

**Health and the Embodiment of Neoliberalism:  
Pathologies of Political-Economy from Climate Change and Austerity to  
Personal Responsibility**

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Neoliberalism is commonly understood in terms of the expanding global influence of disembodied market forces and rationalities. However, unlike the invisible hands and competitive calculations it unleashes on the world, neoliberalism's implications for health are neither intangible nor abstract. Instead, they are materially embodied in ways that are deeply consequential for life and death (Navarro 2007). Evoked in book titles such as *The Deadly Ideas of Neoliberalism*, *Dying for Growth*, *Sickness and Wealth*, *Infections and Inequalities*, *Pathologies of Power*, *Blind Spot*, and, in the aftermath of the 2008 financial crisis, *The Body Economic: Why Austerity Kills*, neoliberalism and associated forms of inequality, austerity and precarity have been tied by health scholars to a vast variety of embodied suffering, disease-vulnerability and low life expectancy right across the planet (Rowden 2009; Kim et al. 1996; Fort et al. 2004; Farmer 2001, 2005; Keshavjee 2014; Stuckler and Basu 2014). Rallying against these lethal links, a gathering of the World Social Forum in Tunis in 2015 recently concluded that today's global crises in health, health services and social protection are "in fact the consequence of neoliberal politics globally" (WSF 2015). Meanwhile, amidst all the crises, individuals are also now routinely told that their health is simply their own responsibility, a form of resilience that will only endure if they invest in it with the same individualistic and entrepreneurial prudence that is the trademark of personalized neoliberalism more generally (Brown and Baker 2012). As a result, all sorts of embodied health challenges – hunger and obesity being two especially physical examples – are repeatedly recoded as personal management problems even as they embody neoliberal socio-economic developments in society at large (Carney 2015; Guthman 2009).

How then can we better theorize the processes through which neoliberalism becomes embodied in health? While the ill-effects of neoliberal policies and practices have been spreading across borders like an infectious outbreak, neoliberalism is clearly not a biological disease agent itself. Even if it is conceptualized as an epidemic in terms of transnational health impacts, its extraordinarily diverse sequelae do not constitute a singular medical syndrome (Schrecker and Bambra 2015). The etiologies of illness involved are extremely complex, multi-causal and as geographically uneven as they are historically and economically interconnected (Labonte et al. 2009). Whether it is the global consequences of the cutbacks in healthcare caused by neoliberal austerity, or the impact of business deregulation, privatization and user fees introduced in national neoliberal reforms, or the everyday destabilization of communities caused by increasing income inequalities, social insecurity and environmental deterioration, the varieties of experiences, processes and time-space scales to consider are extremely heterogeneous. And then, on the other side of the ledger, there are the health benefits claimed by the privileged for neoliberal innovations in personal risk management, customized medicine, medical tourism and pharmaceuticals – benefits that also sometimes come with increased risks for others such as organ donors and experimental subjects recruited for drug trials in poor countries (Parry et al. 2015; Sparke 2014). Across such a wide range of economic, political and social life, ‘neoliberalism’ – the term – means many different things. Thus before proceeding here to offer a survey of research on the health outcomes that can be diagnosed as embodiments of neoliberalism, this chapter begins by first unpacking what the term means and how we can best theorize its ties to health.

### *Defining neoliberalism in relation to health*

Put most simply, neoliberalism names a way of governing capitalism that emphasizes liberalizing markets and making market forces the basis of economic

