The Federated Gaze

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Introduction

The systems of information that underpin the global healthcare industry have been shaped by a history that is interwoven with that of modern medicine and the modern state. Investigating these shared technologies can reveal the ways in which they shape experiences of subjectivity and the body. The data that a healthcare service can create, store and utilise constitutes empirical evidence about the interior of their body, and through this, insight into the health of entire populations, extending to bodies and health in general. However medical information is not neutral, it is informed by the technological and political forces that facilitate its creation, both on historical and individual bases. It has the ability to fundamentally change how bodies are understood and cared for, but also represents a fundamental aspect of modern statecraft, being both shaped by the state, and shaping it in turn. To see medical information as carrying the full weight of its history and the meaning it carries for health and the body is to begin to understand the difficulties and risks inherent to medical information technologies. It also makes possible an understanding of how and why healthcare is used in capital accumulation and state power.

The healthcare technologies that facilitate the creation and use of medical data represent a large and fast growing proportion of global GDP,[1] with rising global healthcare costs and cuts to public welfare budgets providing the impetus for utilising as much of this data as effectively as possible. The recent contract between US data analytics company Palantir Technologies and NHS England for the provision of the 'Federated data Platform' (FDP), provides an example of the forces of financialised capital and modern statecraft shaping the provision of care through medical information technology. As medical practice in general and NHS England specifically continues to increase its use of medical data and healthcare technologies, it is important to analyse what the political and ideological conditions that have informed them are, and what their histories can illustrate about how they should be used and understood. This essay seeks to analyse a particular history of medical information and its consequences. It does this with the aim of denaturalising what can too easily be taken for granted as a vessel for pure objective truths about the body, and instead framing medical information technologies as tools co-opted by the modern state and financialised capitalism, contributing to the argument that the mechanisms inherent to capitalism render it antithetical to good care and health in general.

[1] Deloitte Global Life Sciences & Healthcare Market Overview, 'Global Life Sciences Outlook', 2017.

1. The Map in the Territory

Medical information and modern medicine are co-constituent of each other, having both originated with what Michel Foucault termed "the birth of the clinic". The analysis of medical practice presented in Foucault's *Birth of the Clinic* (1963) breaks down the political and philosophical impact of changes in medical knowledge in France around the turn of the 19th century, which led to the establishment of Paris as the centre of European medicine for the next 100 years. The text focuses on the concept of a "medical gaze" developed at this time which allowed medicine to "at last hold a scientifically structured discourse about an individual".[2] The medical gaze is the act of seeing and perceiving which Foucault credits with separating the clinic from the fantastical systems upon which previous medical practices were based. Foucault states that with the clinic a "new alliance was forged between words and things, enabling one to see and to say".[3] Seeing and saying here are discrete acts which by remaining separate facilitate the act of observing without the interference of language and its theories and systems — symptoms should be observed without trying to classify or sort them into a pre-existing system. This break between perception and language allows medicine to start to describe and record truths about the body without reducing it to the status of an object.

> The gaze is no longer reductive, it is, rather, that which establishes the individual in his irreducible quality. And thus it becomes possible to organize a rational language around it.[4]

This is the first time objective truths can be discovered and recorded about an individual and their health, the act which underpins modern medicine and produces medical information.

Medical information contains both individual medical observations and the kinds of collective knowledge shared throughout a state and internationally, the accumulation and use of which constitutes state power. In 1778 the Société Royale de Médecine (SRM) was established in Paris, the origin of which was, according to Foucault:

> The definition of a political status for medicine and the constitution, at state level, of a medical consciousness whose constant task would be to provide information, supervision, and constraint, all of which relate as much to the police as to the field of medicine proper.[5]

Originally formed to collect information on disease outbreaks and provide guidance and regulation, the SRM was able to expand from its role as nascent state epidemiology into the centralised point of medical knowledge in France. By collecting information not only on epidemic diseases but on endemic illness, the SRM quickly expanded to become a powerful political actor; a means by which state control could be exercised through the regulation of citizens' bodies. This is what Foucault would later term ‘biopower’, a technology of control developed at the end of the 18th century through the use of statistical measurements and observations.[6] Foucalt states that "In the eighteenth century, the fundamental act of medical knowledge was the drawing up of a 'map'" of the pathological world.[7] At the end of the century, the pathological world was expanding to include environmental information

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[2] Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, 1. publ., reprinted, Routledge Classics (London: Routledge, 2010). XV
[3] Foucault. XIII
[4] Foucault. XV
[5] Foucault. 29
[6] Michel Foucault, *Society Must Be Defended: Lectures at the Collège de France, 1975-76*, ed. Mauro Bertani, trans. David Macey (New York: Picador, 2003). 243
[7] Foucault, *The Birth of the Clinic*. 33

relevant to endemic illnesses such as location and weather, as well as living conditions and diet. As this pathological map was being renounced in favour of a purer form of perception, the geographical map was also being carved up and subjected to similar forms of observation. The SRM functioned by moving between these two levels of medical knowledge, creating and disseminating information both from within France and abroad.[8] In this way the medical gaze created a new form of medical knowledge; one that began the kind of holistic capture of information recognisable in the contemporary surveillance state, as well as originating the collective pool of medical knowledge still drawn from and contributed to by 21st century medical practice:

> What now constituted the unity of the medical gaze was not the circle of knowledge in which it was achieved but that open, infinite, moving totality, ceaselessly displaced and enriched by time, whose course it began but would never be able to stop—by this time a clinical recording of the infinite, variable series of events.[9]

The creation of the medical gaze and medical information is inextricable from biopower and state surveillance. In fundamentally reconstituting the body, the medical gaze also reconfigured the relationship between the state and the bodies of its population. The French state gathered and compared broader statistical information and specific medical information, synthesising them into the unity of the medical gaze. This arrangement prefigured medical data and healthcare technology as it exists in the present.

