MEDICINE, POWER, AND SOCIAL CONTROL IN MODERN SOCIETY

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Abstract

Medicine has always been considered a field of study that is aimed at disease prevention and ensuring the common good. However, in modern society, its functions have expanded beyond therapeutic ones and become caught up in the machineries of political, economic, and social power. This research explores medicine as a social control institution through the sociological lenses, addressing such processes as medicalization, normalization, and health commodification processes. The qualitative documentary approach was utilized, and it included an integrated review and thematic analysis of the current scholarly literature on medical sociology, public health, and social theory published in the period between 2020 and 2025. The results show that medicalization expands the medical power into daily life when the social and behavioural states are redefined as medical problems that need professional treatment. Moreover, healthcare commodification supports access disparities, i.e., benefiting wealthy groups and disadvantaging vulnerable groups. According to the Foucaultian approach, medicine is a biopower process that is governed by state regulation, policies of public health, and practices of surveillance that can be imposed on populations. Moreover, social determinants of health show the role of structural inequalities in access to care and health outcomes. The research finds that medicine is both a therapeutic process and a social control system. Although it has played a role in the enhanced health outcomes, its incorporation in capitalist economies and institutional power regimes has turned health into a market product at the expense of accepting it as a basic human right. Health is a fundamental right that should be reinstated in a bid to ensure that healthcare systems are equitable and socially responsible.

Keywords: *Medicine; Social Control; Medicalization; Commodification of Health; Biopower*

INTRODUCTION

Medicine has been traditionally targeted as a key institution to prevent disease and promote the health of the population. Nevertheless, modern research takes a different approach to the subject and tends to think of medicine as a social institution, deeply rooted in political power, economic gain, and cultural patterns. Traditionally, healing activities used to be locally structured responses to diseases based on common knowledge and collective assistance. In the course of time, medicine became professionalised and institutionalised, and was incorporated into broader systems of governance and regulation (Schramme, 2023). This has been an institutional growth that has changed medicine to a service that is more of a complex field where clinical decision-making intersects with administrative standards, policy priorities, and social ordering (Davies et al., 2020). Such framing is necessitated by a review article since it needs an analysis of the structural location of medicine, and not a description of clinical progress. The sociological approach to medicine, health and illness cannot be reduced to biology since they are created and interpreted through social and economic situations that affect exposure, diagnosis, and care (Gostin et al., 2020). This literature underlines that diagnostic categories, treatment guidelines and public health programmes are not put in a value-neutral space, as they serve to help establish what normal, deviant and acceptable behavior is. Hanna and Gough (2020)

demonstrated that medical knowledge is capable of stabilising social expectations through the classification of conditions and standardisation of interventions that can indirectly control individual behaviour and justify specific institutional priorities. A functioning of these classificatory and regulatory functions within settings, the interests that they provide, and what form of exclusion they can generate, as opposed to seeing them as the necessary results of scientific progress. The authority of the medicine ought to be examined as being socially consequential and its impacts on autonomy, equity and governance.

Medicalization is one of the major processes by which medicine has a social impact. The term medicalization can be defined as a situation where non-medical life items are redefined and addressed as medical issues that are to be monitored and handled by professionals. It widens the scope of medical power to include mental health, aging, and behavioral disorders, and strengthens the power of healthcare experts and alters the normality expectations of society (Svetlichnaya & Smirnova, 2022; Saleh et al., 2026). As a result, legitimising medical intervention also redefines individual identities and social roles. Medicine is a control mechanism that dictates the norms of behavior and encourages conformity to society. Bio-power, a concept by the French thinker Michel Faucault is another way of understanding the relationship between medicine and power (Gómez et al., 2021; Schramme, 2023). Foucault developed the concept of biopower as a type of control by the institutions whereby life processes, including birth, death, and health, are controlled by the institutions. Modern theorists emphasize that contemporary nations use medical knowledge and policies of public health and surveillance to observe and regulate bodies, which guarantees productivity and social control (Golikov, 2020). Here, the healthcare systems emerge as a tool of governance affecting behaviors by preventative measures, epidemiological surveillance, and health promotion programs. Even though these interventions are vital in protecting the health of the people, they are also indicative of other larger processes of power in contemporary societies.

