CHAPTER 7

Neoliberalism and Social Investment: Paving the Way for Medicalization and Psychologization

Mareike Ariaans and Nadine Reibling

In the three previous chapters, we illustrated examples of medicalization and psychologization in the context of unemployment, poverty, and childhood (problems). While each social problem has its unique characteristics that shape the specific form and consequences of medicalization and psychologization dynamics, these changes nevertheless need to be evaluated in the light of a common political and societal context. Over the last three decades, neoliberalism and social investment thinking have shaped public discourses and guided the substantial restructuring of the German welfare state (Olk, 2007; Sowa & Zapfel, 2015). Although neoliberalism and social investment are not commonly associated with medicine and psychology in the welfare state literature, both medicalization and

M. Ariaans (✉)
University of Siegen, Siegen, Germany
e-mail: ariaans@soziologie.uni-siegen.de

N. Reibling
Fulda University of Applied Sciences, Fulda, Germany
e-mail: nadine.reibling@gw.hs-fulda.de

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psychologization have been part of this contemporary welfare state transformation.

Neoliberalism and social investment are the two policy paradigms that have shaped the reform agendas of many European welfare states over the past three decades (Hemerijck, 2018). Generally, the neoliberal agenda preceded the implementation of social investment policies; however, the scope and timeline of both policy paradigms differ from country to country (Hemerijck, 2018) Although the welfare state literature has analyzed the two paradigms, their implementation and consequences in various countries (Abrahamson, 2010; Morel et al., 2012b), the link to medicalization and psychologization processes has received little attention in this work. Instead, the medicalization and psychologization literature has considered the role of neoliberalism quite extensively (Adams et al., 2019; Barbee et al., 2018; Esposito & Perez, 2014; Foster, 2016; LaMarre et al., 2019; Madsen, 2018; Sugarman, 2015), but rarely with a focus on social policies or on the welfare state (Hansen et al., 2014; for exceptions see: Holmqvist et al., 2013; Mills, 2015; Peeters, 2019; Wong, 2016). In the present chapter, we follow the assumption that neoliberalism and social investment constitute the discursive context in which actors have operated and in which institutional changes within the welfare state have been designed and legitimized. We reveal that due to the resonance of both paradigms with the medical and psychological construction of social problems, the co-evolution of medicalization and psychologization in welfare states during the rise of these paradigms has been overlooked.

The present chapter first describes how neoliberalism can be defined and how the neoliberal agenda entered welfare state policies in many European welfare states. Adopting a focus on Germany, we discuss neoliberal welfare state reforms and the manner in which they have contributed to medicalization and psychologization processes. In so doing, we focus primarily on examples from the previous chapters and interpret them in the light of the neoliberal agenda. Second, we describe the process of implementing social investment policies and explain this process's similarities to and differences with the neoliberal paradigm. Focusing on Germany, we then exemplify how the social investment paradigm has contributed in different ways to the rising importance of medicine and psychology in social policy. In the third and final section, we discuss the role of the political context for medicalization and psychologization processes during the past 30 years. We conclude that both paradigms set the stage for medicalization and psychologization processes both as promising solutions

intentionally selected by certain actors to achieve political goals and as unintended effects of policy reforms, changing discourses and institutions.

7.1 Neoliberalism and the Individual Responsibility for Health

Neoliberalism can be described as a policy paradigm that relies on the market to organize and structure virtually all aspects of society. In a stricter definition, "neoliberalism signifies an ensemble of ideological and institutional forces whose primary purpose is to create a social reality where all facets of human life are reduced to economic concerns" (Esposito & Perez, 2014, p. 432). Consequently, the influence of neoliberalism has gone beyond the economy and the welfare state and now stretches to issues such as marriage (Marzullo, 2011), imprisonment (Wacquant, 2010), and sleep (Barbee et al., 2018). Generally, the Reagan and Thatcher administrations of the 1980s are considered as the starting point of neoliberal transformations of the welfare state. Neoliberal ideas have been implemented in policy agendas with the aim of limiting state intervention in the economy and in the life of individuals. Neoliberal reforms include policy measures such as cutting taxes, reducing government spending (particularly for benefits and social services), and deregulating political institutions (Harvey, 2010).