coordination, social distribution, and personal motivation (Sparke 2013). At a macro scale these developments can be seen as comprising 'neoliberal governance', a set of governmental norms including privatization, business deregulation, and trade liberalization, that reconstitute politics in the shape of the market and repurpose the state as an entrepreneurial actor that governs through proliferating public-private partnerships in the interests of business classes and global investors (Brown 2015; Harvey 2005). At a more intimate scale of personal behavior it becomes 'neoliberal governmentality', a suite of practices in which individuals across a much wider set of social classes are enlisted into becoming competitive agents who invest in their human capital as entrepreneurs and who reimagine the meaning of their lives, citizenship and individuality – including their personal health – as calculating consumers constantly comparing metrics of ownership, mobility and social ranking (Brown 2015; Dardot and Laval 2013; Lemke 2001). And at once enabling and mediating developments across these different scales, neoliberalism is also a set of economic-turned-political ideas: ideas (like von Hayek's view of health as just another consumer choice) that keep evolving as adaptive and protean yet hegemonic common-sense about market norms and necessities, and ideas that thereby continue to inspire both the macro policies and micro practices of neoliberalization in different ways in different places (Gaffney 2014; Mirowski 2014; Peck 2010). All these accounts of neoliberalism are useful, but, as has been widely cautioned (including by many of the authors cited above), each one risks turning the term into a singular and seemingly inevitable metanarrative when divorced from attention to the historical-geographical circumstances in which neoliberal ideas and discourses actually shape assemblages of neoliberal governance and governmentality (Ong 2006; Sparke 2006; Springer 2012). This is precisely where studying neoliberalism in terms of embodiment becomes so critical, offering a way of coming to terms with how all the global-to-local processes of neoliberalization come together materially to condition and, too often, to shorten and diminish human life.

Not surprisingly, scholars of health have already led the way in reconceptualizing neoliberalism in terms of embodiment. They are not all necessarily informed directly by

the account of illness as ecosocial embodiment offered by epidemiologist Nancy Krieger (2001, 2005; but see Birn et al. 2009). All sorts of other ecologies and ‘epidemiologies of inequality’ have been charted as well (Heggenhougen 2005): some stressing the ties between ill-health and the high in-country inequalities created by neoliberal reform (Pickett and Wilkinson 2010; De Vogli, Labonté, and Schrecker 2013); others surveying the severe constraints placed on poor country primary health care, health services and, more recently, on health systems strengthening by the structural adjustments and neoliberal austerity imposed by international finance and its political representatives (Birn and Dmitrienko 2005; Gloyd 2004; Kim et al. 2000; Pfeiffer and Chapman 2010); others highlighting in turn the complex biosocial mechanisms through which everything from dam-building to user fees, curtailed drugs programs, and other structural adjustments materialize as structural violence on the poor (Farmer 2005; Farmer et al. 2013); and yet others identifying the particular routes through which poor people’s bodies, blood and biological material have been turned into new molecular frontiers for capitalist growth amidst the crises and speculative leaps of neoliberal globalization (Cooper 2008; Crane 2013; Rajan 2007). These varied epidemiologies are informed in turn by varied analyses of the pathways through which neoliberalization comes to be embodied. Some stress the transfer mechanisms of neoliberal ideas through international financial institutions, free trade deals and NGOs (Labonté and Schrecker 2007; Rowden 2009; Keshavje 2014). Others emphasize the class interests and policy reforms of neoliberal governance, including health services privatization (Navarro 2007; Schrecker and Bambra 2015; Schwiter et al. 2015). And yet others address the prudential risk-management practices of neoliberal governmentality, whether as they are practiced by consumers of personalized medicine in privileged contexts (Brown and Baker 2012; Lupton 2015), or as they are extended, however unevenly and incompletely, to aid enclaves of therapeutic citizenship in desperately poor contexts (Ngyuen 2015).

The main focus in what follows are the pathways that can be addressed in terms of *conditionalization*, including under this heading the diverse developments through

which neoliberalism in macro political-economic governance has become embodied in various forms of premature mortality and morbidity. Given the limited space, less attention is paid here to the various forms of personalized *responsibilization* through which more micro modes of neoliberal governmentality have come to be embodied in individual experiences of risk and biomedical self-management. However, by way of a conclusion, the last part of the paper points to how both *conditionalization* and *responsibilization* are increasingly coming together to shape contemporary global health *formation*: the formation of a field of research, intervention and outcomes in which we see micro neoliberal innovations in personalized health risk management frequently being advanced as answers to the destructive legacies of macro neoliberal structural adjustment. It is a field in which neoliberal market failures are at once acknowledged and contested even as neoliberal assumptions still strongly shape the ways that corrective counter-measures to the legacies of neoliberal structural violence are imagined, assessed and defended (Kenworthy 2014; Mitchell and Sparke forthcoming). But to understand the global health problems in poor countries that corrective global health interventions are designed to address we first need to come to terms with the ways in which embodied experiences of health have been structured by neoliberal conditionalization.

