a catastrophe that profoundly changed Europe’s demographic, economic, and social fabric (Genç, 2010). Similarly, the 1918-1920 Spanish Flu pandemic, which claimed an estimated 50 million lives globally, also disproportionately affected the poor and marginalized (Alfani, 2022). Factors such as overcrowded living conditions, lack of access to healthcare, and underlying health issues contributed to higher mortality rates among the poor. This pandemic caused more deaths than World War I, especially among men aged 20-40. The disease’s spread began in the overcrowded military camps of the war fronts, and soldiers returning home facilitated the high death rates in this age group (Yamin, 2020). The first case was recorded in the spring of 1918, and the pandemic spread from Europe to North Africa, India, China, and Australia, affecting the entire world. Therefore, the pandemic's impact stemmed not only from biological factors but also from social conditions such as war, economic circumstances, population density, and food supply (Schoenbaum, 2001). As with the Black Death (Plague), the Spanish Flu had a disproportionate impact on the poor and disadvantaged communities, further worsening existing inequalities and leading to long-term economic and social consequences. The severity of the pandemic's impact on the poor was exacerbated by social and economic disruptions such as income loss, food insecurity, and strain on healthcare systems (Schoenbaum, 2001). Along with the Black Death (Plague) of the 14th century, the Spanish Flu demonstrated how seriously pathogens should be regarded.

The HIV/AIDS pandemic, which emerged in the 1980s, also had a profound impact on the lives of the poor in both developed and developing countries. The high cost of treatment, stigma, and lack of

access to healthcare meant that the disease often devastated poor communities, further intensifying existing socioeconomic divisions. In short, the HIV/AIDS pandemic disproportionately affected disadvantaged communities, deepening structural inequalities. Individuals living in poverty, in particular, face higher HIV infection rates and worse health outcomes (Alang and Blackstock, 2023).

The COVID-19 global pandemic has similarly had profound social and economic effects worldwide. Poor and disadvantaged groups have been notably affected due to job losses, income reductions, and difficulties in accessing healthcare. Since the onset of the global pandemic, economic inequalities have widened, and the gap between wealth and opportunity has grown. Those living in densely populated areas and low-income countries have been at greater risk due to the spread of the virus and the limited capacity of health infrastructure. This has posed additional risks for individuals with chronic health conditions, further complicating their access to healthcare services (Stok et al., 2021). For instance, the British Medical Association (BMA), which represents all doctors and medical students in the UK, stated the following regarding the pandemic's impact on public health and health inequalities: "The effects of the pandemic on people's physical and mental health were not felt equally across society. Some groups were more deeply affected. For instance, infection and death rates were much higher among the elderly, certain ethnic groups, and individuals with disabilities. During the first wave, the risk of death was three times higher for disabled individuals and Black African men compared to non-disabled individuals and white men. This was largely due to pre-existing health inequalities and was worsened by modifiable factors, such as a lack of targeted support. Additionally, public health messages were not always culturally competent or inclusive" (British Medical Association [BMA], 2021). Moreover, the unequal distribution of COVID-19 vaccines has further exacerbated these inequalities, with low-income countries falling behind wealthier nations in the vaccination process (Figure 1). The systemic failure to ensure equitable access reflects a global health architecture that often prioritizes industrial and market interests over humanitarian needs, leaving a significant portion of the global population at continued risk.

**Figure 1.** Percentage of the Total Population Vaccinated with at Least One Dose of the COVID-19 Vaccine




**Source:** World Health Organization (2024)

This situation also negatively impacts efforts to mitigate the long-term effects of the pandemic, as the equitable and fair distribution of vaccines emerges as a critical global health priority. Ultimately, pandemics have deeply affected societies and economies throughout history, exacerbating existing structural inequalities and disproportionately impacting the most vulnerable populations. From the Black Death (Plague) to the Spanish Flu, HIV/AIDS, and COVID-19, all these pandemics have led to a worsening of social inequalities.

## IV. IVAN ILLICH'S CRITICAL FRAMEWORK

Ivan Illich (1926-2002), a multifaceted academic and social critic, remains relevant in the 21st century as we grapple with the complexity of global health crises, particularly through his sharp critiques of institutionalized education, transportation systems, and most notably, medical institutions. At the heart of Illich's critique of modern medicine are the concepts of "iatrogenesis," "counterproductivity," and "medicalization." These interconnected ideas offer a framework for understanding how well-intentioned systems, designed to improve human well-being, can inadvertently produce harm, undermine autonomy, and exacerbate the very problems they aim to solve (Illich, 2017).