In the field of social policy, neoliberalism entails three components: the individualization of risks, the privatization of social services, and the decentralization of regulation (McGregor, 2001). Furthermore, social policy measures—such as limiting and targeting passive social benefits, deregulating social welfare markets by incentivizing the privatization of social services, and limiting the power of trade unions—have transformed many welfare states over the last three decades (Putzel, 2020). These policy measures were designed with the individual as the main target of intervention in mind and with the aim of shifting the responsibility for life course risks from society to the individual (Peeters, 2019). In particular, the market integration—and thus, also the employment and employability—of each individual marks the central policy aim of neoliberal welfare state policy (Morel et al., 2012a):

> I think we have gone through a period when too many children and people have given to understand 'I have a problem, it is the Government's job to cope with it!' or 'I have a problem, I will go and get a grant to cope with it!'

> [or] 'I am homeless, the Government must house me!' and so they are casting their problems on society, and who is society? There is no such thing! There are individual men and women, and there are families, and no government can do anything except through people, and people look to themselves first. (Thatcher, 1987)

The neoliberal agenda has been pushed and supported by international institutions and organizations such as the OECD, the Word Bank, and the EU (Fougère et al., 2017; Hermann, 2007). In fact, the EU has been an influential actor in spreading the neoliberal agenda on an ideational level but has also actively pursued the paradigm through its fiscal and monetary policies (Hermann, 2007). For example, the Maastricht Treaty and the strict budgetary requirements that were included within it were designed to keep EU member states' welfare state spending under control (Hemerijck, 2018). Furthermore, in 1993, the EU launched a white paper entitled "Growth, Competitiveness and Employment," which included many neoliberal policy ideas on employment, such as promoting the flexibility of workers by reducing social benefits in case of unemployment, reducing employment protection rights, and investing more in active—and less in passive—labor market benefits (European Commission, 1993).

Another welfare state area in which neoliberal ideas have been disseminated by international organizations is education policy. In this area, employability has also been the main target of policy-making. One major actor in pushing neoliberal ideas into education policy has been the OECD. Via the Programme for International Student Assessment (PISA), which provides an international assessment of education systems, 15-year-old school children in a growing number of countries have been tested on their reading, mathematics, and scientific literacy since 2000. Both the fact that children's competencies are tested and the selection of tested skills have been evaluated as a form of dissemination of neoliberal educational ideas (Bouhali, 2015; Martens, 2007). International educational testing leads to the dissemination of a specific educational agenda of skills that are most important in the (global) labor market, thereby leaving little room for national or local characteristics (Bouhali, 2015; Rutkowski, 2007). These scientific evaluations can also be found in the reasoning of the OECD for its first PISA study, which states that "[t]he assessments [are] designed to contribute to an understanding of the extent to which education systems […] are preparing their students to become lifelong learners and to play constructive roles as citizens in society" (OECD, 1999, p. 8).

Furthermore, the OECD clarifies that the emphasis on the competencies that PISA tests lies in the "mastery of broad concepts, [which] is particularly significant considering the concern among nations to develop human capital," which the OECD defines as "[t]he knowledge, skills, competencies and other attributes embodied in individuals that are relevant to personal, social and economic well-being" (OECD, 1999, p. 11).

7.1.1 The Role of Health and Psychology in the Neoliberal Agenda

Individual responsibility, market integration, and employability are thus key aspects of neoliberal social policy. The question now involves how health and psychology come into this picture and which role they play. In general, being and remaining in good health is a precondition for being able to find employment, remaining employed, and increasing the time spent in employment. Nevertheless, references to healthcare, rehabilitation, or prevention are rarely found in the overall neoliberal agenda. For example, the EU white paper "Growth, Competitiveness and Employment" (European Commission, 1993) uses the term "health care" only five times. Thus, at first glance, medicine and psychology do not appear to be a central part of the neoliberal agenda as viewed from the social policy perspective. However, the fact that neoliberalism and its three central dimensions—namely individualization, privatization, and decentralization—have reorganized our understanding of health and illness is obvious when we examine policy documents from international organizations that focus specifically on healthcare, rehabilitation, and prevention. These documents take up neoliberal ideas, for instance, by demonstrating how healthcare contributes to growth, productivity, and employment. For example, the World Health Organization (WHO) has experienced decreasing significance and a worsening reputation since the 1980s, when the World Bank began to promote the view that health and healthcare should contribute to economic growth (Chorev, 2013). Hence, the WHO has been forced to react to the World Bank's view—which called into question whether health is an aim in itself—by adopting neoliberal policy frames and connecting to these communication frames:

