Rhetoric in Debt

Sharp-Hoskins, Kellie

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While in popular and public discourses in the United States consumer debt is conceptualized as a foregone conclusion or matter of fact (see the introduction to this book), its effects are increasingly contested, as seen, for example, in calls for loan forgiveness, relief, or cancellation. Without denying debt as factually extant, those who call for debt forgiveness or cancellation propose that debt does not necessarily need to be a fact of life. The 2016 and 2020 US presidential campaigns, for example, included explicit calls and proposals from multiple candidates for student loan forgiveness and medical debt elimination. And the 2020 “pause” on federal student loan payments during the COVID-19 crisis contributed political firepower to arguments calling for their cancellation. Such arguments also undergird RIP Medical Debt, a charity organization founded by two (former) debt collectors and a (former) health care administrator that is explicitly premised on buying—and forgiving—unpaid medical bills. As articulated in Jerry Ashton, Robert Goff, and Craig Antico’s polemic End Medical Debt: Curing America’s $1 Trillion Unpayable Healthcare Debt, medical debt is “the enemy of everyone. That’s not what we expect here in America” (36). This pithy claim reflects, perhaps, the authors’ sense that medical debt is categorically distinct from other kinds of individual debt—“Medical debt is not like debt incurred by buying a big screen TV one cannot afford. It should not be treated the same way” (16)—neither wholly volitional nor irresponsible. And yet medical debt is distinct in, if not unique to, the United States: institutionalized in relation to medical institutions and practices and health care itself as the cost of doing business. That business, of course, is health insurance. Though run as a business, however, health insurance in the United States is also, as of March 23, 2010, with the passage of the Patient Protection and Affordable Care Act (ACA), the law of the land. Widely known as Obamacare, the ACA was intended to expand health insurance opportunities and availability beyond employer-based
coverage, filling in the gaps that are too often met with medical debt. And yet, as suggested in a 2021 report in the *Journal of the American Medical Association* (JAMA), medical debt in the United States is estimated to be $140 billion. While this total number pales in comparison to total student loan debt in the United States ($1.76 trillion as of fall 2022), the dollar-for-dollar impact of medical debt can be much more challenging for those who hold it, in that it often accompanies debilitating medical events and strongly correlates with loss of work and aggregating financial hardships (Dobkin et al.).

The definition of medical debt is straightforward enough—“a debt arising from the receipt of health care services” (Law Insider)—and, like other forms of debt, rests on the taken-for-granted implication of individual responsibility. Explicated by Robert Goff (of RIP Medical Debt), it is the result of persons who are “unable to take personal financial responsibility for the economic results of medical efforts to restore (or try to restore) them to good health” (17). Affirming the individuating premises of (medical) debt, Goff nonetheless acknowledges that “personal medical debt does not stop with the debtor…. All of us pay for medical debt, if not our own, then the medical debt of others” (36). And indeed, such arguments helped carry the day for the Affordable Care Act, when medical debt was explicitly cited as a reason to expand Medicaid and federalize (in part, anyway) medical insurance options; an expanded market for Medicaid gives the government expanded negotiating power (to improve coverage, lower costs, and so forth). Even as insurance carriers themselves define health insurance, as behemoth Cigna does, as “a legal agreement between you and a health insurance company” that “includes a health plan that helps you pay for certain medical care and services, so you don’t have to pay all the costs on your own,” and, as BlueCross BlueShield does, in terms of helping “you pay for doctor visits, hospital stays, prescription drugs and important preventative care,” health insurance is, of course, premised on collectivities. As the Stanford University Vaden Health Services explains, “The way it typically works is that the consumer (you) pays an upfront premium to a health insurance company and that payment allows you to share ‘risk’ with lots of other people (enrollees) who are making similar payments. Since most people are healthy most of the time, the premium dollars paid to the insurance company can be used to cover the expense of the (relatively) small number of enrollees who get sick or are injured. Insurance companies, as you can imagine, have studied risk extensively, and their goal is to collect enough premium to cover medical costs of enrollees.” In the United States, this risk-sharing model of health insurance, where money is pooled and
directed to pay the health care expenses for people in need—always in the context of the aforementioned agreement between individuals and their health insurance provider—participates in the conditions of possibility for significant medical debt, because while risk is ostensibly shared, economic responsibility for shares is once again articulated as individual, volitional, and moral. Not only do the uninsured incur debt when they are “unable to take personal financial responsibility for the economic results of medical efforts to restore (or try to restore) them to good health” (Ashton et al. 17), but so too do the underinsured: those whose agreements with health care providers are insufficient to cover the costs of care for their medical needs. Moreover, insurance that should be adequate to the health care costs and needs of an individual can fail to meet the financial exigencies of an unexpected medical event or crisis, and thus the insured can likewise find themselves with significant medical debt.

As health economists and historians make clear, and as I review in more detail in this chapter, the emergence of the US health care and insurance industries—which integrate premiums, out-of-pocket expenses, and other costs easily dispersed as medical bills (and thus debt) into their business models—was not inevitable. Indeed, assuming a business (or profit-based) model itself was just one option of many in the late nineteenth and early twentieth centuries, when industrialization (and its concomitant appetite for healthy workers) invited increased public attention to and debate about issues of health care. At the same time that wealthy individuals could bear the costs of health care as individuals (never mind the intergenerational wealth that made this possible), efficient production and economic might on a broader scale required health care for those who were unable to shoulder costs alone. Thus began practices of pooling resources in specific industries for workers to share in the costs of health care for the community. Contributing to “sickness funds”—the predecessor of health insurance—while in good health gave workers a safety net in case of illness or accident. The collected funds worked with the logic that not all workers would need them at the same time; they thus pooled not only resources but risk itself.

Health care in the United States has evolved into what the health policy historian Rosemary A. Stephens characterizes as beset by “Byzantine challenges of healthcare organization and financing” (vii), and it continues to reflect the resources and risk-sharing logics and practices of its antecedent forms. And built on then-nascent actuarial science, such logics and practices account for medical debt as the by-product not of inadequate mathematical models but of
insufficient individual contributions, where money due is not matched by money paid. Indeed, as I argue in this chapter, while calculated risk sharing apparently grounds the relationship between contemporary health insurance policies and health care, it does not redistribute risks, whether they be health based or financial, but carefully redirects attention to individuals’ “preexisting conditions” and medical and financial planning, wherein individual choices predict whether (or not) they will require credits for care (in the form of medical debt). The result of such accounting practices is that risk sharing becomes another way to exacerbate historical and contemporary inequities, requiring individuals to draw on specific, normative, and entangled health and financial literacies to forecast their own health and economic futures and allocating debt to the economically precarious under the banner of access to health care.

Moreover, I propose that the individuating premises on which US health insurance as a market are based allow medical debt to become the necessary rejoinder to “market failure.” That is, whereas market tools and technologies are assumed to accurately predict and account for risk, matching needs with care, failure to match insurance with coverage sticks to individuals, requiring those with health and medical needs (all) to enter contractual obligations for care and assume responsibility for any expenses rendered in excess of the contract. In a context where actuarial science and technologies are not held to (full) account for the uncertainties of health care needs, presumably “fully informed and knowledgeable” (Donaldson and Gerard 18) medicalized subjects are expected to forecast their health and financial risks and futures and take responsibility for managing their own care under the banner of choosing “managed care” options. In this context, accounting for rhetoric in debt surfaces the implicit differentials meted out onto individuals, where increased (medical) debt and decreased health outcomes entangle with and exacerbate extant economic, health, social, and political vulnerabilities.

