

# SCREENING FOR CANCER RISK: ESPOSITO'S IMMUNIZATION PARADIGM, CAPITALISM AND THE LOGIC OF FANTASY

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## Introduction

This paper is about the biopolitical paradox by which, in the name of improving health, the medical industrial complex is progressively harming health. It is also an enquiry into the adequacy of a classical biopolitical theory, the immunisation paradigm, to explain this paradox compared with Marx' and Lacan's theory of the unconscious, and the logic of fantasy.

The expansion in programmes to screen for risk factors and for early diagnosis are causing increasing harms to health by over-diagnosis as well as through the bankrupting of public health services (Gilbert Welch, 2012; Marmot, 2012; Moynihan et al, 2013; Prasad et al, 2016). One such process is the production of estimates for individual risk of specific future diseases. As an example, in this paper I examine the use of a fairly new genetic profiling test called Oncotype-DX™. This is a test that estimates a woman's risk of a cancer recurrence after she has already had treatment for what is called 'early' breast cancer, a cancer often detected by screening. This 'risk' estimate is used to help with difficult decisions about further chemotherapy, difficult because in these circumstances the risk of recurrence is always fairly low and chemotherapy itself can cause serious harms. However, the developers of the test claim that it provides improved accuracy compared to the current methods, and therefore claim that it will save costs and harms due to unnecessary chemotherapy. However the findings in this paper suggest that overall, in part due to its expense, this technology will cause net harm to health. And we should also note that this conclusion has relevance for all such predictive medical technologies and screening procedures. Importantly, these prophylactic processes are applied to *asymptomatic* individuals and measure personal risk or attempt to provide early diagnosis. Such technologies are increasing in scope all the time and in the UK include, for example, various national cancer screening programmes (breast, lung and bowel), national screening for risks of heart disease, and screening for depression in diabetics, and a lowering of thresholds for family doctors to refer for suspected cancers (GPonline, 2015).

This topic is important because there is controversy over the both the efficacy and affordability of these procedures for public health services. This is because of uncertainty over whether researchers overestimate their benefits, and whether they in fact cause more harm than is appreciated both to individuals and to the effectiveness of public health services overall.

Esposito's immunization paradigm is a biopolitical theory and a fairly recent attempt to provide a unifying vision of the biopolitics of such prophylactic procedures. It is based on a *negative* logic of protection, as

well as of a reduced obligation to others: hence the term 'immunisation'. It is based on a logic of *preserving-life*, of protecting against life's relentless expansivity and acquisitiveness and uses concepts of sovereignty, property and freedom. However it fails to, or at least doesn't attempt to, account for the mechanisms underlying the capitalist structure and its production of subjectivity, and for capitalism's renunciation of simply preserving life in favour of the imperative to produce surplus life. Instead Esposito's paradigm is an idealist worldview based on a fully aware self-consciousness that fails to acknowledge the role of the unconscious. Based on the examination of Oncotype-DX™, I argue that rather than a logic of *negative* protection to *preserve* life it is capitalism's *positive* logic of production and desire for *surplus-life* that provides the desire to repeatedly innovate and purchase risk as a commodity. This results in a hyper-immunitary dialectic. Marx' theory of the commodity form and capitalism's logic of fantasy are used to uncover the role of the unconscious and the implications for subjectivity and agency. The expansion of medical prophylaxis for the asymptomatic individual is a symptom of capitalism's endless need to innovate and increase productivity. Finally, the decision to purchase Oncotype-DX is shown to degrade the effectiveness of the NHS as part of an increasingly necropolitical liberalisation of healthcare. Once the consequences of purchasing this test for the UK NHS have been examined, the adequacy of Esposito's paradigm will be critiqued in relation to Marx' and Lacan's theory of the Logic of Fantasy and the unconscious.

First of all we will consider 'personalized medicine', subjectivity and agency, and biopower, before moving onto Esposito's immunisation paradigm. Two main issues are highlighted here: a) the potential destruction by personalised medicine of much healthcare for those 'really ill' now, and b) the presumed nature of subjectivity as a fully aware self-consciousness even whilst acknowledging choices are constrained.