For the state to make use of medical knowledge, it had to be rendered mathematically legible for use on a national scale. This required the creation of classification systems for diseases, which were formalised at the end of the 19th century with the creation of the first International List of Causes of Death at the International Statistical Congress in Paris in 1893.[10] This was the first edition of what is now called The International Classification of Diseases (ICD), the worldwide standard for disease classification. The work of William Farr (1807-1883) provided the basis for the first International List of Causes of Death. In Farr's letter to the Registrar-General in 1839 (published as part of the annual report of births, death and marriages, for which he served as medical statistician) he argues the importance of a standardised classification system, which also gives some sense of the difficulties faced before the ICD was adopted:

> The advantages of a uniform statistical nomenclature, however imperfect, are so obvious, that it is surprising no attention has been paid to its enforcement in Bills of Mortality. Each disease has, in many instances, been denoted by three or four terms, and each term has been applied to as many different diseases: vague, inconvenient names have been employed, or complications have been registered instead of primary diseases. The nomenclature is of as much importance in this department of inquiry as weights and measures in the physical sciences, and should be settled without delay.[11]

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[8] Foucault, 35.
[9] Foucault, 33.
[10] World Health Organization, *ICD-10: International Statistical Classification of Diseases and Related Health Problems*, 10th revision, 2010 ed (Geneva: World Health Organization, 2011). 164.
[11] Registrar General of England and Wales, 'Annual Report of the Registrar-General of Births, Deaths and Marriages in England' (London, 1839), 99.

In *Sorting Things Out: Classification and its Consequences* (1999), Bowker and Star explore the difficulties inherent in systematising and classifying in general, but by tracing the history of the ICD they are able to illustrate these difficulties and the ways they have shaped healthcare.[12] For this the authors were given access to the archive kept by the World Health Organisation detailing the development of the ICD, which they describe as "not a record of gradually increasing consensus, but a panoply of tangled and crisscrossing classification schemes".[13] William Farr's frustration over the confused nomenclature of the 19th century would not necessarily have been eased by how the ICD developed. In 1985 the ICD was lamented as having "... no coherent conceptual or organizing theme".[14] While still retaining Farr's original scheme of classifying diseases by anatomical site, the most recent revision – the ICD-11 – also defines diseases according to aetiology, environmental factors and other properties.[15] While Farr may have been correct that a system of classification is of as much importance to medical knowledge as systems of weight and measurement are to scientific inquiry in general, the medical gaze that founded modern medicine requires silence to provide distance between the body and the systems that define it. The relationship between language and the body will always be distanced and classification systems attempt to close that gap and reduce an individual to an object, in doing so risking the loss of the truth and objectivity originally granted by the power of the medical gaze.

In the 21st century the ICD exists as an invisible, spatially distributed infrastructure that facilitates similar activities to those carried out by the SRM. It captures data about all factors that could affect health, from genetic to social, and is used in a wide range of functions such as by insurance companies to work out payment scales, governments to determine public health interventions and epidemiologists to locate possible causes of disease. Bowker and Star state that:

> Management of the ICD played a part in the creation of the modern state, in many protocols for state-to-state negotiations, and in many international organizations. The degree to which it came to constitute medical knowledge is unknown, and that story is yet to be told.[16]

The ICD represents part of the infrastructure by which 'biopower' operates contemporarily, having assisted in the development of the modern state. It does not hold the status the SRM did of being the locus of medical knowledge as it is a distributed infrastructure rather than a centralised organisation. However, it is a large part of the network facilitating the creation and distribution of medical knowledge, upon which modern states rely to manage the health of their citizens. The authors point out that, as the ICD has influenced the modern state, this influence flows both ways when they ask to what degree the ICD (and therefore the state) came to constitute medical knowledge itself.

The way that information is structured can often be naturalised. This can be seen in how few records exist of the process of developing new editions of the ICD throughout the 19th and 20th centuries, despite the massive amount of work and coordination such a technological and bureaucratic

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[12] Geoffrey C. Bowker and Susan Leigh Star, *Sorting Things out: Classification and Its Consequences*, 1. paperback ed., 8. print, Inside Technology (Cambridge, Mass.: MIT Press, 2008).
[13] Bowker and Star, 21.
[14] Kerr L. White, 'Restructuring the International Classification of Diseases: Need for a New Paradigm', *The Journal of Family Practice* 21, no. 1 (1985): 17–20.
[15] 'ICD-11 Reference Guide', accessed 29 June 2024, https://icdcdn.who.int/icd11referenceguide/en/html/index.html#content-model-and-definition-of-disease. Aetiology refers to the causal mechanisms of a symptom.
[16] Bowker and Star, *Sorting Things Out*, 115.

achievement requires.[17] Classification systems, when considered by those other than their creators, are felt to reflect an inherent, perfect logic, as opposed to being historically contingent – reflective of the technological and ideological conditions in which they and the information they contain were formed. The ICD itself doesn't claim that its structures and systems produce or reflect any inherent truths about the nature of diseases, but this distinction can be lost by the organisations using it. For example, the ICD's historical context as a scheme for classifying and enumerating causes of death for governments means that it treats diseases as separate and distinct, when in reality there are often multiple, linked causes of death. In attending to this gap between "formal systems of knowledge representation and informal, experiential, empirical, and situated experience." Bowker and Star explain:

> it is never the case of "the map OR the territory." One may try to hold a representation constant and change practice to match it, or vice versa. Using the example of medical classifications, however, both coconstruct each other in practice. Thus we have "the map IN the territory" (making the map and the territory converge). It is not a case of the map and the territory.[18]

By explaining the ICD as being "the map in the territory", the authors begin to address the question of how much influence the ICD has over medical knowledge. Both medical knowledge and the systems around it co-construct each other. It is not a case that either can be understood alone, or outside of the context of the modern state. This is the fundamental character of classification.