*Neoliberalization as global political-economic conditionalization.*

“Last year, our imperfect world delivered, in short order, a fuel crisis, a food crisis, and a financial crisis. It also delivered compelling evidence that the impact of climate change has been seriously underestimated. All of these events have global causes and global consequences, with serious implications for health. They are not random events. Instead, they are the result of massive failures in the international systems that govern the way nations and their populations interact. In short: they are the result of bad policies.... In far too many cases, economic growth has been pursued, with single-minded purpose, as the be-all, end-all, cure-for-all. The assumption that market forces could solve most problems has not proved true.”

Margaret Chan 2009

She did not use the word neoliberalism itself, but in 2009, in one of the most critical speeches ever made by a Director General of the World Health Organization, Margaret Chan delivered a damning diagnosis of the effects of neoliberal policymaking on health outcomes around the world. At the center of the “bad policies” she targeted for critique in this way was the single-minded pursuit of economic growth, and her subsequent references to globalization, market forces, and trade liberalization indexed in turn wider neoliberal developments as the underlying causes of the widening global crises. Coming on the heels of the 2008 global financial crisis, Dr. Chan thereby summed up a widespread realization that the neoliberal norms tied to market-led global growth were creating massive problems of inequality, volatility and precarity. “Something,” she said, “has gone horribly wrong.”

Dr. Chan’s diagnosis was by no means just a rhetorical response to a bad year. It built upon a comprehensive assessment of the WHO’s own *Commission on the Social Determinants of Health* which had already reached similar conclusions collected together in a report that was published in 2008 before the full scope of the global financial crisis even became clear (WHO 2008). “Social injustice is killing people on a grand scale,” announced this report (WHO 2008, 26). And, as well as presenting voluminous data to buttress their critique, the commissioners also sought to chart some of the pathways of causal connection linking high mortality and morbidity around the world to the structural force of neoliberal policies and associated economic imperatives. The report also did not use the term neoliberalism. It only showed up once in a reference to an online paper on uneven health outcomes and neoliberalism in Africa (republished as Bond and Dor 2007). But as they endeavored to describe the market-made and market-mediated “structural drivers” that set the conditions in which people “are born, grow, live, work, and age,” and as they documented how these political-economic forces are experienced and thus embodied as ill-health, the commissioners effectively underlined a form of conditionalization linked to globalization that others would clearly recognize as neoliberalization. “This toxic combination of bad policies, economics, and politics,” they argued, “is, in large measure, responsible for the fact that

a majority of people in the world do not enjoy the good health that is biologically possible” (WHO 2008, 26).

Irrespective of the terminology used, one of the most useful lessons of the analyses offered by the WHO chief and the 2008 WHO report on the social determinants of health is their focus on the processes of *conditionalization* through which global structural forces become embodied in health outcomes. Conditionalization is a useful term to employ here for two reasons. First of all it indexes the many indirect ways through which neoliberalization around the world has set the basic conditions in which people strive to live their everyday lives. Conditioning connects in this way to vital processes of social reproduction, as well as communicating as a verb – ‘to condition’ – how living conditions in turn become embodied in people’s health. Inequality, financial volatility, and the so-called ‘race to the bottom’ tendencies associated with the relentless global competition for investment and jobs, are all important aspects of neoliberal health conditioning in this respect, as too are the massive challenges of climate change, pollution, and food and water insecurity, all of which have been further exacerbated by market liberalization and associated efforts to attract and accommodate business interests globally. More directly, the second reason for using the term conditionalization is that it also points to the very specific neoliberal policies known as ‘conditionalities’ comprising the rules imposed on poor countries around the world by the IMF, World Bank and US Treasury Department as conditions for support with debt management from the debt crises of the 1980s onwards. Also known as the ‘Washington Consensus’, the rules of conditionality – rules that included privatization, trade liberalization, financial deregulation, austerity, cuts to health programs, user-fees for health services, cuts to food and fuel subsidies, and diverse experiments in export led development – constituted the main components of the so-called Structural Adjustment Programs or SAPs administered by the three agencies based in Washington DC. These same SAPs have subsequently become the subject of a powerful set of critical studies documenting the structural violence and suffering that structural adjustment imposed on societies across the global south, violence and suffering that has in turn

been embodied in a whole series of diminished health outcomes (Pfeiffer and Chapman 2010). Let us now examine these contextual and structural patterns of health conditionalization in more detail, starting with the most generalized and global conditioning affect of all: namely, climate change.