### **Personalised Medicine**

Rose has provided a sociological perspective on the biopolitics of preventive and predictive medicine with his concept of biopower through active bio-citizens 'brought to work on themselves' by 'authoritative' expertise (Rabinow and Rose, 2006). Bringing citizens to work on themselves is achieved in part by marketing new medicine e.g. the genetic medical technology as personalized, and thereby encouraging self entrepreneurship and claiming to avoid the harms of too much generic intervention en masse. However, Rose points out the potential dangers of too much personalized medicine: (a) much health gain (e.g. socialized medicine in the UK after the second world war) has been through population based measures, and b) doctors say their care is already personal.

The rush to personalize, to predict and to prevent, to intervene early on those who have no symptoms but are judged at risk on the basis of such tests, not only expands the scope of medicine in the developed world, but potentially diverts crucial resources from the health care of those who are really ill, or at risk of disease from well known environmental factors that must be tackled, not on the basis of personalization, but using precisely those impersonal, population wide,

solidaristic social interventions that have proved so effective in the past (ibid., p348).

He notes that, in relation to expensive cancer treatments, e.g. in the USA, “ ... this form of “personalization” thus creates an important opportunity for those who market genetic tests, but *one that greatly increases healthcare costs.*” (ibid., p345, my italics).

### **Subjectivity and Agency**

Foucault describes biopower as the way the political economy of capitalism maintains itself through the control of populations through subjectivisation (Foucault, 2004). In this process, ‘the object of pastoral power is subjugated to its own objectivisation and is objectivized in the constitution of its subjectivity’ (Esposito, 2008a, p35), as a *homo-oeconomicus* or *homo-geneticus* (Gaudillière, J.-P., (1995), ‘Sequenzieren, Zählen und Vorhersehen. Praktiken einer Genverwaltung’ *Tüte, Sonderheft: Wissen und Macht – Die Krise des Regierens*: 34–39. cited in Lemke, 2004, p561) who, by investing in his own human biocapital or genome, as an “entrepreneur of himself”, “produces his own satisfaction”(Foucault, 2004, p 225) and “reaps economic interest”.

Rose and Rabinow’s concept of biopower includes:

a) “ ... one or more truth discourses about the ‘vital’ character of living human beings, and an array of authorities considered competent to speak that truth ... as in the contemporary relations of genomics and risk, merged in the new language of susceptibility.” b) “ ... strategies for intervention upon collective existence in the name of life and health ... as in the emerging forms of genetic or biological citizenship.”, and c) “ ... modes of subjectification, *through which individuals are brought to work on themselves*, under certain forms of authority.”(Rabinow and Rose, 2006, p197)

The implication here is that the subject retains a full self-awareness, whilst at least acknowledging that subject choice may be constrained. This puts a limit on the activity of Rose’s active biocitizen and ‘freedom’ here has been shown to have limited conditions of possibility (Jørgensen, 2016). Rose acknowledges that capitalism may lead to what he calls ‘racial segmentation’ and the implied politics of apartheid, and that this requires conceptual tools for its analysis where ‘health and vitality become key stakes’. However, strangely, there is a notable silence on Marx’s analysis of capital and what this has to offer in terms of the logic of production of an alienated subjectivity, of surplus product and of surplus value.

Rose and Rabinow elaborate upon Foucault’s concept of biopower (Foucault, 1997), and argue that this is far removed from Agamben’s thanatopolitics of nationalist eugenics, and emphasise its performance through capitalism:

This is capitalism and liberalism, not eugenics, by either the front or back door .... we still need to develop the conceptual tools for the critical analysis of the ways in which biopolitics plays out in relation to biocapital and bioeconomics, in circuits in which health

and vitality become key stakes in market relations and shareholder value. (Rabinow and Rose, 2006)

At the same time, by contrast, Rose recognizes racial segmentation as a potential consequence:

... the development of drugs whose efficacy is specific to particular population groups will no doubt give further incentives, if they were needed, for pharmaceutical companies to invest in products *for the most valuable markets*, not the medical needs of those who suffer from the most prevalent diseases. Hence the fear of *a new kind of racial segmentation of medicine*. (Rose, 2013, p344 my italics)