Facilitated by the birth of the clinic and its attendant medical gaze, the creation of medical information and data has allowed not only great advances in medical practice but in statecraft and the exercise of state power. By expanding the definition of medical information, it became possible to survey more of the lives of citizens. And by creating, for the first time, objective information about the body, 19th century clinical medicine was able to imbue medical information with the exactitude that made statistical observations possible. In this way medical information underpins not only the development of modern medical practice, but the modern state. Bowker and Star state that this became increasingly mediated by technological developments following the Second World War.[19] The state, through its relationship to medical information and classification, came to be formed by international corporations and finance, facilitated by the flow of digital information around the world. As this happened, private companies were also empowered by their access to medical knowledge, developing the network of private healthcare providers, insurance companies and pharmaceutical corporations that today represent the "unity of the medical gaze" – deciding the priorities of research and development and thus the direction of medical knowledge.

[17] Bowker and Star, 111.
[18] Bowker and Star, 193.
[19] Bowker and Star, 123.

2. Precious Signals

Where the birth of the clinic took place directly after the French Revolution, the Second World War preceded a similarly seismic shift. During the French Revolution the health of the population was central to the goal of creating a freer and fairer society.[20] But the provision of more healthcare ultimately served a dual purpose, as discussed above, in that it later advanced state power and control. In the UK during the Second World War the state took over or subsidised much of the provision of healthcare, and by 1942 the creation of a permanent state medical service was planned for after the war ended.[21] This was in part due to the work of the Socialist Medical Association, which had been arguing for the universal right to health since its foundation in 1900, on the basis that "capitalism per se and the capitalistic organisation of medical care both contributed to individual and national ill health."[22] However the SMA did not consider the NHS as it was implemented in 1948 as "a truly socialised health service" or as functioning outside of or without capitalist mechanisms such as the labour exploitation of healthcare workers.[23] The NHS represents a vast, complex organisation with a unique relationship to medical information and state formation. To continue following a thread from the birth of the clinic it is useful to look at the ascension of neoliberal thought – whose birth was concurrent with that of the NHS – to see how it has produced the conditions for the state to continue using medical information for surveillance and control, as well as how it has affected conceptions of health and the body.

The inauguration of the NHS in 1948 represented the type of welfare service reforms initiated after the war that led many on the right to fear the loss of the entrepreneurial values they saw as having driven economic and technological progress since the 18th century.[24] These economists and other scholars gathered at the first meeting of the Mont Pelerin Society (MPS) in 1947. Credited with the birth of what is now known as neoliberalism, the group developed an economic and ideological project that championed governance based on the principles of a free market economy.[25] They saw the movements of the free market as "precious signals" that contain information about a population's economic position and intentions.[26] In their view, the more that governments tamper with these signals, either by assisting citizens with public infrastructure or welfare, or by regulating private industry, the more state intervention is then required, as economic agents are no longer able to read these signals and make informed decisions. The two solutions were to ensure that the free market was protected and to encourage citizens to treat their own lives as businesses, increasing competitiveness and reducing the possibility of class solidarity. After several decades as a fringe economic and political position, the reforms championed by the MPS were eventually enacted by Ronald Reagan and Margaret Thatcher.

In the 70s, the increases in productivity and profitability brought about by Fordism were declining, and in order to remedy this neoliberal thinkers championed deregulating capital markets. They saw the issue as being a disconnect within corporations between power and ownership, with

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[20] Mervyn Susser and Zena Stein, *Eras in Epidemiology: The Evolution of Ideas* (Oxford ; New York: Oxford University Press, 2009), 38.
[21] John Stewart, *The Battle for Health: A Political History of the Socialist Medical Association, 1930-51*, The History of Medicine in Context (Aldershot, Hants ; Brookfield, VT: Ashgate Pub, 1999), 365.
[22] Stewart, 311.
[23] Stewart, 15.
[24] Michel Feher, *Rated Agency: Investee Politics in a Speculative Age*, Near Futures (New York: Zone Books, 2018), 10; See also Jessica Whyte, *The Morals of the Market*, vol. 1 (Verso Books, 2019).
[25] Foucault, *Society Must Be Defended,* 131.
[26] Feher, *Rated Agency*, 14.

managers, including salaried CEOs, wielding more power than the shareholders who owned the businesses. This managerial form of capitalism lead to a friendly relationship between the public and private sectors:

> on account of the cultural affinities between the salaried managers of large corporations and senior civil servants, the former were not only prone to behave like the latter — thereby entrenching the technocratic turn of business culture — but also relied on their assistance to evade competition.[27]

In order to separate private and public organisations and put power back in the hands of capital owners, the Reagan administration deregulated capital markets. This had the effect of disciplining managers within corporations, who could now be ousted by shareholders through leveraged buyouts and hostile takeovers. Companies were encouraged to act in a more ruthlessly profit focused way, with the stakeholders most distant from the actual operations of a business making the decisions for it. This resulted in the provision of goods or services being de-prioritised in favour of producing returns for investors. It no longer mattered what the quality of a company's provisions were, only that the market was reassured. Far from fostering the entrepreneurial spirit that the neoliberals of 1947 sought to rekindle, the effect of this has been the retrenchment of existing companies into monopolies and megacorporations, with a market that demands nothing unexpected or unpredictable disturbs business-as-usual. As Michel Feher points out in *Rated Agency* (2018), these effects were not permutations brought about by the particular implementations of neoliberal ideas that began in 1979, but can be credited to MPS doctrine itself, as an unexpected outcome of the founding ideology of neoliberalism.[28]