> an effective way to earn the support of finance ministers was not to talk about health, but to talk about finance. Hence, the WHO abandoned its long-held position that health was an aspect of social development that

> should be pursued independently of economic concerns and, accepting the neoliberal reduction of social development to economic development, adopted instead the premise that health was good for economic growth. (Chorev, 2013, p. 643)

One of the key ideas and consequences of neoliberalism is that the individual is responsible for their own life course and the risks associated with their own life course decisions. Thus, if life course risks hit and interventions are necessary, then these interventions are more commonly focused on the individual. This idea resonates with medicine and psychology, which as disciplines (with the exception of specific subfields) take the individual (organism) as their focal point: "biomedicine and neoliberalism have made natural bedfellows, sharing as they do an emphasis on individuals as being autonomous and rational consumers ultimately responsible for their own risk behaviours and their own wellbeing" (Rushton & Williams, 2012, p. 154).

Instead of being targeted at the societal level, both health and the responsibility for being healthy have been transferred to the individual (Esposito & Perez, 2014). As Barbee et al. (2018, 5) put it, "[I]n a neoliberal society where people are expected to maximize and protect their own welfare […], 'good' health is also an individual, moral project […] designed to maximize workplace productivity." On the institutional level, this development has been underlined, for example, by state policies that foster individual prevention measures that focus predominantly on the behavior of individuals instead of on the social context (Michailakis & Schirmer, 2010), Furthermore, individual responsibility has also been strengthened through the reconfiguration of the patient as a consumer on the healthcare market. In this vein, choice and health literacy have become central concepts, with patients now being "put in the driver's seat" of their own healthcare journeys: "The shift from patient to medical consumer puts the responsibility for medical decisions and their outcomes on those seeking help, guidance, and care from the medical system" (Sulik & Eich-Krohm, 2008, p. 8).

These developments of medicalization and psychologization through individualization are further underlined by another dimension of neoliberalism: the privatization of welfare services. Privatization developments have unfolded differently in different OECD countries. In some countries, privatization can be seen via an increase in the number of private health insurers and providers, which leaves the individual with more

choices to insure against individual health risks. Germany has borne witness to strong privatization in the hospital sector, with the share of privately owned hospitals having increased from 15.5% in 1992 to 38.5% in 2020 (Institut für Arbeit und Qualifikation, 2022). For example, both per capita expenditure for voluntary healthcare schemes and out-of-pocket expenditure have increased in almost all OECD countries since the 1980s. In Germany, expenditure rose from about $200 in 1980 to $420 in 1990 and $630 in 2000 (current prices, current PPPs) (OECD, 2023). In other countries, privatization has also increased the need for individuals to be insured individually against all necessary health risks and to choose a provider. For example, in the Netherlands, the large healthcare reform in 2006 has left individuals with a choice regarding the extent to which they want to be insured against risks that do not fall within the basic benefit package (Kroneman et al., 2016).

7.1.2 The Case of Germany: Neoliberal Policies and (Un)intended Medicalization and Psychologization

This turn to being responsible for one's own health during neoliberal reforms can also be seen in the era of neoliberal policy implementation in Germany. Neoliberal policies were gradually implemented during the early 1990s under the Christian Democrats and the Liberal Party (Hinrichs, 2021). However, these reforms can be labeled small-scale first- or second-order policy changes and have therefore rarely been discussed in the public discourse as a neoliberal turn. The neoliberal turn in German welfare state policy is mainly associated with the Social Democratic—Green government, which took office in 1998 under Chancellor Gerhard Schröder (Hinrichs, 2021). This coalition government implemented third-order changes in pension and unemployment systems, which increased individual responsibility and decreased publicly ensured benefit levels (Eichhorst et al., 2010; Hinrichs, 2021). These reforms were based on two expert commissions, one of which—the Rürup Commission—developed policy proposals on social security, whereas the other of which—the Hartz Commission—developed policy proposals on (un)employment. The final reports of both commissions promoted a neoliberal welfare agenda. The Rürup Commission's report focused on reforming social security systems in the light of "growth and employment" (Rürup-Kommission, 2003, p. 1) and stressed the future economic impact of the proposed reforms while largely neglecting the societal and individual consequences of the