### **Esposito's immunisation paradigm**

Esposito acknowledges Foucault's achievement in describing the process of biopower through subjectivisation, described previously. However, Esposito sees this biopolitics, the link between life and politics as an enigma left unsolved by Foucault, and asks: "What is it that brings 'bios' (the life of the citizen) and politics (the regulation of civil society) together?" Contrary to Rose's dismissal of Agamben's concept of sovereignty and thanatopolitics noted above, Esposito maintains that biopower remains haunted by sovereignty. Biopower and sovereignty have a 'co-presence', and are mutually reciprocally dependent, but the sovereignty is concealed and acts through 'the juridicisation of *dispositifs* of control put into action by biopower' (Esposito, 2008a, p40). He claims that this enigma is solved by the immunitary mechanisms, mechanisms that exercise a kind of dialectic. Esposito argues that it is necessary, to maintain order and sustain authority of the sovereign, to exercise the power of sovereignty over the subjects' property as his/her identity that inheres in the body. This is achieved through mechanisms that promise a negative kind of freedom (from harm by the other). And this is in the name of preserving life but actually sacrifice life's 'ecstatic fullness' (Esposito, 2008b). He draws upon Nietzsche's vision of life in its unstoppable expansivity and three concepts to explain the paradigm: a) sovereignty, b) property and c) liberty. Importantly, however, we should note a) that this theory presents a worldview, i.e. as if this representation is 'real', is the way things really are and not just an experienced but illusory 'reality' and b) that the subject of this paradigm remains a subject fully self-aware even if his or her choices may be constrained by regulation or custom.

Esposito draws upon Nietzsche's 'will to power' in a 'vacuum of sense' that propels man to always confront the powers that restrain him, so that political power, to maintain its power, must always intensify its restraint.

The wish to preserve oneself is the symptom of a condition of distress, of a limitation of the really fundamental instinct of life, which aims *at the expansion of power*, and, wishing for that, frequently risks and even sacrifices self-preservation. (Nietzsche cited in Esposito, 2008a, p 87, italics in original)

The 'vacuum of sense', Esposito suggests, is man's failure to grasp 'origin', a failure that 'propels' man to make sense of his origin, the

origins of time, and his own mortality (2008a). Following Foucault, the problem is described by Esposito as the 'originary difference', this refers to the 'interval' of difference (that is to say a non-identity) between the 'origin' and what is presupposed by man as constituting its essential essence (2008a). And, for Esposito, it is this *non-identity of life with itself* that creates the 'vacuum of sense' that drives Nietzsche's 'will to power'. Therefore 'order' must be maintained by what Esposito calls *intensifying* immunitary mechanisms, which, he suggests, were first intuited by Nietzsche.

Against the vacuum of sense that opens at the heart of life that is ecstatically full of itself, the general process of immunization is triggered "The democratization of Europe is, it seems, a link in the chain of those tremendous prophylactic measures which are the conceptions of modern times." (Nietzsche cited in Esposito, 2008a, p 89)

### **Sovereignty, Property and Liberty**

These three concepts form the basis of the mechanisms by which the paradigm works. And the sources for them are Hobbes, Locke and Berlin (Esposito, 2008b). Sovereignty is based on Hobbes notion that because of man's 'limitless acquisitiveness' coercion by the sovereign power is necessary to ensure the protection of the individual from harm by others and to ensure not only the preservation of life but 'happiness' as well. The body is the site of formation of identity and is the property of the individual according to Locke, and therefore the body is a central site for sovereign control. Liberty, is describe using Berlin's conception of freedom as a negative freedom from harm based upon the freedom to be one's own master, and Esposito sees in this the freedom to be free of obligations to the other as well.

### **Alienation, subjectivity, social relations, and the preservation of life**

There are four key features of the immunisation paradigm worth considering here. Firstly that it is based upon the idea of an 'originary' alienation, from a 'vitalism' a drive or life-force derived from a negativity, '... in ways different from Marx, not only can the alienation not be reintegrated, but indeed it represents the indispensable condition of our own identity.' (Esposito, 2008a, p 48). Secondly, that the subjectivity that emerges is implicitly fully self-aware, '... the life of the ego divided between the driving power of the unconscious and the inhibiting one of the superego, is the site in which such an immunitary dialectic is expressed in its most concentrated form.' (Esposito, 2008a, p 49). And thirdly that in a politico-juridical sense immunity implies '... exemption on the part of the subject with regard to concrete obligations or responsibilities that under normal circumstances would bind one to others.' (Esposito, 2008a, p 45). And finally that the paradigm is concerned with the preservation of life, and not a drive for surplus life '... in order to save itself, life needs to step out from itself and constitute a transcendental point from which it receives order and shelter' (Esposito, 2008a, p 58).

