The Global Financial Crisis, Austerity, and Mental Health: The Case of Walker's Wisconsin

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Abstract: A case study of health care in Wisconsin under Governor Walker is presented in order to explore some effects of austerity in the United States. The case study follows the trajectory of rhetoric employed by the Walker campaign, linking it to policy changes and subsequent health outcomes for people in the state. I argue that, despite Walker's proposal for funding mental health, the trajectory of mental health services in Wisconsin is toward increased constriction of public services. Additionally, Walker is able to both endorse individual agency and simultaneously promote policies that restrict it through a politics of need (Robertson 1998:1421). In the case of Walker's Wisconsin, the politics of need works to hide cuts to services for the poorest people in Wisconsin by appealing to American ideals of individualism.

Key Words: mental health, structural violence, politics of need, Medicaid, Affordable Care Act

When I moved to the state of Wisconsin in September of 2011, everyone I encountered was talking about Governor Walker's extreme actions in his first few months in office. My professors, classmates, neighbors, co-workers, and even the cashier at the grocery store were all talking about the new context of Walker's Wisconsin. I felt as though I had moved to a place where the ground was shifting right underneath everyone's feet, and no one knew quite how they were going to stand up in this new environment. It was not long before I noticed my neighborhood was smattered with "Recall Walker" signs.

Walker's actions involved deep spending cuts, many of the effects of which the state has only begun to experience. In this paper, I present a case study of health care in Wisconsin since Walker took office in 2011. The state under Walker's budget cuts provides a good case for exploring the effects of austerity in the United States. The case study follows the trajectory of rhetoric employed by the Walker campaign and links the rhetoric to policy changes and

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subsequent health outcomes for vulnerable people in the state. I particularly focus on providers and consumers of mental health services. There are two key questions that I explore in this case study: How has access to mental health changed as a result of austerity cuts in Wisconsin? How has Walker's rhetoric changed over the course of his governorship? I argue that, despite Walker's proposal for funding mental health, the trajectory of mental health services in Wisconsin is toward further constriction of public services. Additionally, Walker is able to both endorse individual agency and simultaneously promote the very policies that restrict it through a politics of need. As Ann Robertson (1998:1421) describes, the politics of need creates contention around what constitutes a need. In Wisconsin, Walker employs a politics of need to hide cuts to services for the poorest people in the state by appealing to American ideals of individualism.

In this case study, I seek to engage with issues of concern for Wisconsin residents through social critique that "draw[s] linkages between individual or group suffering and structural factors by examining harms in historical context and within relations of power" (Low and Merry 2010:208). The project presented here draws attention to how the structural factors under austerity are affecting some of the most vulnerable in Wisconsin. I begin the paper by discussing many of the public health debates surrounding the global financial crisis and world health, in order to identify common themes and issues within the global context of austerity. From there I draw on health statistics, local news reports, reports from local non-profit organizations, and Governor Walker's speeches, press releases, and website to present a case study of health care in Wisconsin during austerity.

Global financial crisis and health

Since the global financial crisis began in 2007, many people who work in public health have been commenting on the connections between the crisis and health around the world. These discussions within public health are very important for recognizing common themes and issues within the present day context of health care, and several trends have emerged at the intersection of austerity and health care.

The first trend is the use of crisis situations to make cuts to public health care. As Jonathan Oberlander (2011) points out, one strand of rhetoric in American politics fosters the idea of a deficit crisis. Oberlander goes on to ar-

gue that, "In a crisis environment, policymakers are more likely than usual to take on powerful interest groups and contemplate controversial reforms" (2011:1075). Because health programs are often very large, they are quickly targeted in times of austerity, and cycles of crisis and reform have been associated with Medicaid and Medicare since the 1980s (Bronstein 1996:23; Oberlander 2011:1075). Since Medicaid and Medicare are almost one-fourth of all federal spending, in the current rendition of crisis and austerity, "the long-term deficit problem is seen largely as a health care problem" (Oberlander 2011:1076).