reforms (Rürup-Kommission, 2003, pp. 20–22). One proposal made in the Rürup Commission's report was to increase the pension age. The report explicitly stressed that there should be no exceptions regarding having a higher pension age for the long-term insured or for those who are insured in a physically demanding job (Rürup-Kommission, 2003, p. 8). As this recommendation would have led to high pressure on incapacity pensions, the commission advised keeping incapacity benefits at a low level and further decreasing the incentives for applying for incapacity pensions (Rürup-Kommission, 2003, p. 9). The Hartz Commission displayed a tight connection between both welfare and (un)employment policies on the one hand and both economic and fiscal policies on the other hand. Furthermore, unemployed individuals were given a central role in overcoming the situation of being unemployed (Hartz-Kommission, 2002). The Hartz Commission's report emphasized the notion that unemployed individuals must search for employment and that if they are deemed to have not sufficiently engaged in the job search process, sanctions are to be applied (Hartz-Kommission, 2002, pp. 24–25). Thus, both documents stressed individual responsibility for market integration and therefore also for health, which was required to be maintained individually.

The Hartz Commission laid the groundwork for the reforms of the unemployment system in the early 2000s, which mainly implemented neoliberal ideas (Marx & Schumacher, 2013). The implemented policies and institutions were designed to increase individual responsibility for (un)employment. Although the political intention was not to strengthen the role of medicine or psychology in unemployment policy (see the analysis of parliamentary debates in Chap. 5), the reform constructed ill health as the only specified path out of the logic of active job search, Thus, the medicalization and psychologization of unemployment became the path-dependent result of these decisions, as can be seen in the increasing importance of sick leave for the unemployed in Germany following these reforms (see Chap. 4). Our analyses of public opinion data have additionally revealed that the quid-pro-quo idea of activation is also seen as being adequate for health problems, with a large portion of the population supporting mandatory rehabilitation measures for physically and mentally ill unemployed individuals (see Chap. 4). Moreover, activation and the notion of increasing employability rely in many ways on psychological concepts and technologies. For instance, profiling motivation and personality characteristics has become important within activation regimes across countries (International Labour Organization/European Commission,

2017). This is also true for Germany, where the testing and development of competence profiles have been essential in creating measures for unemployed people and where psychologists may act as coaches in activation training programs (Ott, 2016).

Similar to unemployment, educational policy in Germany was also transformed in the early 2000s with the aim of redirecting curricula more toward skills that are considered necessary on the (international) labor market (Tillmann et al., 2008). The results of the international education system evaluation (PISA) conducted by the OECD spurred a vast discussion about the quality of the German education system and the competitiveness of the future generation of workers in the knowledge society (Seitz, 2003). Hence, German school systems and curricula have been transformed to cater to the neoliberal principle of future employability. This transformation has included focusing curricula on reading, mathematics, and natural science competencies as well as on (creative) problem-solving and much less in social or cultural competencies. Furthermore, these competencies are now regularly assessed via standardized tests (Seitz, 2003). These assessments set standards that children are expected to achieve. If children fail to achieve a given standard, this is considered a problem that stems from the individual level and triggers the search for individual explanations and solutions. As we outlined in Chap. 6, medicine and psychology are two primary disciplines that are called upon by the education system, for example, when conducting an assessment for a learning disorder which is a common explanation when students fail to achieve standards in mathematics or reading.

7.1.3 Medicalization as an Unintended Effect of Neoliberal (Employment) Policy

Political decision-makers in most European countries—including Germany—have implemented neoliberal policies with the aim of increasing the efficiency and decreasing the costs of the welfare state system. Instead, the aim of medicalizing and psychologizing welfare was hardly part of the discourse and the specific political goals during this period (see also the policy analysis in the Chap. 5). However, neoliberal reforms have in fact included or resulted in these processes. For example, Holmqvist (2010) revealed that the activation turn in unemployment policy has led to more processes in which unemployed individuals are constructed as "disabled" in order to deal with problems of activation and employability

in Sweden. Similarly, Wong (2016) demonstrated that welfare retrenchment in the United States has increased access to medicalized welfare benefits, especially in areas with high poverty rates and low educational attainment. In our analyses, we found the category of sick leave for the unemployed to play a significant role as an institutional mechanism for dealing with long-term unemployed people who have difficulties accessing the restrictive German incapacity pensions (see Chap. 4).