In the sections that follow, then, I once again invoke a methodology of accounting for rhetoric in debt to draw attention to the emergence and effects of medical debt across temporal and spatial scales. This work includes and incorporates rhetorical attention to the texts and discourses through which medical debt is terministically framed: public debates and laws, for example, which I consider later in this chapter. But I turn first to the history of health insurance and the accounting methods on which it is premised—actuarial science—to consider how and why medical debt has come to occupy distinct discursive territory in the US imaginary of health and economics that is premised on
distinguishing between “planned” and “emergent” medical events. This actuarial, rhetorical distinction asymmetrically distributes financial and embodied risk, exacerbating lived inequalities and livability itself. This case study thus demonstrates how “individual” financial and health literacies are tied to spatial and ideological access, or what Harriet A. Washington calls “medical apartheid”: not only differential access to medical care but asymmetrical need for medical debt. By drawing on a methodology of accounting for rhetoric in debt in this chapter, I collate close attention to texts—historical and contemporary—and their effects with broader, scalar conditions of possibility in which they emerge. I thus demonstrate not only the rhetorical work of medical debt but, once again, the affordances of a methodology adequate to the complexity of its objects (Royster).

Emergence of Insurance, Emergence of the Insured

In *The Blues: A History of the Blue Cross and Blue Shield System*, Robert M. Cunningham Jr. and Robert Cunningham III track the rise of what would become the “largest managed care network” (Stephens vii) in the United States to “an unlikely man to have started a revolution in medical economics” (Cunningham and Cunningham 4). In 1929, hired to rehabilitate the financial situation of Baylor’s University Hospital, Justin Ford Kimball developed a hospital prepayment plan through which individuals could pay a monthly fee in case of, and in anticipation of, needed future medical care. Modeled in part on the idea of the “sick benefit fund” for teachers that he had administered in his previous role as a school superintendent, Kimball’s hospital prepayment plan invited community members to “budget against future hospital bills” (Cunningham and Cunningham 5). By collecting money in advance, Kimball shifted hospital financing away from relying on either a consistent patient base (i.e., people reliably and consistently using hospital services) or charitable contributions (often required to bridge the gap between costs of care and available funding), creating a more sustainable economic model. James E. Stuart, a future leader in the Blue Cross organization, described the plan in these terms: “The Plan was hospital prepayment in its simplest and purest form. There was no third party. The hospital collected the money directly, underwrote the risk directly, guaranteed the benefits and had the means of control of the utilization under its thumb” (qtd. in Cunningham and Cunningham 5).
The apparent simplicity of the plan, however, required accurate data on which to make decisions about price, cost, and use: How many people use the hospital, for what services, and how often? How many people needed to sign up to cover the costs of those who used it? How much would individuals need to prepay to cover the services used? Importantly, these were the questions that motivated Kimball, who admitted that his interest in the problem of health care was “primarily actuarial” (Cunningham and Cunningham 6). This focus aligned well with ongoing local, regional, and national discussion of health care possibilities, coming “after nearly three centuries of widely scattered and diverse experiments to solve problems of cost and access in health care” (8). The actuary-science historians Steven Haberman and Trevor A. Sibbett track this history to the 1792 publication of Observations on Reversionary Payments, written by the Welsh mathematician and moral philosopher Richard Price, which “set up the first hypothesis about the rate of sickness and calculated tables of contributions to provide weekly allowances during incapacity for work by reason of sickness or accident” (2).

Rooted in experiments with “sickness funds” in Great Britain, the seeds of actuary science began to root (and later flower) in the United States in a variety of industries in the later nineteenth and early to mid-twentieth centuries. Sickness funds operated with low overhead costs and key restrictions, and their goal, as articulated by the historian John E. Murray, “was consistent with the principles of insurance: to protect the insured from the shock of an unexpected adverse event” (7). From their inception, he continues, “restrictions were intended to exclude those who had already experienced the adverse event of ill health or who expected to experience illness in the near future” (8). Successful as they were in accomplishing their goal to protect the insured individual against financial shock, even in the face of the financial upheaval and uncertainty of the Great Depression, sickness funds were ultimately replaced by commercial insurance because, as Murray explains, “they could not withstand . . . the development of a technologically superior alternative, namely, actuarially sound group health insurance” (218).

In the United States, the development of this actuarial technology—or statistical models adequate to the task of making insurance plans financially sound—emerged alongside political and ideological struggles over questions of how health care should be funded. As Beatrix Hoffman recounts in her historical account The Wages of Sickness: The Politics of Health Insurance in Progressive
America, “When Progressives first proposed government-sponsored health insurance in 1915, their vision of protecting working people from the economic burden of sickness seemed well within reach” (1). Just five years later, however, a disparate collection of stakeholders, led by the American Medical Association (AMA) but including commercial insurance companies, labor organizations, and employers, “joined together in an unprecedented and highly effective alliance against compulsory health insurance” (3). Allied against government-sponsored insurance on economic grounds, these groups also rejected encroachments on their autonomy (3). As Hoffman explains, “The story of the Progressive Era health insurance campaign demonstrates that America’s limited welfare state was born not simply of preexisting structural constraints but of political and ideological struggles and turbulent historical changes” (5). Indeed, as an example, she cites fissures in women’s groups over the support of this item in the Progressive agenda, some enthusiastic about maternity benefits with leave and sick pay and others nervous about how these benefits might be exploited by men, who would send their wives to work to capitalize on this benefit (4). Apprehensions of this sort foreshadowed what would become (and remain) a significant principle on which actuarial risk prediction rests, moral hazard: “a change in the attitude of consumers and providers of health care which results from becoming insured against the full costs of such care” (Donaldson and Gerard 35). More generally, the terms and rhetoric of the Progressive-era debate continue to structure the possibilities for contemporary health care.

Viable Actuarial Models, Moral Hazard

In the context of complex political tides shaping the persuasive potential of arguments for government-sponsored health insurance, then, commercial insurance became viable as it developed actuarial technology capable of making health care profitable, using statistical models and inferences to accurately assess how the insured would use benefits as a group. As Murray argues, “the concentration on the political role played by these insurers has obfuscated their role in a critical episode in the history of technology” (219). In this history, actuarial science became charged with accounting for the complexity of the relationships between individual and groups, considering how uncertainty on the level of individual illness or accident could emerge in precise and predictive statistical models. As Cam Donaldson and Karen Gerard further explain, “For
the individual, illness is unpredictable. In general terms it may be possible to predict the prognoses associated with various chronic conditions and to predict in probabilistic terms how people of varying ages, circumstances, and pre-existing conditions will fare in terms of their health status. But at the level of the individual, future health status is likely to be uncertain” (32). From the time of the Progressive debates to the mid-1930s, then, insurers—eager to monetize the possibilities of the need for health care—focused on developing actuarial science and technologies that could account for group health and risk, entangled as it was in individual behavior and risk and necessary to develop insurance commercially (Murray 219).

As Murray explains, working with “sickness tables” was crucial but insufficient to this goal, capable as they were of accounting for the likelihood of the insured getting sick but incapable of projecting “the incentive consequences of sick pay benefits” or how individuals might change their behaviors (and thus risk profiles) on the basis of their access to insurance (219). As actuarial science and technology advanced, then, it shifted from accounting for probability of sickness, illness, or accident in general to how these probabilities interfaced with key premises about behaviors of the insured. In other words, to be predictive and profitable, risk projections needed to account for the effect of insurance itself on how individuals (statistically speaking) would make choices. Building in the assumptions of moral hazard, that the insured would be more likely to “overconsume” health care services and less likely “to adopt healthier lifestyles” (Donaldson and Gerard 35), actuarial science could better forecast how commercial insurance might be economically sustainable and profitable on a large scale.