Illich argued that while medical interventions have a profound capacity to heal, they also inevitably carry the risk of causing harm. This leads to the categorization of human experiences as medical problems, thus expanding the reach of medicalization (Maturo, 2012). Iatrogenesis, or harm caused by medical personnel, can manifest in various ways:

Clinical iatrogenesis refers to the direct adverse side effects of medical treatments, such as complications from surgeries or drug reactions. These harms include medication side effects, hospital-acquired infections, and iatrogenic disabilities (Illich, 2017). Illich highlighted the "incredibly high amount of harm occurring in hospitals" and the "unimaginable number of people permanently disabled or killed due to medical treatment" (Illich, 2017; Maturo, 2012). Social iatrogenesis describes how the expansion of medical institutions contributes to the spread of diseases, while cultural iatrogenesis explains how medical practices undermine individuals' ability to cope with illness, pain, and death autonomously (Illich, 2017). Beyond these categories, modern health policies often transform medicine into a mechanism of social control, where defining "normalcy" and "health" allows institutions to exert sovereign power over the individual, effectively turning citizens into lifelong consumers of medical services (Kurtdaş, 2017). For instance, Illich argued that reduced tolerance for psychological distress has led to an increase in depression cases requiring treatment (Maturo, 2012). Illich claimed that "medical services destroy people's autonomous ability to manage their humanity, pain, suffering, and mortality" (Illich, 2017). In other words, the professionalization of healthcare erodes individual and community-based healing and health practices. It is crucial, however, to frame this critique with nuance. Illich's perspective is not a wholesale rejection of modern medicine's triumphs; the undeniable successes of biomedical interventions, from the rapid development of COVID-19 vaccines to the efficacy of antibiotics, stand as a testament to scientific progress. This paper argues that these achievements do not negate Illich's central thesis but rather exist in a paradoxical tension with it. The true value of his framework lies not in dismissing medical advancement, but in forcing a critical examination of the institutional structures that monopolize health, revealing how an over-reliance on industrialized solutions can simultaneously save lives while deepening the very social inequalities that make populations vulnerable in the first place.

Central to this analysis is also the concept of 'medicalization of life' and its inherent counterproductivity. In his analyses, Illich argued that the medical institution has expanded beyond the traditional boundaries of healthcare, medicalizing various aspects of human existence. He defined medicalization as "the process by which more aspects of life are handed over to the medical system and defined in medical terms" (Doğan, E., 2023). According to Illich, this phenomenon leads to "the proliferation of diseases through the expansion of medical categories in everyday life" (Maturo, 2012). This expansion often results in a "medicalization of the budget," where increasing financial incentives

for the health system do not necessarily correlate with improved health outcomes, but rather foster a structural dependency that can mask rising mortality rates in highly medicalized environments (Doğan, 2023).

**Table 2: Comparison of Normalcy and the Process of Medicalization**

| Situation | Normal Process | Medicalized Process |
|---|---|---|
| Aging | A natural phase of life. | Anti-aging products and treatments. |
| Menstruation | Women's natural cycle. | Considered as Premenstrual Syndrome (PMS). |
| Menopause | A natural phase of life. | Hormone Replacement Therapy (HRT). |
| Adolescence | Physical and emotional changes in youth. | Acne treatment, growth hormone therapy. |
| Nutrition | Eating habits. | Dietitians and supplements. |

*(Created by the authors within the scope of this paper.)*

As seen in Table 2**,** as people begin to perceive certain conditions as illnesses, medical intervention increases, and individuals are directed toward more medical services. This is an example of Ivan Illich's concept of medicalization.

In addition to medicalization, Illich also introduced the concept of counterproductivity, which refers to when the means of production surpass their intended purposes. Illich argued that the medical establishment becomes counterproductive in its efforts to improve health because it often creates more problems than it solves. When health becomes a commodity to be purchased or managed by experts, the social determinants of health are marginalized, creating an advanced yet socially alienating system that erodes the individual's innate capacity for self-care (Metin and Erdem, 2019). Excessive reliance on medical technologies and the medicalization of life lead to a loss of individual autonomy and the weakening of traditional, community-based approaches to health and well-being (Toraman and Erdem, 2016).

Applying Illich's concepts to historical and contemporary pandemics reveals the limitations of purely biomedical approaches and underscores the importance of addressing the social and political dimensions of health crises. For example, while the Black Death (Plague) was undoubtedly a biological disaster, the response to the plague was shaped by prevailing social structures and medical beliefs. The practice of bloodletting, common at the time, likely worsened the severity of the disease, serving as an example of clinical iatrogenesis. Moreover, the persecution of disadvantaged groups scapegoated as the source of the plague illustrates the dangers of social iatrogenesis. Similarly, the Spanish Flu pandemic highlighted the counterproductive nature of neglecting the social determinants of health. Overcrowded wartime conditions, combined with widespread malnutrition, fueled the spread of the virus, emphasizing the limitations of focusing solely on medical interventions. As Illich noted at the time, "The medical institution has become a major threat to health."

