UDC 316.42(045)

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MEDICALIZATION OF PUBLIC LIFE IN A PANDEMIC SITUATION

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Abstract. *The article is devoted to the medicalization of public life as an instrument of political power. Based on the Fukodian analysis of power, seems to be especially relevant in a pandemic that has gripped a globalized society, it is established that medicalization techniques are increasing helplessness of socially vulnerable groups. As a result of the exclusion of socially vulnerable groups from various aspects of public life (political processes, labor market, education and health care systems, cultural life of society, etc.) they have all the rights to take part into, there is a breakdown of social ties. Both voluntary taken and socially imposed restrictions under the pressure of quarantine bans due to the risks of infection during a pandemic are barriers to overcoming unequal access of social groups to public goods and processes. Out-of-dateness or insufficiency of measures aimed at overcoming social exclusion can lead to the fact that part of the population will fall out of the processes of social development, being in a state of social stagnation.*

Key words: biopower, exclusion, inclusion, medicalization, pandemic, socially vulnerable groups.

Introduction

The state of medical science is primarily determined by social needs, the level of socio-economic development of the state, as well as its scientific and technical potential. In modern society, the development of medical science and health care as a social institution is closely linked with the emergence of the social phenomenon of medicalization.

The term "medicalization" was first introduced into scientific circulation in 1960 to explain the growing social and political role of medicine and health care (Migrants and the COVID-19). At this time, "medicalization" means penetration into the mass consciousness of medical language and style of thinking, medical concepts and ideas of the causes, forms of diseases passing and treatment, increasing dependence on medicine in everyday life and professional activities, fixing medical stickers on some human qualities or types of behavior (Шлюмбом, 2008: 159). The relevance of a comprehensive study of medicalization, which dictates the perception of human life as a medical problem, man as a patient, and his body and mind as objects of medical control and regulation (Макарова, 2015: 10), is growing rapidly in a pandemic.

The aim of the study is analysis of the social consequences of the expansion of medicalization in a pandemic.

To achieve this goal it is necessary to perform the following research **tasks:**

- to reveal the essence of the medicalization process in the context of the binary opposition "health / illness";
- to study the equality of access of social groups to the sources of welfare and the main mechanisms of integration in a pandemic.

Research methods

The anthropological theme of biomedical discourse is set in the researches of Yu. Habermas, B. Yudin, P. Tyshchenko, and others. The studies of the interdisciplinary type, which includes medical discourse in a broad cultural context, include the works of M. Foucault, W. Jaeger, A. -I. Marr, P. Giro, M. Hasparova, J. Le Goff, N. Truon, F. Aries, D. Michel, and others.

The methodology of research of medicalization as a socio-cultural phenomenon is revealed in the works of M. Foucault, G. Bashlar, M. Merleau-Ponty. The methodology encompasses the historicity, comparability, complementarity principles.

Research results

For the first time the scientific interest in situations of health and disease within social processes, as well as of the impact of medicine on people's lives and health arose in the late XIX c. E. Durkheim, who studied the norm and pathology in society, the causes of social diseases and ways to overcome them, did not equate the phenomena of disease and health, perceiving both of these phenomena as varieties of the same order, mutually clarifying each other (Дюркгейм, 1995: 23-32). The scientist expressed the general meaning of the concept of "social health", which meant the normal development of the vital forces of the individual, social group and society as a whole, their ability to adapt to environmental conditions and use them for their development. Hence, according to the social approach, health means a state of complete physical, mental and social well-being, rather than the absence of disease or physical defects.

It should be noted that along with a broad (social) approach to the definition of health, you can find a narrowly determined (medical) one as the sum of the reserve capacity of the main functional systems of the body. In our work we will use a social approach, the feasibility and legitimacy of which is explained by the complexity and multifaceted nature of the phenomenon of health.

Health as a social phenomenon is inextricably linked with a specific habitat, with different areas of human life, its main goals and purposes (Краткий словарь, 1988: 70). The formation of specific social circumstances is influenced by the nature of the distribution of money, power and resources at the global, national and regional levels as a result of the state's social and economic policies. Consequently, the social conditions which people are born, grow, live, work, age, and die in, including health care systems, become social determinants of health.

Later, T. Parsons proposed a new differentiated approach to determining the social meaning of disease and health, according to which the disease is a form of "social deviation" and health – a set of optimal capabilities of the individual to perform the social roles and tasks effectively. Further study of the health – disease problem has led to an understanding of the social meaning of the health care system as an institution of social control. For the first time the function of normative regulation of the social role of the doctor was substantiated by T. Parsons (Parsons, 1951: 428-479). This conclusion became the basis for the scientist's

reasoning about the importance of expert knowledge in the implementation of the social role of the doctor and the maintenance of official order in a society in which medicine is the most important agent of social control.

It is advisable to take into account the fact that the processes of globalization and the development of digital technologies are forcing the transformation of medicine, changing the values, social roles and statuses of people, one way or another associated with it. On the one hand, the accelerated digitalization of society leads to an underestimation of the traditionally high status of the "living doctor", preferring high-tech, but at the same time purely instrumental diagnostics, which generates alarming trends. Thus, the report of the World Health Organization (WHO), presented at the Third Global Forum on Human Resources for Health in November 2013, states that in 2035 the world will lack 12.9 million health workers; nowadays, the shortage is estimated at 7.2 million people (Савинкина, Шепелова, 2014).