Internationally, a theoretical debate on the medicalization and psychologization of poverty has been ongoing (Hyman, 2018). In our research, we could show empirically that medicine, psychology, and public health have played an increasingly larger role in the international poverty discourse over time. This research literature has established a strong connection between poverty and ill health, which is also well acknowledged in governmental reports and public discourses in Germany. The policy consequences are often seen in health promotion and prevention, where several new programs have been developed over the last decades, such as the German Collaborative Network for Equity in Health[1] (founded in 2003) or the Federal Foundation for Early Childhood Interventions[2] (founded in 2012). Thus, the political reaction to the well-established link between poverty and ill health has generally focused on illness, while it is well-known that ill health does not only cause poverty, but poverty primarily causes ill health. However, at the same time as the German government has launched these new programs toward reducing health inequalities and supporting the health of individuals and specifically children in socially disadvantaged situations, other policies such as the reform of unemployment and minimum income schemes—have resulted in rising poverty rates and a reduced effectiveness of the welfare state at preventing poverty (see Chap. 5).

Children are among the group most affected by poverty in Germany, and poor socio-economic conditions are considered major contributing factors to ill health as well as to various childhood problems. Nevertheless, both the increasing number of diagnoses and our analyses of professional discourses suggest that medicalization and psychologization is often the strategy with which these problems are addressed rather than improving the socio-economic situation of children (see Chap. 6).

[1] https://www.gesundheitliche-chancengleichheit.de/
[2] https://www.fruehehilfen.de/

7.2 Social Investment and the Turn to Health and Personality as Assets

By the end of the 1990s, a new social policy paradigm had entered the stage: the social investment approach (Jenson, 2010). This paradigm—which was centrally developed by Giddens (2013) and Esping-Andersen (2002)—argues that the welfare state has to reorient itself toward investing in human capital that enables individuals to participate in the labor market and to be productive. The social investment approach could be viewed as an alternative to, an advancement of, or a complement to neoliberalism. In the social policy discourse, in particular, the social investment paradigm has gradually replaced the neoliberal paradigm, whose limitations have been increasingly often documented (Jenson, 2010). The strong focus on the individual and on the goal of labor market participation mark the continuity from neoliberalism to social investment (Deeming & Smyth, 2015; Jenson, 2010, 2017). Therefore, social investment has not abolished neoliberal thinking; rather, social investment can be viewed a derivative of neoliberalism (Jenson, 2010):

> governments adjusted their social policies to incorporate the social investment perspective. In doing so they did not try to return to the Keynesian past; they did not reject all of the social thinking of neoliberalism. They did, however, begin to retreat from classical neoliberalism's emphasis on markets and communities as the main pillars of wellbeing and started to identify ways to better address the new social risks of contemporary economic and social relations. In doing so, they were redesigning social citizenship and relations between the state and citizens more broadly. (Jenson, 2014, p. 61)

While the focus on the individual—particularly the emphasis on participating in the labor market—remains in the social investment perspective, all responsibility is not left to individual citizens. Instead, the social investment perspective stresses the notion that the state has—and should assume—responsibility for its (most vulnerable) citizens and that state activities are often a prerequisite for individuals' ability to participate in social life. Prominently, Esping-Andersen (2002) argued that the state should invest more in children, education, and family policy due to the positive effects that such investments have on other welfare state areas, such as employment:

> Active training and mobility policies can only be effective if they complement a strategy of prevention and this means, once again, the need for major social investments in childhood and youth. Or, to put it differently, our employment policies need to join hands with our family policies. (Esping-Andersen, 2002, p. 24)

Following these ideas, social investment policies no longer hold the view that the main role of the welfare state is to decommodify and financially protect individuals from social risks (e.g., old-age, illness, unemployment, poverty). Instead, the welfare state should provide benefits, which should first prevent people from getting into situations in which they need societal help and second enable people to find (individual) solutions for getting out of situations such as unemployment, poverty, or illness (Hemerijck, 2017; Midgley, 1999). These two main aims are often supported by the provision of social services, but targeted benefits can also be implemented to achieve these goals (Busemeyer et al., 2018; Choi et al., 2020). In principle, a large variety of measures are possible because the meaning and particular aims of social investment can vary to a large degree (Jenson, 2010).

