Neoliberal Regime Change and the Remaking of Global Health: From Rollback Disinvestment To Rollout Reinvestment and Reterritorialization

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Abstract

This article examines the impacts of two interconnected but distinct regimes of neoliberalism on global health. The first is the 'rollback' regime associated most commonly with the 1980's and 1990's when efforts to build universal primary health care systems around the world were undermined by Structural Adjustment Programs (SAPs) and associated forms of austerity and market rule. This rollback regime of neoliberal conditionalization led to widespread health service cutbacks, user fees, and other market-driven reforms that effectively replaced plans for 'health for all' with more selective and exclusionary approaches. The second neoliberal regime has been rolled-out in part as a response to the resulting gaps in care and associated forms of suffering and ill-health. Where the rollback regime enforced disinvestment, the 'rollout' regime insists instead on prioritizing investment. But even as it thereby addresses the health risks produced by financialized neoliberal conditionalization, this reformed rollout regime has doubled-down on selectivity by adapting

calculations from global finance to manage global health interventions. This emphasis on rationed and targeted life-saving investment is theorized here as illustrating a shift from the rollback regime's laissez-faire 'macro market fundamentalism' to an aidez-faire rollout of 'micro market foster-care'.

> "Countries will not be able to compete in tomorrow's economy unless they invest much more, and more effectively, in their people – especially in health and education, which build human capital" (Kim, 2018a).

In January 2018, in a report from Davos entitled 'What keeps the President of the World Bank up at night?' Jim Yong Kim addressed globalization and associated aspirations and frustrations before ending with a telling translation of his longstanding global health concerns into an argument about investment in human capital. He complained that: "Too many heads of state and finance ministers tell us, 'First we'll grow our economies, then we'll invest in our people'." In response, Kim explained that the World Bank was seeking to reverse these priorities by incentivizing investment in people with a new *Human Capital Project.* He further highlighted how the project would feature a ranking "which we hope will create much more demand for countries to invest in health and education." And, underlining the Bank's interest in ensuring maximal returns on such investments, Kim claimed that the project's data and analysis would also "help us advise countries on where to invest resources for the biggest impact in improving outcomes in health and education" (Kim, 2018a).

As another competitive ranking regime designed to incentivize 'best buy' investments and to maximize returns, the *Human Capital Project* exemplifies a much wider economistic use of rankings and metrics in contemporary governance (Darian-Smith, 2016). But more than this, it also illustrates a systemic shift in development thinking towards targeted cost-effective social investment (Jenson, 2010). This is a shift that has profoundly reshaped the ways in which interventions in development are imagined and implemented in the new millennium (Berndt and Wirth, 2018; Mawdsley, 2018; Mitchell, 2017). Focusing on

this regime change and its impacts on global health policies and practices in particular, this article argues that the shift has led from the destructive disinvestment dictates of traditional neoliberal austerity towards programs of reinvestment in health that are much more constructive but which are also constrained and contorted by enduring neoliberal concerns with economic returns on investment. To trace the contours of these limitations, the article highlights how the shift from the rollbacks of disinvestment to the rollout of new reinvestment rubrics also enacts significant *reterritorializations* of global health as an assemblage of globalizing but simultaneously localizing ideas and interventions. Historians of global health such as Randall Packard remind us that the resulting pattern of top-down, disease-specific interventions that are imagined and implemented from afar can be traced right back to colonial medicine (Packard, 2016). But as enduring and injurious as these historical continuities are, this article argues that neoliberal regime change – or, more precisely, a tendential and dialectical shift in emphasis towards neoliberal crisis-management amidst still ongoing forms of neoliberal crisis-creation – has played a significant role in reproducing such global health reterritorialization today.

Kim's rollout of the World Bank's *Human Capital Project* is a telling example of neoliberal reinvestment with which to begin, particularly in light of his subsequent January 2019 resignation from the Bank which he explained in terms of taking-up an unexpected opportunity at a private investment fund (compare Kim, 2018b and Bond, 2019). This is not where the arc of neoliberalism began at the Bank, and still less is it the end point that Kim is depicted as pursuing in *Bending the Arc*, a movie about the struggle for global health by the NGO *Partners in Health* (Davidson, 2017). Instead, the Bank was central to the global expansion and enforcement of rollback neoliberalism in the 1980's and

1990's, and it was against the associated structural violence, suffering and dispossession that Kim's collaborations in global health were originally organized as oppositional alternatives (Rice, 2016). Indeed, after his nomination by President Obama, his suitability for serving as World Bank President was questioned by economic elites precisely because of his co-editorship of one of the most comprehensive early indictments of traditional market fundamentalist neoliberalism (Harding, 2012). Entitled *Dying for Growth*, the book began with an introduction co-authored by Kim that named neoliberalism explicitly as the problem, and which also thereby highlighted how associated market fundamentalist assumptions led to failing policies for the poor:

> "The idea that robust economic growth will automatically lead to a better life for everybody is comforting. Unfortunately, it is also wrong... The proponents of neoliberal principles argue that economic growth promoted in this way will eventually 'trickle down' to improve the lives of the poor. Increasingly, however, such predictions have proved hollow" (Kim *et al*, 2000: 7).

Having thereby introduced *Dying for Growth* by critiquing neoliberal 'trickle down' visions about good growth leading to good health, Kim and his colleagues went on in the book's conclusion to venture a vision that perceptively anticipated how market-rule might morph rather than decline in the new millennium:

> "History repeats itself. While the names may change, the fundamental relations between rich and poor remain the same. Yesteryear's colonialism laid the foundation of today's neoliberalism, doubtless soon to be replaced with a new "ism" for the new millennium… Unless the fundamental relations change, however, the poor will probably continue to suffer a disproportionate amount of violence and disease" (Kim *et al,* 2000: 384).

This article does not propose to critique a new 'ism', but the main argument of the pages that follow is that global health has been remade through a form of regime change in neoliberal norms that has unfortunately preserved all too many of the inequalities between rich and poor that were critiqued by Kim and his colleagues back in 2000. It is a regime change that is theorized here in terms of the shift from the *market fundamentalist* 'rollback' emphasis on disinvestment and deterritorialization in the 1980's and 1990's, to a 'rollout' emphasis on *market foster-care* reinvestment and reterritorialization in the new millennium. This is not to suggest that austerity and socio-economic abandonment have been overcome as major threats to health. Disinvestment in health, and in health services for poor people in particular, continues to damage health outcomes around the world, including in highly unequal rich countries such as the US and UK where associated neoliberal norms of self-blame are increasingly embodied in self-harm such as suicides and drug overdoses (Case and Deaton, 2017; Hiam *et al,* 2018; Sparke, 2017; Stuckler and Basu, 2013). Nor is the point here to imply that neoliberal arguments for investing in health as a form of human capital are new. Indeed, the neoliberal framing of health spending as a form human capital investment can be traced back to Chicago School arguments from the 1960's that Gary Becker and others have continued to develop ever since (*e.g.* Mushkin, 1962; and, Becker, 2007). For these reasons, this article is not postulating some simple historical break between completely distinct neoliberal periods. Instead, the two tendencies towards disinvestment and reinvestment respectively are better seen as counter-balanced and contradictory neoliberal imperatives tied to shifting policy-making emphases. The rollout of reinvestment policy-making is theorized thus as being more actively promoted today as a response to disinvestment dynamics that nevertheless remain active.