Commodification of health is another important area of the role of medicine in social control. The growth of the healthcare market-based systems has also turned health services into economic products and goods, focusing on profitability rather than on equitable access. Liu et al. (2020) demonstrate that neoliberal health policies have led to increased inequalities because the accessibility to care is tied to socioeconomic status, consequently supporting health outcome disparities. In this regard, medicine is a global health economy that favors technological advancement and individual investment at the expense of vulnerable groups (Jakovljevic et al., 2020). This commodification puts rights-based accounts of healthcare to the test by redefining care as a service that can be purchased as opposed to a right based on universal human dignity. Meanwhile, studies in the field of social determinants of health reveal that the inequalities of income, education, job security and living standards influence the exposure to sickness and access to high-quality medical care promptly (Liu et al., 2020; Lindwall & Lohne, 2021). The fact that these determinants repeat patterned disparities in morbidity and mortality, as shown by Marmot (2020), means that the determinants of health are recreating broad processes of social stratification, and not individual choice. When combined with commodification, social determinants suggest medicine is not a passive reflection of illness, as it is also itself a part of, and possible contributor to, the social settlement of uneven distributions of risk and resources.

Although there is much literature on medicalization, biopolitics, commercial determinants of health, and social determinants of health, the literature is still divided into distinct arguments and is inclined to discuss these processes independently. Numerous studies concentrate on an individual mechanism without tracing the interaction of these mechanisms to generate cumulative types of social regulation and inequality within the modern health systems. That gap is filled in this review, in terms of synthesising evidence and developing an explicit integrative explanation of the joint work of medical authority, state regulation, and market incentives as a linked governance structure. It is not a general assertion that medicine deals with power; thus, the contribution is a systematic synthesis that characterises the relationship between medicalization, biopolitical instruments, and commodification

and places these processes in the framework of the social determinants that pattern disadvantage. The separate value of the review is its explanation of the dual therapeutic and regulatory role of medicine using an interactional framework that is often lacking in single-strand studies.

LITERATURE REVIEW

Health as a Social and Cultural Phenomenon

Health has been broadly understood as a multidimensional state that is influenced by the biological processes as well as the social and cultural environment where illness is experienced and dealt with. The definition proposed by the World Health Organization presents health as the physical, mental, and social wellbeing, which emphasizes the fact that health should not be equated to pathology (World Health Organization, 2021, 2022, 2023). Early sociological analysis of health also addresses illness as socially organised, as norms, roles and institutional expectations have an impact on the interpretation of symptoms and access to care. An example is that the sick role was based on the premise that sickness, social rights, and social obligations are regulated and therefore put medicine as an institution that maintains social order by the use of legitimate power (Golikov, 2020; Assaf et al., 2025). Subsequent sociological explanations indicated that professional power and medical knowledge determine what is considered to be illness and whose demands to care are legitimized, a fact that supported the idea to examine health as a social phenomenon, rather than a clinical phenomenon (Svetlichnaya & Smirnova, 2022). Modern sources of research about health inequality have built upon these premises, showing that structural conditions such as income, education, and housing assign risk and limit access to care to create patterned disparities in outcomes across social groups (Marmot, 2020; Othman et al., 2025). The interaction between health and society can be interpreted through the prism of medical sociology. According to Hanna & Gough (2020), the line between health and illness is a constructed matter that is influenced by cultural norms and institutional practices. The expectations of society shape the mental health, disability, and age perceptions, showing that the medical classifications tend to represent the existing social values (Alkasasbeh et al., 2025; Momani et al., 2025). Medicine therefore influences a lot in the definition of normality as well as behavior regulation, making it an enforcer of social control.

Medicalization and the Expansion of Medical Authority

The process of transforming the elements of everyday life into medical conditions and implementing professional intervention is known as medicalization, which is one of the key themes in the sociology of health. Hanna & Gough (2020) support the idea that medicalization has grown tremendously in contemporary societies, which includes matters of attention disorders, reproductive health, and mental health. This growth indicates the increased role of medical institutions in the formation of the social norm and self-identity. Svetlichnaya & Smirnova (2022) emphasize the effects of medicalization on social control and autonomy, stating that the authority of medicine justifies the expertise of professionals to control behavior and determine the right standards of health. Moreover, pharmaceuticalization of healthcare is a good example of how medicalization can integrate with economic interests, supporting the commodification of health services and increasing health markets globally (Liu et al., 2020; Al-Amoosh et al., 2024). These changes can be seen as examples of how medicine is going beyond the therapeutic roles to shape social systems and power dynamics.

