URBAN HEALTH CARE SAFETY NETS: CATCHING PEOPLE AND PROFITS IN MILWAUKEE'S HEALTH CARE DELIVERY SYSTEM

by

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(Under the Direction of Nik Heynen)

ABSTRACT

Like other systems supporting social reproduction, the US health care delivery system has been transformed by the expansion neoliberal economic logics throughout the state and voluntary sector. This study examines neoliberal capitalism's spread within the voluntary sector of Milwaukee's health care delivery system. I provide an economic geography of urban health care delivery in the US, with a particular focus on the relations between capital, the state, and the voluntary sector that continually (re)produce it. These relations are explored through my analysis of the growth of free clinics in the city, and the further privatization of the Milwaukee Clinical Campus, a public-private partnership that historically provided health care to the un/underinsured. Second, my political geography of the free clinic movement examines how this political project, grounded in a particular interpretation of Christian ethics of care, both 'reworks' and 'resists' the development and impacts of neoliberalized health care delivery in the city. This qualitative study using participant-observation, semi-structured interviews, and archival research contributes to current geographical work on the voluntary sector, privatization, urban social reproduction, and social movements.

KEYWORDS: Urban health care delivery, Neoliberalism, Voluntary sector, Privatization, Social movements, Christianity

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DEDICATION

This work is dedicated to Dr.Barbara Horner-Ibler, RN Rick Cohen, Jan Schimming and the rest of the staff, volunteers, and patients at the Bread of Healing Clinic whose tireless efforts to improve the health of themselves and their communities was an inspiration to my research.

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CHAPTER 1

INTRODUCTION AND LITERATURE REVIEW

The US Health Care Delivery System and Health Care Reform

In the past eighteen months, the US health care system has become a major target of political discourse and public policy discussions. During the summer of 2010, cities and town halls across the country erupted with impassioned and sometimes violent rhetoric regarding proposed changes to the federal government's role in the nation's health care delivery system. Despite the contentious debate, President Barak Obama signed the Patient Protection and Affordable Care Act, followed shortly by the Health Care and Education Reconciliation Act in March of 2010. The bills were extensive and their major legislative impacts included: requiring insurers utilize community rating premium pricing[1]; expanding Medicaid eligibility up to 133% of the current Federal Poverty Level; creating health insurance exchanges where individuals and small businesses can compare policies and premiums, as well as buy insurance; closing the Medicare Part D coverage gap; requiring physicians who treat Medicare patients be reimbursed at the full rate; increasing Medicaid payment rates to match Medicare payments; offering increased subsidies to low income households to be used to purchase health plans; introducing minimum standards for insurance coverage; and the elimination of all annual and lifetime coverage caps.

Efforts to change our current health care delivery system were the result of two problems with the current structure frequently focuses: access and costs. In terms of access the discussion f on the number of uninsured residents in the US. The US Census Bureau estimated the number of uninsured residents in 2006 to be approximately 47 million, or 15.8% of the civilian, non

[1] Community rating ensures that all insurance premiums for individuals of identical age and sex in a geographic area are the same regardless of individual health attributes.

institutionalized population (DeNavas, Proctor and Smith 2008). This represents a considerable increase from the levels present in the 1970s and 1980s (Cutler 2002; Kronick and Gilmer 1999). Research has demonstrated that access to health care is an important component to an individuals' overall satisfaction with their current health care options and their health status and outcomes (Andrulis 1998; Ayanian *et al*. 2000; Bodenheimer and Grubach 2002; Hadley, Steinberg, and Feder 1991; Kasper, Giovannini and Hoffman 2000; Newacheck, *et al*. 1998). Consequently, access to health care is a significant issue for US social policy.

The second issue, closely related to the first, is escalating health care costs. Health care costs in the US are shared by: tax financed, state programs (e.g. Medicaid, Medicare and the Veterans Administration), private employers (e.g. employer contributions to health insurance plans) and private individuals (e.g. personal contributions to insurance premiums and co-payments). A recent article by the director and senior analyst of the Congressional Budget Office (CBO) estimated total health care costs, at present, are shared equally between public and private financing (Orszag and Ellis 2007). As a result, their projections regarding future health care spending are alarming for both the public and private sector. Health care costs currently account for almost 16% of GDP; this represents a 100% increase in just over twenty years (Orszag and Ellis 2007). If these trends continue, it is estimated that health care costs will reach 20% of GDP by 2016. Furthermore, they estimate by 2050 federal spending on just Medicaid and Medicare will represent roughly the same share of the total US economy that the entire federal budget accounts for presently. Individuals and families are also at risk, as a recent study by Himmelstein *et al.* (2005) concluded half of all the bankruptcies during 2001 in five federal courts were related to medical costs.

The concerns over access and costs are interdependent. There has been a significant decrease in the percentage of the US population with health insurance since the late 1970s and 1980s. As Bodenheimer (2005) points out, rising health care costs contribute in three ways to the growing number of uninsured residents in the US: (1) employers cease offering health insurance to employees due to rising health insurance premiums, (2) employees stop taking advantage of employer-based health insurance, as a result of increases in their own contributions to those health insurance premiums, and (3) states tighten Medicaid eligibility in order to insure fewer low-income people enroll, a consequence of the rising costs per enrollee. While this may save companies, individuals, and the state money in the short run, the increase in uninsured residents can lead to rising health care costs for everyone. For example, Hadley *et al*. (2008) estimate that $14.1 billion of uncompensated care financing was provided through costs shifting.[2] Increases in this practice may contribute to rising health care costs overall.

It was in this context that President Barak Obama made health care reform one of his legislative priorities during the first two years of his presidency. This research was largely conducted prior to the passage of the major health reform bills in March of 2010. While the effects of health care reform are unknown, as of yet, a more complete understanding of the issues affecting access to health care in cities can contribute to more informed policy discussions in the future, as US residents, academics, and politicians seek to improve access while controlling costs, in the attempt to construct a more humane and effective health care delivery system. In particular, my focus on the economic, political, and cultural ideologies informing the current articulation of health care delivery in US cities provides insight into the possible challenges as health care reform is rolled out over the next decade.

[2] Cost shifting is the practice of increasing the price of medical services for those with private insurance in order to offset the losses incurred while treating the un/underinsured.

This research examines changes to the health care delivery system in Milwaukee, WI. Milwaukee offers and particularly appropriate location from which to speculate about the possible future of health care in the US. In 1996, it closed it last remaining public hospital and replaced it with a publicly financed county health insurance program, the General Assistance Medical Program (GAMP). Theoretically this program should have significantly reduced the number of uninsured residents and increased access to health care. However, as this research will demonstrate, the impoverished residents in Milwaukee, both those insured through GAMP and the uninsured, continued their struggle to access even basic medical care. The central questions this research answers are: (1) what changes to Milwaukee's health care delivery system have decreased the un/underinsured residents' access to health care; (2) what processes and logics have produced these changes; and (3) how have institutions committed to increasing access to health care in the city responded politically and materially.

This research is grounded on the assertion that health care delivery changed in Milwaukee during the 1990s. I will argue that these changes were steeped in the deepening of neoliberal economic logics that prioritize market mechanism of service delivery, including public services, as well as market disciplinary technologies such as accounting practices and bond ratings. However, before introducing my case studies in Milwaukee, it is instructive to spend some time reviewing the previous health care delivery regime in the city. This is particularly important because the neoliberalization of health care delivery in the US generally, and Milwaukee specifically did not begin in the 1990s. Rather its role as a governmental logic emerged much earlier in the 1970s and it encountered a service sector that was a hybrid mix of public-private financing and delivery.

Earlier Rounds of Health Care Delivery Restructuring

This research focuses on changes occurring throughout the 1990s and early 2000s to urban health care delivery systems and in particular health care safety nets in US cities. In many regards this research examines the efforts by cities to overcome the same problems that have plagued the US health care system since at least the late 1960s: dwindling access and rising costs. While a comprehensive historical-geography of health care delivery in the US is beyond the scope of this work it is useful to briefly review the chief components of the health care delivery system leading up to the events this research examines, in order to better understand the changes that were unfolding. There are three areas that are particularly important to examine: financing, regulation, and delivery spaces.

Financing

The US lacks a comprehensive scheme for financing health care delivery (Ayers 1996; Sultz and Young 2009). Instead, health care is financed through a mix of governmental (federal, state, and local funds) and private (individuals and business) sources. The ratio of these funding sources has undergone a dramatic transformation in the past fifty years. In 1960, 75% of health care financing was provided by the private sector (Pointer and Williams 2004). These funds originated primarily through private, individual, or employer-based health insurance schemes. The federal government, through the Veterans Administration (VA), was the primary funder of the remaining 25%. In 1965, the US government vastly increased its role in funding health care delivery when it amended the Social Security Act and created the Medicare and Medicaid programs (Sultz and Young 2009). The Medicare program was designed to solve the problem senior citizens faced when attempting to purchase insurance in the individual insurance marketplace. As a result of the increased health care costs older people incur, health insurance

for seniors was almost non-existent prior to 1965. The Medicare program allows every American, sixty-five or older, to enroll in a government funded health insurance plan. It consisted of two programs: Medicare Part A, which covers hospital care, outpatient surgeries, diagnostic services and short-term home care; and, Medicare Part B, which covers physician services. With the creation of the Medicare program the federal government became a primary actor in the health care delivery apparatus. In 2009, Medicare had 46 million enrollees and was expected to spend $528 billion on health care services in 2010 (Congressional Budget Office, 2010).

Along with Medicare, the federal government created the Medicaid Program in 1965 as well. Medicaid is a public health insurance program for certain segments of the poor, or the "deserving poor." It is financed through federal and state funds, with the federal government setting general eligibility criteria and coverage standards, while also allowing for significant state oversight in constructing the actual program delivery. For example, under current law only pregnant women and children are federally mandated to be eligible for the Medicaid program (Ayers 1996). Additional eligibility criteria are typically defined by states based on age and economic status. The federal government's share of the financing of Medicaid varies by state, but on average it supplies 57% of the total funding (Congressional Budget Office 2010). In 2009, the federal government spent $251 billion on the Medicaid program; this was 25% higher than the previous year as a result of rising unemployment and the federal stimulus package (Congressional Budget Office 2010).

Together in 2009, the Medicare and Medicaid programs cost the federal government $750 billion and accounted for over 20% of federal spending (Congressional Budget Office 2010). In just fifty years the federal government's share of health care financing had swelled

from a mere 25% to 50%. This change from private sector financing to a hybrid model fundamentally shifted the dynamics of health care delivery in the US. First, it decreased the pressure on health care providers to contain costs. As part of the political compromise struck between the federal government and medical professional associations, such as the American Medical Association (AMA), to pass Medicare and Medicaid the government agreed to minimize its interference in the relationship between physicians and patients. This allowed physicians to offer an increasing array of high-tech diagnostic tools and medical interventions, whose medical value was rarely measured, but whose financial benefit was well established (Perkin 2004; Richmond and Fein 2005). The increased costs associated with these medical services would be almost entirely paid by private and publicly funded health insurance programs. As Richmond and Fein (2005: 82) recall:

> …a hospital general director described the change that resulted from the new flow of government funds. He stated that in the pre-Medicare/Medicaid days he had a list of new devices that the medical staff wanted, and so he tried to match items on that list with prospective donors. With the advent of Medicare/Medicaid, the list disappeared: a wealthy donor, a member of the family, one Uncle Sam, had appeared…Presumably, the laws of arithmetic had been repealed.

By becoming a major funder of health care services the federal government altered the medical marketplace by reducing one of the primary pressures for containing costs: the self-payer.

Lagging behind this first change was the second impact of the passage of Medicare and Medicaid: governmental efforts to contain costs. With the rapid escalation of health care costs and the government's new role as a major financier, pressure quickly mounted to control governmental expenditures. This goal is still one of the primary objectives in the current

wrangling over health care delivery and was also an important motivation for many of the changes that occurred in Milwaukee in the 1990s and 2000s. While the passage of Medicare and Medicaid proved to be a financial bonanza for the health care service sector, it also paved the road for a more activist's federal government, both in terms of financing and regulation.

Regulation

Governmental regulation of the health care industry has historically been weak. Much of this is the result of effective lobbying by organizations, like the AMA, that sought to ensure self-regulation through the control of medical education, licensing, and board certifications (Starr 1982). However, the creation of Medicare and Medicaid created new motivations for government to pay closer attention to the health care sector. In the 1970s government regulation took the form of involvement in the planning of hospital construction and the purchasing of expensive new equipment. The major legislative acts paving the way for governmental involvement in the health care sector were the Hill-Burton Act of 1946, the Regional Health Program of 1965, the Comprehensive Health Planning Act of 1966, and Certificate of Need Laws passed at the state level beginning in 1964 and at the federal level in 1972. All of these acts were, theoretically, created to organize health care delivery into an efficient system.

In this first wave of interventionist regulation, the economic theories of industrial organization served as the basis for the government strategy. The industrial organization school believed that governmental regulation could and should be enacted towards the "public interest" (Ameringer 2008). Researchers working within the industrial organization school assumed that by understanding how industries operate policy makers could craft regulations that would improve the "economic welfare" of the sector and therefore advance "public interest." At the time most of these legislative actions focused on decreasing the duplication of services and

maximizing the utility of current health care delivery spaces (Ameringer 2008; Perkins 2004). This was to be accomplished through regulatory bodies that would oversee the construction of new hospitals and the purchase of capital-intensive equipment.

Yet, in practice the regulatory capacity of these boards was thin and their formation through partnerships with major players within the health care sector limited their function to the overall goals of these strategic partners. In all of these instances the regulatory bodies resisted interfering with the overall goals and objects of the hospital, insurance, and physician regulatory partners (Ameringer 2008). Consequently, their objectives of decreasing or containing costs and improving access and quality were limited. Furthermore, by the end of the 1970s a different economic model of government regulation of the economy was gaining influence: neoclassical economics.

Neoclassical economic theory would prove to be the driving force behind a new era of government regulation in a numbers of sectors of the economy. Its central premise was that "it is wrong to entrust the control of resources to government officials no matter what social objectives they may be pursuing" (Reder 1982:31). This shift in economic theory produced a wave of governmental action to deregulate entire industries and led to the elimination of significant governmental oversight in the airlines, transportation, and communication industries (Ameringer 2008). The health care sector presented a different challenge for government regulators. Many of the most important regulations of the health care sector were the result not of government regulations, but rather professional organizations, such as state medical societies and accreditation bodies. Consequently, deregulation was not a viable option for constructing more perfect health care markets. Rather, the government went after the professional associations that enacted the market regulations of health care delivery through the Federal Trade Commission

(FTC) and the Department of Justice (DOJ) (Ameringer 2008; Perkins 2008). The actions by state regulators helped bring an end to attempts by the AMA and medical societies to restrict the development of pre-paid group practice and other innovative health care delivery organizations. Through a series of court cases, the ability for the medical profession to self-regulate was diluted. This was done through the economic theory of "managed competition." The goal was to create more perfect competitive marketplaces and eliminate the construction of medical monopolies. Throughout the late 1970s and 1980s the federal government was successful in greatly weakening the long-standing mechanisms and institutions organizing the delivery of medical services controlled by medical associations. In the end, the governmental agencies initially responsible for health care planning were allowed to fade away, replaced by watchdog agencies such as the FTC and DOJ who became much more active in trying promote competition within the marketplace.

Delivery Spaces

The most important development to the delivery of medical care since the 1940s has been the rising significance of corporate medicine. For much of the history of medical care in the US, professional medical organizations had successfully limited the infringement of corporate models of health care delivery (Starr 1982). Starr's seminal work on the development of the US medical system, *The Social Transformation of American Medicine*, provides the most precise definition of corporate medicine. He (1982: 428) defines corporate medicine as a dynamic process that includes:

1) Change in type of ownership and control from governmental and nonprofit toward private, for-profit institutions;
2) Increased horizontal integration, or the loss of free standing community health providers;

3) Diversification and corporate restructuring through the integration of health care providers into networks operating throughout a variety of health care markets;
4) Vertical integration or the integration of diverse types of care into one organization (HMOs); and
5) Industry concentration of more and more health care providers under the control of a smaller number of health care conglomerates.

Throughout the most of the century physicians were able to limit the reorganization of medicine along cooperate management techniques through their effective lobby organization the AMA. Any attempts to create new practices models, which might interfere with physician-patient relationship, or more importantly the financing system, were blocked by AMA political mobilizations (Starr 1982). When legislation threatening physician control of medical delivery was passed, the AMA was effective at weakening the legislation to the point of undermining its enforcement ability (Ameringer 2008). This meant that until the 1970s medical services were still primarily delivered in physicians' offices or hospitals and financed through individual, self-payment or fee-for-service insurance plans.

However, by the 1970s health care administrators and hospitals themselves were recognizing the economic benefit of "integrated" service delivery. Integrated service models sought to link all types of primary and specialty medical services, as well as pharmaceutical and rehabilitation services into on health care system. This allowed for the integration of care as well as the capture of revenues within one institutional organization (Perkins 2004). This led to the rapid consolidation of health care resources within large, complex, integrated health care systems. These systems were further strengthened through their purchase or affiliation with Physician Group Practices, which were new health care institutions trying to replicate the economies of scale enjoyed in the acute, and specialty care institutions (primarily hospital systems). These changes fundamentally shifted the medical delivery landscape. Perkins (2008:

74) notes: [b]y the end of the century 40 percent of US hospitals belonged to systems (that owned their assets), and 32 percent belonged to networks (that did not own their assets). Milwaukee's experience is emblematic of this transformation. Recently it was revealed that nearly 2/3rds of all Milwaukee area primary physician practices were owned by, or affiliated with one of the five integrated health care systems (Task Force on Milwaukee Health Care Delivery 2009). The idealized family doctor, working out of his private practice, putting his own economic interests second to his patients, was finally put to rest by the 1990s. Medical delivery was now focused on "managed competition" and delivered through the various corporate arms of the integrated health care systems. Before introducing health care safety nets and the changes that would result from the shifts in financing, regulation, and delivery spaces it is important to take a step back and discuss how the changes in medical delivery in the US related to broader changes within the regulation of the US economy.

Urban Neoliberalization Projects

The literature on neoliberalization is diverse and extensive and consequently its central features are hard to determine. However, I find Peck, Theodore and Brenner's (2010: 104) definition useful for identifying many of its general principles. They state:

> …projects of neoliberalization tend to be associated with a certain cluster of recurring features, tendential characteristics, and family resemblances - among which we would enumerate a structural orientation to export-oriented, financialized capital; deep antipathies to social collectivities and sociospatial redistribution; and open-ended commitments to market-like governance systems, non-bureaucratic modes of regulation, privatization, and corporate expansion - but these are always, inescapably, forged in context-specific ways.

At its core, the literature on neoliberalization examines the absorption of neoliberal logics, such as the belief in the market as the unquestionable arbitrator of both the production and distribution of human labor, within specific locations and institutions. Academic analyses of

neoliberalization are often complicated by the fluidity of neoliberal discourses. As many authors have commented, one of the political strengths of neoliberal ideology is its lack of coherence (Plehwe 2009). Neoliberal ideology is utilized *both* in support of 'rolling back' government regulation and intervention (i.e. the sale of formerly public utilities and assets), as well as 'rolling out' government financial resources and programs seeking to stabilize and/or encourage markets (i.e. the Troubled Asset Relief Program). This fluidity makes academic analyses as well as political mobilization against it challenging.

One particularly troubling feature of neoliberalization is its effect on the processes and institutions supporting social reproduction. Social reproduction, within a Feminist framework, is both the reproduction of human bodies as well as the conditions organizing the production and distribution of goods and services necessary to those same bodies survival (Katz 2001). Consequently, social reproduction can be understood as both the reproduction of bodies through access to health care, as well as reproducing the processes of gaining that access (i.e. private insurance, a national health service, charity, etc,). It is clear that neoliberalization projects have affected social reproductive activities enormously. Projects of neoliberalization frequently exacerbate unequal access to important resources of social reproduction, such as water, housing, electricity, and environmental amenities, (Addie 2008; Brenner and Theodore 2002; Bond and McInnes 2007; Heynen, *et al.* 2007; McCarthy 2004; Roberts 2007). In addition, neoliberalization projects typically involve a decrease in government spending on social welfare, such as public housing, the transfer of ownership and/or operation of formerly government services to the private sector, and an increasing desire to protect spaces of capital from the material costs of such processes through increased securitization of public and private space. My research shows, inline with other research, these changes ushered in under a discourse of

neoliberal rationality, or 'common sense', regularly lead to increases in human suffering and, especially in the US, incarceration (Beckett and Western, 2001; Wacquant 2001; Gilmore 2007).

Fundamental to understanding the changes in systems of social reproduction attributed to neoliberalization is knowledge of the former regime of regulation: Fordist-Keynesian capitalism. Typically the neoliberalization of the state is understood to begin with the dismantling of the Keynesian welfare apparatuses that emerged after the economic crisis of the 1930s (Brenner and Theodore 2002; Peck and Tickell 2002). The Keynesian 'compromise' produced a more active welfare state, funded through corporate taxation. In the US this included programs such as the federal Food Stamp Program, the Tennessee Valley Authority (a rural electrification program) and the Social Security Program. While this portrayal of neoliberalization is accurate at a general level, scholars have increasingly recognized the need to analyze neoliberalization as it interacts with geographically and sector-specific institutions and political frameworks. This recognition led to Brenner and Theodore's and Peck and Tickell's (2002) influential works calling for theorization and analysis of 'actually existing neoliberalism'.

This recommendation is particularly important for the US health care system, which was never fully enfolded into the US welfare state as it was in the United Kingdom (UK), Canada, New Zealand and Australia, four other nations important to neoliberal experimentation. In the US, health care delivery's incorporation into the Keynesian welfare state didn't occur at any significant level until the waning days of its hegemony as a political-economic regulatory framework. Other than the establishment of the Veterans Administration (VA) in 1930, the two most significant health care programs in the US, Medicare and Medicaid, weren't created until 1965. Furthermore, to date, only Veterans and seniors (US residents over sixty-five) are guaranteed access to medical care. This is a far cry from the more comprehensive programs

created in the UK, Canada, New Zealand and Australia. In the absence of a robust entitlement to medical care in the US, a network of voluntary sector institutions emerged to form a health care safety net. This has important implications for neoliberalization projects within the US health care delivery system.

The US health care safety net is composed of a mix of government-funded programs (Medicaid, State Children's Health Insurance Program, Disproportionate Share Hospital Program, Federally Qualified Health Centers, etc.), voluntary sector institutions (non-profit hospitals, free clinics), and private charity provided in physicians' offices. The creation of a public/private welfare system is often the result of neoliberalization, rather than the landscape neoliberalization first encounters. This creates challenges and opportunities for the logics of neoliberalism as it seeks innovative techniques and discourses through which to restructure US health care delivery systems towards one where market mechanisms, even if poorly functioning, are deepened and extended.