On the other hand, medicalization "as a form of social control when patients come under the supervision of health professionals" (Гидденс, Саттон, 2018: 247), significantly violates the established practices of interaction between doctors and patients, based on social solidarity. According to the researcher I. Ilyich, the state of modern medicine can be described as "expansion", which causes more harm than good due to growing of diseases caused by medical intervention, which in turn, leads to an artificial need for medical services (How will Coronavirus affect).

A similar situation is associated with the medicalization of normal conditions, as in the case of hyperactivity of young children, sadness and mild depression, chronic fatigue syndrome and others. The problem with these types of treatments is that once diagnosed in medical terms, curing implies medical intrusion too, often with the help of expensive drugs that have serious side effects.

As medicalization increases, people become less able to monitor their own health, control their condition, and become dependent on doctors. Such dependence increases the need for medical services and leads to the expansion of medical care within a wider vicious circle, which pushes up medical budgets through medical services (Гидденс, Саттон, 2018: 248).

The individual in society has always been limited in making decisions that are contrary to the interests of power, usually without realizing it. The emergence of such restrictions is due to the fact that the actual consciousness of the individual is formed under the influence of prevailing values in society, beliefs, rituals and institutional procedures supported by the government. The implementation of a healthy lifestyle is determined by a person's interest in health, perception of it as a basic life value, conscious goal of health, meaning-making, as well as personal psychological and physiological characteristics of man, his upbringing and education. The implementation of a healthy lifestyle is facilitated by the presence of a person's model of a healthy personality and a positive inner picture of health, self-identification with healthy people, allowing you to make a choice in favor of healthy practices. The choice in favor of an unhealthy lifestyle can be explained by a lack of experience, education and (or) information, as well as destructive human tendencies.

In the course of lectures "Security, territory, population" (Final Report of the Expert Group Meeting) M. Foucault speaks of biopolitics as a life process incorporated into state policy in connection with epidemics and public health in general. He proposes a scheme of three types of power relations: supreme, or legal power ("system of legal codes"), the power based on discipline ("disciplinary mechanisms"), and biopolitics, or the security apparatus. The first of metioned above acts through prohibitions and punishments, i.e. through laws, the second one is no longer carried out by the law, but through supervision, control and correction, and the third is through calculation and implementation of measures (intervention). M. Foucault draws distinctions between supreme power, discipline and security / biopolitics. Each type of power is combined with a type of life where each of the variables justifies and articulates that power. If the supreme legal power is embodied for M. Foucault through a highly centralized confrontation between the state and the subject, and disciplinary – through a centralized node of institutions, the third type of power is characterized by references to the regulatory process of calculation and modulation and expresses power relations through technology that modify the biological fate of species.

M. Foucault refers to the measurement of public health and cases of epidemics. He examines three historical cases of epidemics: leprosy in the Middle Ages, the plague, which periodically recurred in Europe, and smallpox in the XVIII century, which broke out at a time when vaccination had already begun. Each of these cases had its own historical, political and medical context, each provoking different socio-political reactions.

In the case of the leprosy epidemic, the political-theological reaction was expressed in the principle of "excluding and dividing" by ritually expelling the leper from the city to special places and declaring him "dead among the living." During the plague epidemic, another principle was used – "include and organize": for example, in the middle of the XIV c. in some Italian states, temporary health committees were set up to establish quarantine in cities and on ships, to register the sick and the dead, and to control the import and export of goods. The smallpox epidemic is of particular interest to M. Foucault, as the reaction to it was inoculation and vaccination and their transformation into health and hygiene programs, where the politico-economic method of accounting is combined with prevention and treatment of the disease.

Yu. Thacker in the article "Shadows of Atheology: epidemics, power and life after Foucault" (Thacker, 2009: 141) illustrates the approach of M. Foucault with the following table 1: **Table 1**

	The leprosy epidemic	**Plague epidemic**	**Smallpox epidemic**
Diagram	Exclusion	**Inclusion**	**Normalization**
Action	Separation	Organization	Intervention
Techniques	Eviction	Quarantine	Vaccination
Ontological principle	Religion / law	Political Economy	Public health
Power	Law / supreme power	Discipline	Security

M. Foucault identifies three historical types of political power that are inherent in the Western world: sovereign power, disciplinary power and biopower. It should be understood that the French researcher himself never set himself the task of a strict and systematic presentation of a certain concept of power, consisting of three successive stages in Western society. This is indicated, for example, by the fact that in his work "Supervise and Punish" M. Foucault examines in detail only two models of power: the so-called, royal and disciplinary model, while the topic of biopower arises greater interest for M. Foucault in the later "The will to truth."

Sovereign power, according to M. Foucault, dates back to the Middle Ages and is held by the sovereign through the control of human resources and uses the law and the state legal system. Sovereignty and law are the foundations of this power. M. Foucault describes the main methods of exercising sovereign power in his famous book "Supervise and Punish". Public punishments with the use of torture, public works in public as a demonstration of power finally refer to the end of the XIX century.