A second trend is that policy changes in the name of austerity are often short-term in focus (Oberlander 2011:1077; Benatar et al. 2011:650). The result is that the short-term policies produce cost shifts, not cost savings. One example is the proposal to raise the eligibility age for Medicare (Oberlander 2011:1077). While on paper this proposal looks like it saves money by decreasing the number of years senior citizens ultimately use Medicare, the policy would increase total health care spending (those same seniors still need health care) and shifts costs to employers, private health insurance, and seniors (Oberlander 2011:1077).

Third, there is a movement toward increased privatization and decreased public health services. Not only are modern advances in health care (including pharmaceuticals) increasingly driven by market forces (Benatar et al. 2011:649), but also public health care systems are contracting while private ones are expanding (Benatar et al. 2011:648; Konodilis et al. 2013:e1-7). Privatization outside of the health care arena has also proved detrimental for health. One of the most striking examples involves food. Neoliberal economic policies, including reduced subsidies for basic foods and policies shifting agriculture toward exports instead of internal food production, have lead to a situation where food prices are regulated in the global market (Benatar et al. 2011:648). The result has been starvation and malnourishment in many places around the globe, particularly in parts of Africa.

The fourth trend is an increased socioeconomic gap in access to health care on a global scale (Benatar et al. 2011; Marmot and Bell 2009; Porter 2013). This trend is strongly connected to the previous one. As global markets increasingly control prices on basic foods and medicines, increased unemployment has simultaneously hit developing countries (often lacking meaningful social health services) and middle-income countries harder than high-income

countries (Benatar et al. 2011:649). People who are at the bottom of the economic hierarchy are at greater risk for communicative diseases and mental health problems (Konodilis et al. 2013:e1). Meanwhile, research funds overwhelmingly go to developing treatments and pharmaceuticals to be sold in high -income markets neglecting less expensive treatments for diseases common in low-income communities and putting expensive treatments out of reach for the majority of people in the world; approximately 90% of global health spending is spent on less than 20% of the world's population (Benatar et al. 2011:649).

As other scholars have indicated, these four austerity trends are intertwined with discussions of the social determinants of health and a need for increased attention to social justice and human rights (Benatar et al. 2011; Buchanan 2013; Horton 2009; Konodilis et al. 2013; Levy and Sidel 2009; Leyland 2012; Marmot and Bell 2009; Oberlander 2011; Richards 2012; Schrecker et al. 2010). Like public health scholars, anthropologists have argued that people living in impoverished situations are more likely to suffer from greater health problems, a condition resulting from structural violence.

Anthropology, structural violence, and the conditions of neoliberalism

The term "structural violence" was first used by social theorist Johan Galtung (1969). Galtung (1969:143) argued that violence was not only direct, but could also occur indirectly and invisibly. In his definition, structural violence refers to harm that comes to people because of the social structures in place that stop people from enacting their agency (Galtung 1969:142). Paul Farmer (2010:295) has made it a cornerstone of his career to use the term to show how suffering is implicitly tied to social structure, a fact that is ignored in "desocialized" biomedical understandings of health and poverty. Farmer (2010:328) creates a hierarchy of suffering arguing that some people suffer more than others, and those who live in poverty suffer more than the middle class or the wealthy. There is strong anthropological evidence that shows how structural violence produces tragic suffering and poor health for people living in extremely impoverished conditions (Biehl 2007; Bourgois 2002; Scheper-Hughes 1992).

Arthur Kleinman (2000:228) has applied the concept of structural violence to people living in relatively wealthy conditions arguing that structural violence affects other social groups as well, and may be more invisible and go unrecognized to a greater degree than the more obvious harms that can be

seen in extremely impoverished contexts. He prefers the term "the violences of everyday life" and posits that these violences occur across social settings and in many different forms. One form that he addresses he labels "bourgeois varieties," describes a middle class woman who suffers from chronic pain as a result of a very abusive relationship (Kleinman 2000:228). Kleinman's conceptualization of structural violence as multiple and not bound to a hierarchy of suffering, is useful for understanding the ways that structural violence factors into contexts in the United States.