Another aspect of neoliberalization with which geographers have recently grappled with is the contestations and resistance movements emerging in response to it (Boyer 2006; Featherstone 2008; Katz 2001; Leitner, Peck and Sheppard 2007; Pile and Keith 1997). As the literature makes clear, neoliberalization projects have not been implemented without significant opposition. Geographers have examined these variously scaled resistance moments analyzing their spatialities, as well as the challenges they encounter in mobilizing resistance/contestations. Katz's (2001) work in particular highlights the contradictory space oppositional movements grounded in social reproduction exist within. She states (718):

> …social reproduction is vexed because, again almost by definition, it is focused on reproducing the very social relations and material forms that *are*[3] so

[3] Her emphasis

> problematic. Social reproduction is precisely not "revolutionary," and yet so much rests on its accomplishment, including – perhaps paradoxically – oppositional politics.

The paradoxical space oppositional movements focused on social reproduction occupy is certainly evident within the politics of US health care reform. For example, activists in Milwaukee opposed to the dwindling access to health care accompanying neoliberalization projects were instrumental in the rapid increase in number and scope of free clinics in the city. Yet, as my project demonstrates, these clinics are quickly incorporated into the market-focused strategies of the corporate health care systems and state. Consequently, the US health care delivery system, and in particular the grassroots mobilizations attempting to lessen its inhumanity, presents an important opportunity to inform our understanding of how neoliberalization projects. In particular my research illuminates how these projects continue to transform space, even spaces already highly impacted by earlier waves of neoliberalization.

Fundamentally the relationship between abstract neoliberal ideologies of "market triumphalism" and health care are muddy. While in general we can understand the events in Milwaukee that this research examines, as well as the more general changes in government regulation during the past twenty years as following some of the general tenets of neoliberalism: increasing state austerity and attempts to deepen and expand free markets. However, the implementation these abstract economic theories often relied on tactics and techniques that were contrary to pure neoclassical economic theory and led to a greater increase in governmental involvement in the private health care delivery sector. The most obvious contradictions were the increased governmental regulation of the organization of health care delivery through the investigations and lawsuits brought against medical societies and the AMA by the FTC and DOJ. Furthermore, while much of the rhetoric regarding governmental involvement in health care

revolved around costs containment and efficiency, the actual presence of tax-financed health care swelled during the rise of neoliberal economic policy in cities, states and the federal government. Ultimately, the US health care sector provides a glimpse at the elasticity of the abstract theories of neoliberalism as these ideologies become complements to governmental techniques, such as regulation which are contrary to many of the most basic assumptions of neoclassical and neoliberal economic theory, that government should play no role in the regulation of markets no matter what the social objective. So while much of what this research project exams can be understood through the lens of neoliberalism, it also offers an account that fails to fit into any normative understanding of abstract neoliberal theory. Rather it shows how neoliberal rhetoric can be useful for the construction of a wide range of government actions and regulation, many of which contradict the basic premise of neoliberalism itself.

The Health Care Safety Net

Access to health care is a critical component of maintaining social reproduction; the ability to see a physician, nurse, physical therapist, etc. can be the difference between a healthy person and one who struggles to take part in the economic, cultural and/or social opportunities that exist within one's daily life. Changes in the locations and institutions supporting social reproduction during the neoliberalization of the state, economy and civil society are well documented by geographers (Brenner and Theodore 2002; Brown and Barnett 2004; Cloutier-Fisher and Skinner 2006; Hankins and Martin 2006; Katz 2001; Kearns, Barnett and Newman 2003; McCarthy 2004; Peck 2001, 2002; Peck and Tickell 2002). However, geographers have largely failed to focus their analysis upon the US urban health care delivery system during this age of neoliberalization. This omission is striking given the importance of medical care, not only to social reproduction, but also its role within the larger US economy. The US health care sector

employed 14.3 million workers in 2008 and included ten of the nation's twenty fastest growing jobs (Bureau of Labor Statistics 2010). Truffer *et al.* (2010) estimate the health care sector was responsible for 17.3 percent of GDP in 2009. This increase of 1.1 percent over 2008 levels was the largest increase in the health care share of GDP ever recorded. This peculiarity of health care delivery in the US – its importance in producing/maintaining healthy bodies and as an important element of economic growth – makes it a critical arena for academic inquiry.

This research project begins to address this absence in the literature by focusing on the processes and consequences of neoliberalization on health care delivery in Milwaukee, WI, as well as the contestations resulting from it. I use two events occurring within Milwaukee's health care delivery system to ground my analysis. The first is the dramatic growth of free clinics during the 1990s and 2000s. In 1987, there was one free clinic in the city, serving primarily homeless men. Currently, there are twenty-five free clinics serving a wide range of people and neighborhoods in Milwaukee County (Planning Council for Health and Human Services 2009). The growth of free clinics in the city suggests significant change within the city's previous health care delivery system. The second event was the termination/resignation[4] of sixteen faculty members of the Milwaukee Clinical Campus (MCC). The MCC is an Academic Medical Center providing medical education to students at the University of Wisconsin-Madison Medical School (UWMS). The program is located within Milwaukee's largest central city hospital, Aurora Sinai Medical Center. In addition to training medical students, the MCC has, historically, sought to provide access to health care to the medically underserved residents of Milwaukee. However, in 2005 the affiliation agreement between Aurora Health Care (a corporate, non-profit health care system) and the UWMS was restructured. The affiliation agreement was the document

[4] The difference between termination and resignation is semantic in this case and is based upon whether their contracts were up for renewal at the time of the restructuring. In both cases it was the faculty members who decided to end their employment at the MCC.

structuring the rights and responsibilities between Aurora Health Care and UWMS in operating the MCC. In response to changes in the new affiliation agreement, sixteen out of the sixty-four faculty members left the MCC program. These two related incidents provide the spaces and moments through which my analysis of the neoliberalization of health care delivery in Milwaukee takes place.

My fieldwork relied on a number of qualitative methods including participant-observation at one Milwaukee area free clinic, forty-six semi-structured interviews, and archival research of health care documents and newspaper articles. As a participant-observer, I spent over 100 hours performing various tasks for one of Milwaukee's larger free clinics. I worked primarily as a receptionist, scheduling appointments, recording basic medical information and organizing and filing paperwork. Volunteering within the clinic provided me with considerable time to interact with the clinic's patients, staff and other volunteers. Field notes from clinic observations informed my conclusions in a general manner, but were most useful in generating interview questions for formal, semi-structured interviews. My semi-structured interviews included eight Milwaukee area free clinic administrators and three medical directors, fifteen patients at one area free clinic, the administrators of two Federally Qualified Health Centers, the former president and vice-president of one of the largest health care systems in the state, the Medical Director for the city of Milwaukee, as well as the former lead administrators of the now closed public hospital, four former employees of an important safety-net provider, the Milwaukee Clinical Campus, and the lead organizer for a political action organization working on health care issues. I interviewed several of these individuals multiple times over a four-year span; this provided an opportunity to revisit previous interviews and confirm or complicate previous discussions. My archival research reviewed hundreds of newspaper articles, primarily

in the Milwaukee Journal Sentinel, the hospital archives available at the University of Wisconsin-Milwaukee library, and internal communications and legal documents structuring the MCC. Many of these were used as primary document sources, as well as for generating questions to interview participants.

In the remainder of this introductory chapter I will first briefly introduce the previous health care delivery system in the US, the literature on urban neoliberalization discussing its general elements with a particular focus on its intersection with social reproduction and the emerging literature on resistance/contestation. Next, I discuss the medical/health geography literature and the previous work on the neoliberalization of health care delivery. I conclude with a brief introduction of my three case studies examining the neoliberalization of Milwaukee's health care delivery system. I will demonstrate how each of these case studies examines either the processes of 'actually existing neoliberalism' as they embed themselves within the historically and geographically specific institutions comprising Milwaukee's health care delivery system, or the consequences and contestations of these processes. Milwaukee is an important and useful case study for examining such processes for two reasons. First, Milwaukee's economy, long stagnant from the impacts of deindustrialization, offers a lens through which to understand the challenges cities face in providing access to health care in challenging fiscal environments. Second, Milwaukee serves as an important strategic testing ground for neoliberal experimentation as many of the 'trial' projects conducted in Milwaukee, such as private school vouchers, workfare, Medicaid managed care, have been exported to other cities nationally and internationally. This makes case studies of the city instructive for understanding possible trajectories in other economically strapped cities in the Global North.

Medical/Health Geography

While the critical economic geographers have largely ignored health care delivery systems, scholars working within the medical/health geography field have analyzed the effects of neoliberalization projects on health care delivery and human health. Medical geography was formalized in the early to mid-20th century, as medicine was increasingly professionalized. Originally the domain of physicians (Brown and Moon 2004), for decades its work focused on the distribution of diseases (Kearns and Moon 2002; Litva and Eyles 1995; Parr 2003). Specifically, medical geography examined how environmental and population characteristics affected disease distributions. In the 1970s, research expanded to examine barriers to accessing medical care and the creation of health inequalities (Litva and Eyles 1995; Parr 2003). In recent years medical geography underwent a substantial transformation as scholars reflected upon its epistemological foundations and argued for an expanded research agenda (Kearns 1993; Kearns and Moon 2002; Parr 2003). As part of this process of self-reflection, the subdiscipline splintered into medical and health geography. As Parr states (2003: 213), "those working under the assumed title of 'health geography' have been broader in their considerations of care, at least in the sense that they have been open to human experiences of care that go beyond the medical and are bound up with particular qualities of therapeutic environments and landscapes." For the purpose of my research, I will use medical and health geography interchangeably, and will therefore refer to each of them as 'medical/health geography'. I find both research agendas useful for analyzing changes within the US health care delivery system and a comprehensive engagement with the health/medical geography debate is beyond the scope of this project.

Most of the analysis in the medical/health geography literature of the entanglement between neoliberal ideologies and health care delivery has taken place outside of the US.

Although there was some early work by Bohland and Knox (1989) and McLafferty (1989) on hospital privatization, as well as some recent work by Brown (2003, 2004) on the shift in location of hospice care to the home, a majority of the research on the neoliberalization of health care delivery focuses on the UK, Australia and New Zealand. In general, this research examines two elements of the neoliberalization of health care delivery. The first is the transformation of health care facilities, typically hospitals, through privatization and public-private partnerships. The collaborations between Brown and Barnett (2004, 2006) on the restructuring of hospital operations in Australia are typical of this work. In their research on Australia's health care delivery system they document both an increase in hospitals operated and financed through public-private partnerships (Brown and Barnett 2004) as well the number of investor-owned hospitals (Barnett and Brown 2006). In both instances they connect the changes in Australia's 'medical landscapes' to broader changes in the state welfare apparatus accompanying neoliberalization projects. This work is similar to that of Mohan (1988, 1991, 1995), who identifies related transformations within England's National Health Service (NHS).

The second element found in the medical/health geography literature on neoliberalization and health care delivery is best represented in the work of Kearns and Barnett (1999, 2000, 2003). Their work focuses on the reproduction of health care spaces through place marketing and naming, as well as the shift in discourse regarding medical utilization from patients to consumers. Kearns and Barnett trace the changing representations of hospitals in New Zealand, highlighting the role of language in facilitating the material reorganizations of health care spaces. For example, they demonstrate the importance of branding a newly constructed children's hospital, *Starship Hospital*, to the pursuit of private financing, as well as shifting the experience of hospital care for children and their families to one of spectacle (1999, 2000). Throughout

their work Kearns and Barnett link the political-economic aspect of neoliberalism to its cultural project, each providing the means by which the other is understandable. This research provides a valuable complement to the more narrow political-economic explanations of health care reforms.

The medical/health geography literature provides an important foundation for examining the transformation of the US health care delivery system. However, it also points to several important gaps that should be addressed. First, how has neoliberal ideology embedded itself within the US health care delivery system? This question is particularly important for two reasons. First, it provides a glimpse at the possible future of neoliberalization projects. With the initial phases of neoliberalism now over thirty years old in the largest Western economies, these communities have experienced the privatization of many of their formerly public assets and aspects (Mohan 1988; Joseph and Chalmers 1999; Bakker 2000; Desai, Lukas and Young 2000; Berkowitz 2001; Smith 2004; Ward 2007). These are the changes that geographers and others have been documenting for many years now. Left behind are communities managed through systems of governance prioritizing capital (increasingly financial capital) and shifting responsibility for ensuring social reproduction towards public-private partnerships or the voluntary sector. This landscape of neoliberalism generally describes what has existed within the US health care delivery system for decades. Consequently, by turning our analysis to this sector we may gain insight into the question of: do the historical mechanisms of neoliberalism (i.e. privatization, the dismantling of the welfare state, etc.) embed themselves into already neoliberalized spaces? Second, analyses of how neoliberal logics are embedding themselves within the US health care delivery system may inform our understanding of the process and consequences of the neoliberalization of health care delivery systems in the UK, Australia and New Zealand. By examining the weaknesses (i.e. large numbers of uninsured residents who lack

access to primary care) and strengths (i.e. very high quality and expensive care for those with comprehensive health insurance) of the US health care delivery system, we may inform political and policy discussions in other strategic sites of neoliberal expansion and experimentation.

The Neoliberalization of Milwaukee's Health Care Delivery System

My dissertation is organized in the following manner. The first paper broadly examines one aspect of Milwaukee's health care delivery system neoliberalization: the voluntary component of Milwaukee's health care safety net's rising diversity and importance. Theoretically, it engages with the 'shadow state' literature and its narrative of increasing state dominance, through funding mechanisms and regulation, of the voluntary organizations now responsible for formerly public services and spaces. Throughout the literature on the voluntary sector and the shadow state the diversity of the sector is often acknowledged and quickly disregarded as scholars seek to generalize about factors influencing its spatial distribution, political capital, impact on communities, and/or its emancipatory or regressive potential (Wolch 1990; Milligan 2000; Fyfe and Milligan 2003; Milligan and Fyfe 2004; Cloutier-Fisher and Skinner 2006). Lost in these abstractions are the quite different motivations and rationales behind organizing institutions as non-profit. In the US, this is particularly evident within the health care delivery sector, where non-profit institutions dominate and are sites of incredible surplus value production. This first paper illustrates the diversity of the voluntary sector through an examination of two types of voluntary organizations central in Milwaukee's health care safety net: corporate non-profit health care systems (CNPHCS) and free clinics. I reveal the challenges of discussing a singular voluntary sector given the different spatial strategies and competitive impulses exhibited by free clinics and CNPHCS. In addition, I argue that CNPHCS are sites of *shadow capital*, where maximum surplus value is accumulated through a corporate non-profit

legal structure. This surplus value is then available to be transformed into capital through the often-exuberant salaries paid to physicians, administrators, as well as advertising and legal firms. This project suggests the voluntary sector(s) perform a multiplicity of roles both in support as well as in opposition to neoliberalization projects.

My second paper examines the processes and techniques of neoliberalization at a micro-scale. Neoliberalization is commonly understood to signify a shift in modes of government from methods supporting full employment and a limited social safety net operated by the state, towards modes that prioritize capital accumulation, particularly finance capital, and social safety nets organized through public-private partnerships or the voluntary sector. Yet, this narrative of neoliberalization has become complicated by earlier phases of neoliberalization and its impacts. Previous rounds of neoliberalization have resulted in urban geographies already largely deficient of public social welfare institutions. This is particularly true within the US health safety net that was never fully enfolded into the Keynesian welfare state, as it was in Western Europe, or the US food stamp program. While we may question whether the US health care delivery sector was ever 'Keynesian', especially for those US residents that are non-citizens or between the ages of eighteen and sixty-three, the market-centric logics of neoliberalization are still embedding themselves within its health care safety net. However, given the lack of pure public health care safety net institutions, neoliberalization is occurring through what Brown and Barnett (2004) refer to as 'privatization by stealth'. This paper identifies the more hidden and subtle methods through which neoliberalization projects continue to occur despite the lack of a robust public welfare state. It suggests that neoliberalization, with its market-centric logic, is still a powerful mobilizing ideology despite the lack of the stable political-economic 'other', the Keynesian welfare state, which provided neoliberalization with its origins.

Finally, my third paper assesses the current political impacts, as well as the future possibilities, of one response to the neoliberalization of Milwaukee's health care delivery system: the growth of free clinics. It uses the geographies of resistance literature to assess free clinics as a response to the neoliberalization of health care delivery. It underlines the multiple political spaces free clinics occupy as a result of the entanglements of a diverse range of identities and practices within the clinic space. In Milwaukee, the primary entanglement occurs between the progressive Christian identity inspiring the practices of free clinic volunteers, and the commodified identity of the corporate non-profit health care systems that dominate health care delivery in the city. This paper suggests understanding the transition from oppositional identities, such as progressive Christianity, to resistance is an important next step in constructing more robust responses to neoliberal capitalism and other exploitive social relations.

The goal of this project is to shed light on how neoliberalization projects and logics have restructured urban health care systems in the US and examine what political potential for opposing these changes exists within the health care safety net itself. This is a particularly important time for such an examination because the future organization of the US health care delivery system is being contested. Geographical scholarship can help unpack our common sense understandings of the spaces of the 'state', 'market, and 'voluntary sector', and uncover the political, economic, and cultural elements producing those spaces. A more thorough understanding of the infiltration of all of these elements into the production of health care delivery systems may inform our understanding of current health care reform efforts. In particular, it should cast doubts upon whether our current health care crisis is one of insurance status and escalating costs or rather the commodification of access to health care where capitalist logics have gained dominance even our 'non-profit' sector. Additionally, this project provides

further evidence of the fluidity of neoliberal ideology. Its logics and common sense still resonate in an urban landscape with fewer public spaces and programs representative of neoliberalism's other: the Keynesian welfare state. This suggests that rather than entering a phase of post-neoliberalism, we maybe encountering new derivatives of neoliberal ideology and policy prescriptions as its advocates restructure its mechanisms and discourses to 'make sense' in our now neoliberalized world.

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CHAPTER 2

"MARGINS BEFORE MISSION': VOLUNTARY SECTOR(S) AND NON-PROFITS AS SITES OF SHADOW CAPITAL[5]

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Abstract

The academic scholarship on the voluntary sector has contributed several significant theoretical insights regarding its distribution and relationship to the state. In particular, Wolch's (1990) articulation of the voluntary sector as a form of *shadow state* has proven useful in understanding new forms of state-civil society relations.. Throughout this literature the diversity of the voluntary sector is often acknowledged and quickly disregarded as scholars seek to generalize about factors influencing its spatial distribution, political capital, impact on communities, and/or emancipatory or regressive potential. Lost in this abstraction are the quite different motivations and rationales behind organizing institutions as non-profit. In the United States, this is particularly evident within the health care delivery sector, where non-profit institutions dominate and are sites of incredible surplus value production. My paper illustrates the diversity of the voluntary sector through an examination of two types of voluntary organizations central in Milwaukee's health care safety net: corporate non-profit health care systems (CNPHCS) and free clinics. I reveal the challenges of discussing a singular voluntary sector given the different spatial strategies and competitive impulses exhibited by free clinics and CNPHCS. In addition, I argue that CNPHCS are sites of *shadow capital*, where maximum surplus value is accumulated through a corporate non-profit organization. This surplus value is then available to be transformed into capital through the, often exuberant, salaries paid to physicians, administrators and construction, advertising and legal firms.

Shadow Capital and the Myth of the Voluntary Sector

The voluntary sector has been a critical component of the social reproduction apparatus in the United States and other locations around the world for centuries. At various times and locations it has functioned as the primary provider of food, shelter, and health care, as well as

offering spaces for civic engagement and political participation. In the last two decades geographers have examined the changing structure and spatial organization of the voluntary sector and its relationship to the state, social reproduction, political activism and acts of caring (Chouinard and Crooks; 2008; Cloutier-Fisher and Skinner 2006; Fairbank 2007; Fyfe 2005; Fyfe and Milligan 2003; Lake and Newman 2002; Milligan 2000; Milligan and Fyfe 2004; Mitchell 2001; Morison 2000; Perkin 2009; Trudeau 2008; Wolch 1990). This work has produced important insights into the changing spatial distribution and structure of voluntary sector activity during the era of neoliberal capitalism and the shrinking welfare state that often accompanies it. Yet, throughout this work the diversity of voluntary institutions, while acknowledged, remains under-examined and their differences in relations to the state and markets under-theorized. The abstraction of all non-profit institutions into the 'voluntary sector' enables scholars to detect important trends in their composition and political economic function. However, the price for these theoretical advances is the continued reinforcement of the concept that there is a *singular* and *monolithic* voluntary sector whose relationship to these different entities can be generalized.

For example, in Wolch's (1990) highly influential work, *The Shadow State: Government and the Voluntary Sector in Transition*, she discusses the difficulties in defining the voluntary sector as a result of the tremendous diversity of organizations and institutions that compile it. Yet, in the process of illuminating the changing organization of the neoliberal capitalist state and its reliance on voluntary organizations to reduce social unrest and support social reproduction, her work largely ignores substantial differences among voluntary organizations in funding, institutional organization and their efforts to fulfill their 'public benefit'. A more recent example of this dilemma can be found in Milligan and Fyfe's (2004) work on voluntary organizations in

Glasgow. In their article they offer an excellent discussion of the value of a geographical perspective on voluntary organizations and analyze many of the factors affecting their composition in Glasgow. Yet, once again, their analysis makes no distinction in the spatial processes, relationships and dynamics between Quarriers, one of Scotland's largest voluntary organizations with over 2,000 employees, and the small charity shops run out of community centers or churches. This is not to insinuate that there are not similarities between these two types of voluntary organizations; rather I want to suggest that there are likely very important differences as well. It was my own research on Milwaukee's free clinics and CNHCSs that elucidated the problem with this sort of abstraction, and is the basis for this article.

I spent nearly two years in Milwaukee, WI researching the uneven development of the city's health care delivery system, completing over 40 interviews with physicians, health care administrators, government officials and volunteers, reviewing hundreds of newspaper accounts and other documents, as well as conducting over 100 hours of participant observation in one neighborhood free clinic. Nearly all of the health care facilities that comprise Milwaukee's health care safety net are part of the 'voluntary sector'[6]. These include the emergency rooms of several Milwaukee hospitals, six Federally Qualified Health Centers (FQHCs), and over a dozen smaller free clinics operating in church basements, office parks, and community centers. As I explored these various institutions, I turned to the literature on the voluntary sector to help me understand the development of Milwaukee's health care safety net. The dominant narrative on the voluntary sector in the era of neoliberal capitalism is that of an expanding voluntary sector in response to the dismantling of the Keynsian welfare state (Brenner and Theodore 2002; Mitchell 2001; Wolch 1990). Scholars have demonstrated the voluntary sector's spatial distribution is affected not only by need, but by state funding patterns as voluntary sector institutions chase

[6] The uncompensated care provided in private physician's offices being the only exception.

after territorially or thematic based funding opportunities (Fyfe and Milligan 2003; Milligan 2000b; Milligan and Fyfe 2004). Furthermore, the voluntary sector is portrayed as serving as a form of 'shadow state' or para-state space where state governmentality flows through non-state institutions (Milligan 2000a; Mitchell 2001; Morison 2000; Trudeau 2008; Wolch 1990).