For now, these features of the immunisation paradigm can be borne in mind. We will return to them later to discuss to what extent they are sufficient to explain the commodification, consumption, and

consequences of predictive medical technologies in capitalism. In particular we will ask whether in capitalism the production of labour-power (patients), surplus product (risk) and surplus value (wealth and bios-‘security’) involves further alienations, the production of a subjectivity that is not fully self-aware, and the breakdown of social relations.

Now we will turn to the analysis of the generation of, and decision to purchase, the genomic signature Oncotype-DX

### **Genomic Expression Profiles**

The human genome is a set of what are called genes in clusters. It is possible for these to be chopped up into different sequences. And by using very powerful computerised algorithms it is, in theory, possible to identify sequences that can be matched to an individual’s genome in order to provide an indication of the risk of developing specific future diseases. Of course the main problem lies in the accuracy of this prediction and despite the early hopes the genome has not proved to be a predictive as was once thought. One of the features of science in capitalism is the drive to continually improve upon mechanisms that prolong life. This process is seen as potentially highly profitable and receives much financial investments by venture capitalists and is subsidized by the governments of wealthier countries such as the UK. The science provides limitless possibilities and Rose describes the Genome Wide Association Studies (GWAS) that develop predictive gene cluster patterns (Rose, 2013, p345). The genomic profiling tests considered here are for cancer recurrence are very expensive, and millions of dollars have been invested in their creation and design (Association of European Science and Technology Transfer Professionals (ASTP), 2015).

The test considered here, Oncotype-DX is a prognostic predictive biomarkers for patients already diagnosed, and treated, for an early breast cancer, and having to decide whether to have further chemotherapy to prevent a possible recurrence. The ‘sensitivity’ thresholds for such tests are commonly set so that the test will correctly pick up at least 90% of patients whose cancers *would* recur (Drukker et al, 2013). However, setting this ‘sensitivity’ threshold as high as 90% also means it is less ‘specific’, resulting, in this case, in up to 80% patients being given chemotherapy, even though their cancer was never going to recur.

For these early cancers, often screen detected, the chances of cure can be high, and of recurrence low. So, there is a cost-benefit calculus here, that, in order for few to benefit, many may suffer harm.

### **Oncotype-DX: in the UK**

Oncotype DX™ is a genome derived prognostic marker, based on 21 genes. It generates a risk score, stratified into low, intermediate and high risk categories. Although there has been no independent appraisal confirming its clinical utility in practice, it has been included in the National Comprehensive Cancer Network guidelines in the USA (McKesson Associates, 2015). As a result, it is now routinely used in USA

oncology clinics, but, so far, less so in Europe (Miller et al, 2011). It is also expensive, retailing currently at \$4,175 per test.

The American based company applied to NICE for approval for the test to be marketed to the NHS. And approval was granted. The decision to grant approval is based upon the appraisal of the scientific evidence of its cost-effectiveness and a panel that decides on affordability. It is worth considering in some detail how affordability is decided since this gives us important insights into the political-economic basis of the decision and, ultimately, the consequences of the decision for health services overall.

### **Affordability, the incremental cost effectiveness ratio (ICER) and opportunity costs**

The ICER determines how much money you would *no longer* be able to spend on *displaced services* on, *if* you spend it on the new intervention. This is the *opportunity cost*. The UK NHS healthcare system has a ring-fenced ‘budget envelope’, set by parliament, so that any ‘escalating costs’ means that there will be a corresponding reduction in the amount of money available for existing services for other healthcare needs. In this case then, the *existing* health services would have to sacrifice costs available for the health needs they serve, or, an “*imposed cost to forgo QALYs*” elsewhere (Claxton et al, 2015).