The austerity trends I described previously, and the main points made by medical anthropologists about structural violence, echo critiques of neoliberalism and increasing global inequality. David Harvey, for example, points to a number of similar issues arguing that in lieu of generating wealth as neoliberal policies purport to do, they actually redistribute wealth (funneling it from the poor to the wealthy) through a process of "accumulation by dispossession" (2007:159). Accumulation by dispossession has four main features: privatization and commodification, financialization, the management and manipulation of crises, and state redistributions (Harvey 2007:160-163), all of which have been cited in the public health literature on austerity and health.

One important aspect of the management and manipulation of crises is the use of exception. Carl Schmidt (1922) argued that a state of exception is the defining factor of state sovereignty, not control of the use of force. Exceptions can establish and maintain boundaries around who is a citizen and who is not, creating a whole class of citizenless people with no rights (Agamben 2005:2), and can involve inclusion and exclusion in a number of political arenas (Ong 2006:5). Invoking a state of exception is a powerful move because it allows the state to make decisions outside of political order, exercising swift and autonomous political control over a population.

It should not be surprising that the public health discourse on the present state of health under austerity aligns with arguments about the troubling aspects of neoliberalism. If neoliberalism established conditions of inequality as Harvey (2007) and others (di Leonardo 2008; Elyachar 2005; Graeber 2011) have argued, the financial crisis and neoliberal response has heightened those conditions. As Oberlander (2011) reminded us, health care is one of the first targets of austerity measures. What separates the public health discourse from the critiques of neoliberalism is that much of the public health work ends by calling for increased discourse on human rights while rarely interrogating

(Benatar et al. 2011 being a notable exception) how major players in the non-profit sector (e.g. The World Health Organization) also perpetuate neoliberal ideals while simultaneously employing discourses of human rights (Benatar et al. 2011; Buchanan 2013; Horton 2009; Levy and Sidel 2009; Leyland 2012; Marmot and Bell 2009; Oberlander 2011; Richards 2012; Schrecker et al. 2010). Interjecting discourses of human rights is not a solution that will promote meaningful changes on its own. It must be accompanied by careful analysis of current human rights discourses and clearly use the language of human rights in new ways to realize the changes many of these authors call for. In the next section, I analyze one such human rights discourse embedded in the context of health care policy in Wisconsin.

The case of Wisconsin

Within six months of taking office, Governor Scott Walker's policies were embroiled with controversy, and a recall effort was underway. Legislation stripping public workers of meaningful collective bargaining rights and dramatic budget cuts were the main points of contention. Mental health organizations were particularly hard hit by the funding cuts. Simultaneously, national discussions related to mental health care were occurring around the issues of mass killings and national healthcare reform. In this section, I analyze health statistics, local news reports, reports from local non-profit organizations, as well as Governor Walker's speeches, press releases and website to explore some effects of austerity on mental health care in Wisconsin. As we will see, the politics of need takes a central role in framing the decisions Walker made about health care funding in Wisconsin.

National context

When Walker took office as Governor of Wisconsin in January of 2011, President Obama was running a tough campaign to reclaim the White House for a second term. One of the major issues of the campaign was the Patient Protection and Affordable Care Act (commonly known as Obamacare or the Affordable Care Act), which Obama had signed into law in 2010. The Affordable Care Act involves an expansion of public funds for Medicare and Medicaid programs while also creating markets of private insurance that individuals can purchase ("Health Reform in Action – About the Law" n.d.). The law mandates that everyone (except in severe cases of economic hardship) have health insurance coverage, but it allows individuals to own their own

health insurance, instead of relying on employers for access to affordable group health ("Health Reform in Action – About the Law" n.d.).