Yet, in Milwaukee this theorizing fails to explain the changing spatial distribution or structure of the city's health care delivery system. First, non-profits have long played a central role in Milwaukee's health care delivery system, as well as the US welfare system more broadly. While, it is true that Milwaukee sold its public hospital in 1995 to a local Corporate Non-Profit Health Care System(CNPHCS), nonetheless non-profit hospitals have long served as safety-net providers in the city. If we understand the neoliberalization of the welfare state to mean the withdrawal of the state's role in providing the resources necessary for survival and the increasing reliance on voluntary sector institutions instead, than parts of the US health care sector were already 'neoliberalized' before the dominance of neoliberal capitalism as a state economic regulatory framework. Furthermore, rather than non-profits organizing themselves to maximize public funding opportunities, many (but not all) of Milwaukee's non-profit health care organizations are constructing obstacles to discourage those with public insurance from using their facilities; while others, such as free clinics, are providing services without significant state support. These differences amongst the non-profit institutions forming Milwaukee's health care safety net draw attention to a gap in our current understanding of the voluntary sector and its relation to neoliberal capitalism.

My purpose in this paper is two-fold: first, I disrupt the theoretical stability of the term 'voluntary sector' through my examination of Milwaukee's changing health care safety net. I demonstrate that the term 'voluntary sector', in many cases, is too broad a category for

understanding the socio-spatial relationships between markets, the state and non-profit institutions. The diversity within the voluntary sector, at least within the US health care system, and I suspect more generally, necessitates greater sociospatial and historical specificity when discussing these relations. There is no singular voluntary sector, but rather multiple sectors. Secondly, I advocate that in particular within the US health care sector, the non-profit legal apparatus is not only utilized to provide public benefit, but also to maximize the accumulation of surplus value. This paper reveals, at the risk of being trite, that non-profit institutions in Milwaukee's health care sector serve as a form of shadow capital. Spaces of shadow capital serve as sites for maximizing the accumulation of surplus value despite organizations that are commonly understood as existing on the periphery of circulation of capital. In the case of Milwaukee's health care delivery system not all of the non-profit institutions are expanding service delivery in response to a shrinking welfare state. Many are expanding their presence in the inner city in response to the declining commitment to proving care to the un/underinsured by the larger CNPHCSs. This demonstrates that rather than operating solely within the neoliberal state, the econocentric logic of neoliberal capitalism is embedded within the voluntary sector(s) as well.

My paper addresses these issues by examining two different types of voluntary institutions: corporate non-profit health care systems (CNPHCSs)[7] and free clinics. Both institutions emerged in the late 1980s, in part, the result of the rise of neoliberal capitalism and welfare state restructuring at both the federal and state levels of government. Both sets of institutions fit the classic definition of voluntary organizations as they are overseen by non-paid

[7] I use the term Corporate Non-profit Health Care System to denote large, integrated health care systems that operate through 501(c)(3) legal frameworks. These organizations differ from other portions of urban health care safety nets due to the large percentage of privately insured patients they treat. This differs from free clinics and FQHCs who treat almost exclusively the un/underinsured.

boards of directors, were created to perform a 'public benefit', and do not distribute profits to shareholders. However, my paper addresses the substantial differences in their response to the changing political economic climate accompanying neoliberal capitalism. While neighborhood free clinics expand their presence and financial commitment to providing access to health care for Milwaukee's un/underinsured, the CNPHCS's multiple roles in the health care safety net are more complicated. As this paper will demonstrate, the behaviors of the CNPHCSs are often times more consistent with for-profit corporations seeking to maximize market share and profit margins. These differences are central to both theoretical contributions this paper raises, namely that there is no singular 'voluntary sector' and the non-profit legal apparatus not only operates as a form of 'shadow state', but also as a form of shadow capital. In the following section I will provide some background on Milwaukee to provide context for the importance of non-profit institutions to Milwaukee's health care safety net.

The Historical Geography of Milwaukee's Health Care Delivery System

The Neoliberalization of Milwaukee's Health Care Delivery System and Health Crisis

Milwaukee is a large deindustrialized city and one of the poorest and most racially segregated urban areas in the United States (Poston 2009). Consequently, Milwaukee's health care safety net is an important site for maintaining the health and survival of the city's poorest residents. There is ample evidence of the neoliberal restructuring of Milwaukee's health care delivery system beginning in the 1980s and continuing into the 1990s (Andrulis 1997; Norton and Lipson 1998; Rowland and Lyons 1987). In October of 1984, Milwaukee's Aid to Families with Dependent Children (AFDC) recipients were enrolled in one of the largest Medicaid managed care pilot projects in the country (Rowland and Lyons 1987). This pilot project, initially limited to Milwaukee and Dade County, eventually became Wisconsin's statewide

Medicaid system. This marked the transition of Wisconsin's Medicaid payments from a Fee-for-Service (FFS) system, in which doctors are paid for services rendered, to a capitation system based upon Health Maintenance Organizations (HMOs) receiving payment for maintaining the health of their participants, regardless of services utilized. There are multiple types of HMO systems, however, the one adopted by Wisconsin is the most aggressive at reducing expenditures (Freund and Hurley 1995). Milwaukee County has the largest population in the state and is typically one of the state's two poorest counties as well[8]. Subsequently, the changes in Medicaid financing disproportionately affected Milwaukee County by reducing the financial resources available to support its health care safety net.

In addition to the reduction in state funding of health care for the poor, the state also ended its historic role in providing health care to the un/uninsured in Milwaukee. Wisconsin had a long maintained a statuary requirement to provide health care for the 'indigent'. In 1995, Republican Governor and presidential hopeful Tommy Thompson and the Wisconsin state legislature eliminated this obligation. Within twelve months John L. Doyne Public Hospital, the sole remaining public hospital in Milwaukee County, was sold to a CNPHCS[9] the operated a neighboring hospital. Doyne's sale was partly in response to its increasingly fragile financial situation. This was a consequence of the reduction in Medicaid funding, the increasing number of uninsured patients arriving at its emergency room and a decreasing commitment by other area CNPHCSs to supply uncompensated care (Victoria 2008; Gault 2006)[10].

The loss of the public hospital was particularly devastating to Milwaukee's uninsured as it was historically the largest supplier of charity care in the county (Bruen and Wiener 2002;

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[8] The other county being Menominee County, home of the Menominee Indian Reservation.

[9] Now known as Froedtert Health.

[10] In most cases interview participants names have been replaced using pseudonyms to protect their identity. This was done to either protect the identity of patients, or other professionals and activists involved in Milwaukee's health care delivery system.

Dickman and Ksobiech 2005). For example, in 1995, its last year of operation, Doyne provided $44 million dollars of charity care (Bovbjberg, Marsteller, and Ullman 2000). The transition to Medicaid Managed Care and the withdrawal of the state in the direct provision of care was a contributing factor to the reorganization of Milwaukee's health care 'voluntary sector' as the city's residents sought new resources to replace the loss of state funding and new sites to provide care in the absence of a public hospital. Yet, this now classic story of neoliberalization is complicated by the fact that the CNPHCS's commitment to provide health care for the un/underinsured was also eroding and was partially responsible for Milwaukee's public hospitals deteriorating financial situation in the 1990s (Victoria 2008).

The expansion of neoliberal capitalism throughout Milwaukee's political economy occurred during a time of crisis for its health care delivery system. Data and reports on Milwaukee's failing health care system are difficult to obtain. This is partly the result of the lack of attention US urban health care systems have received from scholars and its decentralized nature with multiple non-profit institutions providing health care services to the un/underinsured. But it is clear from my interviews and local newspaper reports (Boulton 2004a, 2004b; Held 1995; Manning and Marchione 1995; Marchione and Manning 1995; Williams 2003) access to health care in the city was a growing concern for health care providers and city officials. Several interviewees point to the 1990s as the period when Milwaukee's health care safety net broke down (Horner-Ibler 2006; Vilardo 2006; Victoria 2007). While data on the changing health care delivery system is not widely available, there is ample evidence of Milwaukee's health crisis. For instance, a 2006 assessment of Wisconsin counties ranked Milwaukee County last in health outcomes and second to last in health determinants (Vila, *et al* 2006)[11]. Research by Vila *et. al.*

[11]Health outcomes are based on mortality and health status measures; health determinants are based on the categories of health care (access to care, quality of outpatient care), health behaviors (exercise, tobacco and alcohol

(2007) found neighborhoods in Milwaukee's poorest zip codes were significantly less healthy than nearby communities with higher incomes. A health assessment of Milwaukee's central city conducted by Aurora Health Care[12] (2006) found that in the previous year: (1) 27% of respondents self-assessed their health as fair or poor; (2) 26% of respondents resided in households where a family member lacked health insurance; (3) and 17% of respondents were unable to receive needed care. In addition, Milwaukee routinely has one of the highest infant mortality rates (IMR) in the country. In 2008, its IMR was 10.6 infant deaths for every 1,000 births; this was nearly one and a half times higher than the national average.

Milwaukee's Health Care Safety Net

The medical providers, administrative staff and volunteers of Milwaukee's health care safety net are largely responsible for trying to decrease the health care crisis in the city. Milwaukee's health care safety net is comprised of five local hospital emergency rooms (operated by four different CNPHCSs), six Federally Qualified Health Centers (FQHCs), a network of twenty five free clinics and uncompensated care provided through local private physicians and medical centers. This research focuses on the organization and practices of the CNPHCSs and free clinics operating in Milwaukee. I focus, in particular, on Aurora Health Care (AHC) and the *Bread of Healing* Free Clinic. The selection of these two entities is in part strategic and in part symptomatic of the chance encounters existing in all qualitative research. AHC is the largest health care system in the state and operates the largest number of health care facilities in Milwaukee and its neighboring suburbs. *Bread of Healing* is one of the largest free clinics in the city and is closely linked to AHC through AHC's financial support of the clinic, and the personal ties between the staff of both institutions. All of the *Bread of Healing*'s lead

use), socioeconomic factors (income, education and social disruption), and physical environment (air quality, water quality and lead risk).

[12] The largest of the five CNPHCSs this research examines.

medical personal and administrators previously worked in AHC facilities before joining the clinic. Just as importantly, people affiliated at both organizations were willing to participate in interviews regarding Milwaukee's health care safety net and their own organizations.

AHC operates health care facilities throughout the eastern part of the state and is a central player in area efforts to organize an 'efficient' health care safety net. It is an integrated health care system, meaning it owns primary care physician practices, specialty care practices, hospitals, urgent care centers, and even pharmacies. It was formed in 1984 during the early days of hospital consolidation in Milwaukee when two independent hospitals merged to form the Aurora Health Care system. Currently, AHC operates facilities throughout 90 communities in Wisconsin and employees over 3,4000 physicians (Aurora Health Care 2010b). It operates seven hospitals in Milwaukee or within 30 miles of the city and is building an eighth in the suburban area of Oconomowoc. Aurora, in 2009, generated over $4 billion dollars in gross revenues and contributed over $25 million to "charity care", or uncompensated care, as well as donated nearly $6 million dollars in funds and services to free clinics, including *Bread of Healing*. Additionally, Aurora provided nearly $30 million dollars for other community health outreach programs. While these funds were not exclusively distributed in Milwaukee, given the city is AHC's largest market and the location of their corporate headquarters, Milwaukee received a significant portion of those funds. Consequently, AHC is an important component of Milwaukee's health care safety net.

The *Bread of Healing* opened its doors in 2000 as part of the ministry of Cross Lutheran Church. Their primary facility is located in northwest Milwaukee in a highly impoverished neighborhood. The surrounding zip code (53205) has a medium household income of $14,660 and 46% of the residents live below the poverty line (US Census 2000). Since 2000, the clinic

has provided primary care to over 1,500 uninsured residents and operates two additional satellite facilities that see approximately 50 uninsured residents every month (Horner-Ibler 2008). Their total operating budget is over $300,000 a year and the estimated economic value of the services they provide is over $1 million (Bread of Healing 2010). The number of patient visits the *Bread of Healing* provides has continued to expand each year since its establishment. This generates pressure to identify new resources and volunteers to meet the areas rising need for health care services. AHC is an important strategic partner for Bread of Healing, placing medical students at the clinic and donating substantial amounts of lab services and some financial support for clinic operations. AHC's relationship to Bread of Healing extends beyond just financial resources. Three former Aurora employees were central in creating the clinic: Dr. Horner-Ibler, Dr. Lang, and RN Cohen. Consequently, there are numerous personal and financial ties between the two institutions. Yet, despite these connections between Aurora and *Bread of Healing*, there are important differences in their responses to the rising health care crisis.

Variations Within the 'Voluntary Sector of Milwaukee's Health Care Safety Net

Voluntary Sector(s): Spatial Strategies

There are clear distinctions between the spatial strategies utilized by the Milwaukee area CNPHCSs and those of local free clinics. While both CNPHCSs and free clinics have aggressively expanded in and around Milwaukee, the nature of that expansion is strikingly different. Free clinics' expansion in Milwaukee has taken place where you might expect a non-profit, charitable health care institution to locate themselves: in communities with high rates of poverty and uninsured residents. In my discussions with free clinic administrators, two variables were fundamental in determining clinic creation and placement: 1) identifying neighborhoods in

need of health care services and 2) the availability of free or affordable space (Horner-Ibler 2006; Clarke 2007; Lang 2007; Lum 2007).

For example, the Marquette Clinic for Women & Children initially opened in the fall of 1997 in the back of a men's homeless shelter. This location was chosen as a result of the steady increase of women and children seeking refuge at the shelter and the shelters willingness to provide space for the clinic (Clarke 2007). The Bread of Healing clinic was created in 2000 as a response to the dwindling access to health care in northern Milwaukee (Cohen 2008; Horner-Ibler 2006; Vilardo 2007). Its creators, Rick Cohen, Barbara Horner-Ibler and Arthur Lang all worked at AHC's Sinai Medical Center, the last remaining downtown hospital in Milwaukee. During their time at Sinai, the health and economic costs resulting from the scarcity of primary care facilities in the central city were evident. They sought to create a space where uninsured patients could access care before, or in lieu of, emergency room visits. The Bread of Healing was established at Cross Lutheran Church due to its close proximity to large pockets of poverty as well as Rick Cohen's role as Parish Nurse and Tom Lang's longstanding membership at the church. As a result of these relationships, space was made available to the clinic at no charge and the clinic provides care to a large number of the church's parishioners and their friends and family (Horner-Ibler 2006; Lang 2007). The Open Door Free Clinic began in the summer of 2006 at Unity Church on the south side of Milwaukee. Its formation was a direct response to the deindustrialization occurring in that community and the loss of health insurance accompanying it. Once again, its specific location resulted from its organizer's church membership and Unity's willingness to donate the space free of charge (Lum 2007). These examples are emblematic of the two central factors influencing free clinic creation and placement: need and the availability of space.

These strategies, shared with me by clinic administrators are, reflected in the data on free clinic operations. Of the twenty-five Milwaukee area free clinics nearly half were located in the 53204 (four), 53205 (five), and 53209 (three) zip codes (Planning Council for Health and Human Services 2009). Those zip codes represent some of the poorest neighborhoods in Milwaukee County, with high concentrations of people living below the poverty line. According to the 2000 census, the percentage of residents living below the poverty line in the 53205 zip code was 45%; for 53204 it was 32.4% (US Census Bureau 2010). Free clinics seek out economically depressed neighborhoods with limited health care options. This spatial strategy is the result of free clinics focus on providing care versus obtaining profits. Seventeen of Milwaukee's free clinics are completely free to all patients. Of the clinics that do receive some payment, seven treat residents with public insurance[13] in addition to the uninsured, and six have a nominal flat fee or sliding scale, typically between $10 and $15 dollars (Planning Council on Health and Human Services 2009). Consequently, factors such as market share or payer mix; two variables central to the considerations of CNPHCSs are not factors for free clinics.

The spatial strategies of the CNPHCSs reflect a different set of logics and considerations. Rather than expanding into areas based primarily on the need of the communities and the availability of space, CNPHCSs are expanding in an effort to increase their market share of those with private insurance and, as a result, modify their payer mix. Payer mix is the term used to discuss the ratio of privately insured patients to those on public insurance or uninsured. A 'healthy' payer mix is one that seeks to reduce the number of patients served with public insurance or uninsured (with lower reimbursement rates or no form of payment) while maximizing those with private insurance. This strategy was evident when the, then, Vice-

[13] Due to low reimbursement rates, many Milwaukee residents with the recently defunct Milwaukee County public insurance, General Assistance Medical Program (GAMP) or Medicaid, struggle to find health care providers to treat them. They compose the underinsured demographic.

President of AHC stated (Gault 2007), "clearly there has been a business strategy from all of the hospitals [CNPHCSs] to maximize market share of commercial paying patients and *minimize, not abandon, but minimize exposure to government or no-pay patients*[14]. This outlook was shared by another former Vice-President at Wheaton Franciscans who stated, "[s]o I think the system is producing exactly what the incentives have created…you compete for business and big payer mix…payer-mix drives profits" (Applebaum 2007).

In an effort to modify their payer mixes, expansion by CNPHCSs is occurring, largely in the wealthier suburban fringe of Milwaukee with low rates of uninsured residents and poverty. For instance, AHC has built or is in the process of building two new hospitals in the Milwaukee-West Allis Metropolitan Statistical Area (MSA). They are located in the suburban enclaves of Oconomowoc and Grafton. In contrast to Milwaukee's high poverty rate, with nearly 20% of its families living below the poverty line, Oconomowoc has a family poverty rate of only 0.8%, while Grafton's is slightly lower at 0.6% (Planning Council for Health and Human Service 2009). AHCs expansion into Grafton and Oconomowoc was highly controversial as non-AHC affiliated hospitals were already located in both communities and many thought additional hospitals were unnecessary and may, in fact, lead to higher health care costs (Loudon 2001; Rinard 2006). In Oconomowoc, AHC's planned expansion resulted in prolonged legal battle between AHC and the city of Oconomowoc.

AHC is not the only Milwaukee area CNPHCS seeking to expand into more lucrative marketplaces. In recent years, six CNPHCSs (including AHC) operating in and around Milwaukee have spent a combined $1.3 billion building new facilities or expanding existing ones (Boulton 2009). AHC's contribution to this medical build-up, with their new facilities in

[14] My emphasis

Oconomowoc and Grafton, is only $373 million of this expansionary budget (Boulton 2009). In each case the expansion is occurring not in the central city were the need for greater access to health care is highest. Rather, the fixed capital build-up is almost exclusively in the wealthier suburban areas of the Milwaukee-West Allies MSA.

In addition to expanding into wealthier communities another element of the CNPHCSs spatial strategy is reducing their presence in Milwaukee's central city. At a time when AHC was aggressively expanding in suburban Milwaukee it was cutting back its services to the un/underinsured in Milwaukee's central city. Aurora shut down its pediatric clinic, located at Aurora Sinai Medical Center in 2003. The facility treated 11,000 children with Medicaid in its last year of operation (Manning 2003a). Additionally, that same year, AHC closed down their inpatient behavioral health clinics at both of their Milwaukee area hospitals, transferring the staff and beds to their suburban psychiatric hospitals (Manning 2003b). AHC's Positive Health Clinic, an outpatient clinic treating 300 area HIV/AIDs patients, was discontinued in 2005. In 2006, one of AHC's inner city primary care facilities was relocated from a neighborhood adjacent to the Westlawn Public Housing complex to a location much closer to the affluent communities of Wauwatosa and Brookfield (Goodman 2006; Horner-Ibler 2010). At AHC's Johnston Primary Care Clinic, one of their few primary care centers remaining in the central city, the number of patients they treated enrolled in the county's public insurance program (GAMP) was reduced, citing costs concerns, from 1,434 to 367 (Manning 2004b). Joining AHC in closing down facilities in the central city was Wheaton Franciscan, who in 2006 closed the doors at one of its last remaining hospitals in the city of Milwaukee, citing mounting economic losses.

In addition to their aggressive expansion into the wealthier suburbs of Milwaukee and reduction of facilities in the central city, there have been other attempts to modify the spatial

organization of Milwaukee's health care delivery system in order to reduce the number of un/underinsured residents that each CNPHCS serves. The most well-publicized of these, was AHC's decision to no longer treat patients with Medicaid or GAMP at their flagship hospital, Aurora St. Luke's Medical Center, located on Milwaukee's south side (Boulton 2006b). The new policy directed most residents seeking treatment with public insurance (with the exception of Medicare) or no insurance to one of AHC's other facilities, such as Aurora Sinai Medical Center or West Allis Memorial Hospital. This move created additional barriers to nearby, un/underinsured residents by asking them to travel greater distances to access medical care. This move was justified using an explicitly spatial metaphor as Aurora St. Luke's spokesperson Michael Brophy stated, "[w]e are going to give care to people *where it's appropriate and where we provide those services*[15]." When asked if this policy of treating patients where most 'appropriate' included those with commercial insurance and/or Medicare and their higher reimbursement rates, Brophy had no comment (Boulton 2006b). The un/underinsured are further discouraged from AHC primary and specialty care facilities through the receptionists, some of who were instructed not to provide appointments for new patients with state insurance or no insurance (Horner-Ibler 2006). Moreover, in an effort to discourage the 'inappropriate' use of their emergency room as a site for primary care, Wheaton Franciscan became the first emergency room in Milwaukee to introduce a flat fee of $150 for all emergency room visits. The true intention of this policy was demonstrated when they sent 5,000 uninsured patients, who owed the hospital for previous care, a letter stating their next visit would cost a minimum of $150 dollars (Manning 2003c).

The CNPHCSs and free clinics operating in Milwaukee have applied very different spatial strategies in the years following the demise of Milwaukee's broader economy. The

[15] My emphasis

CNPHCS have continually sought to insulate themselves from the economic costs of the un/underinsured by expanding into more lucrative markets and reducing their presence and consequently access in Milwaukee neighborhoods with high rates of poverty and the un/underinsured. Free clinics, on the other hand, have continually sought to expand clinic operations and services in these same communities shunned by the CNPHCSs. The differences between these two voluntary sector institutions are as significant as the impacts of their strategies.

Voluntary Sector(s): Collaboration Versus Competition

Another key difference between Milwaukee's CNPHCSs and free clinics are their interactions amongst themselves. There is evidence of collaboration between both the CNPHCSs and free clinics in Milwaukee. Many of the Milwaukee area free clinics worked together to establish the Free Clinic Collaborative and five of the area CNPHCSs were important in launching the Milwaukee Health Care Partnership. Both organizations are seeking to find ways of improving the access to health care, in particular primary care, for the un/underinsured in Milwaukee. However, their commitment to collaboration and willingness to incur financial costs to improve access is profoundly different. The free clinics have a collaborative relationship, one in which they share resources, information, and in some cases physical space. This is distinct from the CNPHCSs who compete aggressively with each other in the marketplace, each seeking to capture an ever-increasing piece of the lucrative commercial insurance market.