The distinction between ‘rollback neoliberalism’ and ‘rollout neoliberalism’ is itself adapted here from an influential theorization of neoliberal regime change by geographers who also explored the spatial implications of the shifting emphases (Peck and Tickell, 2002). Following this line of analysis into global health, the shift from the roll-back to roll-out emphases can also be analyzed in terms of a double movement from deterritorializing disinvestment to reterritorializing reinvestment. This double movement of deterritorialization and reterritorialization serves thus as geographical short-hand for describing how the undermining of nationally-organized ‘horizontal’ health systems, protections and plans by rollback neoliberalism has actually prepared the ground for their uneven and patchy replacement in the new millennium by the rollout of globally-organized yet often sub-national and ‘vertical’ disease-specific interventions.

Political theorists will note that the terminology of ‘deterritorialization’ and ‘reterritorialization’ has roots in post-structuralist arguments aimed at deconstructing bounded concepts of ‘desire’ and the ‘unconscious’ in psychoanalysis (Deleuze and Guattari, 1983). This intellectual inheritance raises questions about the unconscious and no less bounded cultural politics of ‘reinvestment’ to which we will return here only in conclusion. For the rest of the article, by contrast, it is the more material political-economic geographies of global health policy-making that are the main concern. Peck and Tickell’s own attention to the spatial upheavals of rollback and rollout neoliberalism provide a useful initial orientation in this regard. Back in 2002, they suggested three main ways of theorizing neoliberalization’s geographical implications: namely, i) its forcing of local governments into global competition and regulatory reform; ii) its spatial contingency and resulting variegation across different geographies; and iii) its virus-like global mutation as it spreads across space. In what follows, the first of

these developments is addressed in relation to the deterritorialization effects of rollback neoliberalism, whereas the topic of spatial contingency is taken up in relation to the reterritorialization effects of rollout neoliberalism. But attuned to the multiple 'vectors' of 'structural pathogenesis' highlighted by Sell and Williams (2018) in their introduction to this special issue, the two sections together argue that the virus-like global mutation of neoliberalism can be traced across the whole double movement from deterritorialization to reterritorialization, remaking the policy space of global health in pathogenic ways that are ultimately embodied in uneven experiences of life and death.

The reference to 'policy space' in debates over neoliberalism and development policy is usually applied to the diverse political-economic contexts constraining the ability of governments to develop programs free from the rules of neoliberal conditionality set by the IMF and World Bank (Kentikelensis *et al,* 2016). This is also the starting point here. But, framed in terms of deterritorialization and reterritorialization, two consequential concerns with how neoliberalism reworks territorial sovereignty and governmentality are brought into focus too. First, at the macro level of neoliberal governance globally, the territorial transformations of policy space mean that we must also study how national regulations are overruled and undermined by transnational processes of global uneven development, processes that have also often led to the reterritorialization of international relations at the same time (Harvey, 2005; Tuathail and Luke, 1994). Second, at the micro level of subject formation and biopolitics under neoliberal governmentality, the territorial transformations of policy space are also intimately tied to how national citizenship has itself been recodified by market-mediated tendencies towards individualization, responsibilization and self-investment (Brown, 2015; Dean, 2010). Connecting these macro and micro scales of analysis, and thereby

hybridizing their diverse Marxian, Foucauldian and feminist inspirations, a growing heterodox literature on neoliberalization suggests that the resulting reterritorializations enlist some sub-populations into ‘graduated sovereignty’, ‘denationalization’ and ‘therapeutic citizenship’, while exposing others to pathological experiences of ‘exclusion’, ‘expulsion’ and ‘biological sub-citizenship’ (Brown, 2010; Ngyuen, 2010; Ong, 2006; Sassen, 2014; Sparke, 2017). Put simply, such work suggests that neoliberal attempts at global integration and inclusion often bring new enclosures and exclusions too. It is precisely such concerns with enclosure and exclusion that animate this article’s exploration of the limits of investments in global health that are imagined and implemented in terms of investing in human capital.

Guided by the theories and questions outlined above, the following pages offer a two-part analysis of the concatenation of rollback and rollout neoliberalism in the evolution of global health’s territorial imagination and organization. Section 1 describes the interlinked patterns of disinvestment and deterritorialization, drawing on the large and interdisciplinary literature that now exists on the pathogenic impacts of market fundamentalist neoliberalism and connecting them to the deterritorialization of the policy space of national state regulation, management and protection. Section 2 proceeds in turn to examine the rollout of reinvestment and reterritorialization, focusing on the ways in which the associated targeting of populations for health assistance has been organized by the new concern with fostering the human capital needed to survive in an ever more competitive global market economy.

1) Rollback neoliberalism and the deterritorialization of national health

Rollback neoliberalism is a useful summary term for all the policies and programs promoting privatization, market liberalization, business deregulation and the rolling back of state protections and public services. An early example was the violent overthrow of democratic socialism in Chile in 1973, involving a radical free-market make-over of the country based on the advice of economists trained in neoliberal principles at the University of Chicago (Klein, 2007). This initial neoliberal coup noted, rollback neoliberalism is more commonly associated with the broader 'structural adjustments' that were made a decade later in the 1980's and 1990's. This was a period when the political and economic instabilities bequeathed by the 'stagflationary' 1970's enabled Ronald Reagan and Margaret Thatcher to advance radical pro-market reforms in the US and UK, including the roll-back of diverse welfare-state and worker protections. Conquering stagflation in the US through the imposition of high interest rates by the Federal Reserve (itself a neoliberal rollback of Keynesian principles), in turn precipitated global debt crises that led to the IMF and World Bank imposing systemic neoliberal rollback in the world's most debt-vulnerable countries in the form of conditionality codified in Structural Adjustment Programs (SAPs).

Even though the primary goal of conditionality and the SAPs was to stabilize the global financial system, they nevertheless were very effective in enforcing rollback neoliberalism across the Global South (Packard, 2016). They thereby also came to exemplify how rollback neoliberalism worked more generally to undermine health and health systems. Tracing these damaging impacts – including the rolling back of plans for 'Health for All' that had famously been declared just a few years previously at the WHO meeting in Alma Ata in 1978 – provides a

starting point here for conceptualizing some of the wider ways in which rollback neoliberalism functioned globally to deterritorialize the policy space in which governments could have developed health systems and secured health citizenship rights for their people.

Following the unofficial rulebook of the 'Washington Consensus' about the need to 'Stabilize, Liberalize and Privatize' debt encumbered economies, SAPs obliged affected countries to reduce government deficits, cut public spending, liberalize trade and capital markets, and privatize public services in areas such as health and education. These neoliberal rollbacks constituted the core conditionalities on which loan rescheduling was conditioned by the IMF and World Bank. The resulting cutbacks thereby also came to conditionalize health, directly cutting funding for health systems and health workers, and more generally undermining the plans that many post-colonial states had been developing in the 1970's to provide universal primary health. Health outcomes were further conditionalized by neoliberal shock therapy in areas of governance beyond health itself. As was critiqued by Kim and his colleagues in *Dying for Growth* (Kim *et al*, 2000), these rollback reforms created inequalities and insecurities in the pursuit of market-led growth that also thereby functioned frequently, albeit indirectly, as deadly social determinants of ill-health. Thus, as Alexander Kentikelenis (2017) has made clear in a comprehensive review of the research that has continued to follow these intersecting lines of critique, the causal connections between structural adjustment and ill-health travelled along at least three distinguishable policy pathways: i) policies directly targeting health systems; ii) policies indirectly impacting health systems; and iii) policies affecting wider social determinants of health. Following Kentikelenis, we can use this same threefold distinction here to review the many research articles

and books that have documented evidence of the particular pathways involved as well as charting their continuation into the present.