Moral hazard is not a concept unique to health insurance or contemporary with the emergence of commercial health insurance. As the economic and social historian Robin Pearson argues, the late nineteenth century invited numerous industries to “bridge the gap” between personal trust—on which business had run—and “the emergence of new commercial relations where moral hazard was mass produced and where a commanding knowledge of personal reputations was virtually impossible” (1). Shifting away from personal trust and seeking actuarial methods capable of projecting group risk, however, commercial insurance was (and continues to be) hyperarticulated with assumptions about sovereign-individuals-cum-economic-actors, their knowledges, agencies, and behaviors, as is fundamental to mainstream or classical economic models.
Donaldson and Gerard confirm the relation between insurance models and mainstream economics, noting, “In mainstream economics, individuals are the unit of analysis. Individuals are seen as sovereign. That is they have preferences, evaluate choices and act” (16). The effect of this classical or mainstream model on shaping the health care market, they continue, is that

by definition, fully informed and knowledgeable consumers will weigh up the costs and benefits of health care relative to other goods. They will spend that amount of money on health care which maximizes their well-being. This will result in the appropriate amount of resources being allocated to health care overall and to different types of health care (what is termed in economics language allocative efficiency). At the same time, health care producers, seeking to maximise profits, will produce consumers’ most highly valued types of health care at least cost, so behaving in a technically efficient manner. This combination of technical and allocative efficiency . . . ensures that consumers’ well-being is maximized at least cost to society. (18)

As Donaldson and Gerard make clear, however, the premise of “fully informed and knowledgeable consumers” of health care is impossible due both to the asymmetry of information available to medical providers versus consumers and to the fallibility of doctors as agents of health care (44–45). Among other reasons, they attribute the “market failure” of commercial insurance—or the inability of the market to communicate and regulate health care supply and demand without intervention—to this faulty premise of “fully informed and knowledgeable consumers.” More specifically, “the market fails to inform the consumer of the contribution of health care to health status” (45).

Interestingly, whereas individuals are the unit of analysis of classical models of economics, assumed discrete, sovereign, and agential, they emerge in much more complex terms in actuarial science. That is, ultimately charged with predicting the potential cost of care (and attendant economic responsibility) of individuals, actuarial science must begin with data about groups of people and the qualities that make them into a viable, representative “class.” Such data include, for example, “credit reports, econometric time series, geographic information systems, and census data” (Frees et al. 3). Collated into statistics and models and interpreted algorithmically, these data are the ground for the predictive modeling that is central to actuarial science. As the actuary researchers
and practitioners Edward W. Frees, Richard A. Derrig, and Glenn Meyers explain, “Predictive modeling involves the use of data to forecast future events. It relies on capturing relationships between explanatory variables and the predicted variables from past occurrences, and exploiting those relationships to predict future outcomes” (9). While “exploitation” is used here to denote a technical process that links pasts and futures, it also (rhetorically) speaks to the uneasy relationships between pasts and possible futures. Existing asymmetries in past health outcomes, for example, ground predictions for what might be expected in the future. And integrated into technical models, they take on the ethos of scientific reliability and detachment—data in and data out.

Within actuarial science, then, individuals—including their health needs, realities, and behaviors—become data points to inform statistics and models before they become customers and consumers of insurance products in need of health care. Moreover, as discussed earlier, though behaviors calculated in terms of moral hazard are integral to the calculus of profitable insurance, they are forecast in terms of likelihoods and propensities within a group or class. Conversely, risk profiles are gathered via statistical representation of a class (risk of heart attack, risk of needing maternity care) and meted out in insurance rates and possibilities, packages, and products available to individuals, who—in ideal circumstances—can choose the insurance products or packages that best match their needs and circumstances. Even given the choice, however, individuals are tasked with calculating risk that is not fully accounted for by the most sophisticated actuarial methods; for those without the means to cover the difference, the consequence is medical debt.

Emergent Disparities, Emergent Options

Of course, the emergence of actuarial science and technology and the insurance plans they made possible cannot be divorced from broader sociopolitical contexts of their use and effects, including, as mentioned earlier, issues of gender parity but also what the public health scholar Jenna M. Lloyd refers to as “histories of class and racial exclusion in health care reform” (66). Paradigmatic in this history is, of course, what Harriet A. Washington terms “medical apartheid,” “the history of ethically flawed medical experimentation with African Americans” (20–21), which rendered Black Americans not patients of health care but subjects of medical curiosity and exploitation. Contributing key scientific and
medical insights to medical advancement without consent, compensation, or acknowledgment but with horrifying and predictable medical complications and consequences, including death, this constituency was not only radically excluded from historical practices of health care but continues to, in the words of W. Michael Byrd and Linda A. Clayton, experience “slave health deficit,” what Lloyd explains as “health inequities rooted in chattel slavery and perpetuated by institutionalized racism in medicine and other institutions” (61).

Emerging not only alongside but entangled with this history of racial exclusion and racialized access to and treatment by health and medical institutions, health insurance policies and coverage themselves contribute to inequitable health outcomes along racial lines. Lloyd explains that during World War II, even as political conditions allowed unions to successfully argue for health care in collective bargaining, for example, “the expansion of private insurance through union contracts and employer benefit packages during and after the war largely benefited white workers” (67). Moreover, employer-based insurance expanded alongside rhetorics of self-reliance and individual accountability. Introducing the edited collection Subprime Health: Debt and Race in U.S. Medicine, Nadine Ehlers and Leslie R. Hinkson quote Republican Senator Robert Taft, who in 1949 declared, “It has always been assumed in this country that those able to pay for medical care would buy their own medical service, just as under any system, except a socialistic system, they buy their own food, their own housing, their own clothing, and their own automobiles” (xxi). Such framing, of course, denies any inequities in access to care, framing it as a choice made by and responsibility of individuals and moralizing it as an individual consumer choice. But even the programs intended to support all individuals reinscribed racial inequity. When Medicare and Medicaid were created during the presidency of Lyndon Johnson, for example, political compromises over their implementation reveal race-based attitudes about worthiness. As Lloyd explains, “While Medicare for all people over the age of sixty-five was a universal entitlement, states had tremendous latitude in the benefits they would offer and how many people would be covered under Medicaid. Medicaid thus represented a concession to Southern states that had failed to extend even minimal health and social services to poor and Black residents” (68).

As these and other moments of (historical and contemporary) emergence of and political struggle over health insurance reveal, the industry and its practices cannot be disarticulated from larger social relations. But this is not only a history of the emergence of an industry. Rather, the emergence of health insurance
in the United States tells the story of (medical) debt. Thus, differential patterns in Medicaid access for southern states in the 1960s foreshadow differential expansions of Medicaid with the passage of the ACA in 2010 and give way, as reported in 2021, to significantly different amounts of medical debt between residents of southern and other states (Kluender et al.). Such patterns are not accidents of political history but embedded in the relationships that stick debt differentially to racialized subjects and narrate the difference in terms of individual fiscal and health literacies and behaviors.