The key question now becomes: if the new innovation is purchased, will it be ‘effectiveness-neutral’, will the health service be able to maintain its *equivalent* effectiveness, overall, or will it result in a *decrement* in effectiveness?<sup>1</sup>

### **The central threshold - effectiveness neutral**

Health economists have undertaken empirical research to estimate the cost per QALY that would be gained by those services most likely to be displaced. Using this data, a central ‘threshold’ has been estimated that would maintain the overall equivalence of service effectiveness. This, we can call an ‘*effectiveness-neutral*’ threshold, the level at which effectiveness will remain unaltered. This is set *exactly at* the cost per QALY that would have been gained by the service to be displaced. In other words, this “represents the additional cost (per 1 quality-adjusted life year gained) that has to be imposed on (or the particular spending that must be sacrificed by) the system to forgo 1 quality-adjusted life-year (QALY) of health through displacement.” (Claxton et al, 2015, pxxix, my additions).

They have estimated this ‘*central*’ *threshold*’ to be £13,000 per QALY gained. However, NICE makes decisions around an ‘effectiveness-

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<sup>1</sup> We have here a service A, the Gene Expression Profile, which replaces B, the on-line demographic risk-tool, costing an extra £X/QALY gained. Now, because the total budget is fixed, £X/QALY must be lost elsewhere by displacing intervention C (the particular intervention C is determined, “where decision making is less systematic, and covert” Hughes, D.A., Wood, E.M., & Tuersley, L. (2015) NICE recommendations: why no disinvestment recommendations to offset investment decisions? *BMJ*, 350., by local services). The impact on the effectiveness of the service, as a whole, can be measured by comparing the ICER, the extra cost per QALY, incurred by the new test, e.g. A, with the cost per QALY potentially gained by the service C that would be *displaced*.

threshold' higher than this, which, in any case, it often exceeds. In practice, this appears to be about £20,000 per QALY gained (Claxton et al, 2015). Therefore, since 'positive decisions *above* the threshold, on the grounds of 'innovation', *reduce population health*' at least in QALY terms, the transgression of the 'Limit' of the threshold by NICE will cause the service to become less effective (McCabe et al, 2008, p 743).

Because of the covert nature of the way local health trust disinvest in interventions that often highly cost effective but not highly valued by industry or the public at large, It has been argued that NICE should become a threshold 'searcher'. This would involve identifying and then disinvesting in the technologies that are the least cost-effective, and investing in the technologies that are the most cost-effective. However, in practice there is no current disinvestment programme (McCabe et al, 2008, p 741), and 'the task of specifying disinvestment guidance is by no means easy' (ibid., p 741)<sup>2</sup>.

### **NICE and the ICER 'threshold'**

NICE uses the QALY to assess value for money, and, 'in using the QALY, we assume that a major objective of decision makers is to maximise health or health improvement across the population subject to resource constraints', NICE aims to "to reach a judgment on whether this intervention can be recommended as a cost-effective use of NHS ... resources" (NICE framework document 2005, p28, cited in Culyer et al, 2007), and to "improve outcomes for people using the NHS and other public health and social care services" (NICE, 2016). However, NICE also argues that there is a need to a) consider so-called 'equity-weights', where added value is attributed to health gains for *certain* patient groups (where a treatment "may be the only option") on the basis of 'public opinion', and b) to foster "innovative" research and their 'advances' that promise 'cures', for the future. Therefore, NICE claims, an intervention may be considered cost effective and may be purchased, even if it *exceeds* the central (effectiveness-neutral) threshold incremental cost per QALY, and thereby, *risks a deterioration* in overall population health (Dillon, 2015).

### **The decision to purchase**

We should note, in passing, that the application for approval was declined in Australia. One reason cited for Australia's refusal to approve, was the ICER, which, at \$66,883 (£31628.65)/QALY, was deemed 'unacceptable' (Medical Services Advisory Committee (MASC), 2014). Now, on the other hand in the UK approval to purchase was given, but only after the company offered (*in commercial confidence*) a lowered

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<sup>2</sup> Although NICE have produced a range of 'do not do' recommendations, these are thought to have little impact Garner, S. & Littlejohns, P. (2011) Disinvestment from low value clinical interventions: NICEly done? *BMJ*, 343.. Thus, "the burden of disinvestment is shifted away from NICE or central government to local powers, where decision-making tends to be less systematic, and *covert*. Such an ad hoc approach may result in cost effective interventions being displaced in favour of newer, less cost effective ones..." Hughes, D.A., Wood, E.M., & Tuersley, L. (2015) NICE recommendations: why no disinvestment recommendations to offset investment decisions? *BMJ*, 350.

revised price which yielded an ICER of £22,600 (\$461849.78 ASD) per QALY gained (NICE, 2013).