The free clinics collaborate in several meaningful ways. The first and arguably most important is the Free Clinic Collaborative. The collaborative currently includes fifteen area free clinics, most of which are located in the city of Milwaukee. Its primary function is sharing

information and resources between the Milwaukee area free clinics. One of the most important efforts housed within the collaborative is the Medshare program. The program is located in the Bread of Healing clinic at Cross Lutheran Church and is designed to enable free clinics to share available medications. The creation of one central pharmacy reduces the economic costs and space requirements of each clinic forming its own pharmacy and staffing it. Available medications are housed at the clinic and the inventory is shared with partner clinics. These meds can then be used to benefit patients across Milwaukee. In addition, the site serves as a training site for new technicians who can then work within the program or help staff other pharmacies as they develop. The Free Clinic Collaborative also coordinates applications on numerous grant proposals. Recently, the free clinic collaborative was awarded a $200,000 grant to improve primary care access across the city (Horner-Ibler 2010). Furthermore, the members of the collaborative often refer patients to each other for services that are not available at specific clinics or to enable patients to be seen quickly in the event that the referring clinic is not open (Clarke 2007; Tobin 2007). Finally, the collaborative serves as the chief advocacy organization for the free clinics. One member of the collaborative often participates in other area task forces on health care in the city. During my time in Milwaukee, I observed two *Free Clinic Collaborative* meetings and interviewed a majority of the members. During my observations and interviews, the relationship between the free clinics was always supportive, as they sought to strengthen each other's ability to provide health care services to the un/underinsured.

This is in stark contrast to the relationship between the CNPHCSs who it seems spend much of their time developing strategies to put their collaborators out of business. This is most evident in the alarming increase in advertising revenue being spent in the Milwaukee region by the leading CNPHCSs. By the late 1990s the newly formed CNPHCSs were investing heavily in

advertising. In 1996, the CNPHCSs operating in Milwaukee spent $7.7 million in advertising (Manning 1997). Just six year later, in 2002, this number had jumped to $15 million. This expenditure was more than Milwaukee area fast food chains and banks spent on advertising that year (Hellander 2005). While more recent data is not available for the entire region, advertising continues to be an important part of the CNPHCS's business strategies. Often these advertising blitzes are connected to rival CNPHCS's expansion into a market occupied by a competitor (Johnson 2005; Manning 2002). In addition to the significant investments in advertising the competition between CNPHCSs has also involved legal battles. The most publicized of these was the recent case filed by AHC against the city of Oconomowoc. The case, filed in 2001, was settled in the summer of 2006 and involved government officials in Oconomowoc as well as the leadership of ProHealth Care and AHC. The central issue in the case was whether the city had the right to rezone land in order to prevent AHC from building a new hospital a mile from an already existing ProHealth Care hospital. While the expenses of the protracted legal battle, which was fought in both the media and in the courts, is unknown, it is safe to assume this added substantial economic costs to the construction of the hospital in 2010. All of these expenditures do very little to improve access to health care for the un/underinsured or to reduce the health care costs in the city.

In addition to battling in the courtrooms, the CNPHCSs also actively struggle over local medical practices and staff. In the last ten years the CNPHCSs have competed with each other to buy up area medical practices. The scale of the mergers and acquisitions over the years is remarkable. The consolidation of Milwaukee area medical facilities into the control of the CNPHCSs includes hospitals, primary and specialty care practices, pharmacies and urgent care centers (Boulton 2008a, 2008b, 2009; Manning 1992; Staff 1994). As a result of this massive

consolidation, currently, all Milwaukee area hospitals and nearly two-thirds of primary care physicians are employed by, or affiliated with, one of the CNPHCSs (Task Force on Milwaukee Health Care Delivery 2009). The aggressive purchase of all Milwaukee area health care facilities is an attempt to expand the referral network of the health care systems and thereby capture medical revenues from all aspects of an individual's health care needs. In particular this is done to ensure that more profitable health care services are referred to providers within the CNPHCS network.

CNPHCSs have not only sought to compete against each other for health care facilities and market share but have also enacted punitive measures against physicians who leave their system for a competitor. AHC commonly utilizes restrictive, non-compete clauses with their employed and affiliated medical staff. This ensures medical personal that leave AHC cannot practice medicine within a certain distance of an already existing AHC facility for a specified length of time (Horner-Ibler 2006; Debruicker 2008; Manning 2001; Goodman 2006). The consolidation of medical facilities into the CNPHCSs can result in physicians being unable to practice medicine in the Milwaukee area at all, or even eastern Wisconsin, and this practice is not unique to AHC (Daykin 1996). In another case, AHC destroyed the medical records, personal journals, books and even medical licenses of three physicians who left to work with another area CNPHCS (Rohde 2007). AHC also overruled the election of the new internal medicine chief of staff at its West Allis Memorial Hospital because the newly elected chief was also an investor in a heart hospital partially owned by a rival CNPHCS, Covenant Health Care (Manning 2004c).

The behavior of AHC and its competitors is one that you expect to find in the for-profit world of the capitalist marketplace. Yet, all of these entities are part of the non-profit, voluntary sector now dominating Milwaukee's health care delivery system. The unfettered competition

between Milwaukee's CNPHCSs led one local physician to comment (Horner-Ibler 2006), "it's the business model that is driving...this… not-for-profits should not be permitted to be in the business of putting someone else out of business" (Horner-Ibler, 2006). This is in stark contrast to the collaboration that takes place between the local free clinics, where each clinics success is seen as another critical facility for Milwaukee's uninsured to access health care services.

The Voluntary Sector(s) As Shadow Capital

Scholars who theorize and analyze the voluntary sector often highlight the diversity amongst voluntary sector institutions (Fyfe and Milligan 2004; Morison 2000; Wolch 1990). Consequently, evidence of the different strategies and logics deployed by the CNPHCSs and free clinics are not surprising. Yet, if we return to Taylor's definition of the voluntary sector, we see little indication of these variations. According to Taylor (1992: 171), the voluntary sector acts as, "[s]elf-governing associations of people who have joined together to take action for public benefit. They are not created by statute, or established for *financial gain*[16]." Given the variation of voluntary sector institutions, we must ask if generalizing all non-profits as part of a 'voluntary sector' is appropriate or is Taylor's definition simply inaccurate. To answer this question we must have a clear definition of the public, or those who are benefiting[17]. I find Dewey's (1929) conception of the public as the totality of *publics*, or groups of individuals most useful in this context. With this in mind, an important question surfaces; are CNPHCs and organizational structure for maximizing pubic benefit or is the non-profit corporate organization merely a strategy of maximizing the accumulation of surplus value? If CNPHCSs are simply the best organizational structure for maximizing financial gain, then we may begin to reconceptualize them as sites of shadow capital production.

[16] My emphasis

[17] Although theorizing the nature of the public and public space has a long history within geography (see: Habermas 1989; Lefebvre 1991; Mitchell 2003), this is not the literature I turn to in this context.

Shadow capital might be conceived of as capital without the 'capitalist.' Given that the non-profit corporation lacks 'owners' of assets or shareholders, it does not fit seamlessly within Marx's classic model of capital accumulation. Yet, the money that gets circulated through the voluntary sector of the US health care system typically goes through the M-C-M' transformation, and this M' is often reinvested towards the creation of future surplus value in the form of new hospitals in wealthy suburbs or the purchase of new physician practices. Consequently, the only factor that destabilizes the classic Marxist model of capitalist production is the question of to whom, or where the surplus value (not reinvested into the production system, i.e. hospitals, clinics, pharmacies, etc.), is distributed. If the surplus value produced is utilized to cover the health care costs of the uninsured, provide community outreach programs and improve the health of the community the institution serves, then we might perceive non-profits as replacing a diminishing welfare state, as is frequently posited by much of the geographical literature (Brenner and Theodore 2002; Katz 2004; Wolch 1990). However, if the institution's public benefit is limited, and instead surplus value is distributed to individuals in the form of excessive salaries and benefits then we might perceive this institution to be a space of shadow capital accumulation.

Evaluating the public benefit of the CNPHCS is complicated! There is no doubt the CNPHCSs contribute a great deal of financial and other resources towards the provision of uncompensated care in the Milwaukee community. For example, AHC contributed over $32 million dollars towards their community benefit in 2009, including nearly $6 million dollars to support free clinics[18]. Furthermore, they provided over $25 million dollars worth of charity care. That brings AHC's total contribution towards fulfilling their public benefit to over $57 million

[18] Often the contribution to free clinics comes in the form of free or reduced laboratory services, or specialty care referrals.

dollars (Aurora Health Care 2010a). The significant financial commitment to providing community services is not unique to AHC; Wheaton Franciscan reportedly spent $29.4 million dollars in charity care in their 2009 fiscal year (Boulton 2010); Froedtert spent $30.9 million dollars on charity care (Johnson 2010). This financial commitment by the Milwaukee area CNPHCS to charity care is significant and, if the current economic crisis continues, expected to rise[19].

Yet, while these numbers on their own suggest CNPHCSs are fulfilling their public benefit, a closer inspection of their overall financial picture complicates this judgment. In the same year that AHC provided over $57 million in charity care or other community benefit programs it took in gross revenues of $4.2 billion (Aurora Health Care 2010a). Consequently, Aurora spent 1.35% of its total revenue in 2009 on its public benefit. This number is consistent with other area CNPHCSs. In 2009, Froedtert reported spending 2.2% of its total revenue on charity care, while Wheaton Franciscan reported spending 1.7% (Boulton 2010; Johnson 2010). There are many reasons to question whether this level of charity care is sufficient for CNPHCSs to fulfill their public benefit. Gentry and Penrod (2000) estimate the medium hospital benefit of exemption from income and property tax at 2.5% of total assets each year. Total assets does not just include revenue but also the value of fixed capital. This suggests that Milwaukee area CNPHCS are in fact increasing their profits as a result of their not-for-profit status.

In addition to the value of the tax benefits of the non-for-profit designation, there is other evidence that CNPHCS are operating as sites of shadow capital production. First, there is the payment structure. In 2002, the then CEO of Wheaton Franciscan, John D. Oliverio, received a

[19] It should be noted that Milwaukee area CNPHCSs have gotten into trouble in recent years over their billing procedures for uninsured patients. In previous years the uninsured were billed at a much higher rate than those with insurance which both increased the financial burden for those uninsured patients who made payments and also increased the reported value of the CNPHCS's uncompensated care or bad debt.

compensation package in excess of $1 million dollars (Manning 2004a). Ed Howe, the recently retired CEO of AHC received $3.2 million dollars in salary and benefits in 2003 (Boulton 2006a). It's not just the CEOs who do well at AHC. It spent $2.1 billion dollars on salaries and benefits in 2009 while employing 29,642 employees, for an average employee compensation package of over $70,000 per year (Aurora Health Care 2010a). Given that many of AHC's employees are lower wage orderlies, custodial staff, and other support staff this number is in fact a bit misleading (BLS 2010). Given this bifurcated earnings structure top administrators and physicians make substantially more than this figure. The high salaries given health care administrators and physicians is then available to be transformed back into capital through its reinvestment in financial markets, such as the stock market, currency markets, or real estate.

In addition to the pay structure, the CNPHCSs invest large quantities of money into financial markets through their investment portfolios and pension schemes. The CNPHCS have come under greater economic strain in recent years given the financial crisis, but not for the reason we might expect. Despite the poor economic conditions in the city, there has not been a large increase in the demand for charity care at the facilities of Milwaukee area CNPHCS (Boulton 2010). This is partially a result of the growth and expansion of free clinics. However, these same CNPHCSs are in financial trouble, as all posted significantly smaller profits, or even deficits as a result of losses on their investment portfolios (Boulton 2008c). For example, ProHealth's profit margin dropped 76% in its 2007 fiscal year, largely on losses from its investment activities. Children's Hospital of Wisconsin lost $13.8 million dollars in its 2007 fiscal year as a result of $44 million dollars in losses in its investment portfolio. Froedtert reported total losses of $37 million that same year as a result of its investment activity. The CNPHCSs investment in financial markets has curtailed their ability to increase or even continue

historic levels of charity care as they are forced to make-up for investment losses in their operations department.

Conclusion

The spatial strategies and competitive impulses between the CNPHCSs in Milwaukee are often justified as the costs of ensuring financial stability so they can continue their historic missions of providing health care for the Milwaukee community. However, the general withdrawal of the CNPHCSs from the central city, their efforts to put each other 'out of business', and their salary structure suggests the non-profit designation is much more of a strategy for maximizing the accumulation of surplus value, rather than a structure for ensuring public benefits can be met. Further evidence of this stems from the continued dominance of non-profits within health care delivery in the US, despite the money flowing through the system and the continued spread of neoliberal capitalism and market-centric ideology. While for-profit health care systems do exist, their market share continues to pale in comparison to the non-profit sector. This suggests the non-profit sector offers powerful competitive benefits that serve as barriers to the encroachment by for-profit companies into health care markets. Given that these competitive advantages are not being transformed into maximizing the CNPHCS's public benefit, and in fact it appears they are seeking to minimize this benefit, these institutions should be thought of as part of a shadow capital production system, where maximum surplus value is produced and distributed to individuals. CNPHCS's lack of owners or shareholders should not conceal the fact that this is fundamentally a capitalist production system focused on the creation of surplus value. Health care services are produced for those who can afford them, surplus value is created and distributed to those who control the production system (administrators and physicians), and those who are poor are left with higher incidence of illness and dying younger.

While this is occurring, we see the development of other institutions within the health care safety net seeking to mitigate the loss of the CNPHCSs from the central city. Free clinics' growth and different set of spatial strategies and collaborative spirit highlights the important differences within the voluntary sector. If, as is often the case, both of these institutions are indiscriminately lumped into the abstract category of the voluntary sector, the important differences existing amongst them is lost. Furthermore, one cannot understand the growth of free clinics without understanding the changes occurring within Milwaukee's health care safety net as a result of the growth of the CNPHCSs. This, in contrast to much of the current literature on the 'voluntary sector' that focuses solely on voluntary sector-neoliberal state relations, requires analysis of relations within the voluntary sector itself. So what does this mean for the 'voluntary sector?'

This research demonstrates that to understand the changing nature of the 'voluntary sector' we need research focusing: (1) on smaller spatial scales, which can capture the complexity of voluntary organizations and their relationships with each other, as well as with multiple state agencies and scales of government; (2) on particular segments and/or institutions within the voluntary sector, rather than generalizing about all voluntary/non-profit entities; and (3) we may need research questioning the utility of the term voluntary sector at all. If in fact the term hides as much difference across non-profit sectors and institutions, as the similarities it supposedly represents than we may need to develop new theories and languages regarding non-state and non-capital institutions.

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CHAPTER 3

'PRIVATIZATION BY STEALTH': PUBLIC-PRIVATE PARTNERSHIPS AND THE US HEALTH CARE SAFETY NET[20]

[20] Hossler, P. To be submitted to *Geoforum*

Abstract

The increasing privatization of state assets and services in neoliberal cities, especially those connected to social reproduction, has been well documented by geographers and other social scientist. One result of these privatization efforts is the continued growth of 'public-private partnerships' to deliver formerly public services, such as water or health care. Yet these spaces, produced through earlier rounds of neoliberalization, soon become strategic sites for future rounds as the pressure to create 'competitive' cities continues. This article documents the privatization of these hybrid spaces through more subtle techniques than outright sale. These concealed techniques include: the restructuring of the agreements that organize public-private partnerships, the employment contracts for those laboring within them, and the institutional discourses and practices these documents help constitute. I use the 'privatization' of the Milwaukee Clinical Campus, a public-private health care facility, to demonstrate the mechanisms and some of the consequences of these hidden forms of privatization, what Barnett and Brown (2004) characterize as "privatization by stealth". This case study suggests that rather than a discrete process; privatization should be theorized as operating on a continuum. Furthermore, academics can contribute to the political discussions regarding privatization by highlighting its changing mechanisms and continued effects on cities and urban social reproduction.

Introduction

In January of 2004, I had the misfortune of spending five days at St. Elizabeth's Medical Center in Utica, NY. Although my broken leg suggested ski season was off to a bad start, in most aspects, I was in a privileged position. I just recently became insured after several years of seasonal employment and consequently no insurance. I was left at the conclusion of my five

days in the hospital with a bill of over $20,000 and the anticipation of months of pharmaceutical and physical therapy bills. However, as a card carrying member of the insured, my portion of the total bill, including surgery, post-op appointments, physical therapy and pharmaceuticals, was just over $800. I looked at the mountain of paperwork and bills with a new found awareness of the fragility of my own body; it was hard not to wonder what might have happened if I'd been uninsured. How would a $20,000 bill affect my life? Or, how would my recovery have been different without access to physical therapy, or drugs that allowed me to live semi-comfortably during the long recovery process? How did my status as a white, middle-class, insured man affect my ability to access resources and spaces of medical care?

Discussions of universal health care or Medicaid reimbursement rates make for messy and complicated debates at the national level. This was exemplified by Clinton's failed national health initiative and the recent uproar over Obama's health care 'overhaul.' Yet, the consequences of such debates and decisions are real and important when grounded in the bodies of the uninsured, they have a major effect on, not only, the difference between 'health,' 'sickness,' or 'injury', but employment, housing, mobility, and a host of other life experiences.

Just prior to my time in the hospital I was contemplating a return to graduate school, where I anticipated researching the material consequences of urban poverty. My own recent experience with the US health care system informed my decision to investigate access to health care for poor and economically marginalized US residents. Life circumstance brought me to Milwaukee, WI in the fall of 2005 and a quick review of health data revealed the extent of the crisis in the city. The city's infant mortality rate (IMR) in 2004 was 20; a figure nearly double the national average for the same year. This number, however, conceals an even greater tragedy within African-American homes in the city where the IMF rate was 19.6. This IMR was larger

than the countries of Sri Lanka, Jamaica, Panama, Costa Rica and Chile, and just below the West Bank's in Palestine (McManus 2005). Milwaukee, in 2005 and 2006 rankings of the health determinants and outcomes of cities in Wisconsin, ranked last or nearly last in every statistical category (Vila, *et al.* 2006; Zank, *et al.* 2005). There are significant health problems facing the residents of Milwaukee, problems exacerbated by Milwaukee's legacy of racism, deindustrialization, and neoliberalized welfare systems.

As I began to examine the health care system in Milwaukee, I read several newspaper articles discussing the impeding nonrenewal/terminations of sixteen faculty members at the Milwaukee Clinical Campus (Boulton 2005a, 2005b). The Milwaukee Clinical Campus (MCC) is a joint partnership between Aurora Health Care (AHC) and the University of Wisconsin Medical School (UWMS). AHC operates thirteen hospitals and over 100 clinics throughout eastern Wisconsin making it the largest health care conglomerate in the state. The MCC partnership allows UWMS medical students, based in Madison, to receive training in 'urban' medicine at Milwaukee facilities owned and operated by AHC. UWMS faculty and staff, historically, provided instruction to medical students by providing care to primarily low income and underserved communities. Consequently, the MCC served as an important component of the city's health care safety net[21].

The sixteen faculty and staff resigned, or their contracts were not renewed[22], as a result of disagreements over the restructuring of the affiliation agreement between AHC and the UWMS. The affiliation agreement defined the responsibilities of all parties involved in the MCC. The

[21] Health care safety net is the term used to describe a network of health care providers whose patient mix (the ratio of privately insured, publicly insured and uninsured) includes a large percentage of publicly (underinsured) or uninsured patients. In Milwaukee this includes six Federally Qualified Health Centers, local emergency rooms and a network of over twenty area free clinics.

[22] The difference between resignation and termination in this case was semantic and resulted from the current cycle of their contract. Most of the employee's contracts were up for renewal and therefore their contracts were not renewed rather than terminated.

restructuring significantly changed the MCC by granting AHC greater control over UWMS faculty and residents. In response to the restructuring nearly all the MCCs sixty-four faculty and staff expressed concern. Eventually, several faculty and staff members left before the new agreement was implemented and sixteen faculty members choose not to sign new contracts. This effectively ended their employment with both AHC and the UWMS. The MCC faculty saw the restructuring as an abandonment of the historical mission of the MCC to deliver high quality medical instruction while providing critically needed care for Milwaukee's underserved (Horner-Ibler 2006; Debruicker 2008; Goodman 2006). This was a mission in which many faculty members had been involved in for a decade or longer. The changes to the affiliation agreement were justified by AHC and the UWMS through the discursive utilization of standard neoliberal rhetoric of cost containment, efficiency, and decreasing bureaucracy.

This paper uses the transformation of the MCC to expand and deepen discussions occurring within health and economic geography regarding the impact of neoliberalization on social reproduction (Bakker 2000; Barnett and Brown 2006; Brown and Barnett 2004; Joseph and Chalmers 1996; Katz 2001; Kearns and Barnett 1999, 2000; Kearns, Barnett and Newman 2003; Mitchell 2003; Mohan 1998; Moon and Brown 2001; Smith 2004). The focus of this paper is privatization, a process recognized as a key instrument in neoliberalization projects (Mansfield 2007). I use the MCC case study to investigate how privatization continues to intensify in cities and institutions already stripped of many of their public qualities and dominated by 'partnership' or private sector models of service delivery. This contributes to our understanding of contemporary processes of neoliberalization and health care in two significant ways. First, it expands our current understanding of privatization, both its mechanisms and impacts. Expanding this definition is important if we want to avoid what Barnett and Brown

(2004: 441) refer to as "privatization by stealth", a process whereby privatization is accomplished through more subtle and covert methods than the outright sale of public assets. These hidden methods of privatization may affect public discourse and debate regarding the transformations of public resources and spaces. Second, this paper seeks to add to the growing number of voices calling for health geography to reengage with spaces of biomedical care and the production of health care delivery systems (Kearns and Moon 2002; Parr 2004). This project highlights both how the theoretical work being done on neoliberalization can contribute to our understanding of health care delivery and reform as well as how health care delivery systems can inform our understanding of present and future trajectories of neoliberalization.

In this paper, I first briefly discuss the literature on neoliberalization with a more detailed engagement of the geographic literature on privatization drawing specific attention to the mechanisms used to implement it. Next, I discuss the history of the MCC to provide context for understanding its transformation before turning to the case study and my analysis of the privatization of the MCC. I demonstrate how the privatization of the MCC occurred through more indirect mechanisms, such as reorganizing teaching sites, altering the affiliation agreement, changing the faculty employment contract, and recent discussions of changing the name of the MCC. I conclude by discussing the importance of more nuanced and mobile understandings of 'privatization' in an age of rapidly changing boundaries between public/private spaces. These categories are better viewed as a continuum rather than discrete in contemporary cities as urban social reproduction apparatuses are now often dominated by hybrid spaces.

Neoliberalism and the Privatization of Urban Space

Neoliberalism at its most abstract is a political economic ideology promoting the 'market' as the optimal organizer of the production and distribution of human labor. Operationally, the

techniques of neoliberalization (i.e. policies to create/maintain/expand market mechanisms) in support of an ever expanding array of economic, social, and environmental goals are diverse (Barnett 1999; Brown and Barnett 2004; Fyfe and Milligan 2003; Hankins and Martin 2006; Kearns, Barnett and Newman 2003; Keil 2002; Mansfield 2004; Peck 2002; Roberts 2008). As Castree (2005) comments, this can include: privatization, marketization, deregulation, reregulation, commercialization, etc. Further complicating neoliberalization projects are the wide range of objects upon which neoliberal ideologies and logics operate upon and through. Bakker (2007: 434), for example, highlights three important spaces of neoliberalization in her discussion of resource management systems: institutions (laws, policies, rules governing resource usage); organizations (collective social entities governing resource usage); and governance (process by which resource use is managed). Yet, in spite of this variety of techniques for enacting neoliberalization projects, privatization continues to be a particularly important element of neoliberalism.