Investing before social problems arise—in order to prevent them—is a key notion behind social investment policies. Therefore, measures concerning the acquisition of skills as early in life as possible represent the heart of social investment policies (Hemerijck, 2018). Social investment policies hence stretch across the entire life course and even target children through childcare services and public health interventions. This investment in children reflects the intention to foster their future employability (Lister, 2003). In unemployment policies, social investment focuses on training and re-training unemployed individuals in order to enable them to find and remain in employment and to transition from job to job rather than from work to unemployment (Choi et al., 2020; van Berkel & van der Aa, 2015).

The social investment paradigm has been promoted by international organizations such as the OECD, the World Bank, the EU, and the WHO (Chorev, 2013; Jenson, 2017; Mahon, 2019). As early as in the mid-1990s, the World Bank's policy documents initiated a paradigm shift from a neoliberal perspective to a social investment perspective by stressing the importance of education and human capital development and by beginning to invest in education and skills in early childhood (Jenson, 2017). In 1998, the World Bank published a paper entitled *Beyond the Washington Consensus: Institutions Matter* (Burki & Perry, 1998), in which it stated

that the expected decline in poverty due to neoliberal policies had not taken place and that instead, social inequality had increased (Abrahamson, 2010). Hence, the World Bank called for a new series of institutional reforms, which have been labeled "after-neoliberalism"—or social investment—reforms (Jenson, 2010). Not only has this shift taken place in the global South (i.e., the World Bank's main focus), but it has also gained ground in the OECD and thus in the global North for similar reasons (i.e., concerns about social cohesion and increasing social inequalities) (Jenson, 2017). The OECD's shift to social investment began with two conferences in the mid-1990s that focused on social cohesion, but policy recommendations only began to evolve during the early and mid-2000s. For example, the OECD series *Babies and Bosses* focused predominantly on labor inflow by promoting childcare and parental leave programs designed to keep workers in the labor force, though less focus was placed on early childhood education (Jenson, 2017).

7.2.1 Health in the Social Investment Paradigm

We next turn to the role that medicine and psychology play in social investment policy and investigate how this role differs compared with in neoliberal policies. Goijaerts et al. (2022) have theoretically discussed how health is—and should be—considered part of social investment policies. Focusing on the different functions of social investment policies (e.g., stock, flow, buffer, institutional complementarity) (Hemerijck, 2017), the authors explained how health prevention programs, investments in health (both before and after sickness, and particularly for groups that are inactive in the labor market), expenditures on "old" social risks in the light of lifelong health promotion, and the triangulation of these measures foster the activation, lifelong learning, and productivity rationality of the social investment paradigm.

Both the fact that health and psychology play a role in social investment concepts and the way in which the role of health and psychology changes over time are exemplified by EU policy documents and the policy-making of the WHO. Indeed, the WHO is an example of how an international organization adopts social investment measures as a reaction to the international neoliberal policy agenda. With the spread of neoliberal thinking on the international level, the WHO had to present new argumentation as to why health is an important issue. It was thus no longer enough to state that both individual and public health are an aim in their own right;

instead, the WHO needed to stress the role of health in economic growth in order to legitimize its own function as an organization (Chorev, 2013). In line with neoliberal thinking, the WHO adopted policies that took up economic growth as the guideline for health policy interventions. However,

> the WHO's programs and policies also significantly altered the neoliberal logic. The WHO staff used the concern with economic growth to justify greater financial investment in health and relied on cost-effective logic to call for a 'new universalism'—the delivery of high-quality essential care to all—while maintaining a focus on infectious diseases affecting the poor. (Chorev, 2013, p. 654)

EU policy documents reveal the role that the issue of health plays within the social investment concept. Although the European Commission states that "health is a value in itself" (European Commission, 2013a, p. 1), it also stresses that health expenditures are "growth-friendly" and promote a "job-rich recovery" and that "[p]eople's health influences economic outcomes in terms of productivity, labour supply, human capital and public spending" (European Commission, 2013a, p. 1). Furthermore, the European Commission has stated that investments in health—particularly in preventative measures—are particularly important for children from weak economic backgrounds and for people living in poverty because these investments are cost-effective and thus result in lower costs in other welfare state systems (European Commission, 2013b):

> Children who grow up in poverty often stay in poverty for their entire lives. For example, significant disadvantages faced in childhood in education and health are often compounded over life. Addressing health determinants throughout people's lives is therefore important. (European Commission, 2013b, p. 6).