An important question is whether exceeding this ‘central’ threshold cause *both* forced disinvestment in other services for which funds would no longer be available, *as well as* a deterioration in overall public health service effectiveness?

### **A ‘fact-taboo’ threshold**

We might expect the ICER threshold both espoused and denied by NICE itself to function as a ‘limit’, as a taboo, to protect the existing services, but the opposite is true. It is both necessary fact and impossible taboo. It acts as a discursive weapon to legitimise its own use in degrading the service. The threshold is rendered, both *impossible*, as a *price ceiling* that limits the market, and also as *necessary* as a *signifier* of NICE’s authority. The ‘threshold ceiling’ ‘taboo’ is here functioning to reinforce the authority of NICE to transgress the ‘limit’. This ICER threshold could be called a *‘fact-taboo’*. This relates it to and contrasts it with de Santos’ *‘fact-totems’* of public statistics, such as, for example, NHS productivity, National cancer survival rates etc, which he suggests are mobilized by the Nation State to normalise and universalize identity and opinion through high media profiles (de Santos, 2009).

The UK parliamentary ‘House of Commons Health Select Committee’ has expressed ‘serious concerns’ about NICE’s transgression of the central ‘effectiveness-neutral’ threshold.

The affordability of NICE guidance and the threshold it uses to decide whether a treatment is cost-effective is of serious concern. The threshold is not based on empirical research and is not directly related to the budget, it seems to be higher than the threshold used by PCTs (Primary Care Trusts) for treatments not assessed by NICE .... (Claxton et al, 2015)

Some health economists have specified their concerns, arguing that the transgressed, ‘pragmatic’, threshold results not only in opportunity costs, but in an “inappropriate” reduction in overall service effectiveness, contradicting NICE’s remit: ‘to improve outcomes for people using the NHS and other public health and social care services’, the very thing NICE is, apparently, empowered to protect and sustain (NICE, 2016).

It would seem appropriate, that the value of the threshold gives the NHS and the people it serves confidence that the opportunity cost of the programme is less than the value of the health gain it produces. (McCabe et al, 2008, p. 742)

The NICE executive transgresses the ‘effectiveness-neutral’ thresholds on the grounds of: the ‘impossibility’ of business reducing their prices, and by implication: profits, ‘equity weights’, and innovation.

Unless you believe that drug companies would be prepared to lower their prices in an unprecedented way, reducing the threshold to £13,000 per QALY would mean the NHS closing the door on most new treatments. And drug companies need the discipline of a critical market to make sure that they recognise that *price matters* ... encouraging an *innovative* UK research base, or perhaps valuing more highly specific treatments that may be the only option for people with certain conditions. (Dillon, 2015, my emphasis)

The statement presupposes, as a given, that industry wouldn't "be prepared to lower their prices", this is apparently 'impossible', citing a lack of historical precedence for business lowering prices. This is surely a 'cynical naïveté'<sup>3</sup>, a way of normalising the maintenance of industry's potential to make profit? Couldn't we, justifiably, also say, that the threshold should be maintained at £13000, since there is no precedent for business *not* adjusting its prices to the market's ability to pay, or for it ever being prepared to give up marketing its products?

## A relational ethics

Economists have pointed out the ethical implications, and consequences, for other NHS patients: "if NICE makes a recommendation on equity grounds it must assume that the health gain foregone by those who bear the opportunity cost *is valued less* than that of those who receive the benefit" (McCabe et al, 2008, p. 740). However as we have seen, there is no visible knowledge of who does bear the opportunity cost, since any disinvestment decisions are left to local care providers, who are often under financial duress, and are made covertly (Claxton et al, 2015). "Given the typical pattern of NHS expenditure, the typical bearer of the opportunity cost is, for example, likely to be elderly and in the last year of life." (McCabe et al, 2008, p 740).