The other unexpected outcome of the deregulated capital market was its effect on statecraft. While the neoliberal intention was to curb government powers in favour of market logic and individual entrepreneurialism, governments were disciplined in a similar manner to private companies, with their functions as states and obligations to their citizens deprioritised in favour of appeasing market forces. In order to compete in this new global financial environment, governments had to attract investors to their shores with lower taxation, less labour protection and stronger property rights. This was to ensure that the new multinational corporations would choose their territories as places to do business. But with reduced taxes, governments had to find money to fund public spending or risk not getting re-elected. They did this by increasing the amount of money they borrowed, meaning governments, including in the UK, became beholden to the market in much the same way as corporate managers. If a government did something that would be unpopular with investors (for example, threaten to increase taxation or legislate better working conditions) the interest rates on their loans would increase, with wide reaching negative consequences, both for those in office and for citizens. As Feher states: “the heads of states and governments whose deregulatory initiatives had subjected the fate of corporate managers to the whims of the stock market ended up putting themselves in a similar situation.”[29] How drastic this shift towards a financialised economy has been for a country can be assessed by what proportion of its GDP is accounted for by the financial sector. According to the United Nations, for the UK this figure sat at 34.7% for 2023, putting it behind only Andorra and Luxembourg in a ranking of European countries.[30] The UK government and its services,

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[27] Feher, 21.
[28] Feher, ‘Introduction’.
[29] Feher, 23.
[30] ‘Share of Finance and Business Services in GDP - Data Portal - United Nations Economic Commission for Europe’, accessed 16 August 2024, https://w3.unece.org/PXWeb/en/CountryRanking?IndicatorCode=9.

including the NHS, are acutely controlled by the forces of the market, putting the NHS in the position of a public health service that is not able to prioritise public health over private finance.

Neoliberalism began to be implemented in Britain with the election of Margaret Thatcher in 1980. Alongside market deregulation, the Thatcher government privatised industries and utilities – many of which were initially nationalised by the Attlee Government alongside the creation of the NHS.[31] Margaret Thatcher was an advocate for private healthcare,[32] but she knew that the full implementation of MPS reforms onto the NHS, meaning privatisation and restructuring to maximise profit to investors, would be too politically contentious. After almost a decade in power, in 1989 the Conservative government published a white paper entitled *Working for Patients* that introduced sweeping reforms including the creation of an internal market within the NHS. In lieu of being able to open the organisation up to external market forces, the government placed market competition within the NHS itself by taking away the ability for healthcare services to control their own budget, instead creating separate groups within the NHS with the power to commission, purchase and control the funding of services. This moved power away from the doctors and healthcare workers that ran the services and placed it instead in the hands of bureaucrats who were accountable to the government and not the patients. The majority of the public and the vast majority of NHS doctors held negative opinions about the proposed reforms.[33] The removal of power from those closest to the provision of care mirrors the effects that the deregulation of capital markets had on corporations, with the government taking on the role of shareholders, able to remove managers seen to be too focused on the running of services and provision of care as opposed to creating value for money and enabling private sector outsourcing.

One of the guiding principles of Thatcher's review of the NHS was an emphasis on patient choice.[34] As Annemarie Mol points out in *The Logic of Care* (2008), patient choice is often a substitution for high quality care, leaving the burden of decision-making on the patient alone and reducing the amount of care provided – therefore lowering costs. This echoes and reinforces the neoliberal goal of making each person into an entrepreneur. Members of the MPS posited that to make class conflict obsolete, their reforms would have to encourage even people who don't own capital to make decisions about their lives based on economic rationale. Under this logic a person's health is taken into consideration as if it were a financial asset to make the most financially sound decision about, and patients become customers. As Mol points out, practices of care don't fit into a market logic, and selling health relies on an impossible fantasy.[35] Where the market offers one time solutions and promises of permanent wellbeing (and a return to productivity), care is a constant process that accepts the unpredictability of the body and the abstract, unachievable nature of health. Mol uses the example of an advert for a blood sugar monitor:

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[31] The National Archives, 'Attlee's Britain 1945-1951', text, *The National Archives* (blog) (The National Archives), accessed 9 August 2024, https://www.nationalarchives.gov.uk/education/resources/attlees-britain/.
[32] 'General Election Press Conference (Health and Social Security) | Margaret Thatcher Foundation', accessed 27 July 2024, https://www.margaretthatcher.org/document/106866.
[33] British Medical Journal, 'Correction: Survey Shows Consultants Oppose NHS Trusts', *BMJ* 300, no. 6725 (10 March 1990): 685–685, https://doi.org/10.1136/bmj.300.6725.685. 685
[34] '"Working for Patients" White Paper', Policy Navigator, accessed 19 July 2024, https://navigator.health.org.uk/theme/working-patients-white-paper.
[35] Annemarie Mol, *The Logic of Care: Health and the Problem of Patient Choice* (London ; New York: Routledge, 2008), 11.