The HIV/AIDS pandemic vividly demonstrated the devastating consequences of social iatrogenesis. Stigma, discrimination, and misinformation, often fueled by moral panic, hindered public health efforts and compounded the suffering of those infected. In this context, Illich’s warning that "the medicalization of life turns people into objects of medical attention" was tragically validated. The COVID-19 pandemic also provided a striking contemporary example of Illich's critiques. While the rapid development of vaccines showcased the power of biomedical innovation, the pandemic also revealed the counterproductive nature of neglecting the social determinants of health. Inequalities in healthcare access, vaccine hesitancy driven by misinformation, and the economic consequences of lockdowns underscored Illich's argument that "health is the responsibility of the entire society, not just the medical profession" (Illich, 2017).

In conclusion, pandemics, particularly global pandemics, are not merely biological events; they are complex social phenomena shaped by human actions, institutions, and beliefs. By understanding the concepts of iatrogenesis, counterproductivity, and medicalization, we can begin to challenge the dominant medical paradigm and advocate for more holistic, equitable, and empowering approaches to public health.

## VI. DISCUSSION

The COVID-19 pandemic has exposed the weaknesses of a global health agenda focused on health security, which fails to prioritize equity and justice. Like other pandemics, this global crisis has shown that infectious diseases disproportionately affect the most vulnerable populations and reinforce cycles of poverty. The persistence of the "poverty-disease equation" demonstrates that standard biomedical interventions—such as lockdowns enforced without economic safeguards—can inadvertently deepen the very vulnerabilities they seek to mitigate (Sahasranaman and Jensen, 2020). This underscores the necessity of addressing the root causes of health crises, rather than merely treating their symptoms.

At this point, Ivan Illich's work offers a critical perspective. Illich emphasizes the importance of empowering individuals and communities to take control of their health and well-being, moving beyond narrow biomedical models of healthcare (Airhihenbuwa et al., 2020). This perspective challenges the "medicalization of the budget," where increased institutional spending does not necessarily correlate with improved public health but rather creates a structural dependency that masks deeper social failures (Doğan, 2023). This highlights the need for community-based healthcare models that prioritize prevention, education, and social support rather than institutional approaches. Illich's critique of institutional power and its role in perpetuating inequality provides a starting point for rethinking our approach to healthcare systems, economic structures, and social policies.

During pandemics, community-led initiatives such as mutual aid networks, community health worker programs, and advocacy efforts that emphasize the power of local knowledge not only enhance the effectiveness of healthcare services but also strengthen community solidarity and social capital. These initiatives demonstrate the practical value of resisting "cultural iatrogenesis," thereby reclaiming the autonomous capacity to cope with health challenges. Addressing the root causes of health inequalities requires a fundamental shift towards policies that promote social justice, economic equality, and universal access to essential services such as healthcare, education, and housing. In other words, the concept of health must be understood beyond a narrow biomedical definition, encompassing the social, economic, and environmental factors that shape individual and community health.

## V. CONCLUSION AND RECOMMENDATIONS

Moving beyond critique toward a tangible vision requires a radical reimagining of public health policy. Instead of merely reinforcing centralized medical authority, we must architect systems that foster genuine community resilience. This involves actively dismantling barriers to health by formally integrating and funding community-led initiatives as essential components of our public health infrastructure. It demands a de-medicalization of public health communication, shifting from mandates rooted in fear to a dialogue that empowers citizens with autonomy and trust. Crucially, this shift must deconstruct the identity of the "health consumer," replacing the market-driven demand for medical commodities with a rights-based approach to well-being (Kurtdaş, 2017). Most critically, it compels us to design resource allocation frameworks for health crises that are explicitly based on social vulnerability indices, not just clinical need, ensuring that our response to the next pandemic actively counteracts systemic inequalities rather than amplifying them. While technological advancements have brought significant progress in healthcare and extended lifespans, their effects on poor and disadvantaged groups must be examined more thoroughly and deeply.

Global pandemics, despite technological developments, have demonstrated that these groups continue to be disproportionately affected by health crises. Without addressing fundamental deprivations in housing and nutrition, high-tech medical solutions remain inaccessible luxuries rather than public goods (Pala, 2019). They face severe limitations in access to healthcare, economic resources, and social support, leading to greater challenges during pandemics. Although technology holds the potential to extend individual lifespans, it has not yet fully realized equitable solutions that encompass all segments of society. Therefore, healthcare policies and technological innovations must offer fair and sustainable solutions that are inclusive of every part of society.

In conclusion, empowering individuals and communities is essential to eliminating health inequalities and building a more just healthcare system. Illich's work serves as a reminder that health is not solely a medical issue but also a social one, encouraging the development of more inclusive and equitable healthcare policies.

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