Disciplinary power became the main instrument of capitalism and industrial society, appearing in the XVII-XVIII centuries. The work of disciplinary power was qualitatively different from that of sovereign power. Sovereign power allowed the establishment of absolute power, which requires high costs, intensive use of various symbols of power, its demonstration. At the same time, the disciplinary authorities suggested another method – the minimum cost with maximum efficiency, which can be achieved by establishing rules, regulations, time allocation, registration, constant monitoring in the absence of control, etc. If the mechanics of power set by the theory of sovereignty was based more on control over the land and its resources, then disciplinary power works in another direction, namely – working with people and their activities, or in general, with time and labor. Such a technology of power would also allow us to go completely beyond the theory of sovereignty and, in general, from legal discourse. However, as Michel Foucault points out, this did not happen because, despite the apparent contradiction between the two types of government (based on the theory of sovereignty and discipline, respectively), the legal apparatus could "hide" disciplinary methods under the letter of the law. Disciplinary power with its capillary mechanisms, penetrates into such spheres of human existence over which democratic control is extremely difficult or impossible at all to be controlled. The human sciences that have emerged since the beginning of the New Age are expanding the scope of social control, the agents of which can be the military and police, teachers, doctors, psychiatrists, social workers, experts, and citizens internalized given categories and values (Issue Brief).

Biopower is the last type of power among those aimed at governing people. In the course of its introduction into European life in the second half of the XVIII century, biopower excludes neither the mechanisms that worked in the monarchy, ie the theory of sovereignty and political and legal discourse, nor the mechanics of disciplinary power, which it rather modifies. Biopower has not only become, in chronological terms, the third stage in the evolution of power within Western civilization, but also the third and most global level of human governance. Its main difference, which gives it globality, is that if the sovereign power worked with the individual who signed the contract (transfer of sovereignty), disciplinary power with the human body, the biopower – with the social body, ie with the population, "addressed to man as a living being, a human race" (Фуко, 2005: 256).

Biopower does not put a person under the techniques of supervision, training, punishment, as the disciplinary authorities does. Biopower is concerned with another level of work, namely, the biological processes of life, such as birth, death, human reproduction, disease, and others. Hence, the new type of power does not emphasize the management of the individual through a system of discipline, but regulates the processes associated with large clusters of living beings - people.

We can say that although these three types of power, which constitute the first stage in the evolution of power analysis strategies, appeared in different historical periods, and, overlapping each other, formed a society of normalization. The French philosopher, referring to the book by J. Kangilem "Normal and pathological" identifies several key aspects of normalization for the phenomenon of power (Фуко, 2004: 73).

The main function of the norm is not an exception or rejection, which, however, would be characteristic of sovereign power. On the contrary, normalization constantly works only in a positive way, by inclusion and transformation. The norm does not exclude the participation, for example, of an individual in any social process, it trains him, prepares him, adapts him. However, this is done exclusively from the position of power and is carried out by a number of certain social and political institutions.

In the near future, humanity, obviously, must develop a common set of rules and restrictions that will allow the resumption of international traffic, air travel and travel. For example, it is already obvious that next to the frames of metal detectors in public places there will be frames of devices for measuring temperature. We will remember with amazement the time when a person decided for himself whether to go to work or not, to call a doctor or not. It is possible that people with a fever will simply be forcibly subjected to house arrest (Общество в свете пандемии).

The crisis caused by the outbreak of COVID-19 affected almost all spheres of society and all segments of the population, but it was especially devastating for the most vulnerable social groups. In the Western scientific literature, socially vulnerable groups are distinguished according to the concept that treats vulnerability as a response to risks, including social one. The main components of risk include: a) risky events themselves; b) risk management; c) the result in terms of loss of welfare. Indicators of the magnitude, timing and history of risks and risk response play a key role (Foucault, 2008).

Vulnerability, hence, is defined as the probability of falling below the poverty line over some period of time. Representatives of the sociological approach believe that indicators such as income or consumption are not able to adequately describe the state of vulnerability. Sociologists are more likely to discuss the vulnerability of social groups in terms of their socio-demographic characteristics or social status (Lemke, 2015), namely to identify groups that can be generally classified as vulnerable (elderly, disabled, single mothers, large families, etc). Thus, sociologists propose to expand the definition of assets and in addition to the physical and financial spheres, to include social capital. A number of authors point out that individual vulnerability cannot be separated from the concept of "social vulnerability" (Dilley, 2000), because connections of individuals cause the collective nature of vulnerability.

People may face two different types of exclusion: arisen as a result of deliberate policies and practices in society ("active") or a deliberate rejection ("passive"). Whether quarantine measures related to COVID-19 will lead to social vulnerability and social exclusion depends on the socio-economic policy of the state, which determines the outcome of the interaction of these risks with social norms, social institutions and patterns of behavior.

According to the latest UN data, in 2020, as a result of the economic downturn caused by the COVID-19 pandemic, the number of hungry people in the world could increase by at least 83 million people, possibly even 132 million (Продовольственная и сельскохозяйственная организация).