> (…) appealing to the desire for health in an advertisement for a blood sugar monitor is a remarkable way of playing with desires (...) There are, after all, no limits to the desire for health among people with chronic disease.[36]

This offers some insight into the logic of choice and how it operates by appealing to a desire for health, reinforced by the entrepreneurial logic that ties health to productivity and financial gain. The logic of care accepts that the possession of individual, biological health is a fantasy,[37] and that true health is the constant process of care, often involving multiple people, whereby the demands of the body are accepted and met where possible. In this way care is "to act without seeking to control. To persist while letting go."[38] Health and the body do not conform to entrepreneurial demands or market logic as neoliberal ideology expects them to, and attempts to make them conform can harm both individuals and institutions.

The *Working for Patients* white paper inadvertently began a change in how the NHS is understood and treated within Britain, one that arguably obfuscates the harm that continues to be caused to the NHS. The threat of the Thatcher government's reforms shifted the attention of activists from local actions such as sit-ins and strikes over the closing of hospitals to the fate of the NHS as a whole.[39] This type of activism and campaigning mobilised an idea of the NHS as representing a set of universalist values, imbued within it at the moment of its formation. At the core of these values lies the belief that the government is responsible for the welfare of its citizens and that healthcare should not be subject to the market processes of commodification and the extraction of surplus labour value.[40] Drawing on this, activists and campaigners created a sense of ownership and national pride, captured by the 'Hands Off Our NHS' campaign launched in response to the white paper, which actively constructs an 'us' to whom the NHS belongs as a means to protect it from the threat of ownership by private companies. However, the idea of the NHS as a socialist project is not echoed by the historical record, as mentioned at the beginning of this chapter. The values drawn upon by activists in the 80s were constructed along with the 'us' that they helped to create, and could therefore be reconstructed to serve the kind of political purposes they were created in opposition to.[41] For example, in 2020 Boris Johnson stated "our NHS is the beating heart of this country. It is the best of this country. It is unconquerable. It is powered by love."[42] At this time the conception of the NHS as a point of national pride was being utilised by the government and media due to the Covid-19 pandemic and the epidemiological necessity of the public following government health advice. But this kind of rhetoric functioned to disguise and distract from the unprecedented amounts of outsourcing happening around NHS services, eroding the NHS's capacity to function without the private companies now embedded

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[36] Mol, *The Logic of Care,* 26.
[37] Beatrice Adler-Bolton and Artie Vierkant, *Health Communism: A Surplus Manifesto* (Brooklyn: Verso, 2022), Introduction.
[38] Mol, *The Logic of Care,* 28.
[39] Jennifer Crane, '"Save Our NHS": Activism, Information-Based Expertise and the "New Times" of the 1980s', *Contemporary British History* 33, no. 1 (2 January 2019): 52–74, https://doi.org/10.1080/13619462.2018.1525299. 58
[40] Sally Ruane, 'Public-Private Boundaries and the Transformation of the NHS', *Critical Social Policy* 17, no. 51 (1 May 1997): 53–78, https://doi.org/10.1177/026101839701705103.
[41] Agnes Arnold-Forster and Caitjan Gainty, 'To Save the NHS We Need to Stop Loving It', *Renewal* 29, no. 4 (7 December 2021): 53–61.
[42] 'Boris Johnson Praises NHS as Country's Greatest National Asset after Saying "He Could Have Gone Either Way"', The Independent, 12 April 2020, https://www.independent.co.uk/news/uk/politics/coronavirus-boris-johnson-health-news-hospital-nhs-video-tweet-a9461616.html.

within its operation once the state of emergency declared around the pandemic was called to an end.[43] The way the government positions the NHS turns it into an abstract entity and precludes it from potentially helpful reforms, as well as distracting from the privatisation and austerity measures that make good care impossible to achieve.

In the time since the Thatcher government's reforms, the NHS continues to be broken down and subjected to further market forces, while the government attempts to conceal this by encouraging a sense of national pride. In reality the NHS is used to give public money to private corporations while actively undermining its own capacity and the best interests of the patients it serves. This is called systemic retrenchment, wherein private companies will be awarded contracts to provide a service to public organisations that those organisations used to be able to provide themselves.[44] This is often more expensive for a public organisation in the long run, and removes the expertise, experience and funding required to provide that service from within the organisation. This leaves the public sector poorer both financially, but also in terms of personnel and capacity. Where digital technologies and data are involved there is another level of profitability possible. Technology companies will use the data they have extracted from an organisation (including patient healthcare data) to develop their own tools and then sell that back to the organisation (e.g. hospital) that facilitated the development.[45] There are often deeply unequal power dynamics at play in these agreements. In the case of NHS trusts signing deals with Tech firms like Amazon, the trusts manage the budgets for services and are under pressure to cut costs whilst innovating new ways to increase patient satisfaction and reduce wait times, and are unaware of the value of the data they hold.[46] This leads them to effectively sell patient data with very little benefit to the NHS or patients, who are often unaware that their data is being handed to private companies, expressing strong opposition when informed.[47] The fears patients have are not unfounded, as hundreds of private companies have been found breaching data sharing agreements without having their access removed.[48] However, private companies are not the only threat to individuals' healthcare data. As further reforms have continued to transfer power over the NHS to central government,[49] other government departments have been able to access healthcare data for the purposes of surveillance and control.[50] Neoliberal reforms have therefore increased the British state's

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[43] British Medical Association, 'The Role of Private Outsourcing in the COVID-19 Response' (British Medical Association, 23 July 2020), https://www.bma.org.uk/news-and-opinion/covid-19-conceals-deepening-privatisation-of-the-nhs.

[44] Rosie Collington, 'Disrupting the Welfare State? Digitalisation and the Retrenchment of Public Sector Capacity', *New Political Economy* 27, no. 2 (4 March 2022): 312–28, https://doi.org/10.1080/13563467.2021.1952559.