Individualized Insurance, Managed Care Options

The significance of Senator Taft’s remarks about medical costs being the responsibly of an individual is considerably heightened in a contemporary moment marked by an aggressively neoliberal (political) economy. As Ehlers and Hinson argue, “What Taft raised here was an ideology of personal responsibility for medical care—a viewpoint that has been a continuing thread in national policy related to medical health care in the decades since his claim, and a sentiment that is only augmented within the contours of neoliberalism. Personal responsibility characterizes the neoliberal era, which has revived and intensified laissez-faire individualism and which has subjected almost every aspect of life to the logic and imperatives of the market” (xii). The hypothesis that individuals are best suited to make choices about their health insurance needs is perhaps nowhere more evident than in the marked shift toward, and increase in, “managed care” options for health insurance, which move away from simple prepayment for health care services and toward plans with specific consumer options. While this shift happened over some decades in the twentieth century with developments in actuarial technologies and health care legislation, Donaldson and Gerard, writing in 2005 in Economics of Health Care Financing, confirm, “The greatest change in the US health care market over the past two decades . . . has been the move to the private sector from the domination by private care insurance to ‘managed care,’ as embodied most notably in the proliferation of HMOs and preferred provider organizations (PPOs)” (9). The National Council on Disability explains, “Today, such prepaid health plans are commonly referred to as Health Maintenance Organizations (HMOs),” a term that was “not coined until 1970, with the aim of highlighting the importance that prepaid health plans assign to health promotion and prevention of illness.”
Unlike earlier plans that served as safety nets in the case of accident or illness, HMOs made a rhetorical and substantial turn toward market-based options for health care, ostensibly giving consumers choices about where and how to manage their own care. Assisted by the passage of the Health Maintenance Organization Act (in 1973), its attendant stimulus monies and requirements (for employers, for example), and a “relaxed regulatory environment,” health care moved away from hospitals toward “group practices and open outpatient centers specializing in diagnostic imaging, wellness and fitness, rehabilitation, surgery, birthing, and other services previously provided exclusively in hospital settings” (National Council on Disability). When this lax regulatory environment in the 1980s and increasing costs passed to employers and—by extension—their employees resulted in significant denials for health care coverage in the 1990s, “nearly 900 state laws governing managed health practices were enacted,” and consumers became more apprehensive about a market-based approach to health insurance (National Council on Disability). Despite this seeming turn in public opinion in the 1990s, by the time George W. Bush delivered his second inaugural address in 2005, he touted a “vision of an ownership society,” which referred to “not only the ownership of homes, businesses, and retirement savings, but also that of health insurance” (James Robinson 1199).

This emphasis on ownership continues to be reflected today in the marketing rhetoric of “managed care” by health insurance companies, which explain it as a “model to limit costs, while keeping quality high” (Cigna), with plans based in contracts “with healthcare providers focused on prevention and care management, which helps produce better patient outcomes and healthier lives” (Intermountain Healthcare). As Donaldson and Gerard summarize, “Managed care embodies several features, such as: greater competitiveness amongst funders in attracting enrollees; more active ‘management’ of providers by these funders (through the use of protocols and negotiation of lower fees and prices); and some might say, greater restrictions on the range of services, providers, and other aspects of care made available” (9). While health care providers and economists articulate the “management” of care as a feature of insurance options, it is individual consumers who must manage normative economic and health literacies to make choices about which plans are financially viable and fit their needs. In this way, “ownership” is not only offered to but required of individuals as they interpret information, parse options, and make decisions that impact their economic and health-related well-being. In the United States, managed care plans are rhetorically organized in terms of relationships between premiums (what
customers pay for in advance of care), copays (what customers pay for at the time of care), and out-of-pocket expenses (which fall outside the “coverage” offered by the plan). When options for plans are available, then, individuals are tasked with weighing anticipated health care needs and possible medical exigencies against predicted income streams and other financial obligations.

Managing Care, Managing Literacies

Corroborating the requirement for individuals to negotiate health and financial literacies and assisting in this decision-making in the contemporary moment, HealthCare.gov offers background information for “how to pick a health insurance plan,” introduced with “3 Things to Know Before You Pick a Health Insurance Plan”: (1) “The 4 ‘Metal’ Categories,” which explains cost-sharing options of different types of plans; (2) “Your Total Costs of Healthcare,” which explains the differences between and relationships among premiums (i.e., monthly fees) and deductibles (i.e., out-of-pocket costs); and (3) “Plans and Network Types—HMO, PPO, POS, and EPO.” While explanations are ostensibly simple and thus potentially (rhetorically) accessible to a variety of users of the website, they belie the requirement of complex risk calculations. Introducing the “metal” categories—or types of plans—for example, HealthCare.gov describes “Bronze” in the following terms:

- **Lowest** month premium
- **Highest** cost when you need care
- Bronze plan deductibles—the amount of medical costs you pay yourself before your insurance plan starts to pay—can be thousands of dollars a year.
- **Good choice if**: You want a low-cost way to protect yourself from worst-case medical scenarios, like serious sickness or injury. Your monthly premium will be low, but you’ll have to pay for most routine care yourself. (emphasis in original)

This plan is contrasted with Silver, Gold, and Platinum plans, the last of which is described in the following terms:

- **Highest** monthly premium
- **Lowest** costs when you get care
• Deductibles are very low, meaning your plan starts paying its share earlier than for other categories of plans.

• *Good choice if:* You usually use a lot of care and are willing to pay a high monthly premium, knowing nearly all other costs will be covered. (emphasis in original)

By framing these plans in terms of simple choices (“good choice if”), these descriptions not only ignore the complex and entangled literacies required to make them (and the histories implicated in each) but the material requirements of each. The “Platinum” plan, for example, marketed to consumers who “usually use a lot of care,” requires consumers to forecast their needed care and have the means necessary to pay for it. Perhaps hailing those who pair a history of consistently high income with a chronic health condition, this description leaves out any who do not—or cannot—combine those variables: those who cannot pay a high premium but require significant, consistent care or those who may be able to pay a high premium but cannot project their need for care. Of these two possibilities, both require financial literacy and assessment, but the former disqualifies people without adequate financial means for their health care needs (those who cannot afford a high monthly premium), while the latter penalizes those who cannot adequately forecast health care needs (and thus pay into a plan that they do not need).

The literacies required to make decisions that will not result in medical debt are not only challenging in their own right—that is, navigating information, understanding financial possibilities and risk, and assessing health care needs, risks, and contexts—but all the more so in their commingling, which cannot be accounted for by simple arithmetic or with regard to the capacity of an individual to interpret information and use it to make decisions. The idea of an individual making decisions independently discounts, as mentioned earlier, complex relationships between patients and the medical and health insurance industries (as I discuss in more detail shortly) as well as the role of a doctor or health care practitioner’s interpretation or advice. Explaining this in economic terms by way of comparison, Donaldson and Gerard write,

> In other production processes, like food production, some regulatory processes may be applied, such as in monitoring standards of products. But, in such cases, the consumer is still judged to be the best judge of his/her own welfare. This is not necessarily so in health care because of the
technical relationship between health care and improvements in health. Basically, consumers desire improvements in or maintenance in health status. However, improvements in health status cannot be purchased in the market. The consumer is forced to purchase health care in order to achieve an improvement in health. Health care itself is normally of no value but is linked to health improvements via a “technological” relationship about which doctors know more than consumers. (44–45)

Donaldson and Gerard further contextualize the entanglements of individual health literacy and doctors’ knowledge and expertise with respect to doctors’ positionality within the health care system: positioned to advise their patients, doctors cannot be “perfect agents” who simply or “objectively supply information” because they retain their own interests and needs, distinct from that of the patient/consumer (46). This is not to say that doctors always or intentionally prioritize their own interests and needs above those of their patients but that they do not work outside of their own economic realities and networks of interpretation. Moreover, even shelving financial conflicts of interest, doctors do not have totalizing knowledge of the relationships between health care and improvements in health.

In addition to discounting the role of a doctor in contributing to or facilitating the health literacy of a patient/consumer, an individual interpretation of literacy also elides how it is situated in broader contexts of possibility and meaning. In the United States, the Health Resources and Services Administration explicitly defines “health literacy” as “the degree to which individuals have the capacity to obtain, process, and understand basic health information needed to make appropriate health decisions” and cites low health literacies among “older adults,” “minority populations,” “those who have low socioeconomic status,” and “medically underserved people.” Even accounting for these patterns in relational terms—for example, acknowledging that health care providers may “use words patients don’t understand” or the “cultural barriers to health care”—this definition sticks literacy and its (differential) effects to individuals as a learnable, demonstrable “skill.” As Dawn S. Opel argues in “Challenging the Rhetorical Conception of Health Literacy,” the health care industry’s “skill-based” conception of literacy, which “reinforces the notion of health literacy as an independent and self-sufficient act,” cannot account for the relational aspects of health and health care and leaves “little room for caregiving and socially constructed notions of health and wellness” (138). Focused on aging and older adults’ relationships to
health care, Opel reviews literature that correlates “low health literacy” and the likelihood to “incur more medical costs” and directs attention to the problematics of framing health literacy in individual terms: “Health literacy, narrowly defined as ‘the ability to understand and act on health information,’” she explains, “is a problematic lens . . . as it locates the problem with the individual, alone” (137).