The economists also argue that NICE over-steps its remit as set by parliament:

Appraisal committees' judgments on the cost effectiveness of a new technology must include judgments on the implications for healthcare programmes *for other patient groups* ... and how the cost-effectiveness of the technology being appraised relates to other interventions/technologies currently being applied in the NHS. (Culyer et al, 2007, my emphasis)

It seems *inappropriate* for NICE to honour its obligations to promote *innovation* through such a subsidy and at possible cost to NHS patients. (McCabe et al, 2008, p 740)

## The USA

The 'American Liberalism' (Foucault, 2004, p 217) of the USA, has gone a step further than the UK, and has even *proscribed* consideration of cost-effectiveness thresholds as aids to judgments on affordability of such tests for public healthcare services.

The Patient-Centered Outcomes Research Institute . . . *shall not* develop or employ a dollars per quality adjusted life year (or similar measure that discounts the value of a life because of an individual's disability) *as a threshold to establish* what type of health care is cost

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<sup>3</sup> In connection with proposed legislation to prohibit those under 18 working at night in the 1850s (What cynical naïveté!) "We think that the increase would be more than the trade, with due regard to its being successfully carried out, could fairly bear." (What mealy-mouthed phraseology!) (Marx's comments in brackets) Marx, K. (1990) *Capital; A critique of political economy vol 1 translated by Ben Fowkes*. London: Penguin Books Ltd. Ch. 10, section 4

effective or recommended (The Patient Protection and Affordable Care Act (Neumann and Weinstein, 2010).

This suggests, *not* that the most cost effective treatments must be made available to all, but conversely that there is *no* level of lack of care that is not possible in the USA. This is a policy causing an ultra-radical hyper-immunitary, progressive medical destitution, and health inequality.

### **Problems with Esposito's immunisation paradigm**

We have detailed earlier the most crucial aspects of the immunisation paradigm: the originary alienation, the presupposed negative vitalist force as envisioned by Nietzsche, the ego psychology with its implied fully aware self-consciousness, and the preservation of life as the presumed outcome. And we have also seen how the immunitary mechanism both protect against the pathogenic conflicts that emerge from within society, conflicts that are a necessary product to ensure the sovereign reaction to coerce compliance with negative freedom from harm from others as well as from the obligation to consider the needs of others.

The analysis of the test to predict cancer recurrence is emblematic of analyses that could be made of many other innovative preventive and predictive technologies. And it seems clear that the purchasing process is causing the progressive degradation of access to health services. And this will disproportionately affect the poorest and most in need, those 'really ill today'. So, how can we explain these findings, to what extent is the immunisation paradigm for biopolitics sufficient to account for them?

We can consider the issues of property, responsabilisation of the individual, and the accumulation of a National threat-debt. 'Risk' is being manufactured as a commodity by industry, and sited within the body of the individual who is responsabilised to deal with it. This responsibility is deemed a duty in response to a kind of accumulating risk-debt, or threat level. The threat can be conceived of as produced by industry but as a commodity destined to become the property of the individual. This individualized responsibility for an accumulating national threat-debt certainly seems to abrogate the individual of responsibility for the needs of others. NICE plays the part of a bureaucratic expertise on behalf of a sovereignty that compels innovation, purchase and consumption by 'the people'.

We should consider five features of the 'facts on the ground' presented here that may be at odds with the paradigm:

a) the progressive degradation of the public health service is intellectually known but is ignored by NICE and most of the public/profession, b) the continued investment and increasing socio-economic inequalities go beyond the preservation of life and require further explanation, c) the financial investment in, purchase and expansion of predictive technologies, and the growth of medicalization through over-diagnosis, suggests that it is a desire for surplus security though surplus life and not the preservation of life that is driving the system, d) this is important because it denotes that the system actually renounces simple security or preservation of life, only 'more' will do, which results in perpetual repetition and production, e) the apparent compulsion to purchase the commodities of 'risk' suggests that they have a value beyond their simple use-value. Instead they seem to have a value that is in their difference to,

in relation to, the value of other medical interventions, and this appears to provide it with an exchange-value in its own right, in itself.

### **The logic of fantasy**

These problems presented by the ‘facts on the ground’ are more adequately answered if we turn to Marx’ theory of alienation and the commodity form, and Lacan’s university structure of discourse. My main sources here are Tomšič (Tomsic, 2015) and Kordela (Kordela, 2013).