i) Studies documenting the direct damage done by SAPs to health investments by governments are now numerous (Gloyd, 2004; Rowden, 2009; Pfeiffer &Chapman, 2010; Stuckler and Basu, 2009). Moreover, since the early experience with SAPs, health sector spending has gone on being constrained by evolving forms of conditionality that have been found to have damaging consequences (CGD, 2007; Kentikelenis *et al,* 2015). *Cuts to health spending* are thus the first and most obvious direct pathway linking neoliberal rollbacks to weakened health systems and poor health outcomes. A second direct pathway relates to *limits placed on health worker recruitment and retention*. Wage bill ceilings imposed on public sector systems through conditionality have limited the ability of governments to train and retain the right mix of health workers (Marphatia, 2009; McCoy *et al,* 2008). As a result, country led efforts to fight infectious disease and child and maternal mortality have also been impeded (Stuckler and Basu, 2009). A third direct pathway has involved *reductions in health coverage*, most frequently shifting costs to individuals through the imposition of user fees and co-payments for medicines (Farmer, 2015; Sen and Koivusalu, 1998). And a related fourth direct pathway that has often led to the roll back of health services for the poor has been *health sector privatization*, either through the opening of healthcare markets to private providers (Homedes and Ugalde, 2005), or through the NGO-ization of health service provision (a development tied to the neoliberal rollouts we turn to in the next main section). All four of these pathways consist of context contingent causal connections, and it is important to note in this regard that in some contexts conditionality has actually led to increases in health spending at the same as causing cuts in public spending on social policy and welfare

(Noy, 2011). For the same reason, though, it is equally important to highlight two sets of indirect causal connections relating to these wider influences on heath outcomes.

ii) As Kentikelenis makes clear, there are at least four additional pathways through which structural adjustment and neoliberal conditionality have indirectly impacted health systems. The first is privatization, which has often led to former public sector employees losing health benefits (Stuckler and Basu, 2013) as well as to the fragmentation of health systems (Owoh, 1996). The second is currency devaluation, which has led to spiraling forms of inflation, social insecurity and rapid rises in the costs of imported medicine. The third is conditionality enforced trade liberalization, which has often been implemented through trade agreements that make it harder for countries to manufacture or import generic drugs (Correa, 2006). And the fourth is comprised of a series of uneven impacts on aid flows, which have been mixed and by no means always catalytic of aid (Stubbs, Kentikelenis, & King, 2016). All of these dynamics have continued to conditionalize health long after the SAPs of the 1980's and 1990's, and, for the same reason, they are discussed in greater detail below.

iii) The other main set of indirect causal connections involve pathways through the social determinants of health. These are ties that have been documented exhaustively in the WHO's *Commission on the Social Determinants of Health* (WHO, 2008), as well as separately by scholars involved as contributors to the Commission (*e.g*. Labonté, & Schrecker, 2007; Labonté, *et al* 2009). A key conclusion of this body of work concerns the ways in which the roll-back neoliberal reforms associated initially with SAPs and conditionality have been globally expanded and entrenched in ways that have straitjacketed governments,

systematically blocking them from the sorts of spending on education, welfare, and housing that can protect populations from health threats, while also limiting their ability to pass and enforce laws affecting health and safety at work, and exposure to diverse toxins and environmental hazards. This removal of room for policy maneuver in has been described variously as the curtailment or shrinkage or conditionalization of the policy space in which governments can act on the social determinants of health (Labonté, *et al* 2009; Sparke, 2017). And this kind of conditionalization has continued to condition policy-making into the present, even amidst renouncements of conditionality by IMF leaders and others that set the conditionalization in motion in the first place (Kentikelenis *et al,* 2016). Beyond policy-making space, the wider ecological spaces conditioning health have also been the focus of research exploring indirect pathways between rollback neoliberalism and ill-health. Most notable in this regard are the disease emergence analyses showing how conditionality-induced cutbacks in health services have combined with other neoliberal forces ranging from the impacts of export-led agri-business on forest systems to the imposition of cost-effectiveness constraints on the administration of anti-biotics to co-create the conditions for public health disasters such as the Ebola outbreak in west Africa (Kentikelenis *et al,* 2014; Wallace *et al,* 2016) and the development of drug resistant TB Latin America (Kim *et al* 2005).

An important conclusion of all these studies of the connections between rollback neoliberalism and challenges for health is that all of the pathways have led away from the vision of Health for All articulated in 1978 at the WHO conference in Alma Ata. This certainly does not mean that the WHO has itself been entirely refashioned along neoliberal lines. A neoliberal recoding of world health as a necessary step toward world wealth has happened alongside all sorts of enduring

commitments at the WHO to universalistic programs such as those focused on essential medicines (compare Chorev, 2013, and Greene, 2011). Nevertheless, in the world beyond the WHO the neoliberal eclipse of the principles of Alma Ata has proceeded apace. This is an enduring argument of Kim's colleague Paul Farmer in his critical writing on the structural violence ensuing from structural adjustment (Farmer, 2004; Farmer *et al,* 2006). Along with Kim and the other coauthors of the global health textbook, *Reimagining Global Health*, it is also a critique that they together turn into a form of inaugural turning point in their account of the subsequent rise of contemporary global health (Farmer *et al,* 2013). Alma Ata in this narrative emerges as a zenith of global health idealism and inclusivity that Washington Consensus neoliberalism subsequently eclipsed. Building on the arguments of *Dying for Growth*, they argue thus that conditionality and SAPs in the 1980's effectively rolled back the plans made at Alma Ata for universal primary health care. They explain that other technical and professional influences tied to the intellectual advancement of selective primary health were involved too, and we will turn back to these here in relation to the counter movements towards reterritorialization examined in section 2. But first, following Farmer and colleagues, it remains critical to consider how the eclipse of Alma Ata set the pattern for how rollback neoliberalism would go on to deterritorialize national health governance and health citizenship more generally.

The WHO conference in Alma Ata in 1978 had brought together three thousand delegates from 134 nation-states. The consensus reached after their seven days of deliberation reaffirmed the WHO's own post-war founding definition of health and health rights, insisting explicitly on associated national government health responsibilities for developing universal primary health care (Cueto, 2004). The ten points

of the resulting declaration reflected numerous intersecting influences, including a shared vision that health "as a state of complete physical, mental and social wellbeing… is a fundamental human right" (Framer *et al,* 2013, 355; and Packard, 2016). Arguments from post-colonial nation-states tied to the Non-Aligned Movement and the G77 were critical in advocating this shared vision, including their allied critiques of the failings of traditional Western-dominated development (Thomas and Weber, 2004). Instead of the disease-specific biomedical campaigns associated with such development, and following arguments advanced by WHO director Halfdan Mahler, there was great emphasis on the new model of primary health care already being planned in countries such as Costa Rica, Mozambique, Tanzania, China and Cuba. For the same reasons, the delegates and declaration both underscored the wider need for improvements in the social and economic sectors impacting health as well. But ironically and tragically, it was precisely through these same social and economic sectors – operating as vectors for a mutating neoliberalism – that conditionality and SAPs subsequently came to have their rollback effects in reversing the legacy of Alma Ata in the 1980's.

To be sure, the conference concluded without generating any detailed guidelines about implementation, and also without securing any global funding. These drawbacks certainly help explain why countries were ill-prepared in the 1980's to follow the recommendations for expanding national health systems and honoring the principles of inclusive national health citizenship with universal access to primary health care. Packard argues that the health policy-making lessons drawn from the success of smallpox eradication (and the failure of the WHO's malaria eradication efforts) also played an additional role in the return to vertical, disease-specific approaches in international health (Packard, 2016). But he, along with the authors of *Reimagining Global*

Health, and so many other critical accounts of rollback neoliberalism, all agree that it was conditionality and SAPs that most actively rolled back the plans made at Alma Ata, making their funding and implementation impossible. Both the visions of national government responsibility and of primary health universality that had been laid out in 1978 were thereby undermined, clearing the policy space for its subsequent recolonization by global projects emphasizing selectivity in the years that followed.