According to the World Bank, the economic consequences of the pandemic could lead to the extreme poverty of about 100 million people. Rapid unemployment, loss of income in both developed and developing countries will have long-term consequences. The New York Times calls it to be a white-collar workers quarantine. Work from home is not feasible for the vast majority of Americans: according to the 2017-2018 survey, only 28% said they had the opportunity to work remotely, every second member of the financial sector, business consultants and information service workers said it was available. In industries such as recreation or agriculture, remote work is almost unrealistic - only about one in ten reported its possibility (Coronavirus quarantine).

The possibility of remote work during quarantine correlates with the level of income and decreases with its lowering. According to the US Bureau of Statistics, cited by Bruegel, among Americans in the top 25% of the income distribution, ie in the upper income quartile, more than 60% have such an opportunity, in the middle quarter of the population this figure probabile is 37%, and in the lower one is only 9% (Holzmann & Jorgensen, 1999).

The inequality associated with the ability to work remotely is dictated geographically, depending on the specialization of local labor markets, according to the Center for Cities think tank. Thus, in the UK, in large cities in the south-east, where finance and consulting areas are concentrated (London, Cambridge, Oxford), about 40% of workers can perform their duties from home, while in cities in the industrial north – less than 20% (How COVID-19 is laying bare inequality). According to the British think tank Resolution Foundation, only 10% of people with the lowest salaries will be able to work remotely (Morrow, 1999).

Millions of people who have been forcibly transferred to work from home quickly realize that there is no boundary between working and non-working hours, between working space and living space. This situation contributes into the erosion of labor rights and the gains of the social and trade union movement of the XIX-XX centuries, returning the society to a new technical level in the situation of the previous industrial revolution, when relations between employee and employer were almost not regulated by law.

Preventive measures of the development of the crisis due to the spread of COVID-19 include social distancing and the closure of transport, restaurants, hotels and other service industries. Under these circumstances, low-income workers, the elderly and others turn to be vulnerable. Elderly people are more at risk of contracting COVID-19. Today, they face not only an increased risk to health, but also great difficulties in living in isolation.

According to the OECD (Organization for Economic Co-operation and Development), every third elderly person in the G20 is single. These citizens rely on the smooth running of social services and support at home. To this end, government agencies, NGOs, and providers of medical and social services must make every effort to work in the context of the COVID-19 epidemic and to ensure the continuity of their services (COVID-19: Protecting people).

Although social distancing is necessary to reduce the spread of the disease, such measures to protect the elderly should be applied to them only on a voluntary basis, say UN experts (Illich, 1975).

Many elderly people live in long-term care facilities and old age homes. People in such facilities have a higher risk of infection and adverse effects of the disease because they are in close proximity to each other. As a result, many states are forced to take measures such as restricting visits and group activities, which negatively affects the physical and mental health of the elderly, leading to increased anxiety, tension and isolation.

More than 100 organizations for the protection of the rights of disabled persons called for an immediate response by states to meet the needs of the people of this category to maintain their health, safety, dignity, independence, and full participation in society life throughout the entire COVID-19 epidemic and related health emergencies (COVID-19 Outbreak).

Obviously, the epidemic will stimulate the process that was going prior to it, namely, the erosion of privacy, general transparency. But in democracies, the transparency of the citizen in the face of the supervisory state and corporations will be somewhat balanced by the transparency of the power mechanism itself and the tools of control. In non-democracies, the "inequality of data" between society and the administrative machine will be as great as the inequality of their power.

Discussion

Modern researchers define medicalization both as a progressive phenomenon and as an obviously negative phenomenon. Indeed, few of them deny the fact that medicalization once brought undoubted benefits. For example, hospital delivery is a progressive improvement, for sure. Similarly, medicalization allows disabled people, previously considered simulators, to rely on appropriate medical care.

At the same time, modern medicalization generates a number of significant changes in social development, acquiring the characteristics of biopower. Biopower limits the scope of decision-making of the individual, who obeys the imposed health actions dictated by safety, avoiding an open, clearly visible, conflict. This conflict is hidden and is meant as a contradiction between the activities of the subordinate entity, aimed at their own benefit and the perceptions of the subject of power concerning the permissible scope of this activity.

But we can assume that developed countries may need to take more responsibility for the health systems of poor countries: otherwise they become a source of recovery for those diseases that developed countries have already dealt with. The whole effect of painful and costly quarantine can be destroyed if a new outbreak has started in the country or the state does not have the strength to cope with the previous one. In particular, the Copenhagen Declaration on Social Development (Копенгагенская декларация), which the UN report on the creation of an inclusive society refers to, outlines international commitments to build a stable, secure and just society based on the principles of encouragement and protection of all human rights, as well as on the principles of non-discrimination, tolerance, respect for diversity, equality of opportunity, solidarity, security and participation of the entire population, including vulnerable groups and individuals (Doing what it takes).