Power, Biopolitics, and the Commodification of Health

The association between medicine and power has been discussed widely in the light of Foucauldian theory, especially the concept of biopolitics. Golikov (2020) believes that biopolitics continues to be at the centre of interpreting modern healthcare systems, where surveillance technologies, epidemiological observation, and governance of health influence individual and collective actions. Although it is intended to bring about well-being, public health interventions also act as regulatory and control mechanisms. The health commodification has become one of the characteristics of contemporary healthcare systems (Cioti et al., 2026). Liu et al. (2020) argue that neoliberal health

policies have turned the industry into a commercial product and focus on efficiency and profitability instead of equity. This has increased inequalities in access to healthcare services, especially between marginalized groups. More so, the power imbalances in health systems at the global level are still manifested in global health inequalities (Gostin et al., 2020; Abu-Farha et al., 2026). The overlapping of biopolitics and commodification serves to highlight both the care delivery and the control nature of medicine. Lindwall & Lohne (2021) proved that healthcare practices and policies can not only affect health outcomes but also the overall social dynamics, and it is therefore necessary to approach the role of medicine in contemporary society critically in terms of sociological analysis.

RESEARCH METHODOLOGY

Research Design

This research has followed a qualitative documentary design in the form of a structured literature review to explore medicine as a social control institution. The review is interpretive and critical and synthesises both sociological theory and empirical research that examines the intersection of medical authority and state regulation as well as market incentives. Instead of providing a descriptive account, the design is based on a review format, a limited publication date, clear topical keywords, and predetermined inclusion criteria based on peer-reviewed publications touching on medicalization, biopolitics, commodification of health, and social determinants. The sources that are retrieved are filtered out of relevance to the research objectives and are analysed using a consistent analytic process to determine which concepts, assumptions, and mechanisms will recur. With this methodology, it is possible to conduct a clear study selection and also a replicable corpus to theme route, which allows a coherent synthesis of the current arguments of the institutional role of medicine and its regulatory impacts in contemporary societies explicitly.

Data Collection

A review of peer-reviewed sources published between 2020 and 2025 was used to gather data. PubMed, Scopus, and Google Scholar were searched with the strings of the form (medicalization OR pharmaceuticalization) AND (social control OR normalization) AND (biopower OR biopolitics) AND (commodification OR neoliberal OR market) AND (social determinants OR health equity). Exportation of records, elimination of duplicates, screening of titles and abstracts according to inclusion criteria: English language, open access, direct sociological framing, direct relevance to the field of medicine, and power or inequality. The exclusion criteria were clinical trials that lacked sociological examination, opinion pieces, and those that were published before 2020. Methodological clarity and contribution: Full texts were evaluated on methodological clarity and contribution.

Data Analysis

Braun and Clarke (2021) proposed using reflexive thematic analysis. To facilitate familiarization and to make initial analytic memos associated with the review questions, all the materials covered were read twice. The line-by-line coding was used to obtain units of meaning that explained the mechanisms, actors and outcomes of medicine, power, and inequality. The similarity of codes was noticed among the studies compared and grouped into higher-order themes through an iterative process of merging, splitting, and relabelling to enhance internal consistency. The themes of the candidates were created through mapping how the categories were interrelated with each other and with the theoretical frame, and they were examined against the entire dataset to ensure coverage and distinctiveness. The themes were medicalization, biopolitics, commodification of health and social determinants of health, all of which were supported by clustered codes and representative evidence. The process reinforces transparency and allows the development of themes that can be reproduced.

RESULTS

The results presented are the product of the reflexive thematic analysis of the 2020 to 2025 sources

chosen on the topic of medicine, power, and social control. The use of coding and cross-study comparison generated four analytically distinct yet interrelated themes, which include medicalization and behavioural regulation, biopower and state authority, commodification of healthcare, and social determinants as mechanisms of unequal health outcomes. Every theme was an organized collection of assertions and processes that were repeated within the texts included and that were maintained following theme review as coherent and comprehensive. Combined, the themes demonstrate how current literature defines medicine as both curative and controlling, working via professional classification, policy and surveillance instrumentation, marketplace logics and structurally patterned access to care.