Thus, investing in health from an early age is expected to (1) allow people to remain active and in better health for a longer period of time, (2) increase the productivity of the workforce, and (3) lower the financial pressures on health systems. Health promotion and preventative healthcare are considered particularly important including investing in health and safety at work (European Commission, 2013b). Hence, both health and investments in health from an early age constitute a central element of

the assumptions behind social investment and are actively pursued in welfare state policies.

The social investment logic has also been defined through psychological concepts and relies on psychological technologies and actors. While some conceptions of social investment policies have a narrow understanding of skills, many other conceptions specifically highlight psychological concepts such as optimism, self-efficacy, self-regulation, motivation, or resilience (Friedli, 2015). Services that aim to improve these personal competencies and that more generally seek to improve social and labor market participation through individual coping mechanisms have been part of labor market measures, parental training programs, and services for children and adolescents (Friedli, 2015; Gillies, 2005; Ott, 2016). Parenting programs are an important example. Daly (2017), for instance, outlined how psychological theories such as parenting styles (Baumrind, 1967) and attachment theory (Bowlby, 1958) have been central to the evolution and popularity of parenting as a concept and evolved to a field of government intervention. Moreover, the comparatively higher use of mental healthcare services by children and adults with a lower socio-economic status means that the mental healthcare sector plays a central role in dealing with socio-economic problems (Buffel et al., 2015; Lampert et al., 2018; Reiß et al., 2021). This includes in Germany services offered by psychologists such as psychological psychotherapy. In sum, the long-acknowledged role of psychology in the governmentality of individuals in liberal democracies has been stimulated by the social investment discourse. Psychological concepts are discursively used to re-interpret and individualize marginalization and deprivation:

> Theories of 'individualization' and 'risk' have shifted attention away from the material and structural roots of inequality and sanctioned a psychologized view of class distinctions in terms of personal qualities. (Gillies, 2005, p. 835)

7.2.2 Health and Psychology in the German Turn to Social Investment

In Germany, the stepwise shift from neoliberal to social investment policies was triggered by the public and political criticism following the Hartz reforms and the implemented neoliberal agenda (Brettschneider, 2008).

Although social investment approaches had begun to be discussed internationally in the mid-1990s and in Germany in the early 2000s, these approaches have only been *thoroughly* discussed and implemented in Germany since the mid-2010s (Brussig, 2019). Concerning childcare, social investment strategies have gradually been implemented since the mid-2000s in the form of strengthening and expanding the rights of parents to access leave policies and public childcare (West et al., 2020). In other areas, such as poverty and elderly care, social investment policies have also been implemented since the early 2010s (Brettschneider & Klammer, 2020). For example, the Federal Participation Act (Bundesteilhabegesetz)—which began to be gradually implemented in 2016—has strengthened the rights of disabled people as well as of people in rehabilitation and focuses on (re-)integrating these people into both society and the labor market. Concerning unemployment, social investment was part of the Hartz reforms, but this component was underdeveloped and instead activation and sanctioning was the focus of the initial reforms (Dingeldey, 2020). Hence, the turn to social investment in unemployment policy has gradually increased since the early 2010s via various small-scale reforms that have focused on young unemployed people and on further qualifications for all age groups (Ariaans & Reibling, 2022; Dingeldey, 2020).

However, this focus on investment in qualification and skills has failed to "activate" its most important target group: the long-term unemployed (Brussig, 2019). For Germany, the share of long-term unemployed has not decreased significantly since 2011 (Brussig, 2019). Furthermore, before the turn to social investment, unemployed people who were (evaluated as being) not able to (re-)enter the labor market had shifted to early or incapacity pensions (Giddens, 1998). However, transitions to these programs have been blocked for many individuals in many welfare states during the past century (Ebbinghaus, 2006; Hinrichs, 2021) due to the aim of investing in the employability of these people. Thus, despite social investments in skills and qualifications, the large group of long-term unemployed people who cannot be reached with these types of social investment policies remains unaddressed. And how does the welfare state deal with these unemployed people? Instead of social investments in skills and qualifications, policies have turned to investments in health. As shown in the previous section, health in the form of prevention and rehabilitation has also been introduced in various forms into welfare state policies in Germany in order to promote healthy aging and to increase individual and

societal productivity (Gerlinger, 2018). For example, the Federal Participation Act (Bundesteilhabegesetz) initiated a program (rehapro) that focuses on the medical and occupational rehabilitation of (often long-term) unemployed individuals. This program furthermore establishes a cooperation between various health and welfare state actors, such as employment agencies, health insurers, rehabilitative centers, and employers (rehapro, 2022). Thus, investment in health has become more important on the German policy agenda in recent years. Although this increased focus on health has been a clear political goal, "'Health' alone is still not a particularly strong motive of health policy, but [it] comes into play primarily when it promises to contribute to the achievement of other—primarily economic—goals" (own translation, Gerlinger, 2018, p. 200).