Particular attention should be paid to countries with a high proportion of migrants in relation to the general population. The International Organization for Migration notes several challenges for migrants in the context of the COVID-19 spread (Loughhead & Mittai, 2000). If governments do not include these populations in COVID-19 programs, efforts to combat the virus outbreak will be less effective: more people will be infected. On April 9, 2020, in Singapore 200 out of 287 new cases of COVID-19 infection haapped to the migrants living in dormitories.

In the light of the coronavirus pandemic, international organizations focusing on inclusiveness problem are seriously concerned about the possible deterioration of the situation of vulnerable groups. The United Nations, the World Health Organization, the International Labor Organization (ILO), the United Nations Children's Fund (UNICEF), the International Committee of the Red Cross and many others have issued recommendations to their staff, national governments, the corporate sector and the general public implying the call for ensuring the rights and needs of disabled people in a pandemic.

Conclusion

The steady increase in the scale of medicalization in a pandemic, made the medical institute perform more than the treatment and preventive functions, but the social control, creating new long-term risks and dangers in society. The medicalization of social problems prevents socially vulnerable groups a critical understanding of their subordination to the power. In addition, the medicalization of social problems means that scientific medical knowledge extends far beyond professional discourse and functions actively in the media, political, everyday spheres, which is made possible by the special status of scientific medicine. Nowadays, it is a political instrument of power relations, designed to support the economic, political and social processes of exclusion of socially vulnerable citizens, occurring in modern society in a pandemic.

Literature

1. Гидденс Э., Саттон Ф. Основные понятия социологии / пер. с англ. Е. Рождественской, С. Гавриленко. М. : Изд. дом Высш. шк. экономики, 2018. 336 с.

2. Drotianko L., S. Yahodzinskyi S. Digitalization of educational environment: tendencies and perspectives // Вісник Національного авіаційного університету. Серія: Філософія. Культурологія: Зб. наук. пр. – Вип. 2 (30). – К.: НАУ, 2019. – С. 9-13.

3. Дюркгейм Э. Социология. Ее предмет, метод, предназначение / пер. с фр., сост., послесл. и примеч. А. Б. Гофмана. М. : Канон, 1995. 352 с.

4. Копенгагенская декларация о социальном развитии : принята Всемирной встречей на высшем уровне в интересах социального развития (Копенгаген, 6–12 март. 1995 г.). URL: https://www.un.org/ru/documents/decl_conv/declarations/copdecl.shtml.

5. Краткий словарь по социологии / под общ. ред. Д. М. Гвишиани, Н. И. Лапина. М. : Политиздат, 1988. 479 с.

6. Макарова О. С. Лингвистический аспект медикализации: постановка проблемы. Ученые записки Новгородского государственного университета имени Ярослава Мудрого. 2015. № 2. С. 10–11.

7. Гидденс Э., Саттон Ф. Медикализация. Основные понятия в социологии. М. : Изд. дом Высш. шк. экономики, 2018. С. 248.

8. Общество в свете пандемии. URL: https://ru.unesco.org/courier/2020-3/obshchestvo-v-svete-pandemii.

9. Продовольственная и сельскохозяйственная организация Объединенных Наций (ФАО). URL: http://www.fao. org/2019 -ncov/q-and-a/impact-on-food -and-agriculture /ru.

10. Савинкина Л. А., Шепелова Т. С. Проблемы дефицита медицинских кадров и пути ее решения. Современные проблемы науки и образования. 2014. № 6. URL: https://www.science-education.ru/ru/article/view?id=16466.

11. Фуко М. Ненормальные : курс лекций. СПб. : Наука, 2004. 432 с.

12. Фуко М. Нужно защищать общество : курс лекций. СПб. : Наука, 2005. 312 с.

13. Шлюмбом Ю., Хагнер М., Сироткина И. Введение. История медицины: актуальные тенденции и перспективы. Болезнь и здоровье: новые подходы к истории медицины. 2008. С. 155–160.

14. Coronavirus quarantine: only one in four Americans can work from home. URL: https://amp.theguardian.com/world/2020/mar/27/coronavirus-working-from-home-privilege.

15. COVID-19 Outbreak and Persons with Disabilities. URL: https://www.un.org/development/desa/disabilities/covid-19.html.

16. COVID-19: Protecting people and societies. URL: https://socialprotection.org/sites/default/files/publications_files/document_0.pdf.

17. Dilley M. Climate, Change, and Disasters, in Kreimer, A. and M. Arnold, eds Managing Disaster Risk in Emerging Economies. Washington : D.C., 2000.

