ARTICLES

Solidarity and COVID-19

A Foucauldian analysis*

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Introduction

Solidarity is often presented as a core value underpinning our dealings with the COVID-19 pandemic. Politicians called for it to persuade teenagers and adolescents to help protect vulnerable senior citizens, or to stimulate citizens to unburden the care workers by obeying the social distancing and other anti-corona regulations. Out of solidarity the EU members states decided to provide member states with the lowest rates of vaccination with extra 'solidarity vaccines'. The United Nations as well as human rights organizations worldwide frequently called for international solidarity among countries to fight the COVID-19 pandemic.

In these examples, 'solidarity' is conceived as a moral value or political principle that can be invoked to press or encourage citizens, states and governments to take care of vulnerable or poor persons, groups or countries, without asking something in return or even at considerable cost for themselves. Lacking in this conceptualization is that in order to put solidarity into practice, it needs to be embedded in a social infrastructure, a common 'world', where people meet, act and interact with each other. Even global solidarity, though based on the idea of an imagined community of mankind, not only represents a moral or political value but also a social, infrastructural dimension. Social conditions, concrete practices and social contexts in which people live and act together, and experience their interdependence, are as important for putting solidarity into practice as moral or humanitarian considerations.[1] This is especially the case in times of crisis: social connections strengthen social resilience and increase the chances for survival.

This article investigates what effect the measures to fight and control the coronavirus, taken by governments under the banner of solidarity, have on the conditions that motivate people to care for others, nearby and far away, without expecting something in return. I will argue that lockdowns, quarantines, corona apps and

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1 Related to biomedicine, sociologist Barbara Prainsack and biomedical ethicist Alexia Buyx understand solidarity as a practice, as something that is *enacted*, rather than as an abstract value, normative ideal, or inner sentiment. Analyses of solidarity have to take into account concrete practices, policies and contexts, including how the actor of solidarity is related to the human, natural and artefactual environments. Barbara Prainsack and Alena Buyx, *Solidarity in Biomedicine and* Beyond (Cambridge University Press, 2017), 45-48.

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other disciplining and controlling measures negatively affect the social cohesion in society as well as the quality of the public sphere. The disciplining and controlling mechanisms that governments enforced on individuals and the population at large weaken what Hannah Arendt called the 'web of human relationships', the intangible world in-between people that originates in people's acting and speaking directly to each other.[2] Moreover, the options to interact with strangers vastly declined, which also erodes the conditions that enable and motivate people to care for unfamiliar or strange others.

This article starts with the entrance of the modern concept of solidarity in the western political domain. Elaborating on the historical studies of Michel Foucault, it shows how the intertwinement of a medicine of epidemics and a national state enabled nations to express solidarity and take care for the poor, diseased and miserable within the national borders. Over the course of centuries this intertwinement resulted in health regimes that subject all citizens for their own good to disciplinary and controlling mechanisms. Second, I portray the anti-corona measures as an ensemble of medical interventions, disciplining and controlling mechanisms. I will argue that the side-effects of these mechanisms and interventions, which governments enforced in order to lower the infection, morbidity and mortality rate due to COVID-19, significantly limit the opportunities to act together and practice solidarity. Bottom-up initiatives, democratic deliberation and public exchanges of arguments hardly had a chance to develop. I conclude that, in order to uphold the practice of solidarity, it is not only important that the regulations taken to fight and control the coronavirus are turned back after the epidemic, but also that both governments and citizens invest in the restoral of social cohesion, the public sphere, democratic deliberation and, more generally, the web of relationships that conditions what we as human beings are.

Solidarity, medicine of epidemics and nation state

Solidarity as a political concept emerged in Western Europe in the eighteenth century.[3] Until then, the care of the vulnerable – the sick, the poor and orphans – mainly depended on the charity of religious and private organizations. Sufferers of leprosy, a disease that ravaged Europe for centuries and only disappeared after the Middle Ages, received care thanks to the values of mercy and compassion.

The awareness that the nation had a social and collective duty to assist the vulnerable arose already in the seventeenth century, with the first development of national states in Western Europe.[4] Charity and compassion became less important and gradually gave way to solidarity and other humanitarian values. Due to the

2 Hannah Arendt, *The Human Condition. Second edition* (Chicago and London: The University of Chicago Press, 1998), 183-184.