[45] Collington, 321.

[46] Ada Lovelace Institute, 'Health Data Partnerships: Amazon/Department of Health and Social Care – Ada's View', 16 December 2019, https://www.adalovelaceinstitute.org/blog/health-data-partnerships-adas-view/.

[47] Stephanie Mulrine, Mwenza Blell, and Madeleine Murtagh, 'Beyond Trust: Amplifying Unheard Voices on Concerns about Harm Resulting from Health Data-Sharing', *Medicine Access @ Point of Care* 5 (1 October 2021): 23992026211048421, https://doi.org/10.1177/23992026211048421.

[48] Andrew Gregory and Andrew Gregory Health editor, 'Hundreds of Organisations Breached Patient Data Rules, Reveals BMJ', *The Guardian*, 11 May 2022, sec. Society, https://www.theguardian.com/society/2022/may/11/hundreds-of-organisations-breached-patient-data-rules-reveals-bmj.

[49] Hugh Alderwick, Tim Gardner, and Nicholas Mays, 'England's New Health and Care Bill', *BMJ* 374 (13 July 2021): n1767, https://doi.org/10.1136/bmj.n1767.

[50] Alan Travis and Alan Travis Home affairs editor, 'NHS Hands over Patient Records to Home Office for Immigration Crackdown', *The Guardian*, 24 January 2017, sec. UK news, https://www.theguardian.com/uk-news/2017/jan/24/nhs-hands-over-patient-records-to-home-office-for-immigration-crackdown.

power over its citizens through the utilisation of medical information – specifically healthcare data – both directly and indirectly through sales to private companies.

For the NHS, the implementation of neoliberal ideas has led to a distancing of doctors and patients from decision making processes, which, after a protracted process of multiple restructurings, are now increasingly controlled by central government, the private companies embedded within the NHS and, ultimately, the market.[51] If the goal of market deregulation was to close the gap between ownership and power in corporations, the effect on public organisations has been the opposite. If the public are considered to be the owners and beneficiaries of public organisations, the power in these institutions is instead being given to those who govern in the interest of the market and private companies. Instead of a sense of ownership constructed to disguise this and prevent progressive changes, the patient control argued for by the Socialists Patients' Collective (SPK) offers protection from this kind of exploitation by large companies and true accountability to patients.[52] The SPK points out that everyone contributes towards the infrastructure of healthcare and emphasises the socially mediated nature of illness itself, arguing for patient control over healthcare institutions as well as medical education and the budgets for health and social care.[53] Rather than making the NHS into an abstract figure beyond critique, the sense of public ownership could be mobilised to radically change the NHS into a publicly accountable institution, more in line with the vision of the SMA for a truly socialist form of healthcare. A key aspect of this kind of reform would be full patient control and oversight over their data to ensure the power inherent to this information can't be used against their best interests. A project such as the FDP has the technical potential to create this kind of transparency, but the political, economic and ideological history suggests that this would require a complete re-understanding of medical information.

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[51] Nigel Edwards, 'Implementation of the Health and Social Care Act', *BMJ* 346 (3 April 2013): f2090, https://doi.org/10.1136/bmj.f2090.

[52] Sozialistisches Patientenkollektiv, *SPK - aus der Krankheit eine Waffe machen: eine Agitationsschrift des Sozialistischen Patientenkollektivs an der Universität Heidelberg*, ed. Jean-Paul Sartre, 5., unveränd. Aufl (Heidelberg: KRRIM, Selbstverl. für Krankheit, 1987).

[53] Sozialistisches Patientenkollektiv, 19.

3. Symbolic Bodies

The data the NHS holds has been described as a "goldmine",[54] valued in 2019 at £9.6bn per year.[55] This is in part because of the nature of the NHS as a service, holding information from birth to death on the majority of the UK population, all with individual NHS numbers assigned to them. It is also because the NHS was early to adopt the use of Electronic Health Records, which hold digital medical information for use by clinicians. The department for health helped fund the development of a system to digitally record GP consultations as early as 1972, almost 10 years before the first personal computer was sold.[56] EHRs rely on systems of medical classification similar to the ICD in order to input information, specifically systems of clinical terms developed for healthcare staff to use in patient records. The NHS uses a system called SNOMED CT (Systematized Nomenclature of Medicine Clinical Terms), which in its development was made interoperable with the ICD.[57] SNOMED CT allows clinicians to input precise, computer readable representations of care information.[58] Making NHS data particularly suited for use in clinical studies, data analytics and the training of AI healthcare tools. The utilisation of this data has been posited as the solution to improving the experience of care for users of the NHS and creating cost effective solutions to the issues NHS England is currently facing, such as bed shortages and long waiting lists for treatment, in lieu of increases in funding.[59] This also serves the neoliberal function of removing power and control from government and placing it in the hands of the market via private companies. With this in mind it is possible to understand why the US data analytics company Palantir Technologies specifically sought out a deal with NHS executives to manage the storage and handling of healthcare data.[60]

The inclusion of Palantir into the operation of the NHS has been widely criticised. Their background in intelligence and surveillance raises concerns about patient privacy,[61] and groups representing healthcare workers have protested their ties to the Israeli Military.[62] Palantir represents a new kind of relationship between public and private companies, one based on the kind of systemic retrenchment unique to companies handling data and digital tools. Similar to the MPS's view that the market is the truest possible source of information about people's wants, needs and desires, the ideology Palantir is founded on submits that data can reveal more about the true feelings of