The biggest part of the Affordable Care Act that is relevant for mental health in Wisconsin is the expansion of Medicaid eligibility. People with mental health needs are disproportionately low-income people for whom Medicaid eligibility is key to receiving access to essential treatments (Wisconsin Council on Mental Health 2013). Medicaid and Medicare are often a target of budget cuts due to their relatively high portion of the federal budget (Oberlander 2011:1076). Debates around cuts often highlight Medicaid because it is considered a federal aid program whereas Medicare is considered a benefit. Notably, President Obama's White House website does not discuss the changes to Medicaid. Instead, the President's website highlights changes to Medicare stating:

> Nearly 50 million older Americans and Americans with disabilities rely on Medicare each year, and the new health care law makes Medicare stronger by adding new benefits, fighting fraud, and improving care for patients. ("Health Reform in Action – About the Law" n.d: para. 17)

The reforms aimed at fighting fraud are mentioned several times throughout the section describing changes to Medicare, addressing a popular American criticism and misconception of social programs. Obama's health care reform site makes no direct mention of Medicaid that I could find. One explanation for the omission of Medicaid information has to do with its status as an aid program. The omission thwarts opposition to increasing funding for a program that is regularly characterized as a government handout paid for by those who work hard and pay taxes. Such a characterization creates a dichotomy between those who actually work and those who receive assistance for a need, implying they are not mutually exclusive and effectively creating conflict around what a need truly is.

Despite the lack of information about the changes to Medicaid on the White House website, Medicaid expansion is an important aspect of the Affordable Care Act. Under the Affordable Care Act eligibility for Medicaid was to be increased to people living on incomes at 138% of the poverty line or below ("Medicaid: 3 Issues to Watch" 2013: section 1; Thompson 2012:179). Getting health insurance coverage for approximately 30 million Americans who do not have it was a key goal of the Affordable Care Act; the Medicaid expansion would provide coverage for about half of that group (Aizenman and

Somashekhar 2012:para. 7; "Medicaid: 3 Issues to Watch" 2013:section 1; Thompson 2012:179). In July of 2012, the Supreme Court ruled that the federal government cannot penalize states that do not accept the Medicaid expansions under the Affordable Care Act (Thompson 2012:184). Instead states can choose to maintain their own standards for eligibility; a choice that a number of states are taking (Aizenman and Somashekhar 2012:para. 3). The court's decision upholds most of the Affordable Care Act, a victory for President Obama and his administration. However, the decision to not allow the federal government to enforce Medicaid expansion in the states weakens one of its essential pieces and greatly reduces the number of uninsured people who will become insured through the Affordable Care Act (Thompson 2012:179-181).

Scott Walker

It is within that context of national health reform that the story of Wisconsin has unfolded. As Jane Collins shows in her historical overview of Wisconsin's employment circumstances, the state has undergone broad transformation. Though people from Midwest may think of Wisconsin as a bucolic farming state, less than 2% of state's GDP actually comes from agriculture and forestry (Collins 2012:8). Manufacturing has long been a primary source of employment. Since the 1980s, Collins notes that Wisconsin has lost 80% of its manufacturing jobs to outsourcing, an event that has had major effects on African Americans; by 2000 the poverty rate among African Americans was 34% higher than national average (Collins 2012:8-9). The unemployment rate for the state has been slightly below the national average for the past several years, but income levels have dropped over the last decade and many people remain underemployed according to a report by the Center on Wisconsin Strategy (Collins 2012:1-2).

When Walker took office in January 2011, there was no deficit in the state's budget (Collins 2012:10). In his inaugural address, Walker stated, "My top three priorities are jobs, jobs, and jobs" and went on to call for a special session that would "pass a series of bold reforms that will send a clear message: 'Wisconsin is open for business.'" He repeatedly referred to the size of the government as being a problem and closed the speech saying:

> We, the people of Wisconsin, have every right to reclaim our rightful place in history. We will make this a Wisconsin we can believe in. More than 162 years ago, our ancestors believed **in the power of hard work and determination.** They envisioned a new state with limit

> less potential. Now, it is our time to once again seize that potential. We will do so at this turning point in our history by restoring limited government that fosters prosperity for today and for future genera tions. Justice… **Moderation… Temperance… Frugality…** Virtue. These are the values upon which our state was formed and the values that will drive us forward. (Walker 2011, emphasis added)

Noted here is the familiar appeal to both the hard work ethic and minimizing government need with the values of "Moderation… Temperance… Frugality." The emphasis on job growth as the primary and justifiable reason for making dramatic cuts to essential services and removing collective bargaining rights is particularly disingenuous when one considers that governors' policies likely have very little to do with job growth in a given state (COWS 2011). Instead, it represents one phase in another case of exception. Walker justifies cuts to both budgets and rights under the guise of solving an exceptional problem of unemployment in the state.