Before we turn in Section 2 to the reterritorializing effects of selective reinvestment, it is critical here to highlight first how the deterritorializing effects of rollback neoliberalism have not disappeared in the present. Instead, from the first waves of pro-business reform and structural adjustment in the 1980’s and 1990’s on into the new millennium, the mutating virus of market-led transformation has gone global, making the discourse of globalization itself do double duty as a synonym for neoliberalization, and expanding market rule across countries that never knew classical liberalism and welfare state liberalism in the first place (Sparke, 2013; Zhang and Peck, 2014). With this global expansion and entrenchment of neoliberalism have come at least three distinct kinds of deterritorialization, and with each we need to trace how disinvestment and regulatory rollbacks have undermined possibilities for national health governance and national health citizenship just as SAPs undermined the plans made at Alma Ata.

First there is the evolving impact of *ongoing austerity and conditionality.* Compounding all the disinvestment dynamics generated by SAPs in the 1980’s and 1990’s, structural adjustment was reworked going into the new millennium through the IFI’s ‘Heavily Indebted Poor Country’ (HIPC) programming and repackaged in the

form of Poverty Reduction Strategy Papers (PRSPs). The argument from the World Bank and IMF themselves was that these new country-specific rulebooks for rollback neoliberalism would be authored and therefore 'owned' by the countries subject to their rules (World Bank/IMF 2002). In this way, PRSPs were meant to be comprehensively country-driven, results-oriented, and partnership-oriented (Klugman, 2002). With their declared focus on assisting countries in poverty reduction, they were also supposed to look less like a neocolonial imposition of programs predicated on the financial stabilization interests of the first world (Craig and Porter, 2003). But even as they were announced as a less draconian form of neoliberal nudging towards poverty reduction guided by public participation, PRSPs have continued to enforce market discipline and associated budgetary austerity by making business friendly policy-making an enduring condition for debt management and debt relief in heavily indebted countries (Gould, 2005; Wamala *et al,* 2007). Moreover, whereas this market-compliant conditioning of policy space by PRSPs remains binding, IMF-approved poverty reduction proposals for innovations such as social expenditure floors have almost always been left as 'non-binding' (Kentikelenis *et al,* 2016: 21).

SAPs may no longer be the preferred term of the IFIs, but the sapping of health system capacity and health worker morale continues nonetheless (compare Gloyd, 2004, and Strong, 2017). Meanwhile, efforts to develop sector-wide approaches or 'SWAps' to address such problems with globally sourced development assistance have also been frustrated by the ways in which the ongoing austerity has constrained how much aid can be placed 'on budget' in national accounts (Pfeiffer *et al* 2017). Indeed, these constraints have now combined with the selective disease-targeting tendencies we will explore in section 2 to lead to disinvestment in SWAps since 2010. In

the period from 2010 to 2016 the percentage allocation of development assistance for health to SWAps has thereby declined by 13%, for an absolute disinvestment total of $540 million (see Figure 1 below).

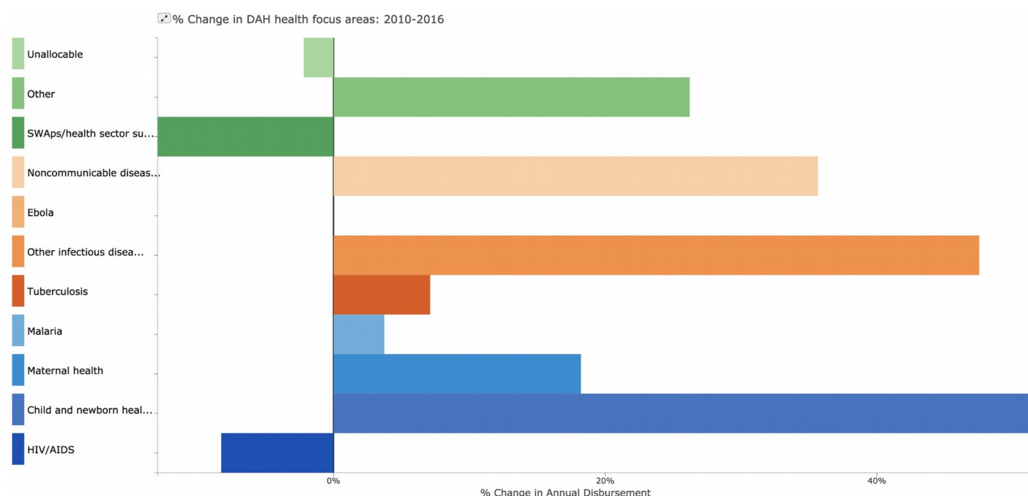

Figure 1: Graph showing % change in DAH focus areas from 2010-16 (IHME, 2018)

Second, often enforced in poor countries by SAPs, but impacting middle income and wealthy countries too, another form of neoliberal rollback driving the deterritorialization of national health systems and health citizenship has been *trade and financial liberalization.* Globalized in the name of liberalizing trade and rolling-back national regulations that inhibit global competition, trade rules have expanded and enforced new market-based regulations and mechanisms that powerfully circumscribe the policy space of national governments. Both the monopoly-creating expansion of intellectual property protections and the competition-creating effects of trade liberalization must be considered in this way in terms of their deterritorializing impacts on national health governance and citizenship. In addition, the autonomy of national governments worldwide has been further undermined by deregulated capital markets, financial volatility, and

the ability of powerful investors to discipline non-compliant countries with downgraded ratings and disinvestment. Scholars of global health have highlighted the pathogenic impacts of all three of these vectors, both as they intersect and as they operate autonomously.

Through international agreements such as the WTO's Trade Related Intellectual Property protections (TRIPs), IP patent extensions across both time and space have created monopolies that systematically increase drug prices, making essential medicines too costly even for some of the world's wealthiest countries and rolling back treatment access for millions (Craddock, 2007; t'Hoen, 2009). Pharmaceutical companies and their representatives argue that the monopoly prices that are secured by global patenting are what provide the profits needed to incentivize investment in research and development into new breakthrough medicines. But even a recent UNDP panel that included corporate representatives concluded that the system was broken, effectively incentivizing disinvestment in innovations that might respond to urgent global challenges such as drug resistant disease (UNDP, 2016). Other critics further highlight the ways in which the globalization of IP protections has also been rolling back some of the few national patent regimes – such as India's – that have allowed for the development of cheaper generic versions of essential drugs (Kapczynski, 2009).

Despite some hard fought victories around access to ARVs in the fight against AIDS (Heywood, 2002), efforts to respond to the more global rollbacks in access continue to be rolled back themselves, including through new 'TRIPS-plus' rules designed to forestall the development of generics by patenting and thereby privatizing the scientific results of drug trials; a complex problem which also raises complex questions about researching such preemption in practice (Sell, 2007; Shadlen,

this issue). Pharmaceutical companies may sometimes concede to patent overrides in a specific case of a first line drug, only so as to better position themselves for market monopolization with second line drugs later (Biehl, 2007). They may go along with the Doha Declaration on the ability of governments to make exceptions in cases of national emergency, all the while knowing that most countries lack the production capacity or importation options that make such exceptions actionable (t'Hoen, 2009). And they are increasingly embracing accommodation with tiered pricing schemes, hoping that this will forestall the wider use of compulsory licensing by governments even as it allows for new forms of price-fixing sanctioned by the world's leading global health agencies (Williams *et al,* 2015).