Medicalization and Behavioral Regulation

The analysis suggests that medicalization plays more of a role in the reviewed literature as an issue of definition debate rather than as a mechanism by which institutions expand their jurisdiction over daily practice. In the included studies, behaviours and life stages that once had social connotations are recoded again and again as medical issues that need to be assessed, monitored, and intervened upon, increasing the powers of the profession and decreasing the possibilities of having non-medical interpretations. Hanna and Gough (2020) attribute this change to biomedical discourse that stabilises the definition of legitimate illness and acceptable response, suggesting that medical categories codify social reality besides describing it. Medicalization is introduced in this corpus as a channel through which the norms of normality are operationalised as far as diagnoses are codes of expectations about treatment compliance, risk mitigation, and change of lifestyle. The second pattern is that medicalization has a relation to behavioural control by means of guideline-based practice as well as routinised treatment pathways. When the diagnostic labels initiate a set of standardised interventions, people are put in a situation of being or not being responsible to match routine and prescriptions made by the clinics and organisations; in this case, non-compliance is exposed. Svetlichnaya and Smirnova (2022) view this as social ordering, which is a medical intervention that can sanction conformity by making institutional control authorised in the name of health promotion. The reviewed work, therefore, presents medicalisation as a form of rule by means of classification and protocol, and not through coercion. Pharmaceuticalization is another repeated sub-mechanism that deepens the medicalization process of the impact of introducing market actors and commercial logics into daily health management. Liu et al. (2020) refer to pharmaceuticalization as the proliferation of medical authority into everyday life and the promotion of commodification because treatment is gradually transformed into a product and constant use. Reliance on pharmaceuticals in the studies that were included is linked with the commercialization of medicine and the impact of the industry on the clinical priorities and the expectations of the population. Altogether, the results of the study describe the medicalization and pharmaceuticalization as mutually dependent processes that widen jurisdiction among professionals and create behavioural standards in line with market growth.

Biopower and State Regulation of Health

Biopower is an idea that offers a critical dimension of the role of medicine in the governance of the state. The modern health policies demonstrate how governments use medical knowledge and surveillance systems to control the population and to control the life process. According to Golikov (2020), the trend of contemporary states involves such health-related interventions as vaccination, epidemiological surveillance, and disease prevention programs to promote social stability and economic efficiency. These interventions indicate how medicine is incorporated into larger systems of rule and regulation. This analysis shows that the role of public health initiatives as a control apparatus that influences individual and group behavior is a reality. The health campaigns that aim to safeguard the welfare of the population via health promotion, which includes vaccination, hygiene, and prevention care, are aimed at safeguarding the welfare of the people, but at the same time, they are a manifestation of the exercise of institutional power. The authors emphasize that the implementation of such interventions tends to focus on the outcomes of the population more than autonomy across individuals, which confirms the importance of medicine as a government instrument (Gostin et al.,

2020). The COVID-19 pandemic demonstrated how biopower was put into practice in modern society. To prevent the virus, governments enacted quarantine regulations, lockdowns, and vaccine requirements. Although these policies were necessary in protecting the health of the people, they also showed the ability of the medical institutions in controlling the global social behavior. The results are an indication that biopower continues to be one of the most significant processes by which medicine can shape governance, not only in terms of shaping the agenda of a country but also the behavior of individuals.

Commodification and Market-Oriented Healthcare Systems

Healthcare commodification has become a new feature of contemporary medical systems. The results reveal that the market-based healthcare systems are characterized by efficiency and profitability, which in most cases comes at the cost of the provision of equitable care access. Liu et al. (2020) claim that the health policies of neoliberalism have turned healthcare into a commodity of the market with reinforcement of disparities in access and outcomes. This change is indicative of greater economic forms that influence the provision and organization of healthcare services. Market-driven healthcare systems depend on private sector investment and technological advancements as a way of increasing efficiency and competiveness. Even though such developments lead to improvements in the technology and service delivery in the medical field, they also lead to inequalities because access to care is connected to socioeconomic status. As Gostin et al. (2020) highlight, healthcare access is often hindered by marginalized populations, because of which they face health disparities and reduced life expectancy. Health commodification also affects the relationship between medical practitioners and patients. Patients are gradually being regarded as the consumers in the healthcare markets where the medical services are assessed with regards to cost, quality, and efficiency (Golikov, 2020; Miller & Vasan, 2021). This consumerist approach alters ethical principles of healthcare because it gives priority to economic over social accountability. The implications of the findings include the fact that commodification does not help health become a human right, and as such, it is essential to have reasonable healthcare policies that are based on social justice and goodwill.