### *Neoliberalism and the contextual conditioning of health*

Climate change is viewed by many health scholars as “the biggest global health threat of the 21<sup>st</sup> century” (Costello et al. 2009). Even if the ties to neoliberalization are not always noted, the health risks of climate change can also in turn be examined as being increased and intensified by neoliberal developments globally (Goodman 2014). The freeing-up of market capitalism has undoubtedly freed-up additional carbon as gas and put it straight into the atmosphere creating the basic conditioning effect – the greenhouse effect – needed to create anthropogenic climate change. The liberalization in neoliberalization takes on a whole new meaning in this regard. As Naomi Klein puts it, “the liberation of world markets, a process powered by the liberation of unprecedented amounts of fossil fuels from the earth, has dramatically sped up the same process that is liberating Arctic ice from existence” (Klein 2014, 20-21). These liberalization links noted, it would be mistaken simply to blame neoliberalism alone for climate change. The Keynesian welfare-state capitalism of the *pre*-neoliberal West was itself the world’s greatest greenhouse gas generator until market-led globalization brought developing countries into the club of big carbon emitters. Looked at like this over longer time-spans, economic development based on energy supplied largely in the form of fossil fuels was always going to lead to the greenhouse effect. Neoliberalism has undoubtedly accelerated the process and enabled recent phenomena such as fracking and tar sands exploitation by blunting government regulation of energy corporations and legitimating new norms for extractive development (Finewood and Stroup 2012;



Preston 2013). But, many other older aspects of global development have been contributing to carbon build-up for far longer.

Pre-neoliberal pollution noted, when it comes to how climate change impacts human health, and how societies might mitigate or adapt to the dangers, neoliberalism makes a very big difference indeed (Fieldman 2011). As Klein underlines, “we have not done the things that are necessary to lower emissions because those things fundamentally conflict with deregulated capitalism” (Klein 2014, 18). Mitigation has thereby been repeatedly mitigated, leading to a series of dead-ends in global climate negotiations from Kyoto to Copenhagen to Cancún to Durban (Bond 2012a). The same economistic appeals to the inevitability of market logics that have helped to naturalize neoliberal globalization have also helped in this way to make shifts away from carbon intensive energy production seem impossible to political elites. As a result, whatever worries endure about climate change are generally transformed into new market-friendly and market-mediated ‘adaptive’ opportunities through developments such as carbon credit markets, weather derivatives, patented climate-ready crops and public forest land grabs privatized as carbon sinks (Bond 2012b; Cooper 2010; Dempsey and Robertson 2012). Thus the dominant neoliberal response to climate change has been to focus on the depoliticizing development of so-called resilience, turning market tools and techniques for risk management into new climate adaptation products for those who can afford to invest in insurance and insulation from the most health-threatening implications of climate change (Bracking 2015; Felli 2015; Gilbertson and Reyes 2009; MacNeil and Paterson 2012; Parr 2013). And far from the centers of financialized climate adaptation, the bodies of the poor are simultaneously left vulnerable under neoliberalism to the floods, storms, desertification, droughts, heat waves, and disease outbreaks that the *International Panel on Climate Change* describes as being created or worsened by climate change, as well as all the associated shortages of reliable food and secure water supplies (IPCC 2014).