Trade-based rollback neoliberalism works in less complex, but in more wide-ranging ways when it comes to the competition and harmonization effects of trade liberalization. Advocates of free trade prefer to see the associated rollback of tariff and non-tariff barriers to trade in terms of economic efficiencies, linking trade liberalization in this way with greater consumer welfare. But by freeing companies to move to low cost and low regulation locations, and by forcing states to compete to keep employers by lowering their taxes and standards, these same competitive economic processes lead to diminished health citizenship rights as they undermine health and safety at work protections, overrule environmental and public health protections, and reduce the tax receipts that can pay for public health services (Labonte and Schrecker, 2007; Labonte *et al*., 2009; Peckham *et al*, 2017). The removal or harmonization of non-tariff barriers to trade also make it much harder for governments to restrict the flow of health hazardous goods such as obesogenic foods (Snowdon and Thow, 2013). Combined with the disciplinary and volatility effects of deregulated financial

markets, the crises created by these global market forces further increase the challenges for governments seeking to protect public health (Benatar *et al.,* 2011). And, as Ted Schrecker argues in this special issue and elsewhere, these same dynamics that undermine government capacity simultaneously serve to exacerbate the vulnerability-inducing machinery of deregulated capitalism itself (Schrecker, 2016). It is to these impacts of rollback neoliberalism on the underlying social determinants of health that we turn next.

Third, the spread of rollback reforms through the social determinants of health in general has been described by many as a form of 'neoliberal epidemic' (Farmer, 1999; 2003; Schrecker, 2016; Schrecker and Bambra, 2015). This epidemiological metaphor is especially useful when it comes to highlighting how the different vectors of vulnerability generated by rollback neoliberalism come together to enable what Sell and Williams in this volume call structural pathogenesis in the social body politic. It also obviously gives an additional epidemiological meaning to Peck and Tickell account of neoliberalism's virus-like mutations as a series of ideas and imperatives spreading across space globally. Critical explorations of these viral movements as they relate to the movement of real viruses have shown in turn that whether the mutations work through political, economic or ecological pathways they end up becoming embodied in unequal experiences of illness, infection and even sometimes, as Rob Wallace and colleagues have shown, the evolution of lethal new viruses too (Wallace *et al* 2016). In other words, neoliberal epidemics are far more than just a metaphor. Their illness inducing impacts lead through the social determinants of health to real restrictions on national health governance and real, which is to say embodied, exclusions from health citizenship.

In the actual epidemiological literature on the social determinants of health it is normally metrics of socio-economic inequality – including its

causes, consequences and the governmental capacity to moderate both – that serve as the main indicators of the neoliberal virus. In their 2008 report on the Social Determinants of Health, for example, the key conclusion of the WHO commissioners was that: "Inequalities are killing people on a grand scale" (WHO 2008: 6). They did not use the words rollback neoliberalism or deterritorialization to describe the causes of increased inequality, but they did highlight how the 'structural drivers' of 'bad policies, economics, and politics' had traversed territory and gone global with market-led globalization. "These 'structural drivers'," they concluded, "operate within countries under the authority of governments, but also, increasingly over the last century and a half, between countries under the effects of globalization. This toxic combination of bad policies, economics, and politics 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).

Appearing in early 2008, the report arrived at the best and worst of times. An epic crisis caused by financial deregulation rocked the world just as it was being published. At once vindicating the Commissioners' arguments about toxic economics and politics, but also replacing their concern for all those left behind by global health improvements with a new frenzy of global concern for the 'too big to fail' economic actors at the center of the global meltdown. Yet again an ideational legacy of Alma Ata – in this case the WHO's 2008 report's emphasis on the problems of inequality – was eclipsed by a material break-down in markets liberalized by rollback neoliberalism.

The following year, in an extraordinary speech before the World Health Assembly in 2009, the WHO Director General Margaret Chan did her best to bring back a social-determinants approach to the multiple

crises of market fundamentalist policy-making. She also did not refer to rollback neoliberalism explicitly, but her epidemiological overview presented a compelling critique nonetheless. As such it is a fitting summary with which to close this review of the damaging deterritorialization effects on national health governance and health citizenship right around the world.

> 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. Too many models of development have assumed that living conditions and health status would somehow automatically improve as countries modernized, liberalized their trade, and improved their economies. This did not happen.” (Chan, 2009)

Rollout neoliberalism and the reterritorialization of global health

In the aftermath of the global financial crisis and of the subsequent ‘great recession’ many voices previously associated with market fundamentalist policy-making started to declare that neoliberalism had been oversold (*e.g.* Ostry *et al,* 2016). But amidst this revisionist clamor, it seems as if the end of neoliberalism has itself been oversold,

and often, as with disingenuous disavowals of conditionality, in ways that obfuscate ongoing forms of market rule (Kentikelensis *et al,* 2016). Rather than being rejected altogether, it appears more accurate to argue instead that neoliberalism is being remade. This is the first of two reasons for emphasizing the regime change of rollout neoliberalism here. The second is that by focusing on the rollout process it is also possible to trace the reterritorializing impacts on global health governance and citizenship. To do so we need to focus in particular on the machinery of calculation, accounting and funding through which today's discourses demanding more investment in global health also turn global health population targets (such as those included in the UN's Sustainable Development Goals) into territorial targets for intervention.

It needs noting at the outset that when Peck and Tickell first distinguished rollout neoliberalism from rollback neoliberalism their main focus was on the disciplinary rollout in the UK and America of interventionist innovations in social policy such as welfare-to-workfare reforms and punitive inner-city policing. They were interested in this respect in how these neoliberal rollouts were designed deliberately to remake societies in ways that might protect rollback reforms from unrest by those who had been excluded and dispossessed. "No longer concerned narrowly with the mobilization and extension of markets," they argued, "[rollout] neoliberalism is increasingly associated with the political foregrounding of new modes of 'social' and penal policy-making, concerned specifically with the aggressive reregulation, disciplining, and containment of those marginalized or dispossessed by the neoliberalization of the 1980s" (Peck and Tickell, 2002: 389). They suggested in turn that the resulting neoliberal policy repertoire included:

> the selective appropriation of 'community' and nonmarket metrics, the establishment of social-capital discourses and techniques, the incorporation (and underwriting) of local-governance and partnership-based modes of policy development and program delivery …, [and] the mobilization of the 'little platoons' in the shape of (local) voluntary and faith-based associations in the service of neoliberal goals" (Peck and Tickell, 2002: 390).

Both the contrasts and continuities with the rollout of global health as an investment in human capital must be addressed carefully. On the one side the aggressive forms of 'neopaternalism' identified by Peck and Tickell, along with their often racist and sexist assumptions about undeserving underclasses, are a far cry from the life-saving and inclusionary interventions of contemporary global health. Indeed, many of today's calls for investing in global health are made explicitly in the name of fighting racist exclusion and empowering women and children. Moreover, it needs to be underlined that the global civil society activism that has driven demands to make global health a reality (and not just a set of programs) is by no means reducible to neoliberalism. Indeed, in cases such as South Africa's *Treatment Action Coalition* it has been explicitly anti-neoliberal (Heywood, 2002). Nevertheless, this has not stopped neoliberal logics and practices from coming to shape how global health programming is done. In turn this means that many other aspects of the policy repertoire of rollout neoliberalism described by Peck and Tickell – partnerships, metrics of non-market capital, and the mobilization of volunteers and NGOs in the place of government services – have come to shape how global health in the new millennium is practiced. And these influential practices raise challenging questions about the limits of global health when imagined and implemented as a compensatory kind of rollout neoliberalism.