First of all, instead of only an originary alienation supposed by the immunisation paradigm capitalism induces two further alienations: a) the selling of labour-power objectifies the subject and alienates him or her from any sense of identity, and b) the exchange of commodities appears to generate the production of more wealth from wealth which provides them with an as-if-magical property of being able to generate wealth simply through exchange, and where the source of the commodity, the exploitation of labour is covered over. The capitalist becomes the personification of capital alienated as a cog in the wealth-generating machine. The loss of identity by the proletariat creates a lack of sense, and a non-specific drive for completion which primes the subject for ‘capture’ by any specific object-desire presented by the market. This creates a subjectivity that has been produced by the non-relation between the proletariat and the capitalist.

The desire presented to the already primed and lacking subject is surplus biosecurity, or in other words what amounts to immortality. This desire is presented in the specific form of objects such as the ‘risk’ measurement produced by a specific medical test. This is the basis of the logic of fantasy in which the subject disavows his or her own mortality and instead ‘believes in’ the promise of surplus life that inheres in the risk measurement. This creates an identity that is not the ego of Freud, but that is divided between a manufactured self-consciousness and a disavowed unconscious. This subject is in an imaginary relation to his or her real existing conditions of exploitation (Althusser, 1984). This fantasy ensures compliance by the subject with the consumption of the threat exposed, and the continued production of individualized bodily threats to life incited and extracted by the production of more risk measurement technologies. This fantasy also sustains the authority of the sovereignty of capital through its bureaucratic experts, here in the form of NICE.

The structure for this is provided by Lacan’s University structure of discourse: ‘... with capitalist modernity, the position of mastery ... comes to be occupied by knowledge itself.’ (Kordela, 2013, p 59). And, ‘... the university discourse produces ... the illusion that the function of knowledge is to reveal objective truths rather than to sustain authority – at the very moment when the function of knowledge for the first time becomes a means for sustaining authority.’ (Kordela, 2013, p 60). The freedom of the individual, one of the pillars of Esposito’s immunization paradigm, and of liberalism is shown to be a secular fantasy,

... the subject provides it (knowledge, NICE) with a surplus fantasy’ (Kordela, 2013, p 61) so that ‘ideological fantasy emerges as an indispensable political factor’ (Kordela, 2013, p 61) ‘... the irony is that ... the real of the subject’s desire is to have a master (i.e. to be a slave), it so turns out that, if the subject believes in

knowledge as objective and power-neutral, then he or she believes there are no masters but just free individuals, masters of themselves. This is the widely praised secular fantasy of the 'freedom of the individual'. (Kordela, 2013, p 61)

## Conclusion

This paper is in part a demonstration of the necropolitics of health care and the dangers of the screening for risks for future disease or early diagnosis in capitalism. It is also an enquiry into the adequacy of a recent philosophical basis for biopolitics, Esposito's paradigm. It also presents a Marxian and Lacanian model as a more convincing alternative biopolitical model. Esposito's assumptions of a) only an originary alienation, b) a vitalist source of drive for an ego psychology, and c) the minimal preservation of life are belied by the hyper-immunitary nature of a destructive necropolitics able to increasingly dominate the western world. The immunisation paradigm is a worldview that attempts to fill in the holes. It fails to account for the ideological fantasy nature of the capitalist structures that produce a divided subjectivity that sustains power that desires always surplus-value. Instead we find in Marx and Lacan a more convincing model. Much of the power of the modern medical-political industry is based upon the illusion of freedom of the individual, and a failure to acknowledge the role of the unconscious. We have seen how modern medicine is ultimately destructive of public health services. This is a conclusion disavowed by NICE and which has been challenged by a small group of economists. There are also resistive discourses by experts within medicine who do not bow to the Master Signifier of surplus life, but are more driven by a Master Signifier of 'doing no harm'. Even this apparently more benign signifier is for a divided subject and in capitalism may still destroy social relations or what Esposito refers to as 'communitas'. Either way we should note that according to Lacan we are all originally symbolically castrated, all alienated by 'ideology founded on a fetishistic split between (unconscious) knowledge and (fantasmatic) belief.' (Kordela, 2013, p 61) In which case it is necessary and only possible to make the relation to these Master Signifiers more ambiguous in order to provoke resistive and more nomadic subjectivities and to undermine the authority of the self appointed experts regulating markets in surplus value.

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