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[54] Sabah Meddings, 'Peer inside the NHS Records Goldmine', 2 September 2024, https://www.thetimes.com/world/us-world/article/peer-inside-the-nhs-records-goldmine-8vdws9lgd.
[55] Owen Hughes, 'NHS Data Worth £9.6bn per Year, Says Ernst & Young', *Digital Health* (blog), 24 July 2019, https://www.digitalhealth.net/2019/07/nhs-data-worth-9-6bn-per-year-says-ernst-young/.
[56] Nicholas Lee and Andrew Millman, *ABC of Medical Computing* (London: British Medical Journal, 1996). 56.
[57] Amy Y. Wang, Jeremiah H. Sable, and Kent A. Spackman, 'The SNOMED Clinical Terms Development Process: Refinement and Analysis of Content.', *Proceedings of the AMIA Symposium*, 2002, 845–49.
[58] 'SNOMED CT', NHS Digital, accessed 2 December 2023, https://digital.nhs.uk/services/terminology-and-classifications/snomed-ct., NHS England - NHS England refers to electronic health records as electronic care records, they are also sometimes referred to as electronic patient records. All terms can be used interchangeably and refer to the same kind of system.
[59] Keir Starmer, 'No More Missing Records or Letters Lost in the Post – I Will Bring in a Totally Digital NHS', *The Guardian*, 22 May 2023, sec. Opinion, https://www.theguardian.com/commentisfree/2023/may/22/digital-nhs-technology-health-service-keir-starmer.
[60] Crofton Black, 'Revealed: Data Giant given "Emergency" Covid Contract Had Been Wooing…', TBIJ, 24 February 2021, https://www.thebureauinvestigates.com/stories/2021-02-24/revealed-data-giant-given-emergency-covid-contract-had-been-wooing-nhs-for-months.
[61] Jacqui Thornton, 'Palantir NHS Contract Raises Criticisms', *The Lancet* 402, no. 10417 (2 December 2023): 2060, https://doi.org/10.1016/S0140-6736(23)02693-4.
[62] Ella Nunn, 'Workers Protest against NHS Contract with Firm Linked to Israeli Military', The Independent, 3 April 2024, https://www.independent.co.uk/news/uk/nhs-fdp-israeli-peter-thiel-london-b2522611.html.

individuals than they can express directly.[63] Palantir is an unusually ideologically driven company, seeking a kind of collective unconscious through data to the ends of "making the West a better society."[64] They are unselfconsciously embedded in the mechanisms of statecraft, with an average of 45% of their revenue coming from the US government as they seek further contracts from other governments.[65] Once Palantir has implemented their proprietary software, it precludes government organisations from building that capacity themselves, meaning they must now rely on Palantir for basic operations indefinitely. For NHS England, Palantir has been contracted to supply the 'Federated Data Platform' (FDP), the goal of which is to connect the different stores of data held by different parts of the NHS. This means that all of the medical information the NHS holds will soon be accessible only via the systems put in place by Palantir, making Palantir the locus of medical knowledge within the NHS, controlling the territory and the map within it.[66]

Since March 2024 patient data has been being transferred to the FDP.[67] Patients are not able to opt-out of this and still access NHS services in England.[68] This is an example of how, as Boris Groys points out in *Philosophy of Care* (2022), in order to access and navigate institutions of care individuals require informatic extensions of their physical bodies. Groys draws on Foucault's aphorism that "health replaces salvation",[69] stating that where the church once cared for the soul of an individual, health and social care now attend to the soul in the form of what he terms the symbolic body. Groys explains,

> They are symbolic not because they are somehow 'immaterial' but because they allow us to inscribe our physical bodies into the system of care. Similarly, the Church could not care for an individual soul before its body was baptized and named.[70]

The FDP is part of this process of inscribing the physical body into the system of care, as a collection of medical knowledge as represented by clinical terms and classification schemes. This is the body as constituted by medical information, and it is treated as more than an abstract representation. Much of the work of healthcare is conducted with attention to the information held about a body, rather than to the physical body itself, as Groys points out:

> In many cases, physicians do not examine our physical bodies at all – the examination of documentation seems to be sufficient. That demonstrates that the care of our physical bodies

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[63] Moira Weigel, 'Palantir Goes to the Frankfurt School', *Boundary 2* (blog), 10 July 2020, https://www.boundary2.org/2020/07/moira-weigel-palantir-goes-to-the-frankfurt-school/.
[64] Will Feuer, 'Palantir CEO Only Wants Employees Who Agree With Mission to Boost the West', *WSJ*, 18 January 2023, https://www.wsj.com/livecoverage/davos2023/card/palantir-ceo-only-wants-employees-who-agree-with-mission-to-boost-the-west-YHDP44oDik2FSkwRSFa0.
[65] https://www.wsj.com/business/palantir-technologies-stock-business-outlook-515f1b5a, 'Palantir's Momentum Hurt by Slowing Growth in Government Deals - WSJ', 22 January 2024, https://www.wsj.com/business/palantir-technologies-stock-business-outlook-515f1b5a.
[66] Bowker and Star, *Sorting Things Out, 193*.
[67] NHS England, 'Federated Data Platform', 2023, https://www.england.nhs.uk/digitaltechnology/digitising-connecting-and-transforming-health-and-care/.
[68] 'Why We're Working to Uphold the Privacy of NHS Patient Data', *Good Law Project* (blog), accessed 7 June 2024, https://goodlawproject.org/update/why-were-working-to-uphold-the-privacy-of-nhs-patient-data/.
[69] Foucault, *The Birth of the Clinic*, 244.
[70] Boris Groys, *Philosophy of Care* (London ; New York: Verso, 2022), 2.