The hazardous contexts for human life created by deregulated risk-evading industry impose risks on human health through more than just greenhouse gas emissions (*e.g.* Mudu 2009). There are many other health-damaging ecologies ensuing from the ways in which the neoliberal competition to attract and retain investment globally has led to diminished controls over corporate activities ranging from power generation to farming, fishing, logging and mining to chemical and pharmaceutical production to the management of food and workplace safety. Ocean acidification, aquifer depletion, overfishing, biodiversity loss, and carcinogenic chemical exposure, all threaten the ecological systems that support the reproduction of healthy human bodies, and they are all intensified by neoliberalization (Castree 2010). Similarly, the ‘race to the bottom’ on (and for) factory floors created by the creation of the increasingly neoliberal global division of labor (*i.e.* competitive, contingent and highly precarious ‘flexible’ labor markets) has led to the sidelining of occupational health and safety protections as well as to the undermining of unions and the historic health and pension benefits secured by collective bargaining (Morgenson 2006). The deaths and injuries of workers through hyper-exploitation, suicide, factory fires, building collapses and other industrial disasters are in this sense just the most egregious embodiments (indeed disembodiments in some cases) of more pervasive tendencies towards increasing work-related stress, vulnerability and ill-health (Baram 2009; Ngai and Chan 2012). Most vulnerable of all, the precarious sub-citizenship of poor migrant workers in today’s global economy – many of them forced into migration by the impact of neoliberalization on domestic economies – leads directly to broken bodies, painful insecurities and, as Megan Carney puts it in her powerful analysis of the food insecurity facing women migrants on both sides of the US-Mexican border, unending hunger (Carney 2015; see also Holmes 2013).

While many workers suffer injury and deprivation in laboring to produce food and other consumer goods and services for the global economy, another way in which workers’ bodies come to embody neoliberal precarity is as consumers too. The free market deregulation of corporate activity and other policy shifts away from social

welfare protection put populations at increased health risks by exposing consumers, and especially poor and poorly-educated consumers, to an increasingly inescapable 'corporate-consumption complex' (Freudenberg 2014). Freudenberg's name for this hybrid assemblage of business interests and networks also underlines – with its echo of the military-industrial complex – the huge importance of public health research into the dangers posed to consumers by industries ranging from alcohol, tobacco and fast-food to firearms, petrochemicals and pharmaceuticals (Mercille 2015; Moodie et al. 2013; Wipfli and Samet 2009). With the increasing globalization of the corporate consumption complex we also return to a form of public health conditionalization highlighted by WHO Director Chan in her account of the rising chronic disease and NCD dangers associated with market-led development. Unfortunately, though, such structural conditioning is simultaneously being downplayed in individualistic approaches to behavioral responsabilization in public health, approaches that focus on cultivating healthy consumer 'choices' and which constitute a form of neoliberal governmentality that is now travelling transnationally to many of the same consumers being chased by global corporations themselves (Cairns and Johnston 2015; Hughes Rinker 2015; Ormond and Sothorn 2012; Parry 2013; Sun 2015). While these micro neoliberal approaches have been theorized as bringing opportunities for customized medicine at the molecular level, and while it is suggested that this new biological citizenship comes without the racial exclusions and other biases of national 20<sup>th</sup> century biomedicine, empirical studies show that they often contribute to personal shame and guilt that leads in turn to the denial of structural conditioning and related forms of vulnerability and dependency (compare Rose 2007, with Eliason 2015; Le Besco 2011; Peacock et al. 2014; and Wehling 2010.). Thus, insofar as this personalized neoliberal individualization of risk management obscures the socialized neoliberal production of health risks, it presents what Sara Glasgow and Ted Schrecker usefully refer to as 'the double burden of neoliberalism' in global public health (Glasgow and Schrecker 2015).

Notable amongst the long list of chronic disease dangers posed by neoliberal development is the lethally embodied obesity threat that corporate food and drink

industries have managed to turn from a non-communicable disease into something that is communicated very easily through the trade ties of market-led globalization, branded beverages and fast food. As a recent critic of 'Coca-Cola Capitalism' has put it, the sweetened drink industries effectively turn bodies everywhere into silos of high fructose corn syrup, setting off epidemics of adult onset diabetes and heart disease that are spreading across borders even further (and in more enduring embodied ways) than acute infectious diseases such as SARs and flu (Elmore 2015). Meanwhile, biological researchers of flu itself indicate that the way neoliberalization has led to more intensive factory farming around the world is now also helping to create the perfect ecology for breeding newly virulent and pathogenic influenza viruses (Wallace 2009). Freed by deregulated meat production and corporate globalization, these viruses are increasingly able to become more lethal and more globally mobile than influenzas of the past because of the spread of so-called Confined Animal Feeding Operations or CAFOs and associated global supply chains. These operations stack sick and healthy animals so close to one another that the lethality of viruses is no longer held in check by the evolutionary need (for viruses) to keep one host alive long enough to move on to another. And often located near the millions of factory workers they are raised to feed, the super-vulnerable animal hosts can in turn quickly pass on the newly lethal viruses to the super-exploited humans laboring at the heart of the neoliberal world's globalized commodity chains (Davis 2005). It should be noted in this respect that one political danger that haunts responses to new infectious disease outbreaks more generally is the cultural formation of what Paul Farmer calls 'geographies of blame': geographies of blame that pathologize certain regions and countries as disease origins without ever examining the global ties that account for disease emergence and cross-border spread (Farmer 2006). Farmer found this to be the pattern with the erroneous blaming of Haiti as the origin of HIV/AIDS entry into North America, and it was a pattern that repeated again with the H1N1 influenza outbreak, when Mexico and Mexicans were blamed for bringing a form of swine-flu into the US when it already had origins tied to factory farming right across the free trade consolidated North American Free Trade Agreement