Social Determinants of Health and Structural Inequality

There exists a significant influence of socioeconomic factors like income, education, employment, and living conditions on the health status and access to medical services of individuals. As Marmot (2020) reveals, health inequalities are directly related to the more general trends of social stratification, which indicate the difference in resources and opportunities. The results show that structural inequalities are still determining the health outcomes in the populations. Poor people with low socioeconomic status survive more chronic diseases, have less access to medical care, and live shorter lives. These differences underscore the overlap between medicine and social and economic institutions, which makes it a reaction to and an expression of the social inequality (Gostin et al., 2020; Kaan Namal et al., 2024). In addition, geographic differences in healthcare access can be seen as a representation of the structural character of health disparities. The underserved communities and rural areas have low access to healthcare centers, medical practitioners, and other critical health services. Such an unequal allocation of resources highlights the necessity of introducing policy interventions to respond to structural determinants of health (Mazhak, 2022). The outcomes reveal that social factors about health are a crucial factor in determining health outcomes and access to care. To curb these determinants, there is a need to focus on comprehensive strategies that combine the social, economic, and health policies to encourage equity and social justice. Medicine as such is, therefore, not only a therapeutic field, but also a mirror of other structures in the wider society that determine health and well-being.

DISCUSSION

The synthesis shows that modern scholarship views medicine as a two-sided institution, which provides therapeutic service as well as organising social life in terms of classification, regulation, and

generating resources. Instead of reiterating medicalization, biopower and commodification as distinct concepts, the studied papers imply that such processes are a connected governance system in which professional knowledge, social power and market forces are reinforced and supported by each other. Hanna and Gough (2020) uphold this understanding by demonstrating that the biomedical categories stabilise the social expectations by implementing routine classification and standardised responses, and Svetlichnaya and Smirnova (2022) extend this argument by viewing such classification as socially consequential since it permits intervention in the name of order and health. This connection is important as it changes the debate into whether medicine is powerful or how this power is played out in the most basic of systems, like guidelines, eligibility rules and risk management protocols.

One of the main interpretations made is that behavioural regulation is not as dependent on overt coercion, but rather on the institutionalisation of responsibility via clinical pathways. Throughout the reviewed work, the labels of diagnostic are more likely to be used as switching points transferring people into observed paths in which compliance can be quantified, and institutions can read non-compliance. According to Hanna and Gough (2020), this dynamic is maintained by the cultural acceptance of biomedical authority, and Svetlichnaya and Smirnova (2022) suggest that the same authority may close legitimate ways of self-interpretation and reinforce conformity. The problem is not just the growth of diagnosis, however, but also the normativity I would impose on patients in order to show compliance and self-management in situations they might not control, especially where social determinants limit the ability to change lifestyle. This construal is consistent with the fact that the review focuses on power as productive, in the sense that it generates norms and duties that organize everyday behavior. It is best to think of the behavioural governance in healthcare as ordinary institutional work instead of an extraordinary constraint.

As the literature is emphasized with the working tools of public health instead of the abstract assertions of state control, the biopower theme can best make its point. Among the tools used by Golikov (2020) in a direct framing of modern health governance is its organisation through surveillance, prevention, and emergency rationalities, whereas Gostin et al. (2020) situate the tools in tensions of global governance that surfaced during COVID 19. Horton (2023) also emphasizes that the response to the pandemic revealed the political nature of health decision-making, such as the way states decide between collective safety and individual freedom and how such trade-offs are made acceptable with expert discourse. The contribution of the review is to take these accounts as a sign of a consistent pattern of governance whereby medicine emerges as a location where legitimacy is negotiated, particularly in times of crisis that have increased the executive space. The key implication of this is that epidemiological effectiveness by itself is insufficient to assure the people of the government's trust: on the contrary, this strategy can be standardized to intensified oversight when accountability is lax. The biopower can be best analyzed when it is followed by certain policy instruments and claims of legitimacy.

The theme of commodification shows that the market logics not only influence the financing process but also change the moral expectation of right to, value, and deservingness. Liu et al. (2020) underline the fact that neoliberal policy orientations favour commercial framing of care, and Navarro (2020) also holds that austerity and privatisation trends strengthen unequal access in crises by undermining the possibility of the state to do so. This is made complete by Mialon (2020), who views commercial determinants as structural processes that define environments, preferences, and institutional priorities, rather than consumer choice. The evidence reviewed suggests a feedback mechanism, in that marketisation causes greater inequality in access, inequality in access causes greater burden of preventable disease among the marginalised groups, and burden is then framed in the language of behavioural narratives that justify further responsibilisation. Schorb (2022) supports the topicality of this loop by the example of how the framework of public health can make a structural issue more individual and thereby justify the interventions directed at bodies instead of upstream determinants. The commodification is a normative regime that has the capacity to shift health as a right with collective responsibility to a right with private purchase and responsibility.