As discussed in previous chapters (in terms of financial literacy), literacy cannot be divorced from the political and ideological contexts in which it arises. Moreover, as literacy scholars attest, it does not reflect individual skill in a defined area but emergent relations and normative expectations of a range of practices and behaviors. In the words of Paul Prior, literate activity “is not located in acts of reading and writing, but as cultural forms of life saturated with textuality, that is strongly motivated and mediated by texts. Given this perspective, it becomes particularly important to examine the concrete nature of cultural spheres of literate activity” (qtd. in Opel 138). The spheres of activity for performing health literacy in the United States are bound to its finance-scapes: health care is a for-profit industry, in which health insurance is purchased by consumers and mediates access to care and medical practitioners, facilities, and technologies. Reading, understanding, and making meaning of health care options thus requires cooperating financial literacies and resources. As articulated in an ongoing, multistate study of “the intersection of healthcare and financial decision making across the lifespan,” “The consumer-driven approach of decision-making assumes that the simple provision of information will be sufficient to affect consumer choice, [but] the process of using data to inform choice is actually quite complex” (NIMSS).

With health care costs in the United States outpacing any other country (globally) while health outcomes lag behind much of the developed world, the health care industry is rhetorically framed in public discourse in terms of financial crisis. But Opel disrupts the scapegoating of individual literacies in this crisis rhetoric by identifying the pattern wherein the “low health literacy of older adults is implicated as a convenient explanation” for the crisis (140). But as she confirms, this “invocation of poor health literacy of individuals is also designed to mask the increasingly bureaucratic imbroglio of American health care. There are very few people that do not have difficulty navigating the American healthcare system, so much so that an Institute of Medicine discussion paper redefined health literacy to be both related to an individual’s competencies and to the complexity of the system” (140). Despite this recognition of the


systemic complexities that circumscribe health literacies and possibilities for successfully navigating the health care industry by one institute, however, the rhetorical framing of both health care and financial literacies as individual competencies has dire and differential consequences for anybody whose health care plans are inadequate to their health care needs. Medical debt is the fiscal remainder in this equation, but its impact cannot be accounted for on a balance sheet. As I review in the following section, it impacts individuals, families, generations, and communities with regard to health, wellness, employment, and financial futures, legislating and reinscribing asymmetrical vulnerabilities under the rubric of (self-)managed care.

Financial and Health Literacies in/as Health Savings Accounts

A recent development in managed care that more tightly yokes health and financial literacies together is the financial product referred to as a Health Savings Account (HSA), metonymically representing rhetorical expectations for how people with health care needs are figured by the health care “market.” In the words of the health economist James Robinson, HSAs not only mark a “philosophical shift in emphasis from collective to individual responsibility for the management and financing of care” but “form the core of the emerging ‘consumer-directed’ insurance plans, imposing greater cost sharing on enrollees but permitting broader choices than the health maintenance organization (HMO) plans of the managed-care era” (1199–1200). Technically speaking, HSAs allow a subset of the insured (those with qualifying plans) to set aside money for anticipated health care costs or health care exigencies without tax implications: it is thus “a financial vehicle, akin to an individual retirement account, to which contributions may be made with pretax dollars and from which balances may be withdrawn to pay medical claims, again without payment of tax” (James Robinson 1200). HSAs are only allowed for high-deductible plans, or “generally a health plan . . . that only covers preventative services before the deductible”; the money can be used on “qualified medical expenses,” predefined by the plan, and might include not only costs that supersede medical coverage but “deductibles, copayments, coinsurance, and some other expenses.” The stated value of the HSA is that it may effectively “lower . . . overall health care costs,” but this is as an effect of “using untaxed dollars” (National Council on Disability). In other words, it is a viable plan for those who not only have economic means sufficient
to set aside money for health care costs but for whom doing so will lower their effective tax. Those who do not have the capital to save, the income bracket to benefit, and the need for a high-deductible plan may have the option for an HSA but will gain no financial advantage from it. And indeed, it is marketed as a tax “advantage,” an economic prize for those who meet its criteria.

No doubt impacting millions of Americans who do fit this profile, the rhetoric of Health Savings Accounts has broader impact still on how health care is conceptualized in the United States as/in relation to health and financial literacies and medical debt. As a “savings account,” HSAs participate in the moralization of projecting financial and health futures. Someone who accurately anticipates health care needs and risks and sets aside or saves money to cover associated costs while simultaneously lowering their own tax liability is not only displaying normative financial literacies but taking responsibility for their own fiscal and embodied health. Thus, an ethos of responsibility sticks not only to the choice itself but to those whose financial circumstances enable them to make the choice. The inverse is also true as “risky” rhetorically frames not only choices but those who ostensibly choose them (Scott, Risky Rhetoric).

Robinson points out the danger of HSAs becoming the model for health insurance, acknowledging that “although some persons can and will function effectively as consumers of health services—pursuing information about quality, comparing prices, and balancing care received today against care that may be needed tomorrow—others will fare less well” (1201). As indicated later in this chapter, these “others who fare less well” are predictable, emerging as a class in relation to histories, practices, policies, and patterns that (materially and discursively) differentiate between those who can purchase health (care) vis-à-vis a savings plan and those who must go into debt.

In shifting toward individual responsibility and ownership, HSAs also shift away from the community logics on which insurance and its antecedents had been historically based, wherein risk was shared across a community and in which “unspent” monies were redirected back to the insurance pool—the “financial benefit going to sick enrollees who claim in excess of their premium payments.” As Robinson explains, however, “contributions to the HSA remain the property of each enrollee,” which “increases enrollees’ responsibility for costs incurred in their own care but decreases their responsibility for costs incurred in the care of strangers” (1201). This fundamental shift does not eliminate the need for risk sharing and insurance pools; in the United States, the costs of care directly to individuals are all but prohibitive. But the rhetoric of the HSA
nonetheless centers “the individual citizen as the appropriate setter of health care priorities,” casing insurance assessment and actuarial methods in individual responsibility and financial fortitude and planning (James Robinson 1201).

Planned Savings, Unplanned Debt

In addition to shifting away from or undermining community care models, the idea of accurate financial projection related to health needs and outcomes also bifurcates planned versus exigent medical events, mapping risky behavior onto bodies along economic, gendered, and racialized lines (Scott, Risky Rhetoric). A middle-class heterosexual couple that signs up for a high-deductible plan in preparation for planned maternity care, for example, becomes a paragon of financial literacy and healthy behavior. Meanwhile, a woman without sufficient maternity coverage for an “unplanned” pregnancy rhetorically signifies as financially irresponsible and morally culpable. But even in the context of two people with identical Health Savings Accounts, the significant difference in maternal care across racial lines means that a Black or Brown pregnancy patient may incur more costs if or when medical practitioners recommend more invasive care options (see also Lloyd).