(NAFTA) region (Sparke and Anguelov 2012). To understand how free trade agreements tend to condition health outcomes more generally, we need now to turn to the ways in which conditionalization works through the structural force of neoliberal rule-setting.

### *Neoliberalism and the structural conditioning of health*

NAFTA, CAFTA, MERCOSUR, the EU and other regional trade agreements (such as the new TPP or Trans Pacific Partnership), along with the global trade rules to which all signatories of the World Trade Organization sign on, illustrate another set of more legal mechanisms through which neoliberal governance comes to have ill-effects on health, even though the economic growth associated with trade liberalization has also been advertised as beneficial for life expectancy in immodest arguments that 'wealthier is healthier' (Pritchett and Summers 1996; for a critique, see Sparke 2009). Three main neoliberalization mechanisms account for the negative health outcomes associated with free trade agreements: namely, competition, harmonization and monopolization. The cross-border competition that is deliberately unleashed by the removal of tariff barriers is what enables industry to move to where the costs of production are cheapest while still exporting back into formerly protected markets. It is the resulting market efficiencies so eulogized in economic theory that simultaneously force the 'race to the bottom' and deunionization developments noted above, with FDI and new factories moving to where labor is cheaper, where workers have fewer health and safety protections, and where environmental protections are less stringent or less well-enforced.

Beyond the well-known competition dynamics, the other two neoliberalization mechanisms of harmonization and monopolization also commonly have health damaging implications too. As the WHO 2008 report on the social determinants of health underlined, this is principally because of the ways in which they shrink the policy space for government and undermine national regulatory authority, something that

more recent reviews have also shown to be key in linking trade agreements with unhealthy nutrition too (Friel et al. 2013). Harmonization is the legal jargon used to describe how trade agreements work to remove non-tariff barriers to trade. Such barriers can include environmental, food and road safety rules that have been established in one country but which are viewed by businesses in other countries as barriers to entering the foreign market. Bans on carcinogenic pesticides and GMOs, controls on pollution, demands for dolphin- and turtle-safe fishing, and rules about vehicle safety checks have all been targeted for removal and reduction in this way by trade lawyers arguing that they constitute non-tariff barriers to trade (Wallach and Woodall 2004). And then there are the monopolization possibilities which are also expanded by free trade agreements. Specifically, these involve the increasing extension of patent rights over intellectual property through regimes such as the WTO's TRIPs (Trade Related Aspects of Intellectual Property) agreement. Drug companies argue these IP monopoly protections provide the necessary profit-making incentive to justify new investments in new drug research and development. But as the WHO 2008 report made very clear, IP protections simultaneously strait-jacket national governments, shrinking the policy-space in which the free or subsidized provision of generic medicines can be advanced, and frequently pre-empting the possibility of issuing compulsory licenses for essential medicines (Craddock 2007; Heywood 2002). This pattern of pre-emption, it should be underlined, persists despite the 2001 Doha Declaration and other declarations that developing countries ought to be able to opt out from the WTO's enforcement of patent monopolies and intensifying neoliberal harmonization (Alessandrini 2009; Beall and Kuhn 2012; Owen 2014).