Rather than judging these questions about limitations in an absolutist or moralistic way, the approach here is to argue that the limits need to be explored in terms of how certain neoliberal logics constrain and contort the resulting interventions. Global health has rarely been imagined in terms of containing unrest, although some geopolitical arguments were made in the US that investment in AIDS prevention and treatment was needed to stop AIDS orphans becoming terrorists (Ingram, 2009). Still less does global health involve penal policing and the incarceration of the dispossessed. But insofar as it has been imagined in terms of reinvesting in those who have suffered disinvestment, and insofar as these logics and languages lead to the subordination of universality to selectivity, they can be evaluated for the ways in which they have also reterritorialized global health.

Three forms of reterritorialization can be charted that to varying degrees represent the flip sides of the deterritorialization dynamics described in Section 1. First, we consider the selectivity of 'investment in health' arguments and the ways in which the search for so-called 'best buys' or cost-effective returns on investment leads to exclusions. Second, we examine the related patterns of sub-national targeting and the ways this leads to a return to disease-specific vertical interventions in often enclaved sites of therapeutic citizenship. And third we consider how the intersection of these global health investment logics with the self-investment practices of personalized medicine is nevertheless socially-situated in ways that create an ongoing struggle over the meaning and scope of global health citizenship.

First of all, the beginnings of today's *investment in health* trends can themselves be traced back to the eclipse of the idealism of Alma Ata. While the declaration's emphasis on Primary Health Care (PHC) was

rendered impossible to implement due to SAPs and conditionality, its replacement by something far less universal and inclusive was enabled by the counter-movement of Selective Primary Health Care (SPHC). For PHC promoters at the WHO, SPHC appeared thus as a 'counter-revolution' (Newell, 1988). Supported by the Rockefeller foundation, UNICEF, USAID and the World Bank, SPHC was argued to be a cost-effective way of targeting interventions on a limited number of diseases in order to maximize the number of lives saved with limited resources. During the 1980's, as resources in debt burdened countries became still more scarce due to conditionality and SAPs, it was precisely this SPHC emphasis on cost-effective targeting that grew in influence, promoted as a way of delivering what an influential UNICEF report called *Adjustment with a human face* (Jolly *et al,* 1984).

The selectivity of UNICEF's 'Child Survival' programming, led by Jim Grant's calls for 'emergency' action with GOBI (Growth Monitoring, Oral Rehydration, Breast-feeding and Immunization), thereby came to dominate over the PHC plans Mahler had been championing as director of the WHO (Cueto, 2004). This is all important to note because it has been the same cost-effectiveness concern with rationing scarce resources that has created the basis for today's financialized focus in global health on maximizing returns on investment. However, along the way the Washington Consensus on market fundamentalism that contributed to the health emergencies amidst which SPHC was first justified has morphed itself into a new consensus on investments in market foster-care (Mitchell and Sparke, 2016).

At the World Bank and among economists in DC the original Washington Consensus was always supposed to encourage investments in primary health care and education. This was in fact the second reform on John Williamson's (in)famous original list of ten

Consensus norms (Williamson, 1990). The problem was that all the austerity forced on indebted countries by conditionality and SAPs made such investments by national governments impossible. Nevertheless, in 1993 the Bank's *Investing in Health* report gave a new impetus and direction to investment thinking (World Bank, 1993). It still retained the consensus cant about achieving health through the pursuit of pro-market macro-economic growth policies, including the promotion of privatization and user fees.

However, in addition it also included a new SPHC-inspired attention to making targeted cost-effective investments in 'minimum packages' of interventions such as immunizations and the treatment of childhood diseases. To rank and justify the priority of such packages in terms of return on investment, the report in turn presented metrics of the Global Burden of Disease (GBD) as measured in terms of Disability Adjusted Life Years (DALYS), the latter being innovatively calculated for the first time as the sum of years lost to premature death and to life lived with disease and disability due to a comprehensive list of causes. The goal of creating this single globally comparable metric was not just to compare the burdens created by different diseases in different contexts. In addition, there was an underlying economic efficiency imperative as well. This was to enable cost-effectiveness comparisons of the number of DALYS averted by different targeted interventions per dollar spent, thereby enabling the comparison of returns on investments by type of intervention, by cause of illness, and by country across the whole world.

DALYS-per-dollar cost-effectiveness comparisons have now become the most influential guide for investment in global health. But even as they allow for reinvestment where rollback neoliberalism led to disinvestment, their employment in selecting 'best buys' in global

health still encodes certain neoliberal assumptions. Critics highlight in this way that the method's underlying assumptions about economic productivity, and the associated age and disability weightings used to calculate DALYS, assume that the capitalist productivity potential of human capital is the ultimate measure of human value (Kenny, 2017; Laurie, 2015). Kenny further underlines how this economization of life represents a fundamental shift from 'Health for All' to 'Health as an Investment' (Kenny, 2017).

More generally, the calculus of cost-effectiveness and all the associated investment language now pervades much of global health. The big new global health organizations with their focus on maximizing returns on investment in their own selective issue areas are all good examples. The *Global Alliance for Vaccines and Immunizations* (GAVI), *Rollback Malaria*, and most notable of all for its overarching investment fund approach, the *Global Fund to Fight AIDS, TB and Malaria*, are constantly seeking to fine-tune and leverage their investments based on arguments about their cost effectiveness. Wide-ranging investment experiments are also being developed by many other public-private partnerships (PPPs), all with a view to maximizing returns on goals sets by donors (McGoey *et al,* 2011; Ruckert and Labonté, 2014). And the Wall Street styled search for fast returns and best buys has even given the design of brochures devoted to the causes of global health the look and feel of financial investment magazines with dollar signs, geared-globes, and corporate sponsorship from big pharma all included.

The arguments made in favor of taking the new investment approach to global health are clear enough. It rationally and transparently rations scarce resources, directing them selectively to the health interventions that will relieve the biggest burdens. It brings clear

metrics of accountability, reducing risks of waste and corruption. It creates the possibility of both leveraging and hedging donor funding through periods of budgetary upheaval and austerity. It communicates global health needs and opportunities in the terminology of global finance and thus of global power and global donors. And, perhaps most important of all, it is ultimately about maximizing returns measured in lives saved rather than riches gained. But with all these arguments noted, it is equally important to highlight how the resulting approaches tend to enclose health governance within selective health burden silos and thereby also exclude from global health citizenship people suffering from the wrong diseases in the wrong places, including especially populations with non-communicable diseases and other health burdens that are not readily treated with biomedical interventions parachuted in from afar. Diabetics in Kenya, for example, have been described thus by medical anthropologists as enduring the 'biological sub-citizenship' of patchy fee-based treatment when compared with the comprehensive and free medical care that has been won for HIV-positive patients in donor-funded AIDS programs (Bosire *et al*, 2018). It is precisely these problems of selective treatment, exclusion from universal primary care, and biological sub-citizenship that are the hallmarks, indeed landmarks, of reterritorialization.

For many critical commentators, the problems of enclosure, of exclusion and of global health interventions administered from afar can largely be understood as a reversion to historical norms established under imperialism and the organization of colonial medicine. Packard’s historical comparisons of contemporary global health with colonial medicine make a compelling case in this way that there are six key continuities (Packard 2016: 8-9).

i) The imposition of health interventions from afar with little local collaboration.

ii) The bias towards biomedical technologies aimed at selected problems.

iii) The bias against primary health and basic health services.

iv) The tendency to tackle health problems only on an emergency basis.

v) The devaluation of local knowledge in contrast to faith in western medicine.

vi) The belief that improving health will lead to wealth.

In each case, these continuities are clear. But insofar as their contemporary reproduction has been enabled as a form of rollout neoliberalism following rollback neoliberalism, it is also possible to argue that the historical regime change in neoliberalism itself has led to many of the resulting reterritorializations.