7.3 Conclusion

The present chapter revealed that the neoliberal paradigm and the turn to the social investment paradigm have both created a societal and political climate in which medicalization and psychologization processes have unfolded. The two paradigms have been actively promoted by international political institutions and organizations and have been implemented as guiding principles in welfare state policy in advanced welfare states since the 1980s. Table 7.1 compares the two paradigms: Neoliberalism and social investment both focus on the individual and on the individual's personal responsibility for their own unique life course risks. Nevertheless, neoliberalism and social investment diverge in terms of how they view self-responsibility and the role of the individual within the market. In a strict sense, the neoliberal paradigm promotes the notion that individuals are solely responsible for themselves when it comes to falling into and getting out of existential life course risks, whereas the social investment paradigm highlights the function of the welfare state to enable individuals from an early stage onward to take responsibility for not entering existential life crisis events and to give these individuals the necessary skills and prerequisites to exit such situations.

Medicalization and psychologization are not found prominently in contemporary discussions of neoliberalism and social investment debates. However, we have shown in this chapter how medicine and psychology have played a part in these discourses and reforms. Medical doctors and psychologists are not at the forefront of social policy debates, but they are included on the micro- and meso-level because they use their specific

Table 7.1 Key characteristics of neoliberalism and social investment

	Neoliberal paradigm	*Social investment paradigm*
Role of the welfare state	The state provides the minimum requirements for societal and economic participation.	Provides services/benefits in order to enable social and economic participation. Prevents individuals from falling into existential life course risks.
Dominant view of the individual	The individual is viewed as the subject in the market.	The individual is viewed as the subject in the market.
Individual responsibility	The individuals are responsible for themselves.	The state supports individuals to be responsible for themselves.
Impact on medicalization/ psychologization	Illness is the only way out of the activation logic. Illness is a hindrance to market integration.	Services/benefits are provided for health promotion, rehabilitation and the development of psychological competences deemed important for a successful life/ labor market participation. Illness should be prevented/ health should be promoted.

professional expertise and abilities to deal with the externalities of neoliberal reforms or to support investment programs through individualized services.

The neoliberal agenda contributes to medicalization and psychologization via individual enhancement and the notion of illness as a state that individuals have to overcome as soon as possible. However, both of these processes appear to also come into play as unintentional side-effects of neoliberal reforms. They take the role of escape routes that buffer neoliberal policies and the consequences of these policies. Health and psychological competencies play an even stronger role in the social investment paradigm as forms of capital that the state invests in. However, the welfare state invests in the health of the population before people become unemployed and additionally helps people to become healthy and consequently to increase their chances of finding a job. Thus, medicalization and psychologization might be more intentional policy processes during the current phase of social investment than they were during the neoliberal policy era.

Medicalization and psychologization from the perspective of both neoliberal and social investment thinking have a highly instrumental nature. The concepts of recovery, labor market participation, and growing up successfully create strong expectations and can lead to the neglect and stigmatization of groups for which these goals are not attainable. Moreover, the new focus on health and psychological competences entails the risk to de-emphasize structural aspects of social problems, e.g., social inequalities (Lister, 2003) or the structure of labor markets (Lindsay & Houston, 2011).

With respect to Germany, medicalization and psychologization have been part of neoliberal and social investment reforms, as we demonstrated and documented in our empirical analyses in the Chaps. 4–6. However, in the social investment period (thus in the more recent years), we can also find discourses and reforms that focus on structural explanations, new redistributive and social security policies, or investments in social infrastructures (e.g., schools). While these changes may have been smaller-scaled and were (not yet) able to affect (child) poverty, long-term unemployment, and social inequality, this socio-economic perspective has not been crowded out by medicalization and psychologization. Instead, social policies that have addressed unemployment, poverty, and childhood problems have moved toward an integrative biopsychosocial approach.

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