Following his inaugural address, Walker called a special session and backed bills that gave $137 million in tax breaks to corporations, thus creating a budget shortfall (Collins 2012:10). With the new budget "crisis," Walker invoked a state of exception claiming a "budget emergency" in February of 2011 and proposed his "Budget Repair Bill." The most discussed and contested aspect of the bill was its barring meaningful collective bargaining rights for public workers. The clearly manipulated crisis beginning with the exceptional problem of unemployment, which was used to justify tax breaks that then created the budget emergency, created the space for a Budget Repair Bill, with restrictions on budgets and rights to be presented. The Budget Repair Bill lead to major protests in the Wisconsin capital, followed by a recall effort that ultimately failed (see Table 1 for a brief timeline and Collins 2012 for a detailed account).

The bill also took control of Medicaid funding away from counties and gave state administrators the ability (with no legislative oversight) to alter Medicaid rules and limit its funding (Collins 2012:6). Ultimately, the Budget Repair Act involved enormous cuts to Medicaid (over half a million dollars), massive slashes to BadgerCare (the state's low-income health insurance program), and set new caps on Family Care (a homecare program for the elderly and people with disabilities) (Collins 2012:6).

January 3, 2011	Walker sworn in as 45th Governor of Wisconsin.
January 25, 2011	State legislature passes Walker supported bills leading to immense tax cuts for businesses.
February 11, 2011	Walker proposes Wisconsin Budget Repair Bill.
February 14, 2011	Protests begin in Madison.
March 11, 2011	Walker signs Budget Repair Bill after forcing a vote with Democrats.
June 5, 2012	Recall Election – Walker survives the recall vote.
February 2013	Walker returned a federal grant for more than $37 million to set up a health exchange in Wisconsin under the Patient Protection and Affordable Care Act.
February 20, 2013	Walker gives budget address in which he proposes $29 million for mental health care.

Table 1: Walker Timeline

Since Walker's massive cuts in 2011, families who rely on public services to meet their mental health care needs have been left scrambling ("Major Cuts" 2011). Already sparse services were left with even greater scarcity with gaps in services for children and community-based programs ("Major Cuts" 2011). Walker's 2013 Budget Proposal, however, has made headlines for its proposed $29 million to mental health services. The funding Walker proposed includes:

> $12.6 million over two years to open two units at the Mendota Mental Health Institute in Madison for treatment of patients who have been committed.
>
> $10.2 million for expanding community-based care programs for people with severe mental illness. These programs can help reduce hospital visits, improve health and increase employment.
>
> $3.8 million for expanding statewide a model of coordinating care for children with behavioral issues who are involved in two or more systems of care, ranging from mental health to long-term care, juvenile justice, child welfare, substance abuse and special education.
>
> $1.3 million for respite centers that offer hotlines, peer support and alternatives to hospitalization.

> $535,000 to establish an Office of Children's Mental Health to address the issue statewide by coordinating programs for children across all state agencies. (Stein 2013: 3)

These funding opportunities have largely been welcomed by mental health providers and consumers around the state under the premise that some increased funding is better than no funding at all (Wisconsin Council on Mental Health 2013). However, they remain skeptical of Walker’s proposal because while it sounds promising, his plan also involves rejecting the federal money for Medicaid expansions under the Affordable Care Act. One in six people who would be newly eligible to receive Medicaid under the Affordable Care Act have a serious mental illness and 25% will utilize mental health treatment (Wisconsin Council on Mental Health 2013). Walker’s refusal of federal Medicaid money means that significant numbers of people needing mental health treatment who could receive insurance through Medicaid will not only lose out on that option in Wisconsin, but could also fall into the group of people who do not meet the income requirements to receive tax cuts for purchasing insurance in the private market.