That pregnancy can be framed in terms of “planned” or “unplanned” itself is, of course, a symptom of the moralization of health literacies. While much scholarship and activist rhetoric acknowledge the consequences of this moralization on differentially legislating women’s bodies, denying access to education, birth control, and abortion services to low-income and racialized bodies, less explicit has been a scholarly focus on how rhetorics of health projection interface with rhetorics of financial literacy to exacerbate this moral accounting or how both are indebted to the temporal emergence of actuarial technologies and health insurance arrangements that yield significant debt. Moreover, as reported by the journal Health Affairs in 2020, “out-of-pocket” spending for maternity care for women even with employer-based insurance is significant, having increased substantially in the seven years following the adoption of the ACA (from an average of $3,069 to $4,569—or 67 percent). That is, while the ACA mandated employer-based plans to “cover” preventative care, maternity care was relegated to an “out-of-pocket” expense born by customers (Moniz et al.). The logics and rhetoric of health insurance and medical debt suggest that such women might have chosen, instead, a different health insurance plan, but
with 98 percent of the 657,061 women surveyed paying some out-of-pocket costs, clearly this “choice” did not exist. HSAs thus become the wise financial plan for those who plan to need maternity care. As noted, however, HSAs only benefit those whose tax liability is reduced by contributing to the account.

Distinguishing between so-called planned and unplanned medical costs using normative financial logics—where “planned” signifies as financial literacy—both elides the specific contexts in which medical debts emerge and corroborates prevailing narratives of the debt (as individual, moral, and volitional). Indeed, as proposed by the 2003 report of the Access Project investigating the health and health care access in three communities, in “The Consequences of Medical Debt,” for example, “unlike other forms of debt, medical debt is often involuntary, the result of an event over which one has little or no control” (2). But even in a direct effort to contest the volitional premises of medical debt, the report corroborates debt itself as a choice. That is, while the report does single out the exigencies for medical debt as distinct, contextualizing it in the business model of health care and the specific needs of the “customers” of health care and specifying health care customers as uniquely vulnerable (given their need for medical care), it nonetheless invokes a distinction between planned and unplanned debt, affirming the former as moral, wise, and creditworthy and the latter as irresponsible—or at least lacking in financial foresight. Even when emphasizing that medical expenses “are often sudden and unplanned and, particularly for people without health insurance, may bring large financial burdens that are involuntary in the sense that they are not the result of a traditional consumer choice,” the report reinscribes debt as the consequences of individual financial “choice” (2).

Consumers, of course, do make choices, both in anticipation of planned and unplanned health care needs and expenses and, importantly, in relation to other debts, expenses, and resources. In a study of the relationships between cancer diagnoses and wealth, for example, Arpit Gupta et al. find that the financial destabilization that follows cancer diagnoses must be contextualized in relation to “understanding how households manage the credit instruments available to them” (6). Savings accounts, they explain, are only useful “if households have not incurred substantial debt” because the high interest rates of debt undermine the benefit of the low-interest-rate yields of savings plans (6).

Further contextualizing medical expenses in relation to other economic indicators, in the American Economic Review, Carlos Dobkin et al. study “the economic consequences of hospital admissions,” guided by the premise that despite
the significant expansion in insurance coverage for American adults created by the expansion of the ACA, “we know remarkably little about their exposure to economic risk from adverse health events” (309). Their findings—based on twenty years of data about insured adults admitted to the hospital—include significant evidence of persistent, even increasing impacts of hospitalizations. Notably, the economic consequences of such hospital admissions “increase out-of-pocket medical spending, unpaid medical bills, and bankruptcy, and reduce earnings, incomes, access to credit, and consumer borrowing” (309). Focused on the adult population that does not qualify for Social Security retirement income (and thus depends on continuous employment), this study makes evident the ongoing consequences of a hospital admission—even for the insured—which includes a decline in earnings “at least three times that of the out-of-pocket medical spending increase” (310). Or, in other words, the money required to cover the cost of care not paid by insurance is only one piece of the economic picture.

Although neither of these studies centers medical debt proper, they both expose the entanglement of unpaid medical expenses with myriad economic factors: insurance, employment, savings, credit, and other debts. Like other forms of debt, it is not the amounts that necessarily make medical debt onerous or debilitating but its relation to debtors. As reported in a survey of people struggling to pay medical bills, nearly one-quarter of respondents had bills of less than $1,000, while 60 percent described their finances as either barely adequate or inadequate to meeting basic expenses (Hamel et al. 8). Meanwhile, of respondents who did not struggle to pay medical bills, over 75 percent reported living comfortably, often with “a little left over for extras” (8). Perhaps an obvious conclusion of the study—that people with medical debt are more likely to be subject to economic precarity on a larger scale—these trends nonetheless point to the cyclical patterns of debt, whereby the inability to pay a debt results, predictably, in the inability to pay a debt. Measured via metrics of responsibility and literacy, however, even small debts signify as personal “struggles,” an indication that someone should have chosen a better insurance option, engaged in preventative health measures, or set aside money in case of emergency.

In fact, many cases of outstanding medical bills do encourage people with health care needs to alter their behavior in response to economic precarities, reflecting what Judy Z. Segal identifies as the machinations at work in North American (US and Canadian) rhetorics of health care, where problems “are typically framed in public discourses as, in the first instance, economic problems” (119). She argues that “the fact that the ‘health care crisis’ is most often represented
in public discourse as a crisis of money itself forecloses, by its own terms, the very policy debate it promises to engage” (120). This shapes not only public discourse but individual behavior, as people seek or avoid health care based on economic calculations. In Michelle H. Moniz et al.’s study of the costs of maternity care, for example, they found that these “financial burdens place women at risk of delaying or deferring maternity care” (22). Avoiding needed health care, of course, can create cascading health care problems (for women and babies). As Elizabeth Sweet argues in “Debt-Related Financial Hardship and Health,” “When medical care and treatment are skipped because of being in debt, it may worsen existing physical and mental health issues that require regular or long-term management, or may lead to new health problems by delaying necessary intervention when an issue first arises” (5). Yet again, however, the decision to forgo care (as a calculation of economic necessity) reveals differential relations to debt, whereby some people have access to its affordances and others only to its risks.

Bad Options, Bad Debt

Corroborating and complicating the mediating influence of debt on health care choices and their consequences in the Journal of Health and Social Behaviors, Lucie Kalousova and Sarah A. Burgard explain:

Indebtedness could increase the likelihood of foregoing care because it may constrain the use of financial resources, but the association could vary depending on the type of debt under consideration. Extant studies have suggested that unpaid credit card balances generate stress, so individuals may allocate resources to pay it back at the expense of other things they need. However, other forms of debt could signal positive financial standing, because the ability to take on some kinds of debt depends on credit worthiness and collateral. Many individuals with substantial debt due to a sizeable home mortgage loan are capable of servicing this kind of secured debt because they earn high incomes or have sufficient assets. Debts that simply reflect credit worthiness and are affordable given financial resources should not be associated with foregoing needed medical care. (205)

Those who would forgo medical care in relation to debt—including medical debt—then, are those for whom debts stick as bad debt, which is to say, as a risk
to financial institutions. “Bad debt” is akin to “moral hazard,” technical terminology used to describe a specific, and ostensibly neutral, phenomenon. That is, whereas insurance literature is quick to qualify the “moral” qualifier in “moral hazard” as only reflecting the economic consequences of risk behaviors and decision-making that are altered by the presence of insurance, the qualifier “bad” in “bad debt” is used in accounting to denote debt deemed unrecoverable. Debt marked as “bad,” in other words, is treated in a specific way. For tax purposes in the United States, for example, bad debt is written off as an “expense” on a balance sheet, a predicted and predictable aspect of any business that extends credit to customers. Bad debt associated with unpaid medical bills accounts for (as of March 2020) 52 percent of all debts sent to collections (Debt.org, “Medical Debt”).