> and their health is integrated into a much bigger system of surveillance and care that controls our symbolic bodies[71]

That is, the care of physical bodies and their health is constituent of the modern forms of power – the state and global financial markets – that control symbolic bodies. The nature of medical information is such that much of healthcare under financialised capitalism can be conducted without attention to the individual the information is representing. This is not the medical gaze that Foucault describes, which is defined by its acknowledgement of the irreducibility of the individual, but is instead the reliance on the informatic mediation of the gaze, such as in medical imaging, as a substitute for good care.[72] The FDP is a repository and conduit for the collective medical gaze and, as with the technologies that have preceded it, has shaped the medical gaze and medical knowledge as it has been shaped by it. This is tied up in a process of co-construction with the modern state. This is a state whose aims are not compatible with the principles of good care, and this will always quietly manifest in the systems that facilitate healthcare.

The modern state employs the neoliberal logics of austerity and entrepreneurialism to the provision of care. As disability scholars have long pointed out, this is an issue for all, not just those whose bodies do not currently fit within the entrepreneurial, market centred ideology of the modern state.[73] Under deregulated, neoliberal capitalism the removal of the welfare state means the section of the population who cannot keep up with the demands of increased productivity and competition are designated as what Marx and Engles termed the "surplus population".[74] In *Health Communism* (2022) Beatrice Adler-Bolton and Artie Vierkant state that those who are designated surplus are not inherently vulnerable, but are made so by the state:

> the characteristic vulnerability of the surplus is not inherent to their existence—that is, it is not any illness, disability, or pathologized characteristic that itself makes the surplus vulnerable. Their vulnerability is instead constructed by the operations of the capitalist state.[75]

When understood as socially determined, illness can be seen as a product of the modern state. It is only when a population is abandoned that they become surplus, rather than being abandoned because they are surplus. The mechanisms of capital demand a person be designated surplus when it deems them to be more profitable that way:

> the surplus population has become an essential component of capitalist society, with many industries built on the maintenance, supervision, surveillance, policing, data extraction, confinement, study, cure, measurement, treatment, extermination, housing, transportation, and care of the surplus.[76]

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[71] Groys, 2.
[72] Eyal Bercovich and Marcia C. Javitt, 'Medical Imaging: From Roentgen to the Digital Revolution, and Beyond', *Rambam Maimonides Medical Journal* 9, no. 4 (4 October 2018): e0034, https://doi.org/10.5041/RMMJ.10355. 7
[73] Marta Russell, *Beyond Ramps: Disability at the End of the Social Contract ; a Warning from an Uppity Crip*, 1. printing (Monroe, Me: Common Courage Press, 1998).
[74] Friedrich Engels, *The Condition of the Working Class in England*, ed. David McLellan, Oxford World's Classics (Oxford ; New York: Oxford University Press, 2009); Karl Marx, *Capital: A Critique of Political Economy*, Penguin Classics (London: Penguin books, 1990).
[75] Adler-Bolton and Vierkant, *Health Communism*, 4,
[76] Adler-Bolton and Vierkant, 5.

By classifying and organising healthcare data, the FDP facilitates the biomedical designation of who is considered surplus on behalf of the state. This allows the state to continue to profit from the bodies of those it has designated surplus. Aside from the suffering caused to individuals and the benefit lost to society when relegating so much of the population to the margins, the disciplinary role that this threat plays affects all subjects. The threat of becoming surplus helps enshrine the care of the self as the fundamental responsibility of a citizen. Those who do not care for themselves adequately enough to continue the smooth operations of capital are profited off by extractive means. Health is therefore revealed as being a "biological, fascist fantasy" embedded within the institutions and architectures that make up the modern state for the "concealment of the social conditions and social functions of illness".[77] Capitalism by its nature takes the health of its subjects as the raw material for the extraction of profit.[78] This means any individual is vulnerable to being designated as surplus, not only because all health is unpredictable, but because capital will continue to expand its designation of surplus in its ongoing search for growth and profit.

The continuation of care under the NHS is fundamentally undermined by the mechanisms of capital accumulation, as are the principles of good care in general. The market logic and budget pressures that have shaped the existence of the NHS since the 1980s have continued to force services to outsource privately, ostensibly to cut back costs but in reality as a way to empower the market. This move is disguised by leveraging public feelings of pride about the NHS, precluding the possibility of useful reforms or real accountability and control for patients. The solutions posed by international technology companies are then purchased instead. In this way technology provides a useful solutionism and the naturalisation of its co-construction of knowledge serves a political purpose. To question these technologies is to question the efficacy of the entire system of global power. By tracing the history of these technologies and mechanisms of power, it's possible to understand them as being socially contingent and often contradictory to their own aims. It is also possible to uncover potential weaknesses and ways to resist. For example, medical knowledge as it is produced by the financialised modern state is encouraged to misuse the medical gaze, losing its ability to produce objectivity through irreducibility as described by Foucault.[79] A patient controlled medical gaze could harness this potential, addressing the processes of representation inherent to classification of medical knowledge within accountable, cooperative, universal healthcare technologies. Ultimately the FDP represents another knot in a thread that leads back to the birth of the clinic. In untangling the web of associations and co-creations that dictate experiences of health, the misdirections and naturalisations that protect the architectures of capital fall away, making the potential for reinvention apparent too. It is in attending to our health, both individual and collective, that this reinvention becomes most urgent, and most possible.

[77] Socialist's Patient's Collective, *Turn Illness into a Weapon*, trans. K.D., 2013, 9.
[78] Karl Marx, *Capital: A Critique of Political Economy*, Penguin Classics (London: Penguin books, 1990), 612.
[79] Foucault, *The Birth of the Clinic*, XV.

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