The importance of privatization to neoliberalization projects is apparent both theoretically and in the policy arena. Theoretically, privatization creates the conditions upon which many other aspects of neoliberalization are predicated. Mansfield (2007: 398) states:

> Privatization…is a disciplinary process that creates new kinds of subjects (both owners and workers)…The deeply transformative nature of the property relation indicates that contemporary privatization is not just one aspect of neoliberalism among many, but instead privatization is the necessary precursor. It is through privatization that neoliberalism becomes possible.

The private holding of commodities, the means of production, or one's own labor are the foundations of capitalist economic systems and the markets that make it possible. However, the extent of privatization brought about by neoliberalization projects makes its form of political-economic regulation unique. As Polanyi (1957), Harvey (2005) and Jessop (2002) point out,

early stages of liberalism maintained a large state presence in the organization and regulation of production, trade and social reproduction. However, with the rise in dominance of neoliberal logics many of these other functions of the state were dismantled based on the belief that the state's role should focus on supporting market mechanism and its interference in other areas should be restricted (Jessop 2002). Within the policy arena, privatization is one of the most utilized components of neoliberalization. Its importance highlighted in Williamson's (1990, 1993) work on the "Washington Consensus", a suite of ten policy directives generally understood to be good economic policy within the (1993: 1329) "economically influential bits of Washington". Privatization efforts continue to be a mainstay of IMF, World Bank and other development programs (Herbst 1990). Often imposed through structural adjustment programs under the pretext of creating the conditions for economic growth, these development programs frequently required the wholesale privatization of formerly public enterprises and utility assets.

Geographers have documented the extensive effects of privatization on production, trade, environmental health and household livelihoods (Bakker 2000; Joseph and Chalmers 1999; Mansfield 2004; Mohan 1988; Roberts 2008; Smith 2004). Yet, a precise definition of its meaning is rarely provided (Mohan 1988; Bakker 2000; Brenner and Theodore 2002; Kearns and Joseph 1993; Kohl 2002; McCarthy and Prudham 2004; Peet 2002; Roberts 2008). Smith's (2004: 376) definition is consistent with most geographers' use the term:

> privatization involves [the state] 'getting out' by not being directly engaged in the production and provision of goods and services. Thus a privatization policy involves a direct transfer of a service, either through ownership/or management, from the public to the private sector.

Smith's definition encompasses the two most discussed dimensions of privatization: the transfer of public assets to private entities (i.e.. sale of public utility company to private interests) and the

shift from the state directly providing services to purchasing those services (i.e. from providing garbage removal to purchasing garbage removal from private contractors).

This theorization of privatization captures important features of the loss of public control over public assets and programs; however, there is increasing evidence of more subtle mechanisms of privatization. Most obvious, is the recent discussions of new waves primitive accumulation or accumulation by dispossession (Harvey 2005; McCarthy 2004; Roberts 2008; Sneddon 2007;). McCarthy (2004: 336) defines primitive accumulation as the "imposed *separation* of most people from the means of production." The concept, as first introduced by Marx (1990) in *Capital Vol. I*, discusses the enclosure of the commons and separation of labor from the means of production as a necessary step in the construction of a capitalist mode of production. While Marx saw primitive accumulation as a distinct temporal period, recent scholarship is exploring new, novel forms of primitive accumulation as the state creates new opportunities for capital accumulation. For example, Guthman (2007) discussing Mansfield's (2004a, 2004b) work points towards examples of privatization through limiting access to public resources, rather than outright privatization of the resource, such as the right to fish in public waters. McCarthy's (2004: 337) discussion of international trade agreements shifts the concept from private ownership over the means of production towards the conditions of production, or "privatizing the right to transform and exploit general social nature in ways that will directly harm others." In each of these cases privatization is not the withdrawal of the state but rather the construction of new economic relations through the state's reorganization of public resources, regulations and institutions.

Another thread in recent scholarship on privatization is Brown and Barnett's (2004) discussion of co-location agreements between public and private hospitals in Australia. The co-

location agreements facilitate the construction of private hospitals next to existing public hospitals, or public and private institutions sharing one hospital. In their discussion (441) of the different strategies and possible ramifications of these agreements they theorize co-location agreements may be a form of "privatization by stealth." Privatization by stealth, in this case, is a covert technique of downsizing public hospitals through the discourse of shared public-private resources facilitated through co-location agreements. It is clear from these examples that privatization is more than merely the withdrawal of the state, rather it is a mechanism reconstructing the relationship between the state and private sector in a manner that reduces the public aspects of state resources and institutions.

The economic and health geography literature also identifies several dominant rationales for the necessity of privatization. It is necessary as a result of the crisis of the capitalist state brought about by the dwindling profitability of Keynesian economic regulation and capital's increasing mobility (Jessop 1995; Brenner and Theodore 2002; Peet 2002). It improves the efficiency and competitiveness of bloated public service systems (Barnett 1999; Joseph and Chalmers 1996; Mohan 1988), as well as increases innovation (Jessop 1993). Additionally, privatization is a tool for facilitating long-term sustainable resources use, avoiding the 'tragedy of the commons' accompanying open access resources (Mansfield 2004a). The diversity of techniques and rationales speaks to the important discursive role privatization plays in rearticulating state-capital-society relations. The question with which the remainder of this paper grapples with is to what extent does this theorization of the mechanisms and rationales for privatization explain the transformation of the MCC?

The Milwaukee Clinical Campus (MCC)

The MCC was created in 1974 by the UWMS and Sinai Samaritan Medical Center of Milwaukee. Its mission was twofold; 1) to provide broader clinical experience than was available in Madison or rural communities and 2) to provide direct care to Milwaukee's underserved (Turkal, Farrell and Howe 2003). The program grew quickly in its early years and at its peak employed over eighty physicians in a variety of specialty areas. Aurora Health Care (AHC) was created in 1987 through the merger of Milwaukee's two remaining inner-city hospitals, one of which was Sinai Samaritan Medical Center. The creation of AHC would prove to be the beginning of a massive consolidation of health care facilities and service providers in the city. Today, every hospital and nearly two-thirds of Milwaukee area physicians are affiliated with one the five area non-profit health care systems, such as AHC. By assuming control of Mount Sinai Medical Center, AHC also inherited the MCC and its partnership with UWMS. Initially, AHC continued to operate the MCC with few changes. However, in 1990, the mission of the MCC was subtly changed from the broadening of clinical experience and the provision of direct care to Milwaukee's underserved communities to "primary care education for students and residents that was *intertwined with serving community needs*[23]*"* (Turkal, Farrell and Howe 2003: 19).

Noticeably absent from this new mission statement is the spatial focus on Milwaukee's underserved communities. The seemingly innocuous removal of underserved in the mission speaks volumes about the trajectory of the MCC. Over the next fifteen years, AHC, with support from the UWMS, slowly but surely implemented a transformation of the MCCs presence and practice in Milwaukee. In response to the increased costs of providing 'charity care,' AHC

[23] My emphasis

sought to limit access to their facilities in neighborhoods with high rates of un/underinsured[24] residents and expand services in communities with potential for capital accumulation. This was accomplished both discursively, such as the transition from 'underserved communities' to 'community need' in their mission statement, and materially through the reorganization of clinics and the structure of the MCC. Throughout each of these changes the public nature of the MCC was slowly rolled back, although not as conspicuously as its sale or complete privatization.

The Privatization of the MCC

The restructuring of the MCC had four critical dimensions. The first was the gradual disengagement by AHC with poor neighborhoods in the city. At first glance one might not perceive this as a transformation of the MCC itself. However, as AHC provided the facilities where MCC faculty instructed medical students this changed the spatial extent of the MCC program. The second was the restructuring of the affiliation agreement. The affiliation agreement outlines the responsibilities of AHC and the UWMS in operating the MCC. The changes to the agreement in the summer of 2005 removed MCC faculty from administrative positions and transferred faculty employment from UWMS to AHC. The third was the reorganization of the employment contract and the terms under which the MCC faculty and staff worked. Not only was employment transferred from the UWMS to AHC, but it also imposed restrictive limits on the MCC faculty's ability to participate in public discourse regarding health care issues as well as their freedom to practice in other Milwaukee clinics. Finally, AHC has discussed the discursive rescaling of the MCC through renaming it the Eastern Clinical Campus.

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[24] The distinction between uninsured and underinsured is based on insurance status. The uninsured have no insurance and consequently all costs associated with medical treatment must be paid by the individual receiving care or be covered by the provider as 'charity care,' 'uncompensated care,' or 'bed debt.' Underinsured is a term most commonly used to describe those on Medicaid or other public insurance programs (not including Medicaid). It is categorized as underinsured as a result of the typically low reimbursement rates paid by the state to cover service costs.

Each of these dimensions is interrelated and often created the context in which the others are possible.

Disengagement with the Poor

During the late 1990s and early 2000s, AHC closed three central city clinics and substantially reduced staffing and services at two others (Aurora Health Care 2008; Manning 2001). While AHC closed clinics in more poverty stricken inner city communities they spent hundreds of millions of dollars expanding their presence in suburban communities with already existing health care providers (Boulton 2010). This included the purchase of many primary and specialty care physician practices and the construction of two new hospitals in the suburbs. AHCs expansion into the wealthy suburb of Oconomowoc included the costs of a five-year legal battle with the city council, which opposed the construction of another hospital in the city (Johnson 2005). These changes altered the spatial distribution of health care delivery in Milwaukee to the detriment of the city's poor and un/underinsured. It also reduced the number of central city locations MCC faculty, staff and students could be placed for their medical education.

The issue of where medical students are placed is not trivial; it carries important implications for the stability of Milwaukee's health care safety net. Medical education is closely linked to access to health care for the un/underinsured by providing the "workforce for care of indigent patients" (Fishman and Bentley 1997: 38). Medical students provide care at minimal cost to the un/underinsured as a part of their medical training. Consequently, whether medical students are placed in facilities near neighborhoods with high rates of poverty and the un/underinsured versus wealthier neighborhoods with high rates of privately insured residents is significant. The closing of inner city facilities and their replacement with suburban ones

restricted the number of sites UWMS medical students could received medical education in settings with high community need for access to health care.

In addition, to the closures and cutbacks, AHC many network doctors, including MCC faculty, to reduce the number of patients they served who were un/underinsured (Manning 2004). As one physician noted (Horner-Ibler 2006), "in my clinic...we have a small percentage of Medicaid, but its too high; 17% is too high. [AHC] want[s] 5%." An AHC official verified this claim when he commented that AHC was "drowning in GAMP patients [a county public insurance program]" (Gault 2007). As part of their efforts to decrease the numbers of un/underinsured patients treated by AHC, they established new admittance policies at St. Luke's, their most profitable hospital, and one of the only remaining Milwaukee city hospitals. The new policies denied treatment at the hospital for most non-life threatening services to the un/underinsured. It was the first hospital in the Milwaukee County to do so (Boulton 2006). Consequently, those area residents who are un/underinsured must travel greater distances to access care, despite AHC's status as a non-profit facility. This, again, helps AHC reorganize the landscape of health care delivery by making their flagship facility inaccessible to a substantial number of Milwaukee residents. These changes reduced the public nature of the MCC in several important ways. First, it reduced the number of entry points through which the public could gain access to health care services. Here the public is defined using Dewey's (1927) discussion of the public as the totality of publics, or the totality of numerous groups of individuals. Consequently, serving the 'public' would include treating patients regardless of insurance status. Furthermore, those with private insurance do not interact with AHC or the MCC as 'public' community members, but rather as consumers of health care services. They come to their facilities through a commodified relationship one which is going to secure financial rewards for AHC. Second, it

reduced the number of public community members the MCC would treat at its remaining sites. The pressure on MCC faculty to reduce the percentage of un/underinsured patients they saw in their practices and the outright refusal to treat un/underinsured patients at one facility further reduced the public nature of the MCC program. It is within this context that MCC faculty and staff perceived a dwindling commitment by AHC to fulfill the program's historic mission to provide health care services to Milwaukee's underserved.

The Affiliation Agreement

The affiliation agreement dictates the responsibilities of both AHC and the UWMS in providing medical education for students. Two different affiliation agreements are important for understanding the restructuring of the MCC. The first was signed in 1999 and the second, negotiated in the summer of 2005, went into effect on July 1, 2006. The new agreement fundamentally changed two aspects of the previous MCC structure in a manner reducing the public nature of the program: the prioritization of Milwaukee and the employment of MCC faculty. The first affiliation agreement (Aurora Health Care and Board of Regents of the University of Wisconsin 1999) contained specific language binding the program to the Milwaukee community. The very first page of the agreement (1999: 1) states, "AHC and the University desire to strengthen relationships *within*[25] the greater Milwaukee community." The following page (2) states, "for purposes of this agreement, units of the Medical School departments located in Milwaukee are designated as 'Milwaukee Departments' of the Medical School." This language continues later in the agreement and even more explicitly solidifies the

[25] My emphasis

special position of Milwaukee when it states (4) the Medical School will, "[f]oster the development of programs to address the health care needs of *urban Milwaukee residents*[26]."

In contrast to the 1999 agreement, the 2006 version all but eradicates Milwaukee from the focus of the MCC, other than a new provision at the end of the document. It begins by confirming (2006: 15):

> …the long-standing commitment of the Medical School and AHC to improve the health of the population of Milwaukee and particularly the health of the underserved residing near communities served by AHC's hospitals and community clinics.

It then agrees:

> …to *attempt*[27] to assign Students to Educational Sites located in underserved communities, to the extent such Educational Sites are available, and to the extent that such assignments meet the educational needs of the Student and will be a positive learning experience.

The discursive use of the term *attempt* highlights a shift away from the prioritization of Milwaukee's underserved by the MCC program. This transition is apparent when the following section states (2006: 15):

> The parties agree that consideration will be given to expanding the Educational Sites from the present concentration in Milwaukee to other clinical sites operated by AHC in eastern Wisconsin."

The second affiliation agreement significantly weakens the Milwaukee focus of the MCC by eliminating the city from much of the documents language and explicitly stating a desire to expand the operations away from the city. The removal of 'Milwaukee' from the Affiliation Agreement language serves to discursively reinvent the MCC from a program spatially fixed to the city of Milwaukee, towards one whose spatiality is more vague.

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[26] My emphasis
[27] My emphasis

The new affiliation agreement also transformed the MCC faculty's employment status. For over twenty years the faculty of the MCC were employed by the UWMS and worked within Milwaukee facilities teaching students and treating the underserved. However, in 2006 this changed, as the new affiliation agreement transferred faculty employment to AHC. The MCC physicians would remain faculty members at the UWMS, in the sense that they would continue to teach medical residents completing rotations at the MCC, but would now be employed by AHC. There were two important aspects of this change. First, MCC faculty would now be signing an employment contract with AHC, a private entity. Important elements of the employment contracts are discussed in greater detail below. Additionally, it granted AHC the power to terminate MCC faculty and staff, with the specific passage requiring their termination from the UWMS as well (Aurora Health Care and the Board of Regents of the University of Wisconsin System 2006).

These changes reduced the public nature of the MCC. The dislocation of Milwaukee from the spatial focus of the MCC reprioritized treating patients with private insurance over providing a public benefit by treating the un/underinsured. In many ways it was a necessary element of AHCs more general disengagement from Milwaukee's underserved neighborhoods. The MCCs mission to treat Milwaukee's underserved was incompatible with AHCs new spatial practice. In this respect privatization occurs through the reorganization of spatial practice towards locations where the public need is low and resource can be reallocated towards private patients and the creation of profits. Additionally, it granted AHC the power to create the MCC faculty and staff's employment contracts. This removed from MCC faculty and staff the privileges and protections (such as the right to participate in public discourse and protection from wrongful termination) granted employees at public (and most private) universities. The new affiliation agreement was

also a powerful symbolic gesture, which while not changing the pay or necessarily the space the faculty and staff work within, dramatically changed the perceptions of those employed at the MCC. Two physicians I spoke with both talked about the disciplining of MCC employees that would likely occur with the new contracts, both in their work environments and in their ability to participate in the health care debates in other venues (Horner-Ibler 2006; Goodman 2006).

The contract

While I have been unable to obtain a copy of the contracts between AHC and MCC faculty, due to protracted lawsuits regarding the transformation, I was able to speak with several former MCC faculty. In speaking with them they indicated that AHC sought to consolidate control over the MCC faculty practice and public discourse through the new employment contracts. This objective was evident in three specific provisions included in the new contracts. The first two provisions affected the ability of MCC faculty to practice medicine in Milwaukee. First, the contracts locked the MCC faculty into two-year agreements with AHC (Horner-Ibler 2006; Otter 2006; Debruicker 2008). This was a major sticking point for many faculty members who wanted to have an option to leave if their worst fears regarding the AHC's withdrawal from the central city came to fruition. By locking faculty in for a longer duration, AHC limited the ability for MCC faculty to resign in order to pursue other practice options.

Additionally, AHC placed a restrictive covenant on MCC faculty's future employment in Milwaukee. The covenant stated that any MCC faculty who signed the new contract and left could not practice within ten miles of existing AHC facilities for a period of two years after their employment with AHC concluded (Otter 2006). With AHC facilities distributed across Milwaukee this effectively prevented physicians and staff from practicing anywhere in the city. The degree of AHC's desire to prevent former MCC faculty from working in Milwaukee was

made clear, when they attempted to use the restrictive covenant to prevent a terminated MCC faculty member from treating patients in her private Milwaukee clinic (Horner-Ibler 2006). Ironically, many of her patients were enrolled in public insurance (the underinsured). These are the same patients whom AHC is continually seeking avoid in their own clinics. The restrictive covenant generated extensive opposition, as it prevented MCC faculty from continuing their mission of providing health care to underserved Milwaukee communities after their time at AHC was complete.

The last provision in the employment contract attempted to limit MCC faculty from participating in the growing public debate in Milwaukee regarding access to health care and the role of the non-profit health care systems. The contract contained restrictive language regarding issues MCC faculty were able to discuss in public forums. The extent of the restrictions were made clear when one physician (Goodman 2006) reported:

> It basically was totally the opposite of what you normally get in a university setting. [In a] university setting you have freedom of speech, you've got autonomy, you've have all these rights. You can essentially speak your mind and they can't do anything about it. With the AHC contracts you can't…and we have this employment lawyer that we're working with; these contracts were worse then the standard AHC contract that he's seen, far worse.

Another MCC faculty member suggested that this was an attempt to silence criticism of AHC by MCC faculty and staff. He stated "[i]n the last two years, the faculty has been battling the management of AHC and Sinai [the AHC hospital the MCC was located within]… our being there is in essence a conscience for them…and…that rubs them wrong all the time" (Boulton 2005a). My conversations with several MCC faculty members indicated that the contract allowed AHC to terminate MCC faculty and staff for criticism of AHC in public forums (Horner-Ibler 2006; Goodman 2006).

The employment contract worked in concert with the restructured affiliation agreement and AHC reorganization of its clinics to further privatize MCC faculty and staff. The most recognizable aspect of this is AHC's role as employer of UWMS faculty and staff. This feature is most consistent with the dominant narrative of privatization. This essentially privatized UWMS faculty and staff. Furthermore the restrictive language in the contracts maintained some level of privatization for up to two years after an individual left the MCC. Even more damaging was the restrictions on public debate the contracts implemented. As former MCC faculty and staff discussed, by signing the new contracts, their ability to participate in an ongoing debate about access to health care in the city would be stifled. This is particularly detrimental due to the very public role some MCC faculty played in the health care debate and the decreasing access to care in Milwaukee. The contract therefore, extended the privatization of the MCC temporally, through the two-year limit practicing near existing AHC facilities and spatially through those same restrictions, as well as the inability to participate in the health care debate in other spaces.

Eastern Clinical Campus

Recently, AHC officials contemplated changing the name of the Milwaukee Clinical Campus to the Eastern Clinical Campus. This is promoted by AHC as reflecting their desire to expand the 'successes' of the program to other areas of Wisconsin and offer medical students additional experiences in rural medicine as well. An AHC official stated, "I think it's how do you take this experience which has been good in an urban community and also get it in…tiny little rural towns relating to our Green Bay hospital, Kenosha Hospital, that's my sense of what that means" (Gault 2007). While this change has not been implemented, to date, it is the clearest example of attempt to discursively rescale the operations of the MCC. By changing the name,

AHC transforms possibilities. This potential transformation was clearly feared by MCC faculty. As one former MCC physician (Horner-Ibler 2006) stated:

> [AHC] also [doesn't] guarantee as to where we would work. No guarantee that we would continue to serve underserved, no guarantee that we would continue to serve the city. Because of those trends…and because they are moving towards calling us the Eastern Clinical Campus instead of the Milwaukee Clinical Campus, which is very symbolic, they are moving students from Milwaukee to Green Bay.

The spatial imaginary of the Milwaukee Clinical Campus is recreated to one that includes all of eastern Wisconsin. Suddenly there is nothing peculiar about having residents and faculty in Kenosha, Green Bay, or Oconomowoc.

While this discourse sounds good and makes sense implicitly with the overall mission to train students, it removes the Milwaukee Clinical Campus from its previous framework and organization. It effaces much of the historical-geographical context of the MCC and its medical education program. The medical students at the University of Wisconsin are already exposed to rural and suburban medicine through their work in and around Madison. The MCC was created in response to UWMS's need to provide instruction in urban medicine as well as to fulfill an important public mission of the university to provide a public benefit. The new affiliation agreement fails to acknowledge that the most pressing need for medical access in Wisconsin is in and around Milwaukee, or even the reservations of central Wisconsin, not Green Bay or Kenosha. It also helps facilitate the privatization of the MCC through the attempt to embed itself with different types of 'publics'. The primary challenge of the previous MCC organization for AHC was the Milwaukee 'public', its residents and community are significantly poorer and unhealthier than the publics of Green Bay, Kenosha, Oconomowoc, or Grafton. Renaming the MCC the Eastern Clinical Campus helps facilitate AHCs selection of new publics to serve; publics that will allow them to maximize the number of privately insured residents they treat and

amount of profit that flows through their system, while maintaining some aspects of 'public' through their affiliation with UWMS.