3 Steinar Stjernø, *Solidarity in Europe. The history of an idea* (Cambridge: Cambridge University Press, 2004), 27.

4 Michel Foucault, *Naissance de la Clinique* (Paris: Presses Universitaires de France, 1963), 39, see also 42-43.

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French Revolution, solidarity became a political concept: solidarity, understood as brotherhood, would pave the way out of inequality and injustice.

The nineteenth century development of modern nation states, in which nation, state and territory overlap, coincided with the rise of a medicine of epidemics. Starting in the eighteenth century, medical doctors and governments wanted to map the incidence and distribution of diseases that affected a large number of persons simultaneously (at that time, the name epidemic referred to the large number of affected persons rather than to the contagiousness).[5] The institutionalization of this new way of observing epidemic diseases brought about 'a medicine of epidemics', which not only mapped epidemic diseases, but also implemented health regulations and a medical police to survey people's compliance with the regulations. As Foucault wrote:

> 'A medicine of epidemics could exist only if supplemented by a police: to supervise the location of mines and cemeteries, to get as many corpses as possible cremated instead of buried, to control the sale of bread, wine, and meat, to supervise the running of abattoirs and dye works, and to prohibit unhealthy housing.'[6]

The intertwinement of a medicine of epidemics and the modern nation state brought about a health regime that expended its reach from the poor and the vulnerable to all citizens. Solidarity became delegated to the state, and later on also to sub-state organizations such as medical institutions, insurance companies and welfare funds. By optimizing the health of each individual as well as the population at large, the outcome was expected to be best for everyone, the poor and vulnerable included.

Foucault describes how a constellation of disciplinary and controlling (or regulatory) techniques developed, which incites individuals and society at large to behave as healthy as possible. Starting in the seventeenth century, a 'political technology of life', 'biopower' or 'power over life' evolved in two principle forms: the first, an 'anatomo-politics', focused on the individual body. It administrated all human bodies, disciplined them, optimized their capacities, increased their usefulness and integrated them into systems of economic control. The second, a 'biopolitics of the population', focused on the biological life of the population at large. It supervised, governed and controlled the population's proliferation, birth and death rate, health level, life expectancy, average life span and so on.[7] The first, disciplinary power ruled by dissolving the multiplicity of men 'into individual bodies that can be kept under surveillance, trained, used, and, if need be, punished'. The second, regulatory

5 Foucault, *Naissance de la clinique*, 22.

6 Foucault, *Naissance de la clinique*, 25 (trans. A.M. Sheridan in Michel Foucault, *The Birth of the Clinic. An Archaeology of Medical Perception* (Taylor & Francis e-Library, 2003), 25).

7 Michel Foucault, *Histoire de la sexualité I. La volonté de savoir*(Paris: Éditions Gallimard, 1976), 182-183. See also Michel Foucault, *Society must be defended. Lectures at the Collège de France, 1975-1976*, trans. David Macey (London: Penguin Books, 2003), 239-263.

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or controlling politics massified the multitude of bodies into a global mass, that is man-as-species or the human race.[8]

These two interconnected biopower forms were the poles of a development in which all biological processes became administered, surveyed, disciplined and regulated at a small-scale as well as a large-scale level. Life entered into history, as Foucault wrote, that is, 'the entry of phenomena specific to the life of the human species into the order of knowledge and power, into the field of political techniques'.[9] The highest function of these bipolar (anatomic/disciplinary and biological/regulatory) political technologies of life was not to put into practice the solidarity with the vulnerable or the poor, but to invest through and through the biological life of all individual bodies and the entire population.

In the gradual refinement of this health regime during the nineteenth and twentieth century, the anatomo-politics transformed into the contemporary molecular politics, which has opened the option to engineer (or discipline) the biological life at the smallest, molecular level, as sociologist Nikolas Rose argues in his book *The Politics of Life Itself*.[10] The post-war transformation of national states first into social welfare states, in which solidarity was taken for granted, and subsequently into (neo)liberal states that delegated responsibility for health to smaller organizations, such as municipalities, companies or private organizations as well as to individuals themselves, has produced today's 'biological citizens', who not only enthusiastically engage with their own health, but also claim to have a right to health and well-being and thus a right to live as long as possible.