18. Morrow B. H. Identifying and Mapping Community Vulnerability. Disasters. 1999. No. 23 (1). P. 1–18.

19. Doing what it takes. URL: https://www.resolutionfoundation.org/publications/doing-what-it-takes.
20. Final Report of the Expert Group Meeting on Creating an Inclusive Society: Practical Strategies to Promote Social Integration. URL: https: //www.un. org/esa /socdev/sib/egm%2707/documents/reportfinal.pdf.
21. Foucault M. The birth of biopolitics : Lectures at the Collège de France, 1978–1979. N.Y. : Palgrave Macmillan, 2008.
22. Holzmann R., Jorgensen S. Social Protection as Social Risk Management: Conceptual Underpinnings for Social Protection Sector Strategy Paper. Social Protection Discussion Paper. 1999. No. 9904.
23. How COVID-19 is laying bare inequality. URL: https://www.bruegel.org/2020/03/how-covid-19-is-laying-bare-inequality.
24. How will Coronavirus affect. URL: https://www.centreforcities.org/blog/how-will-coronavirus-affect-jobs-in-different-parts-of-the-country.
25. Illich I. Medical Nemesis: The Expropriation of Health. London : Calder and Boyars, 1975.
26. Issue Brief: Older Persons and COVID-19. URL: https://www.un.org/development/desa/ageing/wp-content/uploads/sites/24/2020/04/POLICY-BRIEF-ON-COVID19-AND-OLDER-PERSONS.pdf.
27. Lemke T. Foucault, Governmentality, and Critique. Routledge, 2015. 144 p.
28. Loughhead S., Mittai O. Urban Poverty and Vulnerability in India: A Social Perspective : Paper presented at the Urban Forum «Urban Poverty Reduction in the 21st Century». Chantilly : Virginia, 2000.
29. Migrants and the COVID-19 pandemic: An initial analysis. URL: https://publications.iom.int/system/files/pdf/mrs-60.pdf.
30. Nye R. A. The Evolution of the Concept of Medicalization in the Late Twentieth Century. Journal of History of the Behavioral Sciences. 2003. Vol. 39 (2). P. 115–129.
31. Parsons T. The Social System. Glencoe, Ill. : The Free Press, 1951. 600 p.
32. Thacker E. The shadows of atheology: Epidemics, power and life after Foucault. Theory, culture & society. 2009. Vol. 26. No. 6. P. 134–152.
33. 'White-Collar Quarantine' Over Virus Spotlights Class Divide.
URL: https://www.nytimes.com/2020/03/27/business/economy/coronavirus-inequality.html.

References

1. Giddens, E., & Satton, F. (2018). Osnovnye poniatiia sotsiologii [Basic concepts of sociology]. (E. Rozndestvenskaia, S. Gavrilenko, Trans). Moscow: Izd. dom Vyssh. shk. ekonomiki [in Russian].
2. Drotianko, L. and Yahodzinskyi, S. (2019). Digitalization of educational environment: tendencies and perspectives. Visnyk Natsionalnoho aviatsiinoho universytetu, Proceedings of the National Aviation University, 2 (30): 9-13 [in Ukrainian].
3. Diurkgeym, E. (1995). Sotsiologiia. Ee predmet, metod, prednaznachenie [Sociology. Its subject, method, purpose]. (A.B. Gofman, Trans). Moscow: Kanon [in Russian].
4. Kopengagenskaia deklaratsiia o sotsialnom razvitii: priniata Vsemirnoy vstrechey na vysshem urovne v interesakh sotsialnogo razvitiia (Kopengagen, 6-12 mart. 1995 g.) [Copenhagen Declaration on Social Development: Adopted by the World Summit for Social Development from March, 6-12, 1995). (n.d). www.un.org. Retrieved from https://www.un.org/ru/documents/decl_conv/declarations/copdecl.shtml [in Russian].
5. Gvishiani, D.M., & Lapiani, N.I. (Eds.). (1988). Kratkiy slovar po sotsiologii [A Brief Dictionary of Sociology]. Moscow: Politizdat [in Russian].
6. Makarov, O.S. (2015). Lingvisticheskiy aspekt medikalizatsii: postanovka problem [The linguistic aspect of medicalization: problem statement]. Uchenye zapiski Novgorodskogo gosudarstvennogo universiteta imeni Yaroslava Mudrogo, Scientific notes of Yaroslav the Wise Novgorod State University, 2, 10-11 [in Russian].
7. Giddens, E., & Satton, F. (2018). Medikalizatsiia. Osnovnye poniatiia v sotsiologii [Medicalization. Basic concepts in sociology]. Moscow: Izd. dom Vyssh. shk. ekonomiki [in Russian].
8. Obshchestvo v svete pandemii [Society in the light of the pandemic]. (n.d.). ru.unesco.org. Retrieved from https://ru.unesco.org/courier/2020-3/obshchestvo-v-svete-pandemii [in Russian].
9. Prodovolstvennaia i selskokhoziaystvennaia organizatsiia Obedinennykh Natsiy (FAO) [Food and Agriculture Organization of the United Nations (FAO)]. (n.d.). www.fao.org. Retrieved from http://www.fao.org/2019-ncov/q-and-a/impact-on-food-and-agriculture/ru [in Russian].
10. Savinkina, L.A., & Shepelova, T.S. (2014). Problemy defitsita meditsinskikh kadrov i puti ee resheniia [Problems of shortage of medical personnel and ways to solve it]. Sovremennye problemy nauki i obrazovaniia, Modern problems of science and education, 6. Retrieved from https://www.science-education.ru/ru/article/view?id=16466 [in Russian].
11. Fuko, M. (2004). Nenormalnye [Abnormal]. SPb.: Nauka [in Russian].
12. Fuko, M. (2005). Nuznno zashchishchat obshchestvo [Society must be protected]. SPb.: Nauka [in Russian].
13. Shliumbom, Iu., Khagner, M., & Sirotkina, I. (2008). Vvedenie. Istoriia meditsiny: aktualnye tendentsii i perspektivy [Introduction. History of Medicine: Current Trends and Prospects]. Bolezn i zdorovye: novye podkhody k istorii meditsiny, Disease and Health: New Approaches to the History of Medicine, 155-160 [in Russian].
14. Coronavirus quarantine: only one in four Americans can work from home. (n.d.). amp.theguardian.com. Retrieved from https://amp.theguardian.com/world/2020/mar/27/coronavirus-working-from-home-privilege.
15. COVID-19 Outbreak and Persons with Disabilities. (n.d.). www.un.org. Retrieved from https://www.un.org/development/desa/disabilities/covid-19.html.
16. COVID-19: Protecting people and societies. (n.d.). socialprotection.org. Retrieved from https://socialprotection.org/sites/default/files/publications_files/document_0.pdf.
17. Dilley, M. (2000). Climate, Change, and Disasters, in Kreimer, A. and M. Arnold, eds Managing Disaster Risk in Emerging Economies. Washington: D.C.
18. Morrow, B.H. (1999). Identifying and Mapping Community Vulnerability. Disasters, 23(1), 1-18.
19. Doing what it takes. (n.d.). www.resolutionfoundation.org. Retrieved from https://www.resolutionfoundation.org/publications/doing-what-it-takes.
20. Final Report of the Expert Group Meeting on Creating an Inclusive Society: Practical Strategies to Promote Social Integration. (n.d.). www.un.org. Retrieved from https://www.un.org/esa/socdev/sib/egm%2707/documents/reportfinal.pdf.
21. Foucault, M. (2008). The birth of biopolitics. N.Y.: Palgrave Macmillan.
22. Holzmann, R., & Jorgensen, S. (1999). Social Protection as Social Risk Management: Conceptual Underpinnings for Social Protection Sector Strategy Paper. Social Protection Discussion Paper, 9904.
23. How COVID-19 is laying bare inequality. (n.d.). www.bruegel.org. Retrieved from https://www.bruegel.org/2020/03/how-covid-19-is-laying-bare-inequality.
24. How will Coronavirus affect. (n.d.). www.centreforcities.org. Retrieved from https://www.centreforcities.org/blog/how-will-coronavirus-affect-jobs-in-different-parts-of-the-country.
25. Illich, I. (1975). Medical Nemesis: The Expropriation of Health. London: Calder and Boyars.
26. Issue Brief: Older Persons and COVID-19. (n.d.). www.un.org. Retrieved from https://www.un.org/development/desa/ageing/wp-content/uploads/sites/24/2020/04/POLICY-BRIEF-ON-COVID19-AND-OLDER-PERSONS.pdf.
27. Lemke, T. (2015). Foucault, Governmentality, and Critique. Routledge.