Discussion

In two ways the story of the MCC is similar to many case studies regarding privatization and its impact. First, although the direct results on human health of the privatization of the MCC are unknowable given the available date, it is clear the transformation reduced its original intent of providing health care to Milwaukee's underserved communities. For example, in the years leading up to and following the new affiliation agreement, AHC either closed or discontinued placing medical students at six MCC teaching facilities in Milwaukee's central city. They also reduced the placement of medical students in another four health care facilities (Aurora Health Care 2008). All of the affected facilities treat, or treated, unusually high numbers of un/underinsured patients, partly as a result of their locations near impoverished neighborhoods. The reduction of medical student participation brutally impacted the number of patients served by MCC faculty and students. The total number of outpatient visits provided by MCC teaching sites in central city locations dropped from 112,041 in 1999 to 50,242 in 2007 (Aurora Health Care 2008). While parsing out the insurance status of the patients served at these clinics is not possible with this data set, given the location of these clinics, it is likely the reduction in patient visits indicates a decline in access to health care at AHC facilities for Milwaukee's un/underinsured. For example, one of the clinics AHC closed served 11,000 children with Medicaid in 2002, its final year of operation. In this aspect, the privatization of the MCC is another example of the negative consequences of privatization on the poor and disenfranchised (Joseph and Chalmers 1996; Joseph and Chalmers 1999; Kohl 2002; McCarthy 2004; Mohan 1988; Roberts 2008). Additionally, the shift of the MCC faculty from UWMS to AHC

employment is similar to the dominant narrative on privatization regarding the withdrawal of the state and the privatization of state assets. The MCC faculty can be viewed as formerly public assets who are now located in the private sector.

However, the story of the MCC also demonstrates more concealed methods of privatization, and its wider range of impacts. While the employment contract was an important element in the MCCs privatization, it was only one of many. Of equal importance was the gradual disengagement with Milwaukee's impoverished central city by AHC. AHC new spatial organization and its central role in the MCC public-private partnership resulted in the privatization process beginning well before the signing of the new affiliation agreement in 2005. AHC, by the time the new affiliation agreement went into effect, had already restructured its operations to reduce the ability for MCC faculty to treat the un/underinsured in AHC facilities. Milwaukee erasure of from the new affiliation agreement combined with the relocation of teaching sites away from the central city worked collectively to reprioritize the MCCs focus from public benefits to private profits. The MCC restructuring also ran deeper than a mere change in who signs faculty checks. The restrictive covenants on MCC faculty medical practices and political discourse further stripped the public benefits normally accorded to university faculty.

These other methods of privatization support Brown and Barnett's concept of privatization by stealth. Public-private partnerships, like the MCC, are particularly susceptible to privatization by stealth because the particular public-private boundary is often already blurred. Patients who are treated by UWMS faculty and students in AHC facilities have very few signs through which to understand the nature of the MCC program and the partnership that creates it. For many patients and community members the MCC was simply a place to see a doctor. Consequently, the connection between AHCs restructuring of their facilities and the MCCs

community mission is unclear to the average Milwaukee resident, even those involved in the health care delivery system. This assisted in the privatization of the MCC occurring with little public discussion and debate. While it is likely that public debate would not have halted the restructuring of the MCC (the county allowed its last remaining public hospital to be sold for one dollar in 1995 with surprisingly little protest), what is more striking here is the inability to recognize this as privatization at all.

Furthermore, another consequence of the MCC restructuring, not mentioned in the privatizations literature, is its impact on political activism. During the years prior to the reforms several prominent MCC faculty and staff participated in public debates regarding access to health care in the city (Boulton 2005a, 2005b; Manning 2004). In several instances, this resulted in MCC faculty criticizing AHC policies and practices in the *Milwaukee Journal Sentinel* and internally at AHC facilities. The location of the MCC faculty as public officials working within AHC facilities made them ideal commentators on Milwaukee's health care delivery system. Several AHC officials I talked with spoke with frustration about the MCC faculty's perception of AHC's commitment to the poor (Gault 2007; Warner 2008). The new contracts have certainly been effective in silencing the political voice coming from within the MCC. Since the restructuring agreement there has not been a single statement in the *Milwaukee Journal Sentinel* attributed to an MCC physicians or official. This is in on contrast to six articles featuring MCC faculty commentary on health care related issues in the three years preceding the restructuring. Admittedly, one newspaper is an inadequate device for measuring political activism. However, it together with the discussion by former MCC faculty regarding the restrictive language in the employment contract does support the conclusion that the privatization of the MCC also reduced its role in contributing to public dialogue regarding health related issues in Milwaukee. In all

likelihood these contracts also reduced the level of political discussion occurring within AHC itself as MCC faculty now work for the company.

Conclusion

Privatization continues to be an important technical as well as rhetorical tool in the weakening of welfare state apparatuses across the US and internationally. The MCC case study demonstrates that privatization is frequently more than the transfer of assets or shift in government as service provider to that of service purchaser. Privatization is a process through which the public role of state assets, resources and spaces, is weakened. In the case of the MCC these private interest were economically driven. As we enter new rounds of neoliberalization, the ideologies of free markets, unfettered competition and limited government are interacting with public urban infrastructure already decimated by initial rounds of neoliberalization. In this new neoliberalized landscape public-private partnerships have often replaced formerly public government institutions and service delivery systems. It is just such a landscape through which privatization by stealth is so effective. In the absence of clear boundaries between public and private, subtle changes in language and practice can significantly undermine the public nature of spaces. This is apparent in the rapid decline of patient visits provided at MCC clinics after the restructured affiliation agreement. Yet, this process is obscured by the already muddy public/private boundary existing within the original MCC structure.

Expanding our understanding of privatization is important, if for no other reason, than expanding public dialogue about this process. For instance, identifying additional mechanisms and rationales for privatization may prove useful for generating increased discussion about the costs and benefits of privatization. Throughout my interviews with now former MCC faculty members, the consequences to academic freedom and educational praxis resulting from the

privatization of public school faculty members was never brought up by participants. This may be the result of their own inability to locate their struggle within the context of other privatization processes occurring throughout the city. Academics can assist with this connection by detecting similarities and differences across the various dimensions of privatization. This task is crucially important for building broader coalitions against the continued neoliberalization of production and social reproduction

Returning to medical/health geography, the rise of health geography was established on the critique of the biomedical model of health and its positivist theoretical foundation Kearns (1993). The development of health geography continues to expand the theoretical frameworks utilized for understanding health related issues, as well as the multifaceted human-environmental-cultural factors producing health inequalities. However, with a few important exceptions (Barnett 1999; Barnett and Brown 2006; Brown and Barnett 2004; Kearns, Barnett and Newman 2003; McClafferty 1989; Mohan 1988; Moon and Brown 2001; Scarpaci 1989) the (re)production of health care delivery systems in an era of shifting economic regulatory ideologies and governmental practices is considerably under examined. This is particularly true in the US context where access to basic health care has historically been a right for the wealthy while the poor struggle to gain basic services. A re-examination of the production of health care delivery systems is vitally important right now as the US and other countries struggle to construct new health care delivery systems with the hope of expanding access to health care while minimizing costs. The MCC case study suggests that any attempt to work through a combination of public and private resources will continue to face obstacles in the face of contradictory goals and objectives.

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CHAPTER 4

FREE HEALTH CLINICS, RESISTANCE AND THE ENTANGLEMENT OF CHRISTIANITY AND COMMODIFIED HEALTH CARE DELIVERY[28]

[28] Hossler, P. Accepted by *Antipode*. Reprinted here with permission of publisher, 5/2/2011

Abstract

Free clinics are an important part of the US health care safety net and their numbers are rising. This article offers a critical analysis of the politics of free health clinics in Milwaukee, WI. It uses the geographies of resistance literature to assess free clinics as a response to the neoliberalization of health care delivery. It underlines the multiple political spaces free clinics occupy as a result of the entanglements of a diverse range of identities and practices within the clinic space. In Milwaukee, the primary entanglement occurs between the progressive Christian identity inspiring the practices of the free clinic's volunteers and the commodified identity of the corporate non-profit health care systems that dominate health care delivery in the city. This research suggests that understanding the transition from oppositional identities, such as progressive Christianity, to resistance is an important next step in constructing more robust responses to neoliberal capitalism and other exploitive social relations.

Free Clinics, Neoliberal Capitalism and Resistance

In the last two decades the number of free health clinics in Milwaukee, WI rose dramatically. In 1987, only one free clinic existed in the city; today, there are nearly twenty and the number continues to rise. The growth of free clinics in Milwaukee is consistent with broader US trends (Isaacs and Jellinek 2007). Free clinics are the latest manifestation of efforts to provide health care for poor and uninsured. The growth of free clinics in Milwaukee is occurring during a period of significant economic restructuring and welfare retrenchment in the city. This restructuring is consistent with the ideologies and policy prescriptions of neoliberal capitalism[29], and includes: (1) the loss of Milwaukee's traditional manufacturing base, as a result of greater capital mobility and high rates of unionization in the city; (2) the reduction of welfare

[29] Milwaukee has been a central site of neoliberal experimentation, most notably within the education system and welfare administration (Carl 1996; Andrulis 1997; Winston *et al.* 2002; Deparle 2004; Ward 2007).

entitlements and expansion of workfare programs; and (3) specifically related to health care, the privatization of the public hospital system. The neoliberalization of Milwaukee's economy and welfare state has proven disastrous to the health of the city's residents. Milwaukee has one of the highest infant mortality rates in the country (FIMR 2004), is routinely the least healthy city in the state (Booske *et al* 2007; Vila *et al* 2006; Vila *et al* 2007), and its low-income residents struggle to access health care services (Manning 2004a; Rommell 2006). These trends are occurring in a city that was once hailed as the "the healthiest city" in the US (Leavitt 1996). Free clinics attempt to reduce these impacts by providing health care to the un/underinsured residents of Milwaukee. Yet to date, free clinics and their relationship to the neoliberal state and commodified health care system remains largely unexamined.

Geography's theoretical engagement with neoliberal capitalism offers considerable insight into the changing relationships between the state, capital and voluntary sector (Barnett 1999; Brenner and Theodore 2002; Peck and Tickell 1994; Swyngedouw 2005; Wolch 1990). In particular, the geographic literature on resistance and the 'shadow state' contributes to our understanding of new community institutions, such as free clinics, in response to neoliberal capitalism (Featherstone 2008; Katz 2001, 2004; Leitner *et al* 2007; Mitchell 2001; Pile and Keith 1997; Sharp *et al* 2000; Wolch 1990). The 'shadow state', as first theorized by Wolch (1990), is comprised of extra-state, non-profit institutions that deliver services previously provided by the state. Frequently, these services are provided with the assistance of public funding through block grants or other state subsidies. Within this context, the growth of free clinics in the city can be viewed as another example of the increasing importance of the 'shadow state' during the rise of neoliberal capitalism (Mitchell 2001; Wolch 1990).

The shadow state framework is constructive for generalizing about the role of the state during the age of neoliberal capitalism; however, it offers limited insight into the actual political identities and practices of free clinics and consequently runs the risk of generalizing about institutions that are very different. There is incredible diversity amongst the institutions that make up the 'shadow state'. For example, while Planned Parenthood and Crisis Pregnancy Centers can both be understood as filling the void left by the state's refusal to guarantee access to prenatal care and counseling. However, this abstraction overlooks critically important differences between the two groups' perspectives regarding the disciplining of women's bodies and reproductive rights. In the same way, simply conceptualizing Milwaukee's free clinics as part of the shadow state misses a great deal of the political diversity that exists within the practices of free clinics.

The recent work on geographies of resistance/contestation (Featherstone 2008; Katz 2004; Leitner *et al* 2007; Pile and Keith 1997; Sharp, *et al* 2000) provides another perspective on Milwaukee's free clinics, one that prioritizes the political identities of the staff and volunteers working within them. From the perspective of resistance/contestation, the 'oppositional consciousness' (Katz 2004: 251) to neoliberalized health care that motivates many of the individuals involved in free clinics becomes visible. This oppositional consciousness is often overlooked in the literature on the 'shadow state,' which positions institutions as politically impotent as a result of either their own refusal to take sides or as a consequence of their funding from state government (Wolch 1990). However, as my research demonstrates, the relationship between free clinics, the state, and the commodified health care system is considerably more nuanced than this. Opposition to dwindling access to health care in Milwaukee is central to the practices of many of the free clinic's volunteers and staff. Resistance results from the

entanglement of free clinic practices infused with oppositional identities *with* the practices of the commodified health care system and the state.

This paper answers two questions: (1) do free clinics 'resist' the neoliberalization of Milwaukee's health care delivery system, and if so how; and (2) how does identity, in this case religious identity, encourage or deter resistance to the neoliberal state and commodified health care systems[30]. This research contributes to the geographic literature in three important ways. First, its focus on health care delivery and the health care safety net is well-timed given the current debates regarding health care reform in the US. To adequately understand the reform efforts to provide greater access to health care currently underway, we must have a better understanding of the institutions stabilizing the current health care safety net. Furthermore, there are very few spaces where a radical political vision of health care is being organized or implemented. Given the well-financed campaign against the most 'radical' of these reforms (such as efforts to guarantee a right to basic health care for everyone in the US), it is vital to understand the political possibilities and obstacles existing within the health care safety net itself.

Second, this paper further develops the geographies of resistance literature by expanding the discussion beyond the different articulations of resistance towards theorizing how resistance is empowered or curtailed as a result of the identities through which oppositional consciousness is grounded and expressed. I use Castell's (1997) discussion of identity to argue that identities are accompanied by a corresponding set of beliefs and discourses that inform the priorities and practices of oppositional movements, such as free clinics. In the case of Milwaukee, the

[30] In Milwaukee, the commodified health care system is dominated by five, large corporate non-profit health care systems (CNPHCS). The non-profit designation complicates the manner in which the commodified health care system functions, but it does not change its fundamental priorities: to exert surplus value. This priority is exhibited in the mantra 'margins before mission" shared with me by the former CEO of one of Milwaukee's health care system (Howe 2008). The major different between for profit and non-profits is the latter has a vague legal requirement to provide a 'community benefit' and surplus value is not distributed to shareholders.

predominant identity informing the practices of free clinic is Christianity. It serves as the chief moral foundation for the critique of neoliberalized health care, a blueprint for practice, as well as an important network through which financial and material resources are obtained. Yet, free clinics are not merely religious spaces. Free clinics, in an effort to maximize the quality and quantity of services they provide, have become involved with numerous other actors and institutions with different identities and priorities. This relationship with other health care delivery stakeholders produces free clinics as spaces of 'entanglement' (Sharp *et al* 2000), where the practices of free clinics become entwined with those of the state and the commodified health care system. It is from the entanglement of these different identities and practices that free clinics relationship to neoliberalized health care emerges. Understanding how spaces with oppositional consciousness come to occupy diverse relationships to neoliberalism is an important next step in constructing more robust resistance to capitalism and other dehumanizing social relations.

Finally, this paper contributes to the increasing engagement with religion by geographers (Beaumont 2008a, 2008b; Cloke 2002; Critical Geography Listserv 2009; Jamoul and Willis 2008). The increasing attention religion is receiving in conferences, journals and listervs is emblematic of geography's increasing interest in how religion shapes space. Yet, there is considerable disagreement regarding this encounter, with some advocating that religion is an obstacle to social justice[31]. My research contributes to this discussion by demonstrating the importance of religion, as both a powerful cultural force producing space and as a set of beliefs informing specific practices aimed at creating more socially just communities. While sympathetic to critical analysis of the connection between religion and conservative politics

[31] See the discussion on the critical geography listserv on December 1, 2009 (Critical Geography Listserv 2009)

(Dittmer and Spears 2009; Gallagher 1997; O'Reilly and Webster 1998), this paper illuminates an alternative reading of the political possibilities of religious convictions. This is particularly important for geographers seeking to help transform the world they study, as religious ontologies inform a great deal of social justice activism.

Milwaukee: Epicenter of Neoliberalism and Its Failing Health Care Safety Net

Milwaukee was an epicenter of neoliberal experimentation during the 1990s (Deparle 2004). Tommy Thompson, the Republican Governor of Wisconsin, working with the state legislature and local governments, initiated an assortment of neoliberal policies within the spheres of public service provision, the education system, health care delivery and the welfare apparatus. Many of these neoliberal reform efforts were focused on Milwaukee, Wisconsin's largest city and one of the poorest and most segregated cities in the country. These reforms included the increasing use of Business Improvement Districts (BIDs) to provide formerly public services (Ward 2007) and the passage of the 1990 Milwaukee Parental Choice Program, which created the first publicly funded school voucher program in the country (Carl 1996). Additionally, in 1995, Thompson and the state legislature ended Wisconsin's historic state mandate requiring counties provide health care to the 'indigent' (Andrulis 1997). This was quickly followed by the privatization of Milwaukee's sole remaining public hospital in December of 1995. In 1997, Wisconsin became one of three states to fully privatize its Temporary Assistance to Needy Families (TANF) program, taking the additional step of allowing for-profit corporations to bid on state welfare contracts (Winston *et al* 2002). The extent of the neoliberalization of Milwaukee's welfare state was the subject of Deparle's (2004) award winning book *American Dream*. In it he traces the human effects of the transformation of Milwaukee's welfare state. These changes brought Wisconsin and Tommy Thompson national

attention as leaders in fiscal conservatism and welfare reform (Deparle 2004; Dionne Jr. 1997; Goldstein 2000; Pear 1996). It also shifted the responsibility for social reproduction from the state towards the shadow state or voluntary sector.

One area of social reproduction that was particularly hard hit by neoliberal experimentation was Milwaukee's health care safety net. Specific data on Milwaukee's health care safety net is difficult to attain, because the health care safety net in US cities is fractured, disorganized and consequently hard to study (Lewin and Altman 2000). However, it is evident from my many interviews with physicians, hospital administrators, and government officials that the mid-1990s marked the beginning of Milwaukee's growing inability to provide health care to the uninsured[32]. Additional evidence of Milwaukee's failing health care safety net is provided by the increasing attention the plight of the uninsured received in the local media (Aulakh 1994a, 1994b; Evans 1996; Held 1995; Manning and Marchione 1995; Marchione and Manning 1995; Pabst 1997; Resler 1997; Schuldt and Manning 1995). While data on Milwaukee's health care safety net is largely unavailable, we can get a picture of the extent of the city's health care problems by examining the more widely available data on health outcome and determinants.

A 2006 assessment of Wisconsin counties ranked Milwaukee County last in health outcomes and second to last in health determinants (Vila *et al* 2006)[33]. Furthermore, Vila *et al* (2007) found neighborhoods in Milwaukee's poorest zip codes were significantly less healthy than nearby communities with higher incomes. A comprehensive health assessment of Milwaukee's central city conducted in 2005 by Aurora Health Care (2006) found that: (1) 27% of respondents self-assessed their health as fair or poor; (2) 26% of respondents resided in

[32] This research is based on 41 interviews with physicians, health care administrators, government officials and patients.

[33] Health outcomes are based on mortality and health status measures; health determinants are based on health care (access to care, quality of outpatient care), health behaviors (exercise, tobacco and alcohol use), socioeconomic factors (income, education and social disruption), and physical environment (air quality, water quality and lead risk).

households in which a family member lacked health insurance; (3) and 17% of respondents were unable to receive needed medical care. In addition, Milwaukee routinely has one of the highest infant mortality rates (IMR) in the country. From 2005 - 2007, Milwaukee's IMR was 10.9; that's nearly eleven infant deaths, before their first birthday, for every 1,000 births. For comparison, this was over 1.5 times the state of Wisconsin (6.5) and the national (6.7) averages during the same time period (Chen *et al* 2009). Milwaukee has a long history of racial segregation (Levine 2002; Schmid 2004); so, it should come as no surprise that African Americans are disproportionately affected by Milwaukee's failing health care safety net. Milwaukee's African-American infant mortality rate in 2004 was 19.4, an indefensible figure; higher than many countries in the 'majority world' (FIMR 2004). Milwaukee county residents' poor health status and difficulty accessing medical care is indicative of its deteriorating health care safety net. It was this failure that prompted the creation and expansion of a vibrant network of free clinics in the 1990s and early 2000s. In the following section I explore the development and practices of this free clinic network.

Free Clinic's History and Significance

Free health care facilities have existed in the US since at least the late 1700's, when dispensaries provided the poor and 'indigent' free health care in cities throughout the northeast (Starr 1982). Yet, by the early 1900s dispensaries largely vanished from US cities, principally due to the institutionalization of academic medicine within the university and as a consequence of private physician's efforts to undermine them (M. Katz 1996; Starr 1982). While dispensaries disappeared from the urban landscape, the requirement for free health care did not. Following the demise of dispensaries, new institutions emerged to fill this need. While the historical-geography of free health care is beyond the scope of this paper, it is important to emphasize the

demand for free health care and efforts to provide it are long-standing components of social reproduction within the US capitalist system. Rosen (1971: 1620) acknowledges this when discussing neighborhood health clinics in the 1960s. He asserts that there is nothing particularly new about the current health care "crisis" in the US for the working poor. This sentiment, appropriate in the 1960s, is no less pertinent today.

Present day free clinics are modeled on the health clinics organized by the Black Panther Party, Young Lords and the counter-culture movement of the late 1960s[34] (Gandy 2002: Weiss 2006). They were a response to the pervasive racism that materialized into a lack of health care facilities for racial/ethnic minorities, as well as the rising number of transient youth flocking to US cities. In 1970, the first survey of free clinics in North America was conducted. It found fifty-nine free clinics in operation throughout the US and Canada[35]. By 1971, the number of free clinics had jumped to 135 (Schwartz 1971). It is currently estimated that 1,700 free clinics are operating in the US (Isaacs and Jellinek 2007). Although, this is in all likelihood a considerable underestimate given that many free clinics operate in the basements and closets of churches and community centers and as a result are known only to neighborhood residents.

Milwaukee's experience mirrors these national trends. The Black Panther Party operated the "People's Free Health Center" from 1970 until its demise in the mid-1970s (Black Panther Party 1974). Free clinics continued to emerge and disappear and by 1987 only one free clinic was known to operate in the city. However, just over twenty years later the number of free clinics climbed to over a dozen[36], with most of this growth occurring in the late 1990s and early

[34] See Heynen 2009 for an in-depth discussion on the Black Panther Party's "Survival Programs" more broadly

[35] Only five of the fifty-nine clinics operating in 1970 were located in Canada

[36] Getting an accurate count of free clinics is challenging. In addition to their micro-geographies there are additional questions such as, how many patient visits must they provide and what services must be available. For this paper I use the list provided by the Free Clinic Collaborative in the fall of 2007. The *Free Clinic Collaborative*

2000s. The timing of free clinic expansion is consistent with the neoliberalization of Milwaukee's health care safety net, most apparent in the privatization of Milwaukee's last remaining public hospital in 1996.

More important than the number of free clinics is the amount of patients and patient visits free clinics provide. For example, the *Bread of Healing* clinic, where I conducted much of this research, served 800 patients and provided over 4,000 patient visits in 2008. In that same year, the *Free Clinic Collaborative*, a network of Milwaukee area free clinics, estimated the network served over 14,000 patients. This resulted in 39,000 patient visits at an estimated value of $1.4 million dollars (Boulton 2006b). These numbers leave out the work of clinics not included in the network, such as those offering sliding scale fees or requiring nominal payments (typically $5 to $15 dollars a visit). If you include clinics such as these, the number of patients and the economic value of the care provided would likely double. For example, Walker's Point Clinic, which offers fees based on a sliding scale, provided over 12,000 patient visits while serving 4,000 people in 2006[37] (Vilardo March 26, 2007). However, providing access to health care is more than just the number of patients or visits provided; it also includes the types of services free clinics provide and the quality of that care. In both of these regards free clinics in Milwaukee offer an important sanctuary for Milwaukee's poor.