While Walker’s plan forces more people to buy private health insurance, it does not consider how people who are living in poverty will be able to afford to do so. People over 100% of the federal poverty line who would be required to receive services through the exchanges may be unable to because the $2000 deductible will not be affordable to people with incomes of $12,000/year (Wisconsin Council on Mental Health 2013). Additionally, there is yet no guarantee that the private insurance available through exchanges will provide the same level of coverage that Medicaid offers. Refusing the federal Medicaid money creates an environment of restricted agency for mental health consumers in Wisconsin by limiting access to affordable care and medications needed for managing severe symptoms in daily life.

Walker’s manipulation of crises and severe budget cuts echo broader global health trends. Walker framed a crisis in the form of a budget disaster in order to slash health care funding, he introduced policies aimed at decreasing current expenses but will shift the burden of costs to individuals and hospitals, and his policies increase reliance on private health insurance while restricting access to public insurance. In order to make such sweeping moves, Walker emphasized his increase in mental health funding masking his simultaneous rejection of Medicaid expansion dollars that could potentially help a significant

portion of people. When Walker announced his plan to reject the Medicaid funding, he said:

> Government can provide a hand up, but should not provide a permanent handout.
>
> We need to break cycles of generational dependence on the government. Reforming entitlements, like Medicaid and unemployment insurance, puts an emphasis on **independence and the dignity** that comes with working hard to **build a prosperous future** of your own choosing. ("Walker Rejects" 2013:para. 4)

Similar themes of independence and prosperity pervade his other 2013 speeches. In his 2013 budget address, he described the need for increased mental health in terms of lost earnings. Walker began by harkening back to his 2011 inaugural address stating:

> At the start of 2011, Wisconsin faced a $3.6 billion budget deficit and the unemployment rate was 7.8 percent. At the time, **I stated that moderation and frugality in government would lead to freedom and prosperity for our people.** (Walker 2013, emphasis added)

The rest of the speech is aimed at explaining how this budget increases freedom and prosperity and frames mental health care not as a right, but as an impetus for more revenue production in the state:

> And if people are going to perform well in our state, they should be able to improve their mental health as well as their physical health. **Nationally, serious mental illness costs at least $193 billion a year in lost earnings.**
>
> With this in mind, our budget includes the largest commitment to mental health services in 30 years. This investment in community-based services will **increase the independence** of people living with mental health needs and maximize their ability to be contributing members of our state.
>
> Our investments are focused **on improving performance** in Wisconsin.
>
> Now, I will share how our budget will reform state government.
>
> [After discussing rejecting federal Medicaid dollars**] I dare say that I don't think any of us grew up with the dream that someday we would be dependent on the government. It almost seems foreign to the American Dream.** (Walker 2013, emphasis added)

So while Walker claims that funding mental health services is a necessary investment to improve performance in Wisconsin, Medicaid is a handout that even runs counter to the American Dream. The appeal to ideas about personal responsibility and independence is nothing new, and I will discuss this again as an aspect of the politics of need in the next section. Despite Walker's optimism, income levels are low, unemployment remains high, and job growth is stagnant; the unemployment rate for African Americans is the highest in the nation at 25% (COWS 2012:1-2). While Walker ostensibly suggests individual agency is key to the prosperity for the state, his policy of rejecting federal Medicaid funding creates conditions that place restrictions on human agency by limiting access to care, creating structural violence. How is Walker able to appeal to individual agency while simultaneously promoting a policy that will restrict it? The politics of need play a key role here.

The politics of need

Ann Robertson (1998:1419) refers to the "politics of need" as an essential consideration for people interested in health because discussions about public health issues often boil down to what is fundamentally considered a need. The way the politics of need plays out in the United States context stems from Western philosophical ideas of individualism, which are rooted in the Enlightenment. Individualism is a pervasive and underlying concept in all of modern western societies (Gordon 1988:23). It is an example of a concept that is so foundational in western cosmology and ontology that it is naturalized – people perceive it as just the way things are. Individualism is a way of ordering the world where the individual is distinctly separated as a skin-bound entity, with absolute dispositions that define them as sensitive, gregarious, hard-working and stubborn (Gordon 1988:35).