28. Loughhead, S., & Mittai, O. (2000). Urban Poverty and Vulnerability in India: A Social Perspective. Chantilly: Virginia.
29. Migrants and the COVID-19 pandemic: An initial analysis. (n.d.). publications.iom.int. Retrieved from https://publications.iom.int/system/files/pdf/mrs-60.pdf.
30. Nye, R.A. (2003). The Evolution of the Concept of Medicalization in the Late Twentieth Century. Journal of History of the Behavioral Sciences, 39(2), 115-129.
31. Parsons, T. (1951). The Social System. Glencoe, Ill.: The Free Press.
32. Thacker, E. (2009). The shadows of atheology: Epidemics, power and life after Foucault. Theory, culture & society, 26(6), 134-152.
33. 'White-Collar Quarantine' Over Virus Spotlights Class Divide. (n.d.). www.nytimes.com. Retrieved from https://www.nytimes.com/2020/03/27/business/economy/coronavirus-inequality.html.

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МЕДИКАЛИЗАЦИЯ ОБЩЕСТВЕННОЙ ЖИЗНИ В УСЛОВИЯХ ПАНДЕМИИ

Статья посвящена медикализации общественной жизни как инструмента политической власти. На основе фукодианского анализа власти, который приобретает особую актуальность в условиях пандемии, охватившей глобализированное общество, установлено, что техники медикализации усиливают уязвимость малоимущих и социально незащищенных категорий граждан. В результате исключения (эксклюзии) социально уязвимых групп из аспектов общественной жизни (политических процессов, рынка труда, систем образования и здравоохранения, культурной жизни общества и т.п.), на которые у них есть все права, происходит распад социальных связей. Барьерами на пути преодоления неравного доступа социальных групп к общественным благам и процессам выступают и добровольные, и навязанные социальные ограничения под влиянием карантинных запретов в связи с рисками заражения в период пандемии. Несвоевременность или недостаточность принятия мер по преодолению социального исключения может привести к тому, что часть населения будет выпадать из процессов общественного развития, находясь в состоянии социальной стагнации.