The terminology of “bad debt” is somewhat of a misnomer in the health insurance industry, however. That is, while unrecoverable debts are indicated in the accounting methods of the industry, they do not necessarily reflect direct financial losses to (or expenses of) health insurance providers. Lloyd invokes the dissenting opinion of Supreme Court Justice Ruth Bader Ginsberg (in the case of National Federation of Independent Business v. Sebelius) to explain the idea that in the health care and health insurance industries, debts are not absorbed but distributed: “Health care providers do not absorb these bad debts” for unpaid care for the uninsured, she explains. “Instead, they raise their prices, passing along the cost of uncompensated care to those who do pay reliably: the government and private insurance companies” (Ginsberg, qtd. in Lloyd 63). Notably, it is accounting practices and conventions that allow the so-called unrecoverable debt to be written off as a loss or expense, even when such losses (in the short term) enable health care providers to justify increased costs and, by extension, profits. Though ultimately contributing to the financial success of the health care system, however, these “bad debts” nonetheless stick to debtors—those who would not or could not predict risk or manage finances adequate to avoiding debt. Lloyd draws out the implications of this distributed debt onto the beliefs about “bad debtors,” who are positioned as “free riders.” Rhetorically, that is, those who do not have health insurance “become a threat to the insured and to the broader health care system because of their failure to function as paying bodies in a circuit of services, exchange, and accumulation” (63). But whereas functionally medical debt is spread throughout the social body, people without insurance or with unpayable medical debt are marked as drains on the economy and the reason health care costs are high: the culprits in the dysfunction of health care and health insurance.
Individuated Options, Individualized Debt

Mapped onto individual decision-making, the entanglement of medical care needs with financial contexts, which range from creditworthiness and the extension of credit as good debt to the denial of credit and presence of bad debt, shapes not only how individuals or households make decisions about managing their own health care (by pursuing or forgoing it) but how they make decisions about other expenses, including housing. As Jessica E. Bielenberg et al. explain in their study of the relationships between medical debt and homelessness in the *Journal of Health Care Organization*, for example, most of the people surveyed (sixty homeless persons in the Seattle area) reported debt, with two-thirds of respondents citing medical debt and half of those attributing medical debt to being homeless (1). Representing those both with and without health insurance (about half each), the homeless persons surveyed who identified problems paying their medical bills “experienced a more recent episode of homelessness 2 years longer than those who did not have such trouble, even after controlling for race, education, age, gender, and health status” (1). The authors further note that “people of color who had trouble paying medical bills reported almost 1 year more homelessness than whites” (1). Certainly indicating a host of systemic failures, these patterns in the relationships between medical debt and homelessness also invite attention to its significance in shaping the lives and livability of those whose health needs outpace their economic means for health care. As Maurizio Lazzarato reminds us, the function of debt is “to make an enterprise of oneself (Foucault)—that means taking responsibility for poverty, unemployment, precariousness, welfare benefits, low wages, reduced pensions, etc., as if these were the individual’s ‘resources’ and ‘investments’ to manage, as ‘his’ capital” (*Making* 51). As embodied by those whose medical debts result in homelessness, the individuating and responsibility-making of debt is lived out daily as faulty “choices” about “resources” that result in no less than loss of housing. Moreover, the presence of insurance for half of respondents who cited medical debt as a significant contributing factor to homelessness bespeaks the inability of actuarial methods to calculate risk for the insured. And indeed, it is (economic) risk to the insurance provider that is the subject of calculation.

The inseparability of medical debt from its contexts of emergence and use means it intensifies extant economic patterns and precarities as well as health outcomes themselves. Considering the relationship between debt and health in general terms in a 2016 study, “The High Price of Debt: Household Financial
Accounting for Medical Debt

Debt and Its Impact on Mental and Physical Health,” Elizabeth Sweet et al. draw damning conclusions from a study of eighty-four hundred young adults: “In testing multiple indices of debt, we found high household debts relative to assets to be the most consistent and robust predictor of health outcomes. We also found that a high subjective assessment of indebtedness was the strongest predictor of blood pressure, suggesting that psychological dimensions of debt may be particularly salient when it comes to cardiovascular health” (99). Verifying these trends in 2020, Sweet identifies that patterns of changes in behavior (financial and health related) for people with debt correlated with “worse self-rated health, and higher depressive symptoms, anxiety, and perceived stress” (1). Whereas Sweet et al. and Sweet offer compelling evidence of the inverse relationship between all forms of household debt and health, other studies provide a more acute picture of how medical debt in particular shapes health and medical-care-seeking behaviors and outcomes.

For example, in a 2004 study of Baltimore’s urban poor published in the *Journal of General Internal Medicine*, Thomas P. O’Toole, Jose J. Arbelaez, and Robert S. Lawrence, characterizing research subjects as either uninsured, found that “over two thirds of those who either had a current medical debt or had been referred to a collection agency reported that it caused them to seek alternative sites of care or to delay or avoid seeking subsequent care when needed” (775, emphasis added). They correlated this finding with “aggressive debt restitution practices,” whereby “more and more physicians and clinical groups are referring outstanding medical bills to collection agencies much earlier than previously noted” (772). Collection agencies that pursue medical debt, even after it has been accounted for as bad debt (again, debt assumed uncoverable), make pennies on the dollar of what is “owed.” And yet a whole industry is built on the recollection of so-called bad debt, turning it into income and profit for those who collect it.

Differentiating Debtors

To be sure, it is not only aggressive collection practices that influence health-related behaviors of people with medical debt. As discussed in the *Journal of the American Medical Association* in 2021, “medical debt may compromise seeking or receiving appropriate medical care that may lead to delayed diagnosis of health conditions or exacerbations in preexisting conditions and may
potentially contribute to increased risk of premature mortality” (Mendes de Leon and Griggs 228). Moreover, the authors cite “clear evidence for a link of personal debt and financial hardship with poor mental health, which in the case of medical debt could worsen the adverse effects of medical conditions on mental health or vice versa” (228). Careful to qualify these statements with the admission that “little information is available on the downstream health effects of medical debt,” the public-health scholars Carlos F. Mendes de Leon and Jennifer J. Griggs nonetheless conclude that “there is solid evidence regarding the association of wealth with important health metrics, such as mortality and disability, and the likelihood of recovery after illness. In addition, the sudden loss of wealth (such as what may occur after serious illness and because of medical bills not covered by health insurance) has been associated with a significant increase in mortality risk” (228).

The positive correlation between medical debt and adverse health—including mental health—means that demographic distinctions in medical debt holdings also indicate demographic differences in health outcomes. A 2016 report conducted jointly by the Kaiser Family Foundation and the New York Times, “The Burden of Medical Debt,” reveals some of these distinctions, with the following groups more likely than their counterparts to have problems paying medical bills: women, young adults under thirty, adults with children in the house, residents in southern states, people without college degrees, and Black and Hispanic people (Hamel et al. 2). But the “strongest predictors” revealed in the study were not demographics themselves but differences in “income, insurance status, and all 3 measures of health status (being in fair or poor health and having a disability or chronic condition)” (2). Discrepancies, then, among gender and race, for example, are better attributed to the “underlying differences in income and insurance status between these groups and their counterparts” (3).

The report validates findings from the American Journal of Public Health published the same year, which considered the overrepresentation of medical debt among older African American adults compared with their white counterparts. While lower socioeconomic indices qualify proportionally more African American older adults for Medicare and Medicaid, “which should alleviate out-of-pocket spending for healthcare” (Wiltshire et al. 1086), barriers to access to these programs combine with significant economic and social obstacles to result in “2.6 times higher odds of medical debt” for African Americans than whites. Jaqueline Wiltshire et al. attempted to disarticulate “economic measures” from “self-rated health status and other covariates,” controlling for each in an attempt
to isolate the other. They found that “perceived health status explained about 35% of the racial/ethnic disparity in problems paying medical bills, and economic factors explained an additional 39%” (1089). They also found that “older African Americans were more likely than were Whites to be contacted by a collection agency and to borrow money, whereas older Whites were more likely to use savings because of medical bill problems” (1089).