In Western conceptions, various characteristics we attribute to people such as "she's the type of person who always needs to be doing something new," or traits defined in psychology such as the authoritarian parent or the Type A personality are assumed to be aspects of a person's "real self" that is epiphenomenal to culture (an ego-centric cosmology) (Gordon 1988:35). Other ways of ordering the world include defining people in terms of cases, contexts, or social roles, where context is foregrounded in the concept of the self (socio-centric cosmologies) (Gordon 1988:35). When individualism is a central organizing concept, society is conceived as a problem to be overcome and the individual must seek to free her or his true self from society's reaches.

As it is embedded in biomedicine, individualism means that the medical system is constructed under the assumption that both the doctor and the patient are autonomous actors who have consented to a relationship wherein the doctor agrees to provide expertise and the patient agrees to submit to the doctor's care. The model is structured so that patient autonomy is interpreted as the right to complete freedom – in terms of the doctor one sees and the procedures that one (who can pay) receives – which has implications for attempts to assert care from a social perspective. Opposition to programs such as universalized health care, or public aid for low-income families can gain traction when framed as handouts by appealing to the deep-rooted sense of individualism in western societies; it conveys a sense of morality, as Gordon (1998:35) points out, that involves a burden. Understanding freedom as the ability to choose medical providers and procedures masks the deep inequality in services based on structural features, not the least of which is socioeconomic status; freedom is afforded to those who can pay while those who cannot pay receive care in crowded clinics or overextended emergency rooms, if at all.

Walker's rhetoric connecting his health care policies to freedom is convincing to a portion of the population because it appeals to this aspect of American ideology. Countering this rhetoric, advocates for expanded public health services often appeal to a discourse on human rights. However, Robertson (1998:1419, 1427) argues against conceptualizing human needs as rights and argues for a "needs" discourse centered on reciprocity and interdependence of human communities that recognizes that not all aspects of human exchange can be analyzed in terms of costs and benefits. In cases of structural violence, human interactions are interdependent and ultimately influence health. Shifting rhetoric from debates about needs to discussions of interdependence could be an important avenue of response to the global health trends that limit healthcare access for the most vulnerable populations.

Conclusion

Although limited in scope, this project has drawn preliminary answers to the questions I posed above. How has access to mental health care changed as a result of austerity cuts in Wisconsin? Access to medical care has declined since Walker's cuts began in 2011, and a trajectory of continued constricted access is apparent in his proposed 2013 budget; there are no signs of change for this trajectory in the near future. Walker's proposal for millions of dollars in mental health funding looks good on the surface, but serves to deflect cri-

tique of his rejection of potential aid for significant portions of the population who utilize mental health services. How has Walker's rhetoric changed over the course of his governorship? While some of the rhetoric around shrinking government and freedom has remained the same, Walker has also moved from a rhetoric centered on job creation to one centered on the idea of independence, which appeals to a deep-rooted ideology of American individualism. Ultimately, Walker's budget proposal continues the trend of constriction of public services for Wisconsin residents producing an environment of structural violence.

In the case of Wisconsin, we can see that politicians carefully manage crises that require exceptional responses, creating space for extreme policies. Additionally, rhetoric engaging a "politics of need" (Robertson 1996) hides cuts to services for the poorest people in Wisconsin by appealing to American ideals of individualism. Through a politics of need, Walker is able to ostensibly endorse individual agency while promoting the very policies that restrict it. His policies limit access to care for some of the most vulnerable populations in Wisconsin including the mentally ill who often need consistent care to manage severe symptoms in everyday life. I hope that by being aware of this general trajectory around mental health funding in Wisconsin, we can create our own counter narratives that aim to produce new potentialities for the future.

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Notes

[i] I am using "neoliberalism" here to refer to an economic philosophy promoting limited government regulation of the economy and perpetual economic growth. For an extended definition and history of the term see di Leonardo (2008) or Harvey (2007).
[ii] Gordon's argument is somewhat limited in that she does not recognize that cosmologies are not static, and generalizations about entire cultural groups do not hold up under the particularist scrutiny of anthropology. However, her analysis of "individualism" in the west is relevant for this discussion.