Where market fundamentalism led to policies that undermined local governments, neopaternalist patterns of market foster care tend to turn local communities into the smiling but still non-governing groupings of what one critic has called ‘recipiency’ (Kenworthy, 2014). Where conditionality and SAPs made universal primary health care impossible, cost-effectiveness analyses bring biomedical best buys and high tech fixes. Where the 1980’s and 1990’s bequeathed global health crises such as the AIDS pandemic, the new millennium has created serial calls for tackling each crisis in a selective fashion as a targeted focus for emergency action. Where SAPs eviscerated local control and simply overruled local expertise, the global health counterparts of PRSPs such as Global Fund country-coordinating mechanisms (CCMs) advertise country ownership while still pre-selecting the main priorities for intervention. And where the faithful of market fundamentalism believed that adjustment and austerity would eventually lead through wealth to health, the advocates of market foster-care insist that their targeted investments in health will lead to

wealth (Mitchell and Sparke, 2016). Undoubtedly, this post-Washington Consensus neoliberal revisionism has roots in the wider social investment policy norms articulated by self-styled 'Third Way' leaders such as Tony Blair and Gerhard Shröder at the turn of the millennium. "The most important task of modernization," they maintained, "is to invest in human capital: to make the individual and businesses fit for the knowledge-based economy of the future" (quoted in Jenson, 2010: 64). But leading to a New Washington Consensus actively invested in by philanthrocapitalists such as Seattle-based Bill Gates, this future oriented ROI mindset has further narrowed the focus for investment to very specific global health targets. It is to the resulting reterritorialization that we now turn.

Target-setting that repeatedly turns disease and demographic targets into territorial targets for intervention is in fact the second major manifestation of reterritorialization associated with the selectivity of contemporary global health investments. In a useful warning aimed at policy-makers, the public health specialist Laurie Garrett summarized the practical problems well:

> Legislatures in the major donor nations should consider how the current targeting requirements they place on their funding may have adverse outcomes. For example, the U.S. Congress and its counterparts in Europe and Canada have mandated HIV/AIDS programs that set specific targets for the number of people who should receive ARVs, be placed in orphan-care centers, obtain condoms, and the like. If these targets are achievable only by robbing local health-care workers from pediatric and general health programs, they may well do more harm than good, and should be changed or eliminated” (Garrett, 2007: 16).

But despite such warnings, change seems unlikely because of the overarching regime change of neoliberalism that has led to the rollout of investment logics in landscapes devastated by prior rounds of rollback. With its focus on making cost-effective investments in these landscapes, global health keeps setting targets, and this target-setting is what leads in turn to the challenge of identifying particular places for intervention on the ground. A good example of this approach is provided by the work of Jeffrey Sachs. A former market fundamentalist advisor of radical rollback shock therapy, Sachs has gone on to become a major advocate of market foster-care investments in global health. As such his work moves repeatedly between global forms of target setting such as the Millennium Development Goals – which he was central to establishing at the UN – to the practice of identifying spatial targets for intervention on the ground – such as the Millennium Villages that his Earth Institute at Columbia has established for targeted investments in Africa. The overall approach is imagined in terms of making precisely targeted investments in places stuck in cycles of poverty and ill-health, all with the vision of improving health and fostering resiliency in the local populations so that they can climb the so-called ladder of global growth.

The more generalized transformation of population health targets into spatial targets is what creates the need for investment advice articles with titles such as “WHERE TO INVEST IN GLOBAL HEALTH IN 2014”. But as Garrett argued, it also creates problems on the ground such as internal brain drain, problems that can further damage health systems already undermined by austerity. Simon Reid-Henry has observed in this regard that: “Hitting one’s targets may indeed be the quickest way to missing the goal.” (2016: 721). What he means by this is that the global health target-setting and associated accountability metrics lead to such narrowly selective interventions that the larger goal of making

global health truly global and inclusive for all is forever put on hold. “Mainstream global health,” he argues, “is thus best thought of not so much as a solution to the problem of actual health need, but as a solution to the problem of ill-health as an externality of global capitalism” (Reid-Henry, 2016: 722).

The recent *Lancet Commission on Investing in Health* is a good illustration of where this market-accommodating investment approach leads global health (Jamison *et al.,* 2013). Focused on increasing economic growth and the economic value of additional life-years, the Commission’s report argued that through expert analytical targeting of the best investment opportunities “good reasons exist to be optimistic about seeing the global health landscape completely transformed in this way within a generation” (Jamison *et al.,* 2013:1947). The authors were no doubt right about the transformations, but not necessarily in the sanguine conclusions they reached about a grand global convergence in improved world health outcomes by 2035. They made an upbeat investment pitch for sure, and it notably reworked the inevitability assumptions of traditional trickle-down neoliberalism for the cause of persuading policy-makers that health investments will inevitably make the world a more prosperous as well as a more healthy place in a short space of time. But the more likely landscape of transformation, the one in fact that has already been significantly transformed by all the investments, exists on the ground where the selected population level targets become spatial targets for intervention. Due to all the associated disease-specific and place-specific targeting, and due also to the attendant tendencies towards non-collaborative, non-sustainable vertical interventions implemented with public-private partnerships, it has become a patchwork landscape of enclosure, exclusion and fragmentation.

Surveying the patchy and fragmented landscape of global health, a group of leading global health equity advocates responded to the Lancet *Investing in Health* report arguing that it represented a deeply concerning "re-run of the 1993 World Development Report, whose policies contributed to the shrinkage of government institutions and massive privatisation and fragmentation of health-care systems, effectively decreasing coverage and accessibility" (Chiriboga *et al,* 2014). Their critique concluded by arguing that the Commission's report had presented:

> a biased perspective reminiscent of failed neoliberal prescriptions…. The recommendations are based on the principle of return on investment, not on health equity, while creating a double standard: one for the rich and another for the rest of us" (Chiriboga *et al,* 2014).

Another upshot of the subordination of universality to selectivity under the targeting logics of rollout neoliberalism has been the transformation of the meanings of health citizenship and associated health rights in targeted sites of investment. Reflective of the shift away from the standards of equity and inclusion underlined by Chiriboga and colleagues, the disease-specific investment approach appears instead to tend towards the creation of what Vinh-Kim Ngyuen has called 'Republics of Therapy' (Ngyuen, 2010). As an anthropologist physician, Ngyuen is especially interested in how his AIDS patients in west Africa feel obliged in such places to narrate their own seropositivity in such a way as to qualify for the disease-specific treatment that such enclaves of care are offering. In other words, to qualify for health rights and health citizenship in the disease-specific global health republics, patients have to present with the right disease, in the right place, at the right time. And just as the roll-out investments and interventions are siloed by selectivity, Nguyen

thereby depicts a form of therapeutic sovereignty in the republics that creates health citizenship rights and care for some but, because of the reterritorialization of disease-specific health rights, not for all. These enclaving effects appear to intersect in turn with the wider spatial pattern of creating securitized compounds and enclosures of intervention in contemporary neoliberal aid efforts more generally (Smirl, 2015).

A third instantiation of these reterritorialized sovereignty effects relates to the ways in which *the biomedical bias of global health interventions can fail to address the wider social determinants of health*. Another physician anthropologist has described in this way how his patients receiving ARVs in Mozambique suffered terrible hunger pangs due to the fact that the biomedical treatment regime did not guarantee decent food even as it led their recovering bodies to require new nourishment (Kolofonos, 2010). “All I eat is ARVs,” complained one such patient, describing in a single sentence the obvious disconnect of personalized biomedical HIV/AIDS treatment from the wider political-economic context of daily survival. Elsewhere in Kenya, South Africa and India, global health scholars have shown that a disease such as diabetes can be overlooked as a comorbidity alongside AIDS and TB when the treatment of the overall ‘syndemic’ of a wider health-damaging context is replaced by disease-specific treatment in a specific place (Mendenhall *et al,* 2017).