The social determinants theme offers the most significant connection between the institutional power and quantifiable inequality, which explains why the review addresses medicine as both indicative of, as well as contributory to, stratification. Marmot (2020) describes the process of translating gradients in income, education, and living conditions into patterned morbidity and mortality quite clearly, whereas Javadi et al. (2023) illustrate how the inequities in terms of race are commonly addressed unequally in terms of the production of epidemiological knowledge, which influences what is measured, described, and implemented. The interpretive finding, as these findings are read together with the medicalization and commodification themes, is that the clinical governance systems may unwillingly increase the disadvantage by assuming the equality of ability to meet the conditions of compliance, payment, travelling, or self-management. The practical implication here is that equity demands changes in the institutional design, such as rules of eligibility, distributing services, and assumptions of guidelines to consider constrained agency instead of regarding inequity as a social problem external to medicine. The social determinants do not define the circumstances or background, but processes that define the way medical power is distributed and experienced.

The limitations of contemporary evidence base also emerge as a limitation in this review to inform future research and policymaking discussions. To begin with, a great part of the existing literature is robust on the critique and less robust on causal tracing, and prospective research can identify which policy tools mediate the relationship between medical authority and behavioural regulation to the greatest degree, depending on health system models (Gostin et al., 2020; Golikov, 2020). Second, there should be comparative work to differentiate the impacts of commodification in different financing regimes because neoliberal relationships might not work in the same way in mixed systems as in mainly privatized regimes (Liu et al., 2020; Navarro, 2020). Third, equity analysis is no longer about recording the inequities but also assessing the interaction of classification, surveillance, and market incentives into practice, who voices in which categories are made, and which harms come to be unseen (Javadi et al., 2023). In the case of policy, the most powerful implication is the fact that safeguarding population health and safeguarding rights are not incompatible in case governance is transparent, proportionate, and equity-oriented, and clear protection against commercial capture and structural exclusion is in place (Mialon, 2020; Horton, 2023). The discipline has now called forth integrative, instrument-focused studies which can guide responsible and fair health governance, as opposed to a recurrence of conceptual criticism.

Besides, global health governance is important in the determination of health outcomes and health inequity. Phelan et al. (2020) noted that governance is critical in providing equitable access to healthcare and global health security. Nevertheless, the inequality in health governance and allocation of resources still depicts structural inequalities in the international health systems. According to Harvey (2021), the political causes of health disparity emphasize the necessity to take globalized measures to counteract the social and economic determinants of health. Considering such results, medicine should be viewed in its more sociopolitical and economic frames. This can be seen in the penetration of medical authority into the system of governance, market systems, and hierarchies of social order that illustrate how complex a role medicine is in the formation of modern societies. Although medicine plays an important part in enhancing health, as well as increasing scientific knowledge, institutional roles of medicine mirror larger processes of power and social control. It is vital to acknowledge this dual role in order to come up with fair healthcare systems that emphasize human rights, social justice, and the welfare of the people. The research is a contribution to sociological knowledge regarding medicine by painting it as a complex phenomenon, as a therapeutic field, and a social control mechanism. The results highlight the significance of studying more closely the interrelation between medical authority, state governance, and market forces when it comes to the development of modern healthcare systems.

CONCLUSION

This research has explored medicine as an institution, working through care delivery as well as social regulation, taking into consideration how modern health systems incorporate clinical work into political power, economic forces, and social classifications. With a qualitative documentary synthesis of recent sociological and public health literature to aid the analysis process, it is revealed that the medical authority is exercised by mechanisms that are interrelated, such as the practices of classifying, governing and surveilling, market-oriented service organisation and structurally patterned access to resources. The main implication is that the regulatory impacts of medicine are not accidental, as they are products of the normal institutional configuration, which influences the priority of whose needs are pursued, the focus of the targeted behaviours, and the distributive responsibilities of patients and systems. Further studies must hence not just rely on single mechanism explanations but experiment with how certain policy instruments and business dynamics interact with social determinants to generate unequal results in various health system frameworks. In the same vein, the notion of biopower sheds light on the use of medical knowledge and population health by states to control populations by focusing on the government aspect of medicine. Another important aspect of the present state of healthcare in terms of its activity in modern society is the commodification of healthcare. Healthcare systems based on the market are more focused on efficiency and profitability, and contribute to inequalities in accessibility to medical services. The radical change to healthcare questions the fundamental ethical principles of healthcare by weakening the idea of health as a universal human right. The medicine is a dual practice, both a social regulation system and a healing practice. Although it has helped to achieve higher levels of progress in health outcomes and life expectancy, its inclusion in power systems requires a critical analysis.

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