Solidarity and anti-corona regulations

The way governments and sub-state organizations approach the COVID-19 epidemic today cannot be seen as independent from the health regimes that have been developed since the seventeenth century. Today's medicine of epidemics, consisting of epidemiologists, virologists and other biomedical specialists as well as public health and behavioural scientists, intertwined with national state and substate apparatuses are the leading agents in what is called the 'corona crisis'.

The anti-corona regulations staged by this intertwinement of a medicine of epidemics and (sub)state organizations consist of an ensemble of

a medical interventions;
b disciplinary mechanisms;
c controlling mechanisms.

8 Foucault, *Society must be defended*, 242-243. See also: Michel Foucault, *Security, Territory, Population. Lectures at the Collège de France 1977-1978*, trans. Graham Burchell (New York: Palgrave, 2007), 1-27.

9 Foucault, *La volonté de savoir*, 186 (trans. by author).

10 Nikolas Rose, *The politics of life itself. Biomedicine, power, and subjectivity in the twentieth-first century* (Princeton and Oxford: Princeton University Press, 2007).

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Whether these measures are proportionate or not in terms of COVID-19 morbidity and mortality is not the subject of this article. The issue at stake is how these regulations and interventions affect the conditions that enable and facilitate the practicing of solidarity.

Medical interventions

Most governments, medical advice boards and care professionals chose to offer patients affected by COVID-19 the best possible care at the ICU, hospital, nursery home or at home. Since most European countries have national health care insurance systems, which enforce solidarity by obliging all individual citizens to pay insurance fees, it is a commonly held view that each person insured should be helped in situations of need.[11] The epidemic brought the limits of this practice soon into view, while many countries did not have sufficient ICU and hospital capacity to help the large numbers of COVID-19 patients – let alone to provide out of solidarity 'critical care beds' to patients of neighbouring countries. Moreover, care for non-COVID-19 patients had to be postponed or cancelled, a practice that generated heated debates about who deserved solidarity: should the care for COVID-19 patients have priority over the care for patients waiting for breast cancer surgery or with heart problems? Rather than supporting the solidarity that governments and medical specialists called for, these debates gave rise to polarization.

Something similar happened in relation to vaccination. The call for solidarity used by governments and public health organizations persuaded many to get vaccinated, but it also fuelled annoyance about people refusing vaccination. Do patients who deliberately choose not to be vaccinated still deserve solidarity and care? Or should they be punished for their refusal and have no or only limited access to public events or even to hospital care?

A decrease in solidarity is also seen in a global perspective. The pandemic generated competition among nations to be the best performing in terms of infection, morbidity, mortality and vaccination rates. Daily comparisons published online incited governments and medicine to look for strategies that further lowered these rates. In this competition the practice of solidarity was, and still is, limited to each country's own citizens and population. Solidarity with other countries, especially with the poorer ones, is low, as became evident when rich countries prioritized vaccination of its own population far above worldwide vaccination.

Disciplinary mechanisms

In order to prevent the massive spread of coronaviruses and based on the – often exclusive – advice of virologists and other biomedical specialists, most governments have enforced a variety of disciplinary mechanisms, including lockdowns

11 Bioethicist Ruud ter Meulen calls this solidarity 'interest solidarity', meaning that 'individuals pay their financial contributions to the health and social care system merely because they have an interest to do so. They see their contributions as an "investment" in the health care system in the expectation that they will be helped in situations of need'. Ruud ter Meulen, 'Solidarity, justice and recognition of the other', *Theoretical Medicine and Bioethics* 37 (2016): 517-529.