This kind of disconnect represents a kind of reterritorialization that is also repeated in a rather different way in the cubicles of personalized medicine in much wealthier contexts. Providing the individualized healthcare ‘consumer’ with diverse self-investment opportunities, the personalized metrics of disease management are increasingly disconnected from everyday life and a holistic consideration of the

social determinants of health. When illness comes it tends to be reframed thus in terms of personal responsibility tied to individual behaviors and risk factors, creating tendencies towards self-blame that represent a secondary health burden or what some have described as the 'double burden' of neoliberalism (Glasgow and Schrecker, 2015). For more enfranchised biological citizens of personalized medicine, the resulting rollout neoliberal vision is about managing risk and maximizing returns on biological self-investment. But for many others, the outcome is a biological sub-citizenship of self-blame associated with what remains structurally-foreclosed self-investment. As a form of biopolitical governmentality, these effects would seem to align exactly with what Michel Foucault anticipated in his lectures on how health care was being reimagined in American neoliberalism.

> [A]ll activities concerning the health of individuals will thus appear as so many elements which enable us, first to improve human capital, and second to preserve and employ it as long as possible. Thus all the problems of health care and public hygiene… can be rethought as elements which may or may not improve human capital" (Foucault, 2008: 230).

Foucault's points about human capital now bring us back full circle here to the *Human Capital Project* with which this article began. Clearly for Jim Kim there is no contradiction between this World Bank project and his critique of 'trickle down' neoliberalism in *Dying for Growth.* "Measuring the economic benefits of investments in human capital," he contends, "does not diminish the social and intrinsic value of better health and education" (Kim 2018b: 100). But as is noted by the authors of the first global health metrics analysis of the rankings envisioned by the project, the calculus of value does nevertheless shift. "[T]he emphasis on human capital," they note, "signals a shift toward greater consideration of the productive value of health and education,

in addition to humanitarian objectives" (Lim *et al,* 2018: 1230). Considered thus as one more example of rollout neoliberalism preoccupied with producing value in a competitive global economy, and considered as an investment-oriented project tied to making advice to countries about best health and education buys in human capital, the project seems prone from the start to some of the same problems of reterritorialization identified above. It is with some reflections on these problems that we will therefore now conclude.

Regime change and the return of history: concluding reflections

When Kim and his colleagues wrote in *Dying for Growth* about how history repeats itself, and when they thereby warned about how a new 'ism' might replace neoliberalism in the new millennium, they effectively anticipated the regime change from rollback neoliberalism to rollout neoliberalism that has been described in this article. They also might well have been silently quoting Marx's reference to Hegel and history's repetitions at the start of *The Eighteenth Brumaire.* Marx himself continued another few lines later to describe how the "tradition of all dead generations weighs like a nightmare on the brains of the living" (Marx, 1852). Of course, this was most likely *not* what the editors at Davos were thinking about when they published Kim's description of the *Human Capital Project* under the title of 'What keeps the President of the World Bank up at night?' Nevertheless, it surely does raise questions about how the traditions and constraints of rollback turned rollout neoliberalism might still weigh like a nightmare on the reimagination of global health today.

One approach to exploring such questions might be personal and psychoanalytical, perhaps concerning reinvestment thinking as a form compensatory psychological investment in utopianism amidst a deeply

dystopian world. But inspired in part by Deleuze and Guattari's refusals of such gestures, this is not the interpretation offered here. Instead, guided by more material re-workings of the two poststructuralist's terminology – the terminology of deterritorialization and reterritorialization – the overarching aim of this article has been to put the programmatic rollout of developments such as the *Human Capital Project* into a larger global context of developmental regime change. Important interventions elsewhere have asked whether Kim's own biosocial approach has remade the World Bank or has been 'resocialized' by world banking (Bond, 2012 & 2019; Horton, 2013 and 2017; and Shaffer, 2018). By contrast, the focus here on the context of neoliberal regime change suggests that Kim's presentation of the *Human Capital Project* is of a piece with the new neoliberal tendencies towards reterritorialization.

Against this conclusion at least two important objections might be made. The first counter-argument is that there is a big difference between financial investment in human capital and the kind of spending on global health and education that Kim and his colleagues seek to incentivize. Advocates of humanitarianism, human rights and inclusive citizenship have often had to present their arguments in investment language in the past, and Kim's interventions at the World Bank may have been no different. It is worth remembering in this respect that when Edwin Chadwick was campaigning for better treatment and health for the poor in Victorian England, he too turned to an argument about cost-effectiveness: in short "the expenditures necessary to the adoption and maintenance of measures of prevention would ultimately amount to less than the cost of disease now constantly expended" (quoted in Rosen, 1993: 187). In comparison with this gentle accounting, Kim's call to shaming action announced in a speech at Harvard sounded far more radical.

> “We’re going to do a ranking, from 1 to 150. We’re going to rank countries based on their stock of human capital. [As a result] “Heads of state, ministers of finance, must be terrified of not investing more in their people… Let’s make it very uncomfortable to not invest in health and education” (Kim quoted in Shaffer, 2018).

Another objection to the argument that the *Human Capital Project* is just another example of rollout neoliberalism relates to arguments by Kim and his colleagues in *Reimagining Global Health* about contextualizing and diagonalizing global health delivery. The book is forthright in its critique of the rollback relays between “neoliberal policies and the witting and unwitting weakening of public-sector health systems” (Farmer *et al,* 2013: xix), and it is in this same critical spirit that it also advocates for diagonalization as a strategy of using vertical investments in disease-specific programs to support horizontal health systems and their public sector governance.

These arguments align in part with some of the recommendations of the WHO *Maximizing Positive Synergies Collaborative Group* on which Kim worked (WHO, 2009). But they are given great contextual depth and accountability by all the work undertaken by *Partners in Health* (PIH) in countries such as Haiti, Peru and Rwanda. As such, this work might be said to re-contextualize reterritorialization, but collaboratively and with maximal respect for local community leadership and expertise. Human capital investment incentivization is still acknowledged in such efforts as vulnerable to the same reterritorializing constraints and contortions of global health investment more generally, but following the model of work by PIH, Kim’s colleagues in reimagining global heath suggest that the problems can be mitigated in practice. Reimagined as attempts to extend care where both colonialism and neoliberalism cut if off, such work therefore involves explicit efforts to overcome the limits of

reterritorialization through various strategies for fostering health systems strengthening as well as repairing, rather than just managing, the damage done by market forces.

Elsewhere work on Health Systems Strengthening (HSS) suggests that supposedly diagonal lines of investment nevertheless often end up just augmenting vertical delivery system investments in ways that are distant from universal government-run primary health care (Storeng, 2014). Despite heroic attempts by some groups to redirect vertical investment approaches in diagonal directions, therefore, investment imperatives and cost-effectiveness calculations continue to drive much of global health in highly selective and thus both patchy and exclusionary directions. They certainly challenge the deterritorializing disinvestment legacies of rollback neoliberalism, but their neoliberal rollout of targeting logics aimed at maximizing returns on reinvestment leads nevertheless to a patchwork of reterritorializing interventions that in turn tend to enclave and thus limit access to the reconstructive effort. It is precisely this patchy and limiting effect of reterritorialization that this article has sought to examine and explain in terms of neoliberal regime change. Whether or not the *Human Capital Project* can be radically recontextualized in ways that avoids these problems with reinvestment remains to be seen.

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