Free clinics frequently provide services not available to most residents living in Milwaukee's inner city, regardless of insurance status. The Bread of Healing offers social workers, psychologists, psychiatrists, disease management specialists, podiatrists and physical therapists. The House of Peace, another area free clinic, provides specialists in hypertension

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is a network of free clinics that meets monthly in Milwaukee. At the time this research began this list did not include many smaller free clinics and several large ones that have some sliding-scale fee services.

[37] The Free Clinic Collaborative has recently expanded to fifteen area free clinics, including Walker's Point.

management, Adult Wellness Classes, and morning walking groups. Walker's Point offers massage, acupuncture and Pilates. You would be hard pressed to find most of these services anywhere in the neighborhoods of South or Northwest Milwaukee and these are largely free of charge for the patients of free clinics. However, the most important service free clinics in Milwaukee provide is basic primary care. Free clinics provide this with a mix of physicians, physician assistants, medical students and nurses. Primary care is the foundation of maintaining healthy bodies and is a service the uninsured struggle to obtain (Forrest and Starfield 1998; Grumbach *et al* 1993; Newacheck *et al* 1998). While free clinics are not able to provide capital-intensive services such as chemotherapy or MRIs, they do offer a wide range of low cost preventive and health maintenance services. These help keep their patients out of the local emergency rooms and the costs associated with such visits.

In addition to the variety of services free clinics offer, they also provide high quality care to their patients. I was only able to obtain permission to interview patients at the Bread of Healing. Yet, from these interviews and the many hours I spent in the clinic waiting room it is clear the patients overwhelmingly evaluated their care at the Bread of Healing as high quality. When asked about their care, all of the patients I interviewed indicated that it was "good" or "excellent". Frequently, the patients distinguished the providers at the Bread of Healing from other health care providers by citing their 'caring.' The most common elements patients used to identify 'caring' were their ability to get medical services and medications for free and the communication between patients and staff.

I should point out the high quality health care Bread of Healing's patients felt they were receiving could be productively analyzed through the growing literature on the 'ethics of care' (Conradson 2003; Parr 2003; Popke 2006). Yet, this is not the point I seek to make in this

project. My more limited theoretical observation is we should not be surprised the decommodification of health care services at the Bread of Healing contributed to producing it as a 'space of care' (Conradson 2003). Given the profit motive is absent in the relationship between free clinic providers and patients, patients interpret their ability to receive medical services as evidence that free clinic providers 'care' about them. The link between decommodified health care and 'caring' is forged partly as a result of the patients of free clinics deep suspicion of the commodified health care system. As one patient (Patient 4 March 10 2008) commented:

> I mean the doctors [in the commodified health care system] don't *care*[38] what prescriptions they're writing or you know the costs of the prescriptions. They like writing stuff that's new out on the market…the stuff that's new..is tier 3. So, on your insurance it's going to run $125. With my prescriptions it's running $765 a month on top of my insurance amount. That's over $1000 a month for my health care.

Patient 4's comments suggest that physicians in the commodified health care spaces aren't sensitive to the economic realities that poor residents face every day. This suspicion is bolstered by the recent discovery that the corporate non-profit health care systems (CNPHCS) were charging Milwaukee's uninsured residents higher rates for health care services than those with insurance (Manning 2004b; Nunally 2005). The absence of market relations from the space of free clinics creates room for other social relations to form. Caring is the relationship that is most commonly identified by clinic patients and staff.

The decommodification of health care in clinic spaces affects the clinic practice as well. The patients at the Bread of Healing regularly commented about the different types of communication that occurred in free clinics. Patients felt that clinic staff explained their health status more effectively than providers in the commodified health care spaces. As one patient

[38] My emphasis

commented regarding his previous experience with a provider when he was insured (Patient 13 March 26, 2007), "you know you're depending on a person to tell you [a medical provider to tell you about your health], and … a lot of times they assume you know, but you don't know." Another patient at Bread of Healing (Patient 9 March 26, 2007) when discussing her physician at the clinic stated "She's really nice…[she] explains things…the last 2 or 3 doctors I had before…they didn't care." Patients at Bread of Healing experience a deeper level of communication. This is likely a consequence of the absence of time constraints imposed by profit margins, as well as the necessity of effective communication given the limited capital resources for medical tests and medications. Free clinics are vital for the uninsured living in Milwaukee, but do they resist the neoliberalization of Milwaukee's health care delivery system? Or, are they merely a new component of the shadow state, and therefore part of the neoliberal project itself? Before getting into the specifics of my case study a brief review of the current discussions regarding resistance/contestation is instructive.

Are Free Clinics Space of Resistance?

In recent years, there has been a lively and productive discussion within geography concerning local and translocal responses to neoliberal capitalism and other forms of injustice (Addie 2008; Boyer 2006; Elwood 2006; Featherstone 2008; Harvey 1996; Katz 2001, 2004; Leitner *et al* 2007; Pile and Keith 1997). These discussions have engaged with four broad themes: efforts to confront the political economic structures and rationales of neoliberalism (Larner and Butler 2007; Miller 2007); opposition to specific neoliberal policies (i.e. privatization, welfare state restructuring) attributed to these rationales (Bond and McInnes 2007; Boyer 2006; Katz 2004); the mutually constitutive nature of neoliberal capitalism and its responses (Leitner *et al* 2007; Mayer 2007); and the spatialities of resistance (Featherstone 2008;

Leitner *et al* 2008; Routledge 1997; Wainwright 2007). The most important contribution of this literature is its reminder to academics and activists alike of the contingent nature of neoliberal capitalism and the struggles it generates across a variety of spaces and scales.

Recently, the concept of 'resistance' was critiqued for its conceptual muddiness resulting from the abstraction of numerous different responses to neoliberal capitalism into one all encompassing framework (Katz 2004; Leitner *et al* 2007). Katz's (2004) 'categories of response' and Leitner, Sheppard and Peck's (2007) 'trajectories of contestation' offer more refined typologies of the variety of responses to neoliberalism. While I agree with their theoretical intervention, it is important to keep in mind the potentially different priorities between radical theory and praxis. The framing of a variety of responses from foot dragging (Scott 1985) to large-scale occupations of city streets (Wainwright 2007) as 'resistance' draws attention to the diverse manifestations of opposition to neoliberal capitalism. This has important political value as it helps bridge connections across a host of different spaces and scales, identity based politics, and organizations (labor, environmental, religious, immigrant rights) under one shared understanding of the disastrous effects of neoliberal capitalism on human bodies and the environment. That said, Katz's (2004: 241) point that "these oppositional responses [to neoliberal capitalism]…can be unpacked to refine conceptualizations of resistance that have come to seem too broad and too uncomplicated to be much use in the face of the erosive conditions associated with contemporary capitalism" is theoretically important.

Katz (2004) suggests that what is commonly portrayed as resistance is actually three different responses: resilience, reworking, and resistance. Katz (244) theorizes resilience as individual acts of defiance that seek to improve one's chances of survival when confronting the deleterious effects of neoliberal capitalism. Resilience is theorized as individual acts, so it does

not apply to the work of free clinics in Milwaukee. The notion of reworking is theorized as larger scale, collective responses that recognize "problematic conditions and…offer focused, often pragmatic, responses to them" (247). A key aspect of reworking is its failure to challenge the hegemonic social relations that produce inequalities. Instead, it works within hegemonic systems, reallocating resources away from the dominant institutions towards specific projects. Examples of reworking can frequently be found in the practices of food banks, workers centers or homeless shelters. Both resilience and reworking are necessary, yet problematic. Individual and collective efforts to maintain human health and social reproduction in the face of the revanchist practices of neoliberal capitalism serve to affirm two of its basic tenants: individual responsibility and volunteerism. It is this tension that Katz (2001: 717) alludes to when she states that social reproduction is 'not revolutionary.'

Katz (251) defines resistance as practices that "reorder and sometimes undermines the structural constraints that affect everyday life both to make it more livable and to create viable terrains of practice…*with the invocation of an oppositional consciousness*[39]." Here, Katz identifies two important dimensions distinguishing acts of resistance from those of reworking and resilience. The first is reordering or undermining processes that create human suffering. Secondly, Katz suggests that the production of an oppositional consciousness is crucial for acts of resistance. While Katz does not define oppositional consciousness, I interpret her to mean the construction of a consciousness rejecting social relations, such as capitalism or patriarchy, that produce structurally marginalized identities, such as the unemployed or women. Acts of resilience and reworking work to improve material conditions, where as resistance actively opposes the ideologies and practices producing human suffering in the first place. Katz's

[39] My emphasis

framework offers a useful starting point for evaluating free clinics as spaces of resistance or reworking.

Free clinics: reworking access to health care in Milwaukee

My initial interest in Milwaukee's free clinics was a desire to locate spaces resisting the injustices of the US health care system. I first encountered the *Bread of Healing* as a result of the biting criticism its Medical Director, Barbra Horner-Ibler, was directing against the state and the CNPHCSs regarding their commitment to providing health care to Milwaukee's un/underinsured. I began this research with the assumption that free clinics were resisting Milwaukee's health care delivery system that distributed services to those who were privately insured or were deemed 'deserving' of publicly subsidized insurance. However, my research demonstrates that free clinics can best be understood as reworking Milwaukee's health care delivery system. Their main focus is not undermining the commodified health care delivery and the underdeveloped welfare state. Rather, they prioritize recalibrating power relations in order to maximize the quantity and quality of the services free clinics can provide. The staff and volunteers of free clinics use a variety of tactics in this effort.

First, all of the free clinic's medical personnel that I interviewed had experience working in the commodified health care system. This provided them with institutional knowledge about the system that was used to rework it in a manner that maximized the resources free clinics were able to acquire. Obtaining resources from the CNPHCSs, in the form of funding or medical services (i.e., testing and lab work), was a constant struggle. But, the free clinics became adept at identifying tactics for obtaining additional support. For example, one clinic director[40] (Director 1 May 25, 2007) spoke about the constant search for external funding to establish or

[40] Some names have been changed in places to protect the anonymity of interview participants.

expand services. When I asked whether he worried about services being withdrawn after funding ran out, he stated that the free clinic was more successful at obtaining funding from the CNPHCS for already existing programs. He speculated that once the free clinic started a program the CNPHCS feared its discontinuation might produce additional costs for them, through increased emergency room visits. Consequently, they were more likely to offer funds to continue programs than they were to create them. Another example of reworking occurred when patients at the *Bread of Healing* needed services the clinic was unable to provide. While working the front desk one afternoon, I observed a nurse discuss with a patient the language required to ensure she was admitted at one of the local emergency rooms. The emergency rooms have become one of the front lines in the battle by the CNPHCS to limit their exposure to the economic costs of the uninsured. The nurse at the free clinic was providing the patient with important information to negotiate the triage process and increase their odds of being treated. The institutional knowledge of free clinic staff and volunteers assisted them in reworking the power balance to maximize the resources available to treat uninsured patients.

In addition to institutional knowledge being utilized, free clinic staff and volunteers drew upon the network of personal relationships they had with medical personal and health system administrators. Throughout my research interview participant's recounted stories of phone calls made on behalf of patients to various health care facilities. One physician discussed calling every hospital in the city searching for an oncologist that would treat an uninsured man's prostate cancer (Horner-Ibler March 18, 2008). Another discussed calling the financial counselor of a hospital he had worked at to negotiate a reasonable payment plan for a patient that required minor surgery (Cohen March 17, 2008). These networks of personal relationships were instrumental in securing more services for patients.

Finally, while the results are harder to determine, free clinics put pressure on the CNPHCSs and the state through their appeals to the media, primarily the *Milwaukee Journal Sentinel* (Boulton 2006b; Johnson 2009; Rinard 2007; Williams 2003). In most of the news stories free clinic staff and volunteers avoid placing blame on a particular stakeholder, but are quick to point out the injustice of the current system and the human suffering it generates. Media outlets are another space where clinic staff attempt to rework the power dynamic by applying pressure on the city and the CNPHCSs to increase their commitment to providing health care for the uninsured. All of these efforts were less about opposing the processes producing uneven access to health care across Milwaukee; instead they sought to produce greater access to services within the current US commodified health care system. Consequently, these oppositional acts served to rework access to health care in the city, rather than resist/contest the current delivery system.

Free clinics: resisting the working condition of the commodified health care system

Many of the medical providers I spoke with discussed their frustration with their working conditions while employed by the CNPHCSs in Milwaukee. The three main complaints about the labor conditions were the time constraints of patient visits, the pressure to change their 'payer-mix' and their gender dynamics. The first two were a direct result of the increasing pressure on medical providers to generate profits. Medical providers lamented about the mounting demand to speed up patient visits in order to increase productivity. Often, there were monetary rewards and penalties based on productivity. The frustration with this pressure is palpable in the statements from the Medical Director at the *Bread of Healing* (Horner-Ibler December 14, 2006):

> For me this is a mission, this is a ministry. You know…it's a calling, it's not a job, it's not a paycheck and the business model for health care does not

> understand that. They cannot comprehend that. They say, 'what if we pay you $50,000 more to see 2000 more patients.' No thanks. That's not why I do it.

Several of my interview participants stated that one of their primary motives for working in free clinics was the ability to treat patients without these time constraints. Patient visits with physicians at the *Bread of Healing* typically lasted at least forty-five minutes and it was common for visits to last well over an hour. This allowed for different types of treatment options to be explored. For example, medical providers at the *Bread of Healing* would often discuss any obstacles to healthy behaviors in their patient's daily routines and attempt to identify solutions. Interventions that rely on a deeper level of communication are limited by time constraints in other medical settings.

In addition to the time constraints, medical providers were also frustrated with the constant demand to alter their 'payer-mix'. Payer-mix is the metaphor used to discuss the ratio of privately insured to publicly insured or uninsured patients a physician or facility treats. The neoliberalization of Milwaukee's health care system was accompanied by increasing pressure on providers to enlarge the number of privately insured patients they treated. Tom Lang, (May 23, 2007) a physician who worked at one of the city's largest health care facilities for over two decades, described the new working environment as, "there was always this pressure and one suggestion after another as to how to change the payer mix". When I discussed this with the Vice-President of one of the largest CNPHCSs in the state he acknowledged that this was a priority for the organization (Gault May 5, 2007). Medical providers, by working in free clinics, could treat patients regardless of insurance status. In fact, occasionally, at the *Bread of Healing*, medical providers treated insured patients who were having trouble getting treated for various reasons.

The final complaint about working conditions in the CNPHCS is the long-standing, patriarchal, power relations present in the health care field. Women, for instance, are significantly less likely to hold leadership roles in health care facilities and Academic Medical Centers (Kvarner *et al* 1999; Nonnemaker 2000). Additionally, the male-dominated health care profession often marginalize medical specialties, such as nursing and midwifery, with high rates of participation by women (Carter 1994; Dingwall and McInstosh 1978; Gamarnikow 1978). Yet, this is not the case within Milwaukee's free clinics. Women are the lead administrators and/or medical directors at majority of Milwaukee's free clinics. I asked many of my interview participants about this dynamic and most had little to say on the topic. However, the Clinic Director at the *House of Peace* indicated that the CNPHCS was a male-dominated space and female perspectives on medicine and medical practice were commonly marginalized. She (Tobin 2007) stated:

> In my next life I'm coming back as a medical anthropologist, specifically focused on how male dominance in our society and in our health care system influence medical decision-making…there are enough women…in the nursing field who ought to be able to rise up and say you know what, this is a bunch of crap. But they get stuck in roles, they get pushed down they get shoved down and they stay down.

Free clinics are spaces where women's voices are not only valued, they are typically dominant. While none of my other interviews specifically commented on the predominance of women in free clinics, the Director of The Marquette Clinic for Women and Children commented on the more holistic treatment resulting from being staffed entirely by female nurses and nurse practitioners (Clarke 2008). Free clinics offer an important space for opposing the practices of male dominated, CNPHCS by creating an alternative medical space where female voices and perspectives on medical practice are valued.

Free clinics are spaces resisting the commodified and male-dominated labor practices imposed within the spaces of the CNPHCSs. They allow medical providers to treat patients with minimal time constraints and irrespective of insurance status. A majority of the free clinics I examined undertook this project with an oppositional consciousness. This is evident in Horner-Ibler and Tobin's comments. They believe the labor conditions in CNPHCSs are dehumanizing, due to their profit motives and foundation in patriarchal gender relations. Free clinics undermine the neoliberalized health care system in two ways. First they provide a viable alternative space for practicing medicine. Given the increasing monopoly the CNPHCS have on medical personal in Milwaukee[41] the availability of spaces outside of the commodified health care system to practice medicine is vital.

Second, free clinics undermine the commodified health care system through their role as teaching sites for medical students. Medical students often spend months and even years completing rotations and residencies at free clinics. During this time, medical students are exposed to alternative medical practices and perspectives on the commodified health care system[42]. While I did not interview medical students during my field research, it is likely some of this exposure undermines the practices and discourses offered in commodified medical settings. When I asked Horner-Ibler (2010) about the *Bread of Healing's* impact on its medical students, she stated, "that's the only reason we do it, we hope to change their perspectives on medical practice." This is not reworking the labor practices of neoliberalized health care; it is a rejection of those practices entirely. Through the creation of alternative spaces to practice

[41] It was recently revealed during a meeting on Milwaukee's health care safety net that nearly 2/3rds of all primary care physicians in Milwaukee County were either employed by or affiliated with one of the five CNPHCS (Milwaukee's Health Care Safety Net 2008).

[42] The danger to the dominant commodified health care system of exposure by medical students to these alternative medical practices and perspectives might contribute to the recent reduction of medical student rotations in free clinics in Milwaukee and their growth in suburban health care facilities.

medicine and the instruction of medical students, free clinics undermine the dominant medical practices and discourses.

Resistance: The Entanglement of Identities and Practices

Katz's (2004) theorization on resistance is useful for evaluating diverse responses to neoliberal capitalism and other forms of exploitation, but why do oppositional movements manifest differently? Castells' (1997) offers a useful starting point for examining this process in *The Power of Identity*, where he suggests that identity is fundamental to the construction of social movements and their practices. Castells (6) understands identity to be the "construction of meaning on the basis of a cultural attribute, or related set of cultural attributes that is/are given priority over other sources of meaning." He goes on to state that meaning is the process by which people indentify the purpose of their actions. Consequently, identity is important for resistance in its role as the attribute around which groups of people come together and prioritize particular objectives. Within this framework, identity is the foundation for resistance practices whether they are rooted in class, ethnicity/race, gender, sexual preference or religious identities.

Yet, as Katz's work demonstrates simply having a group of people with shared attributes or values, even if these attributes include an oppositional consciousness, is not sufficient to produce resistance. In the case of Milwaukee, the cultural attribute around which the identities of free clinics are constructed is a particular interpretation of Christianity. This understanding of Christianity values relieving human suffering and is generally critical of the retrenchment of services to the uninsured by the state and CNPHCSs. Nonetheless, free clinics are both spaces of reworking and resistance. What explains the difference between free clinic's opposition to labor conditions (resistance) and access to health care (reworking) under neoliberalized health care

delivery in the city, if both emerge from a Christian identity infused with oppositional consciousness?

The discussion of entanglement by Sharp *et al* (2000) is valuable for theorizing the transition from oppositional identity to resistance. Sharp *et al* (24) state:

> The term 'entanglements' is meant to conjure up the threading, knottings and weavings of power, thus deploying a metaphor full of spatial imagery to convey the complexity of what we see in the workings of power, domination and resistance. Yet, our use of the term is also meant to be *more*[43] than metaphorical, and is intended to signal that relations of power are…unavoidably spun out across and through the material spaces of the world. It is within such spaces that assemblages of people, activities, technologies, institutions, ideas and dreams all come together, circulate, convene and reconvene…and it is only as a consequence of the spatial entangling together of all these elements that relations of power are established. In this view, entanglements are a precondition for the appearance of power, and in a sense we might say that such entanglements are precisely what releases power, enables power, permits power to 'do its business'."

This conception of entanglement by Sharp *et al* identifies two important features of the transition from oppositional identity to resistance. First, it highlights the centrality of power to resistance (and domination). It is the medium through which the structures normalizing domination (capitalism, racism, patriarchalism, heteronormativity, etc) might be transformed. Furthermore, returning to Katz, if the practices of oppositional movements or institutions fail to alter the power relations producing marginalized bodies, such as the uninsured, than it is not resistance. Second, they illuminate the importance of space to resistance or any type of social change. Sharp *et al* point out that resistance *requires* an encounter between different "assemblages of people, activities, technologies, institutions, ideas and dreams", and that these encounters inevitably occur in particular spaces. Within this framework the space of the free clinic is fundamental to the encounter between a vision of health care delivery grounded in the Christian principle of relieving suffering and the current system based upon market forces.

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[43] Their emphasis

In the following section I employ Castells' (1997) conception of identity and the discussion of entanglement by Sharp *et al* (2000) to examine how free clinics come to occupy particular relationships to neoliberal capitalism. In my analysis, I connect free clinic's prioritization of particular practices to their Christian identity. I then discuss how resistance is both enabled and inhibited by this identity's 'entanglement' with those of other stakeholders within the space of the free clinics. In doing so, I illustrate how resistance both emerges and is undermined as a result of the entanglement of the Christian identity and practices of free clinics' and staff with those of the CNPHCS

Free Clinics and Their Christian Identity

Christianity is the dominant identity giving purpose to Milwaukee's free clinics and informing their practices. Throughout my research, the religious convictions of the staff and volunteers at free clinics was evident. However, my own unease with Christianity, partly a result of narratives about the Christian right (Dittmer and Spears 2009; Gallagher 1997; O'Reilly and Webster 1998), made me hesitant to place it at the center of my research. I caught myself occasionally projecting my own political perspective onto the motivations of free clinic staff and volunteers. However, while struggling to understand the rationale behind free clinics lack of political mobilization, the importance of religious beliefs to free clinic practice became fully evident.

When I asked the staff and volunteers about the purpose of free clinics their identities as Christians often emerged. Rick Cohen, one of the creators of the Bread of Healing, stated (2009) the clinic's foremost goal was to, "relieve human suffering as directed by Jesus Christ". Georgia Lum (2007) echoed a similar sentiment when she attributed "God's will to heal the poor" as central to the creation of the Open Door Clinic. Nine of the ten clinics that formed the original

Free Clinic Collaborative are religiously based. Five of these clinics are located in churches or on church property. In addition, religious institutions are key sources of financial and material support for all the clinics. Consequently, to understand their practices one must engage with the religious framework that grounds them. Chief among these is the belief that Christian religious doctrine[44] requires them to relieve human suffering. This discourse was brought up countless times by a number of different clinic administrators. It is also a central motivation for many, although not all, of the clinic volunteers, many of whom were recruited from local churches. Religious doctrine did not merely influence the decision to create or volunteer at free clinics. Particular understanding of religious doctrine also affected *how* free clinics attempted to reduce the suffering caused by the commodified health care system.