Ключевые слова: *биовласть, эксклюзия, инклюзия, медикализация, пандемия, социально-уязвимые группы населения.*

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МЕДИКАЛІЗАЦІЯ СУСПІЛЬНОГО ЖИТТЯ В УМОВАХ ПАНДЕМІЇ

У сучасному суспільстві розвиток медичної науки та охорони здоров'я як соціального інституту тісно зв'язані з появою соціального феномена медикалізації. Актуальність всебічного вивчення медикалізації, що диктує сприймати людське життя як медичну проблему, людину – як пацієнта, а її тіло та свідомість – як об'єкти медичного контролю й регулювання [6, с. 10], стрімко зростає в умовах пандемії. **Метою** статті є аналіз соціальних наслідків розширення медикалізації в умовах пандемії. Для реалізації даної мети необхідно вирішити такі дослідницькі **завдання**: - розкрити зміст процесу медикалізації у контексті бінарної опозиції «здоров'я / хвороба»; - вивчити рівність доступу соціальних груп до джерел підвищення добробуту та основних механізмів інтеграції в умовах пандемії. **Методологія дослідження** медикалізації як соціокультурного феномену виявляється в роботах М. Фуко. Методологія включає принципи історичності, компаративності, комплементарності. **Результати дослідження.** М. Фуко виділяє три історичні типи політичної влади, які притаманні західному світові – це суверенна влада, дисциплінарна влада і біовлада. Суверенна влада, на думку М. Фуко, бере початок від Середньовіччя і тримається на владі суверена через контроль людських ресурсів і використовує при цьому законодавство і державну систему права. Дисциплінарна влада стала головним інструментом капіталізму й індустріального суспільства, з'явившись в XVII-XVIII ст. Робота дисциплінарної влади якісно відрізнялася від суверенної влади. Суверенна влада дозволяла заснувати абсолютну владу, яка вимагає великих витрат, інтенсивне використання різних символів влади, її демонстрації. Біовлада, є останнім типом влади, серед тих, які націлені на управління людьми. У ході свого впровадження в європейське життя в другій половині XVIII століття, біовлада не виключає ні ті механізми, які працювали в епоху монархії, тобто теорію суверенітету і політико-юридичний дискурс, ні механіку дисциплінарної влади, яку вона, швидше, модифікує. Біовлада не тільки в хронологічному сенсі стала третьою стадією еволюції влади всередині західної цивілізації, а й третім й найглобальнішим рівнем управління людьми. Її основна відмінність, яка й надає їй глобальність, полягає в тому, що якщо суверенна влада працювала з індивідом, яка підписала контракт (передача суверенітету), дисциплінарна влада із тілом людини, то біовлада – із соціальним тілом, тобто з населенням, «звернена до людини як живої істоти, людини-роду».Біовлада обмежує сферу прийняття рішень індивіда, що підкоряється нав'язаним з огляду безпеки для здоров'я дій, не вступаючи у відкритий, явно видимий, конфлікт. Даний конфлікт прихований і мається на увазі як протиріччя між діяльністю підпорядкованого суб'єкта, спрямованого на власне благо і уявленнями суб'єкта влади, що стосуються допустимого обсягу цієї діяльності. У найближчому майбутньому людству, очевидно, належить розробити певний загальний набір правил і обмежень. Криза, викликана спалахом COVID-19, зачепила практично всі сфери життя суспільства і всі верстви населення, але особливо згубною вона виявилася для представників найбільш уразливих соціальних груп. У західній науковій літературі соціально вразливі групи населення (socially vulnerable groups) виділяються відповідно до концепції, що трактує вразливість як реакцію на ризики, в т.ч. соціальні. **Обговорення.** Сучасними дослідниками медикалізація розглядається і як прогресивне явище, і як очевидно негативний феномен. Міжнародні організації, що приділяють особливу увагу питанням інклюзивності, у світлі пандемії коронавірусної інфекції серйозно стурбовані можливим погіршенням становища вразливих груп населення. ООН, Всесвітня організація охорони здоров'я, Міжнародна організація праці (МОП), Дитячий фонд ООН (ЮНІСЕФ), Міжнародний комітет Червоного Хреста та багато інших випустили для своїх співробітників, національних урядів, корпоративного сектора і широких груп населення рекомендації із закликом звернути увагу на необхідність забезпечення прав і потреби громадян з обмеженими можливостями в умовах пандемії. **Висновки.** Неухильне збільшення масштабів медикалізації в умовах пандемії, внаслідок чого медичний інститут виконує не тільки функції лікування й профілактики, а й соціального контролю, створює в суспільстві нові довгострокові ризики та небезпеки. Медикалізація соціальних проблем перешкоджає критичному розумінню підпорядкування владі тими групами людей, яких воно стосується. Крім того, медикалізація соціальних проблем означає, що наукове медичне знання поширюється далеко за межі професійного дискурсу і активно функціонує у медійній, політичної, повсякденній сферах, що стає можливим завдяки особливому статусу наукової медицини. Сьогодні вона являє собою політичний інструмент владних відносин, покликаний підтримувати економічні, політичні та соціальні процеси ексклюзії соціально-вразливих громадян, що відбуваються у сучасному суспільстві в умовах пандемії.

Ключові слова: *біовлада, ексклюзія, інклюзія, медикалізація, пандемія, соціально-вразливі групи населення.*