Conditionalization through debt management, so-called debt-relief, and global financial discipline has been still more damaging to health and health systems than trade rules. The SAP conditionalities imposed in the 1980s on highly indebted countries as the condition of debt rescheduling and debt management by the IMF, World Bank and associated International Financial Institutions (such as the Inter-American Development Bank) share much with the conditionalization effects of neoliberal trade

agreements. But SAPs shrank the policy space of governments still more directly and dramatically by imposing sweeping neoliberal discipline from the outside, including direct demands to cut health services, cap the wages for health care workers, and impose user fees for medicines as well as more general structural adjustments ranging from austerity to privatization, trade liberalization, and the further expansion of IP protections. The timing and impact of the SAP conditionalities in the 1980s was all the more devastating for two further reasons. First of all they coincided with the global pandemic of HIV/AIDS as well as with other re-emerging infectious diseases such as TB. Due to a set of complex biosocial feedback dynamics (that included conditionality's cutbacks in medical services), SAP conditionality ended-up becoming biologically embodied in the spread and, in the case of drug resistant TB, the molecular evolution of the diseases themselves (Farmer et al. 2013; Hickel 2012; Shahmanesh 2007). Secondly the timing of the SAPs in the 1980s was such that they simultaneously changed the trajectory of governmental health policies globally. They came into effect soon after governments from all over the world had pledged in 1978 at Alma Ata to work for 'Health for All' by 2000, a plan to expand access and improve health outcomes that rested fundamentally on commitments by national governments to invest in systems of universal primary health care (PHC). And it was this plan and the associated governmental commitments that were effectively ripped to shreds by the neoliberal conditionalities of structural adjustment (Rowden 2009).

Due to its double-acting combination with the other complex biological and political forces, it remains extremely difficult to evaluate SAP conditionality as a stand alone independent variable in epidemiological analysis (yet see Cornia et al. 2009; and Stuckler et al. 2008). Nevertheless, pathways of causal connection between structural adjustment and increased morbidity and mortality rates have still been charted with care, including: through the connective thread of increasing in-country inequality (Kawachi and Wamala 2007; Hammonds and Ooms 2004); through their political-economic intersection with social unrest, *coups d'état*, and drug wars as well as free trade deals (Kim et al. 2000); through the links between conditionality and the

vulnerability of women and children (De Vogli and Birbeck 2005; Hickel 2012); through the conditionality-compensating NGO-ization and resulting fragmentation of health systems (Pfeiffer 2003); and through the impacts of privatized health services and user fees – which as Salmaan Keshavjee (2014) shows in his extraordinary account of the impact of Bamako initiative ideas in Tajikistan, traveled from the context of SAP conditionality in Africa to other parts of the world through NGO networking (see also Foley 2009; and McCoy et al. 2008).

The conditionality of neoliberal structural reforms continues into the present in a variety of ways. SAPs have been replaced by so-called Poverty Reduction Strategy Papers (PRSPs). These supposedly involve more country ‘ownership’, but they still often impose wage ceilings and other service-reducing rules in the health sector under the policy guidance of the IMF (Ooms and Schrecker 2005). Likewise, the debt relief announced by European government leaders at Gleneagles in 2005 is still being managed by the IMF in ways that impose neoliberal conditions on recipients (Sparke 2013). And, after the financial crises of 2008, Europe in turn has come to be haunted itself by the specter of debt-based discipline, casting a shadow of austerity across the continent and notably increasing suicides and morbidity in countries such as Greece where people’s everyday lives have come to embody the structural violence of overnight neoliberalization at its most extreme (De Vogli et al. 2013; Stuckler et al. 2015; and Stuckler and Basu 2013). Then, at the World Bank, hopes that Jim Yong Kim (the co-editor of *Dying for Growth* and co-founder of *Partners in Health*) would be a transformative president who would deliver global health from the damaging legacies of conditionality are now also haunted by concerns that the Bank will go on conditioning the meaning and management of ‘delivery’ in neoliberal ways (Bond 2012b). This connects in turn to wider concerns about how contemporary global health efforts to respond to the health-damaging legacies of macro neoliberal reform look set to be compromised by micro neoliberal governmentality going forward.