The belief in the importance of relieving human suffering as an expression of God's love directed much of the work of free clinics towards the scale of the human body. While neoliberalism is often understood as operating at the global, national, regional, or urban scales, free clinic staff interpreted Jesus' scalar practices as directed towards the body. Stories of Jesus feeding and healing individual bodies animated the free clinic's scalar politics. Christianity and the narratives of Jesus importance to the practices of free clinics is evident in the following story shared with me by Barbara Horner-Ibler (2008):

> There's a story about Jesus who heals a women with a flow of blood for twelve years. A woman in his times with flow of blood for twelve years was unclean and she was not touched by another human being...[she] says 'if I just touch his cloak I'll be healed' and she reaches out and touches his cloak. He recognizes that someone touched him... [Jesus] said 'somebody touched me' and the woman knew he was talking to her. She comes to him fully expecting reprimands, stoning…being further ostracized from her community. And Jesus says, 'daughter, you have been healed.' And telling everyone around him, this is not an unclean woman, this is your sister and you are obligated as a human being to receive her and touch her…for me, when I see that kind of thing happen, when

[44] While Christianity is the dominant religious identity in the work of free clinics in Milwaukee, the *Open Door Clinic* received considerable financial support from a local mosque, in addition to a collection of churches.

> people have been disenfranchised in every other institution that they've been in… and then they come to [the Bread of Healing] and it's like somebody hears [their] story, somebody listens, somebody cares.

Horner-Ibler grounds the work at the Bread of Healing within her understanding of the practices of Jesus. It is an empirical example of the connection between identity and practice theorized by Castells (1997). No practice is more important, in Horner-Ibler's interpretation, than the requirement to alleviate suffering as a profession of her Christian identity. As the following section demonstrates the connection between Christianity and the alleviation of suffering becomes problematic for resistance when it becomes entangled with the identities and practices of other health care stakeholders.

Free Clinics, Entanglement and Reworking Access to Health Care

At first glance, it is clear why free clinics focus on healing bodies. Horner-Ibler's story offers a powerful narrative of healing the bodies of the infirm and the outcasts. However, there is another practice present in this story. Jesus does not just heal a body, he tells "everyone around him, this is not an unclean woman, this is your sister and you are *obligated*[45] as a human being to receive her and touch her". In this sense, Jesus is resisting the dominant narrative about women and menstruation and making claims on other stakeholders. So while stories of Jesus' healing direct the practices of free clinics towards human bodies there is also evidence of advocacy in Christian religious doctrine.

Free clinics began opposing the dwindling access to health care in Milwaukee's inner city neighborhoods by reworking the hegemonic power relations of neoliberal capitalism. However, as Katz (2004: 242) suggests "instances of reworking often provide the groundwork for stronger

[45] My emphasis

responses". Recently, one of the free clinics, which I will refer to as the Allen Free Clinic[46], began to discuss becoming more involved in advocacy. This might transition the clinic from a space of reworking to resisting the commodified health care delivery system. This discussion took place at the Allen Free Clinic Board of Directors meetings, in the process of creating a strategic plan for the future of the clinic. Boards of Directors are typically composed of free clinic administrators, and local community members. They also frequently include a patient representative and representatives of important strategic partners. Strategic partners are companies or organizations that contribute significant resources, funding or services, to the clinics. All of the free clinics in Milwaukee have strategic relationships with one of the five CNPHCS that dominate health care delivery in the city. The board of directors is a space of entanglement between the identities and purposes of free clinics staff and volunteers, community members and their CNPHCS partner. The discussion of advocacy by the Allen Free Clinic's board of directors made the power relations between the clinic and their CNPHCS partner (which I will refer to as Plantagenet Health) apparent.

The Allen Free Clinic began discussing advocacy in the spring of 2007 and it quickly proved controversial. There was a general consensus among the board to continue seeking to expand clinic services. However, the discussion of advocacy directed attention to an underlying tension. The need to expand the clinic was created in part, by Plantagenet Health's, and the other CNPHCS, reduction in services to the uninsured. Seeking to resist, rather than merely rework, the dwindling access to health care in Milwaukee's central city would require Allen Free Clinic to resist the actions of Plantagenet Health, its most important strategic partner. As discussions about advocacy began, signals were sent through Plantagenet Health that advocacy might

[46] I was asked not to use specific names or any identifying comments regarding this particular clinic and their health system partner. This was the only portion of any interview that I was asked to keep anonymous. This request speaks volumes about the tensions that exist between service provision and advocacy in free clinics.

undermine the clinic's primary mission of relieving human suffering. The power Plantagenet Health had over Allen Free Clinic was their ability to reduce or terminate the financial support and subsidized lab work they donated to the clinic. At no point was there a direct threat to withdraw support to the clinic by Plantagenet Health, but their potential opposition to increasing advocacy permeated discussions. As the board chair (Chair 1 March 25, 2007) at the time stated: "…one of the issues [in] our strategic plan is going to have to be this issue of … how much of an advocacy group do we become or are we still a service deliverer. There's some real trade-offs in those decisions that are very important. We take care of [hundreds] of people right now and *we don't want to lose our ability to do that*[47]."

The tension between advocacy and service provision is evident in the Board Chair's comments. Power becomes visible within this space of entanglement where the board chair perceives the choice to be *either* advocacy or service provision, not both. Service provision is threatened by the potential reduction or elimination of support by Plantagenet Health and advocacy is impossible without critiquing the power relations that Plantagenet Health's economic success rests upon. The decision also seems clear, as the Board Chair indicates; Allen Free Clinic does not "want to lose our ability" to provide services. In this case the Christian value of relieving human suffering becomes entangled with the economic values of Plantagenet Health. This entanglement is spatialized through both stakeholders involvement with the Allen Free Clinic. While the economic leverage of Plantagenet Health is the mechanism through which power is animated, it is not the obstacle to resistance. The Allen Free Clinic could continue providing services, albeit at a reduced capacity, and politically resist the commodified health care system that produces human suffering. But, the prioritization of relieving human

[47] My emphasis

suffering, by Christian staff and volunteers, over other possible values, such as undermining the commodified health care delivery system, prevents the Allen Free Clinic from taking on an advocacy role and resisting the neoliberalization of health care delivery in Milwaukee.

Free Clinics, Entanglement and Resisting the Working Conditions of Medicine

While free clinics are limited to reworking decreasing access to health care, they are resisting the dehumanizing work conditions of commodified health care. Free clinics have not ended the dominant working conditions found within the commodified health care system, however, they are undermining them by providing a viable alternative to the time constraints and pressure to have profitable payer-mixes, as well as the patriarchal gender dynamics. Furthermore, they are a powerful space to promote these alternative values through their position as teaching sites for medical students. Free clinics emerge as spaces of resistance again through their entanglement with the CNPHCSs. However, this time the power relations differ in two significant ways.

First, while would likely dispute the non-profit status of the five CNPHCS in Milwaukee. Challenging the non-profit status of health care systems has been a popular and successful resistance tactic in other locations around the country (Maiuro *et al* 2004; Pear 2006). The loss of non-profit status is a significant blow to the operations of any CNPHCS, as non-profit status is an important advantage in the health care marketplace (Reinhardt 2000). However, challenges to the working conditions are considerably less threatening because of their commanding market share. For example, it was revealed at a recent meeting on Milwaukee's health care safety net that nearly 66% of all primary care physicians in the city are now employed by or affiliated with one of Milwaukee's five CNPHCSs (Health Care Safety Net Task Force Meeting 2008). In addition,

they have an even greater monopoly on more advanced health care services such as surgeries and cancer treatments. So although free clinics undermine the working conditions of the commodified health care system by offering a space where alternative practices can be realized and then shared with medical students, this threat is relatively minor compared to the risk of losing non-profit status.

Second, free clinics have considerable leverage over the medical schools and the health care systems in regards to medical student placement. Medical students often desire experiences in 'urban medicine.' The medical students I interacted with at the Bread of Healing all came to Milwaukee to complete rotations because they desired exposure to the types of injuries and illnesses that occur in higher numbers in inner city communities. Historically, this experience was gained by rotations in one of Milwaukee's Academic Medical Centers located within two of the CNPHCSs in the city. However, as the CNPHCS have systematically reduced their presence in inner city communities (Boulton 2004a, 2004b, 2006c; Manning 2004a; Rommell 2006) there are fewer locations where medical students can gain this exposure. Free clinics have become important sites for medical student placements. So while the corporate non-profits have attempted to reduce medical student's presence in free clinics, the desire of medical students to gain exposure in urban medicine and their own dwindling presence in the city limits this tactic.

In the end, free clinics have been able to continue their small scale resistance of the commodified health care system's working conditions because they've avoided entanglements where they are forced to decide between resisting working conditions of the commodified health care system and their primary Christian identity and purpose of relieving human suffering. On the contrary, free clinic's entanglement with the CNPHCSs and the state strengthens their resistance to the working conditions found in the commodified health care delivery system. For

example, their limited ability to do lab work and other medical testing encourages them to spend more time with patients determining what is ailing them through communication. Their reduced access to drugs for treatment encourages free clinics to pursue treatment options through lifestyle changes. So within the sphere of working conditions, the entanglement of free clinics with the commodified health care sector produces a space for resisting the working conditions of the commodified health care system.

Conclusion

Free clinics are spaces reworking and resisting the neoliberalization of Milwaukee's health care system. My initial interest in free clinics was in their position as spaces opposing the deteriorating access to health care in the city brought about by the neoliberalization of Milwaukee's health care delivery system. I anticipated uncovering a host of practices resisting this process, while simultaneously providing a sanctuary to those bodies bearing its costs. However, free clinics, identity and purpose is often grounded within a particular interpretation of Christianity that prioritizes relieving human suffering. This identity and purpose was fundamental to the creation of a majority of Milwaukee's free clinics, and churches continue to be an important source of volunteers and financial support. In the end, free clinics' efforts to resist decreasing access to health care are prevented because their Christian identity and purpose becomes entangled with the opposing economic identities and purpose of their CNPHCS partners.

However, in response to the dehumanizing working conditions of the commodified health care delivery system, free clinics are successful at small-scale resistance. They provide a space where physicians can practice medicine under a different set of working conditions, and their importance as medical education sites ensures that these practices are shared with future medical

professionals. Free clinics' entanglement with the CNPHCSs strengthens the viability of these alternative practices because the CNPHCSs require spaces where they can redirect the uninsured, as well as suitable medical education sites. This fortifies the free clinics aim to provide medical services to anyone in need and with limited time constraints. Furthermore, their importance as sites for medical education produces alliances with medical students looking for exposure to 'urban medicine'. This illustrates that given a different set of identities, practices and/or entanglements free clinics can be spaces of resistance, thus there is nothing inherently 'not revolutionary' about free clinics.

Free clinics suggest something else about resistance: to understand how institutions, movements and collectives become spaces of resistance we must examine the identities that inform their practices. In Milwaukee, free clinics' identities are grounded in a specific reading of Christian religious doctrine. This religious doctrine is not embedded within the Christian religious right; it recognizes the suffering resulting from the current articulation of neoliberal capitalism within the health care delivery system. Yet, free clinic's opposition to neoliberalized health care is not enough to produce them as a space of resistance. Their primary objective of reducing human suffering as a demonstration of their Christian identity is a powerful force in the construction of free clinics. But, this same identity is problematic as free clinics seek to become active in resisting the conditions that produce their demand. This problem results from free clinics' position as spaces of entanglement between medical professionals seeking a more humanized vision of health care delivery and the stakeholders of the current delivery system. As my paper makes clear, the nature of free clinics' response to the neoliberalization of Milwaukee's health care delivery system results from the entanglement of multiple identities and corresponding objectives within the spaces of free clinics.

In addition to continuing to engage with theories of resistance, my research in Milwaukee suggests to me that there is a great deal of benefit to be gained from a more thorough engagement with religion and social justice. Although, geography is in the early stages of a stronger engagement with religion, some have already questioned its value[48]. A portion of this skepticism is a consequence of politicians and activists supporting neoliberal economic and neo-conservative social policies positioning themselves as the only political party for Christians. Yet, my research demonstrates the multiple political expressions of Christianity. Is it possible that a portion of the political capital conservatives gain from the Christian church results from the unwillingness of radical, leftist thinkers to explore the possible connections between religious doctrines and radical political theories and practices? Might a more robust political left be created by exploring the areas of overlapping concern between radical thinkers and religious doctrine, or through examinations of other types of religious interpretations, which highlight the importance or resisting oppressive structures not just outcomes, such as liberation theology in the Christian tradition? My own unease with the Christian identity slowed my engagement with important factors underlying free clinic's particular practices. This unease proved to be an obstacle in my analysis of free clinics. Consequently, regardless of whether we believe in the radical political possibilities that exist within religious doctrines, they remain important institutions for understanding many of the social processes geographers care deeply about.

[48] See the recent comments by Allen Scott on the critical geography forum, December 1, 2009

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CHAPTER 5

CONCLUSION

Examining the entanglement of neoliberal economic ideologies with the US health care delivery system is particularly complicated, and yet, it is also particularly important. It is complicated as a result of the tenuous incorporation of health care delivery into the US version of the Keynesian Welfare State. During Keynesian economics' global hegemony (post-World War II through the early 1970s) health care was solidified as an entitlement across most of Western Europe, Canada and Oceania. Yet, in the US, the major health care legislation, Medicaid and Medicare, guaranteed access to health care only for those residents over sixty-four years of age, and specific categories of the 'deserving' poor (i.e. children and their parents, the disabled, etc.). This left large segments of the US population without a state-guaranteed positive right to an important resource for ensuring healthy bodies, or even survival at all. In the absence of a robust national health care system, many residents of the US rely on an informal and fragmented health care 'safety net'. The US health care safety net has existed since the inception of 'modern' medicine as a useful service for maintaining health and/or extending life. During this time, its composition has always been geographically specific, as states and cities developed their own systems for providing acute and public health care services. However, generally, health care safety nets have included a mix of both public and private financing, as well as public and private medical spaces, whose exact materialization continues to change with contemporary economic rationales and crises. One result of this hybridity is the lack of a fully functioning Keynesian 'other' through which the common sense solutions of neoliberalism could manifest.

This creates complications for evaluating the entanglement of neoliberal ideology with the US health care system. If we are to understand the neoliberalization of the welfare state as the reduction of state guaranteed entitlements and their replacement with social supports linked to participation in the labor market or delivered through community-based, 'voluntary', or private sector institutions, then the absence of a Keynesian apparatus to guarantee health care in the US presents a theoretical challenge (Brenner and Theodore 2002; Peck and Tickell 2002). Have the market-based ideologies of neoliberal economic theory embedded themselves within the US health care delivery system, and if so how? More abstractly this question might be posed as, does neoliberal economic theory embed itself into non-, or only partially Keynesian welfare regimes, and if so how? These are the questions my research on Milwaukee's health care delivery system has examined. Answering the abstract question regarding neoliberalization and partially Keynesian welfare regimes, as well as the specific question regarding US health care delivery are both especially important in the present time.

The abstract question is important for two reasons. First, as Larner (2005: 11) points out there is a tendency in the literature on neoliberalization to romanticize the Keynesian welfare state. She states:

> …the accepted story of neoliberalism is one of the decline of the national economy and of social welfarism. Consequently, the focus of academic commentary has been to document the economic, political, and social challenges to the spaces and subjects of the post-war period. In part, this reflects a tendency to see Keynesian-welfarism as a normal arrangement, rather than as a temporary, and always tenuous, political settlement. If I were hard, I would call this 'welfare state nostalgia'.

What Larner is pointing to is the tendency for academics to wax poetically about the 'good old days' of Keynesian economics and the robust entitlements won during this period. Analysis of the US health care delivery system contributes towards a more nuanced analysis of

neoliberalization projects by examining its' entanglement with a hybrid welfare regime that includes the state (Medicaid, State Children Health Insurance Program, public hospitals), voluntary sector (non-profit hospitals, free clinics,), and private sector (private physicians and hospitals) organizations. Research such as this can help establish the partiality and tenuousness of the Keynesian compromise, and help situate the struggles of the poor today within the long history of struggle to survive under capitalist economic systems. The great Keynesian compromise still left many in the US struggling to access the basic necessities of social reproduction, such as access to health care. Academic work on the US's health care delivery system can assist in drawing attention to this continuing struggle

Secondly, the US health care system offers an ideal opportunity to evaluate neoliberalism's continued relevance in spaces already stripped of their public welfare assets and resources and replaced by public-private partnerships, voluntary sector institutions, and private sector welfare 'solutions'. While this hybrid welfare regime has characterized the US health care safety net for decades, it now represents an increasing number of welfare regimes across the globe as states 'roll back' other social welfare entitlements (Barnett 1999; Bond 2007; Chouinard and Crooks 2008; Katz 1991, 2001, 2004; Kearns, Barnett and Newman 2003; May, Cloke, Johnsen 2005;). Consequently, analysis of the entanglement between neoliberal ideologies and the US health care system can provide insight into possible future trajectories of neoliberalization. This can be useful for theorizing possible consequences of continued neooliberalization on social reproduction as well as identifying possible spaces and moments of effective contestation.

In terms of analyzing the specifics of the US health care delivery system, investigations on its neoliberalization can inform or current discussions regarding health care reform. As my

own research makes clear, the expansion of market-based logics is affecting institutions well beyond the state. Any efforts to reform the health care delivery system in the US must deal with issues beyond just health insurance status. In a multi-tiered insurance system, where some are covered with higher reimbursement rates, while others carry minimal insurance, considerations such as 'payer-mix' and 'margins before mission' will continue to enter the calculus of both for-profit and non-profit health care providers. Furthermore, despite the lack of a robust Keynesian health care delivery apparatus, there is still ample evidence for the continued stripping of the public aspects of the system. Any meaningful health care reform will have to address all of these issues, not simply the binary of insured versus uninsured.

This project connected with three literatures of neoliberalization: the voluntary sector, privatization and resistance/contestation. Through my examination of Milwaukee's health care delivery system, I offer new insights into each. My first manuscript examined the diversity within the voluntary sector of Milwaukee's health care safety net. I demonstrated that rather than a single voluntary sector, the differing tactics and spatialities of CNPHCSs and free clinics indicate multiple voluntary sectors, each with different relationships to the state, markets, capital and their surrounding communities. This diversity makes it difficult to say anything concrete about the 'voluntary sector'. Rather it suggests that academics need to further specify typologies within the sector, or develop a new language for discussing commodified institutions that defy traditional definitions of 'capital' or 'profit'. Furthermore, my research demonstrates the voluntary sector is not merely a shadow state where the state maintains its control of social welfare programs through non-democratic mechanisms such as government funding or regulation. Rather, it also serves as a site of shadow capital where profit maximization can occur

by taking advantage of the generous taxation schemes developed to encourage voluntary sector activity.

Politically, this research suggests the need to re-examine the non-profit sector, specifically, with regards to the legal frameworks defining 'community benefit'. If the 'community benefit' clause of non-profit law is so underspecified as to allow CNPHCSs to systematically disengage with the un/underinsured and instead concentrate on 'publics' with high rates of private insurance, then, the utility of such policies for supporting social reproduction must be questioned. Furthermore, this research suggests the political fight for a more equitable health care delivery system must pay more attention to issues such as reimbursement rates and health care costs. In Milwaukee, it is not only the uninsured who struggle to access health care, but also those with lower reimbursed, public insurance such as Medicaid. Expansion of health insurance coverage may not solve the health care crisis if 'payer mix' continues to be an important calculus.

The second contribution of this research relates to our contemporary notions of privatization. Privatization is widely regarded as a central element of neoliberalization projects (Brenner and Theodore 2002; Desai, Lukas and Young 2000; Joseph and Chalmers 1999; Kohl 2002; Bakker 2007; Mansfield 2007; Peck and Tickell 2002;). However, typically it is portrayed as the sale of formerly public assets to private entities or a shift in the state from provider of services to purchaser. Yet, my research demonstrates the privatization occurs through more subtle mechanisms as well. Privatization may be accomplished through specific provisions of affiliation agreements structuring public-private partnerships, or through the reorganization of assets in a manner excluding certain types of publics (i.e., the un/underinsured). These are subtle forms of privatization are important for academics to identify because they may not garner the

political attention that other more spectacular forms of privatization get. Furthermore, in an era where the welfare state has been transformed in a manner reducing the purely public spaces and resources, privatization is likely to occur more frequently through these less apparent mechanisms.

Identifying these more concealed mechanisms is important for both theoretical works on future rounds of neoliberalization as well as for political mobilizations in defense of eroding support for social reproduction. Moreover, my research goes beyond merely identifying privatization mechanisms; I also identify the harmful consequences that result from this process, such as decreased access to health care for the un/underinsured, decreased opportunities for political participation on the health care debate by physicians, and the decreased exposure of medical students to inequality present in our current system. Analysis of privatization mechanisms must include analysis of what is lost in this process, an aspect often left out in the more abstract, theoretical discussion of neoliberalization.

The final contribution of my research is on the political possibilities located within institutions committed to ensuring social reproduction. Academics, in recent years, have paid increased attention to the myriad local and translocal responses to neoliberalization projects (Boyer 2006; Featherstone 2008; Katz 2001; Leitner, Peck and Sheppard 2007; Leitner, Sheppard and Sziarto 2008; Pile and Keith 1997; Sharp *et al.* 2000). However, in much of this research very little consideration has been given to the identities forming oppositional movements. There is a tendency to view large scale responses or political actions as evidence of 'resistance' without carefully unpacking the identities giving fuel to those movements. This is problematic for two reasons: first, the identities informing oppositional movements may generate the desire to contest the neoliberalization of health care in Milwaukee, while also placing limits

on the types of resistance. I demonstrated, by paying careful attention to the Christian identity grounding much of the work of free clinics in Milwaukee, how this identity creates certain opportunities and obstacles for resisting the dwindling access to health care in the city. Oppositional identities influence the parameters of resistance movements and actions constructing the limits to what movements evaluate as acceptable outcomes, costs and risks.

In Milwaukee, the Christian identity manifested in free clinics' willingness to bring attention to the plight of the un/underinsured, teach medical students about the inequality in the health care system and demonstrate alternative forms of medical practice, and place some pressure on the state and CNPHCSs to increase their commitment to the un/underinsured. However, this same identity proved to be an obstacle in generating more public and contentious forms of resistance. Ultimately, their specific interpretation of the politics of Christianity and, in particular, Jesus prioritized service delivery over political advocacy. Through more detailed analysis of the identities that give rise to movements resisting the neoliberalization of life, geographers can contribute to a better understanding of the specific manifestations of oppositional movements. Additionally, my project suggests that dominant academic discourse regarding the role of religion in conservative politics needs to be re-examined. My work in Milwaukee highlights another dimension of religion, progressive, yet equally problematic. Here religion serves as the moral foundation for a critique of the revanchist welfare state, however, it still presents significant obstacles in acting upon those critiques politically. To build more robust political responses to neoliberalization projects, academics should build bridges to these other varieties of Christian ethics and politics. To ignore these, leaves religion, a powerful social force in the production of space to conservative politics.

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