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(enclosure of citizens in their houses or in nursery homes, work from home, bans on gatherings, limited travelling), quarantine for infected individuals, closure of educational institutions, museums, libraries, gyms and so on, and behavioural measures such as social distancing, limiting of social contacts, frequent hand washing, coughing and sneezing into the elbow, and wearing face masks. Assuming that a call for solidarity was not enough to bring citizens and the population at large to the desired behaviour, parliaments introduced special COVID-19 related legal measures, *i.e.*, declared a state of emergency or adopted temporary emergency acts, to be legally able to enforce the lockdown and other disciplinary measures.[12] Although the precise effect of each singular measure is not yet known, it is evident that the sum of these significantly decreased the infection, morbidity and mortality rates.[13]

The side-effect of these mechanisms that force individuals to practice social distancing is that they negatively affect the options to have face-to-face interactions with neighbours, friends, family members, colleagues, acquaintances, co-citizens and strangers. Relationships, especially with people not belonging to the private sphere or one's own digital bubble, became more distanced. Much of the day, online life took over from offline life, thereby eroding the social conditions needed for mutual engagement, mutual bonding and support for people outside of the immediate life sphere. The many efforts governments in Europe have taken since the beginning of the twenty-first century to increase social cohesion in today's meritocratic and progressively more multicultural and diverse societies[14] threaten to get lost because of the lengthy absence of real-life society during the epidemic. The web of human relationships, that according to Hannah Arendt exists 'wherever men live together', where people share their stories and act together, is losing its strength.[15]

Complaints that going back to normal will bring social obligations that people no longer feel for make it likely that the social disconnections during the epidemic will have enduring effects on people's social and societal engagement. Telling is also that the initial, spontaneous and voluntary acts of solidarity, such as collective clapping for healthcare workers and voluntary distribution of food to vulnerable persons enclosed in their homes, soon declined. Ever more individuals and groups started to emphasize the interests of the group they belonged to: the elderly and vulnerable persons and groups demanded more protection for themselves from the government; young people more freedom of movement; shopkeepers, pub owners and museum directors more opportunities to stay open, etc. Self-interest or the interests of one's own group won out over solidarity with others and other groups. Not only solidarity with citizens within one's own country declined, but also soli-

12 https://www.europarl.europa.eu/cmsdata/226107/No.29_Emergency_Laws_and_Legal_Measures_against_COVID-19.pdf.

13 https://www.science.org/lookup/doi/10.1126/science.abd9338.

14 Xavier Fonseca, Stephan Lukosch and Frances Brazier, 'Social cohesion revisited: a new definition and how to characterize it', *Innovation: The European Journal of Social Science Research* 32, no. 2 (2019), 231-253.

15 Arendt, *The Human Condition*, 184.

darity with people in poorer countries – which had from the start not been paramount for national governments.

The bar on face-to-face interactions also negatively affect the public sphere, which is, as Hannah Arendt argued, the public common world where we meet and appear to each other, see and hear ourselves and others, and thus create reality.[16] Being able to interact with others in the social and public sphere is a vital condition for the involvement with and binding to others, and therefore for social solidarity. In this setting solidarity is not grounded in obedience towards government regulations aimed at saving all the human lives that we can afford to save, nor in universal principles as brotherhood or justice and equality for all, but in the social connections and relationships that people enact at a daily level. The closing of most public meeting places, public debating centres, pubs, libraries, theatres and other places where people normally meet to discuss, severely challenged the conditions for democratic deliberation, civic activities, and public debates.

What seems to counteract this argument is that during the pandemic a wave of public protests has taken place. Yet, as political sociologist Paolo Gerbaudo analyzed, most of these protests have a 'premodern', lowly organized form with 'sudden gatherings of people, limited organizational structures, lack of representatives and multiplicity of protest claims'. The social discontent these pandemic protests express could be the prelude to more intense social conflict in societies that are ever more unequal and divided, he warns.[17]

Controlling mechanisms

After the first phase, in which governments and medicine expected that lockdowns and other disciplinary mechanisms would eradicate the virus and stop the epidemic, a second, more realistic path was taken: the virus is here to stay, and as humans we had to learn to live with it. Eager to normalize the population's morbidity and mortality rate, the goal became 'to control the virus'. Governments, public health organizations and tech companies started to set up a broad array of digital controlling mechanisms: corona contact tracing apps, testing facilities, field labs, vaccination apps and algorithms, which jointly made it possible to track the movements of smartphone users (infected and non-infected), to alert them if they had been in close proximity to an infected person, to notify the recent contacts of infected persons, to identify smartphone users' vaccination and corona test status (by scanning a QR code), and to allow or disallow access to restaurants and other semi-public spaces. Whereas disciplining mechanisms are territorialized, enclosing individual bodies in specific spaces, controlling mechanisms are de-territorialized: they survey and massify the multitude of behaviours, movements and exchanges via smartphones, apps and digital networks in order to control and regulate them.