### *Conclusion: Neoliberalism and global health formation*

Global health is a field in formation – an academic field, an epidemiological field of health metrics measurement and mapping, a field of institution-building and policy-making, a field comprised of diverse health interventions and outcomes, and a moral field of humanitarian concern and action. It is also a field where multiple forms of neoliberalization and its discontents come together. As such, global health makes manifest how the ideas, practices and policies of neoliberalism relate and respond to one another, as well as how their outcomes are unevenly embodied. For the same reasons, it is a field where we need to be especially sensitive to how neoliberalization as a set of embodied processes is also often deeply contradictory as well as context-contingent. The contradictions created in the complex middle ground between a) *global health responses to neoliberal legacies* and b) *neoliberal global health responsabilization* are numerous and here only the briefest of overviews is possible.

At the broadest level of global health policy the switch away from the old neoliberal logic of ‘wealthier is healthier’ is clear (Sparke 2013). Many policy-makers around the world have come to the same conclusion as Margaret Chan, and argue that it is a grave mistake to believe that economic growth on its own will lead directly to healthier human lives. But neoliberal market logics and language nevertheless still orchestrate the replacement refrain which can be roughly summarized as ‘healthier is wealthier’. More specifically it is becoming clear that the dominant global policy-making response to ill-health in poor communities around the world is to argue that they need investments in their health so that they can integrate and grow in the global economy. In the micro-economic calculations and neoliberal prudentialism of this newly dominant view, and in the words of the *Lancet 2035* report, the bottom-line is that: “There is an enormous payoff from investing in health. The returns on investing in health are impressive” (Jamison et al. 2013). One particularly prominent co-author of this 2035 report was former US Treasury Secretary Lawrence Summers, the former proponent also of ‘wealthier is healthier’, and a Washington official closely allied with

the old Washington Consensus conditionalities. To the extent that Summers is now therefore advocating the financialized investment logic of healthiness leading to wealthiness, it seems useful to name this new orthodoxy a New Washington Consensus. As critics have pointed out in the *Lancet*, the investment languages and logics, the associated double standards, and the inattention to injustice are all continuous with the World Bank neoliberalism of the 1990s, and just as with the old Washington Consensus there is clearly much global dissensus with the new orthodoxy by those who care about health as a basic human right (Chiriboga 2014). But, given the association with huge new global institutions that are actually implementing the ROI logics (e.g. the Global Alliance for Vaccines and Immunizations), and given the allied influence of new public-private-philanthropic (3P) partnerships – including most prominently those funded out of Washington State by the Gates foundation – the nomenclature of the New Washington Consensus helps name the assemblage of the new neoliberal prudentialism within global health (Mitchell and Sparke forthcoming).

At another more material level, often indeed at the level of micro-biological material itself, critics have also highlighted the extractive logics of global health research as examples of neoliberal embodiment too. Johanna Crane (2013) has shown in this way how much grant-funded research in global health simultaneously relies on the health inequalities bequeathed by earlier rounds of neoliberal conditionalization in order to provide opportunities for western scholars to advance their careers as responsabilized researchers securing results-based support in the competitive grant cycles organized by 3P governmentality. When we turn to the patchiness and unpredictability of the resulting interventions, other scholars suggest further that health citizenship is neoliberalized anew in poor country settings where access to health services increasingly depends on having the right fundable disease in the right place at the right time, as well as being able to tell stories about reciprocity and recovery that can travel (Nguyen 2010). “What results,” argues Nora Kenworthy (2015), “is a vast disruption of political landscapes already marred by earlier incursions of colonialism,

development, and structural adjustment. Reciprocity replaces entitlement; biopolitics and the administration of promises replace the social contract.”

Of course, none of these developments should take away from acknowledging the many global health improvements that are outlined in the 2035 report as a prelude to the authors’ prediction of a great global health *convergence* around longer healthier lives for all by 2035. But the repeated return of neoliberal responsabilization in global health investment practice, and the way the associated outcomes complicate the basic effort to respond to the legacies of prior eras when neoliberalism conditioned health so damagingly now look set to diminish the chances of real health for all. For the same reason, they also in turn underline the importance of the concluding call for solidarity and organization in the Tunis World Social Forum statement noted at the very start of this chapter. This was not an actuarial health convergence predicated on investment logics and languages. Instead and in conclusion it called for a new health rights activist convergence to tackle the many social determinants of ill-health globally, including all the diverse neoliberal determinants described in this chapter. “Let us strengthen the actions for a convergence,” the statement read, “with movements acting on social determinants of health, such as climate, trade, austerity, debt, working conditions, and gender equality” (WSF 2015).

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