16 Arendt, *The Human Condition*, 50-52.

17 Paolo Gerbaudo, 'The Pandemic Crowd Protest in the Time of Covid-19', *Journal of International Affairs* 73 (2020): 61-76.

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The side-effect of these controlling mechanisms is that each person who does not belong to one's household is perceived as a potential deadly risk. This risk perception of others induces a psychological distancing that, in combination with the social distancing of the disciplinary mechanisms, increases the social *distance* towards others outside of the private sphere. An example of this distancing is that the shortage of ICU beds led to a decline in solidarity with persons having obesity or refusing vaccination: they were seen as a security risk and blamed for not taking responsibility for their own and others health.

The calls to solidarity in relation to the COVID-19 pandemic suggest that western healthcare systems are still based on solidarity, even though neoliberal principles of individual responsibility prevail today in most western countries. Solidaristic values, taken for granted in national states and social welfare states, have been replaced by neoliberal values in the twenty-first century. This shift has heralded the end of solidarity: each of us is held accountable for one's own health and well-being.[18]

In the hope to revive the solidarity in light of COVID-19, political leaders, healthcare professionals and citizens expressed phrases like 'Fighting the virus together' or 'controlling the virus together' – if only to make people accept the medical interventions, disciplinary and controlling mechanisms that governments, advised by teams of medical specialists, deemed necessary to minimize or normalize the COVID-19 death and disease rates of their population. In terms of discourse this revival has been successful: the word solidarity echoed all over the media, in political domains, healthcare institutions, schools, companies and neighbourhoods.

Yet, talk about solidarity, no matter how important, does not guarantee that the practice of solidarity 'functions and flourishes', to paraphrase Prainsack and Buyx.[19] Rather the opposite seems to be the case: the erosion of the social conditions that enable and facilitate the practicing of solidarity, induced by the measures to fight and control the virus, could bring about a further disappearing of solidarity in societies that already have a high level of individualism.

After the epidemic

In his book *Discipline and Punish* Foucault argues that the disciplining mechanisms developed for a state of emergency, *i.e.* the seventeenth century pest plague, brought about disciplining schemes, facilities and institutions that subsequently spread throughout the whole social body. Rather than disappearing after the plague, they swarmed over the societal organism and produced what Foucault called 'the disciplining society'.[20]

18 Prainsack and Buyx, *Solidarity in Biomedicine and Beyond*, 23.

19 They speak of 'background conditions' that are important for solidaristic practice and policy to function and flourish. Prainsack and Buyx, *Solidarity in Biomedicine and Beyond*, 172.

20 Michel Foucault, *Discipline and punish. The birth of the prison*, trans. Alan Sheradan (London: Penguin Books, 1977), 209 ff.

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Whether today's disciplinary and controlling mechanisms that governments enforced under the banner of solidarity – but subsequently by legal measures – to fight the current state of emergency, *i.e.* the COVID-19 epidemic, will continue after the epidemic and, for example, be used to fight other risks and threats, is hard to say. However, that many of the disciplinary and controlling mechanisms will not be reversed now that the advantages of disciplining individuals and governing populations have become clear, is beyond doubt. Even massive contestations and protests will not bring back the 'old normal'.

That is worrisome, since it is likely that the enclosures, lockdowns, apps and other disciplinary and controlling measures will reinforce the trend towards individualization, less social cohesion and a less well functioning public sphere, thereby further eroding the practice of solidarity. To counter that development active investments are needed, both by governments and citizens, to restore and restrengthen the social conditions that enable and facilitate social cohesion, the public sphere and the enactment of solidarity. Whether these kind of investments will be strong enough to counteract the side-effects of the governments' corona approach will remain uncertain – even more so if the mechanisms and legal measures enforced would not be turned back after the epidemic is over.

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