The differential correlates of Wiltshire et al.’s research ground the study in tacit acknowledgment of the relationships between health and financial outcomes and the requirement for normative literacies. Accordingly, they cite “the burden of the eligibility and enrollment process,” “the lack of awareness of eligibility,” and “racially segregated, low-wage jobs that offer no retiree health benefits [resulting in] . . . avoidance of medical services and nonadherence to prescribed medications because of costs” as some reasons that the disparity in debt between African American and white adults in the United States is so high (1086). At issue, then, is not only an availability of insurance programs—like Medicare or Medicaid—designed for older adults generally but their entanglement in longer histories and larger systems of inequity and the requirement for health care recipients to navigate these histories and systems. While Medicare and Medicaid may be adequate to the needs of an older adult with a personal history of good health, that history also indicates past health insurance (probably employment based) and medical care; education or experience navigating the insurance enrollment processes and medical bureaucracy; geographically accessible health care; and, crucially, functional interactions with health and medical professionals themselves.

Harriet A. Washington’s exposé of the historical mistreatment and exploitation of African Americans by the medical industry reveals the requirement of normative health care literacies as adding insult to injury: expecting the medically disenfranchised to rhetorically, ideologically, and, ultimately, economically invest in an industry that emerged as viable on the backs of uncredited and hyperexploited bodies. Moreover, as Dorothy Roberts points out, differential, racialized access to and treatment by the medical and health care industry is ongoing and implicated in contemporary sociopolitical and economic contexts. She argues that “race-based” approaches to medicine, though explicitly designed to invoke race-consciousness and to call attention to differential health outcomes, actually subvert attention to the systemic causes and potential solutions to medical inequities. In her words, “race-based medicine helps to promote a biological explanation for racial inequities that obscures their sociopolitical causes and requires
individuals and market-based solutions rather than social change” (538). These market solutions mean that, in the words of Nadine Ehlers and Leslie R. Hinkson, “race-based medicine creates new debts and compounds old ones” (ix).

As an example of market-based solutions leading to new debts, Hinkson examines the correlation between the costs of hypertension medicine and treatments and the demographic patterns of prescription in data collected from 1988 to 1994. With new—and expensive—treatments for hypertension emerging during that period, Hinkson’s analysis reveals that “in terms of direct monetary costs, Black women were disproportionately prescribed what was at the time the newest, most expensive drug” (17). And noting the significant difference in earnings between Black women and their white counterparts (in 1992, during her study, Black women made sixty-four cents on the dollar of white men, while white women made seventy-eight cents), Hinkson found that “not only were Black women being prescribed the most expensive drug to control their hypertension at the time but they were also the least financially able to absorb this cost” (18). While such a pattern might be narrated in terms of the affordances of race-based medicine and their alleged ability to better target and address specific needs of particular bodies and groups, Hinkson notes that the medicine being prescribed was still experimental and thus that “the drugs’ efficacy and safety was still tenuous” (18). Moreover, centering her study on prescriptions related to a disease with a markedly higher correlation with Black patients, Hinkson reminds us that such a correlation itself must be circumscribed in terms of historical, social, and cultural covariates rather than assumed to be a mere matter of fact for Black bodies. Ehlers and Hinkson invoke the journalist Troy Duster’s account of the overrepresentation of hypertension in the Black community to illustrate the point: “If you follow me around Nordstrom, and put me in jail at nine times the rate of whites, and refuse to give me a bank loan, I might get hypertensive” (qtd. in Ehlers and Hinkson xix). One problem with race-based medicine in the United States, then, especially in the context of market-driven medical access and care, is that race is used as a metonym for embodied difference and billed accordingly.

Differential Exposure, Differential Debt

Disarticulating differential health patterns from racialized bodies and acknowledging race in terms of its rhetorico-material production direct attention to
significant factors of health disparity. In addition to differential access to insurance, care, and caregiving, for example, Ehlers and Hinkson cite Rinaldo Walcott’s terminology of “zones of death” to account for the increased likelihood of minorized communities living “in areas where hazardous waste sites, industrial pollution, and lead exposure are prevalent.” They continue, “Landfills and transfer stations, power plants, incinerators, and major highways are more commonly situated in communities of color, creating health risks for minority populations” (xiii). In Toxic Tourism: Rhetorics of Pollution, Travel, and Environmental Justice, Phaedra C. Pezzullo affirms that places subject to what she calls “toxic assault” “tend to occur in or on communities that historically have been segregated from elite centers of power” and to be concentrated in “neighborhoods of people of color and low-income communities” (5). Such concentrations are not coincidental but policy driven, reflecting, for example, histories of segregation, racialized housing ordinances, and differential municipal spending and debt (see chapter 3) as well as explicit legal statutes. As Winona LaDuke documents in All Our Relations: Native Struggles for Land and Life, American Indian tribes and communities have been systematically exposed to toxins via historical and ongoing land incursions that first relegated tribes and peoples to specific areas and then abused them with industrial and nuclear waste.

An increase in the likelihood of exposure does not disrupt dominant discourses of personal responsibility that frame medical debt, which accumulates for individuals who are presumed to have (read: own) health care needs and have medical bills. Moreover, the presence of toxic exposures or other health risks coincides with the absence of medical or health care centers, which shutter when “bad debt,” or bills that cannot be repaid, becomes overwhelming. In response to the correlation of overrepresentation of medical care due to a combination of toxic exposure, costs and inaccessibility of care and healthy food, and violence, this absence has found some response via practices of “medical hot spotting.” Designed to account for the overrepresentation of health needs in low-income communities and communities of color, medical hot spotting, as explained by Ehlers and Shiloh Krupar, coordinates medical data, data from geographic information systems, and “spatial profiling” to identify neighborhoods that would benefit from preventative care and other programs. The authors explain how medical hot spotting, driven by and dependent on market logics, however, emerges in relation to the “expense” of these communities, who are understood to be financially burdensome and to overwhelm resources with their medical needs. In their words, an “incentive of medical hot spotting is the aim of minimizing
health care expenditure, specifically to lower what is known as uncompensated care debt” (32). Rhetorically, the recipients of this care are reinscribed as financially irresponsible—a fiscal drain on communities. The effect of this framing is that “the most vulnerable are positioned as ‘bad’ or ‘failed’ citizens because they are presented as a drain on the U.S. health system and on society at large” (32). Modeled on crime-prediction mapping technologically—itself implicated in racial profiling (see Eubanks; Weisse et al.)—medical hot spotting inverts causal relations between income and race and health, misidentifying the actions and behaviors of low-income and minoritized individuals, households, and communities as the causes of poor health and increased health care need.

Further contextualizing the inverse relationship between medical care and medical debt for African Americans in particular and minoritized groups in general, Ehlers and Hinkson argue that “what ties race-based medicine and debt together is the health debt that has accumulated throughout the African American community over the course of four centuries” (ix). Referencing “foregone health and medical resources,” “disproportionate disease burdens,” asymmetrical debt accumulation, and the “corporeal, financial, and psychological costs that minorities have to bear as a consequence of their otherness,” the authors conclude that race-based medicine “operates in and through a web of debt and indebtedness” (ix). Such debt accumulates for and sticks to individuals and households hailed as consumers of health care. But the relationship between race and debt does not end there. Building on Roberts’s work critiquing race-based medicine, Lloyd considers how debt itself is used as rhetorical cover to protect and reproduce medical inequities across race and class. She recounts the actions of seventy-nine Republicans in the US House of Representatives who, in contesting the ACA in 2013, signed a letter rejecting raising the US Treasury’s debt ceiling, arguing that it would bankrupt the country and undermine health care. For these congresspeople, the financial health of the country supersedes the physical health of constituents, who are presumed responsible for their own debts. The effect, as Lloyd contends, is that “efforts to block expanded access to health care under the ACA explicitly perpetuate existing social and health injustices, and thereby sanction premature death” (59). Ultimately, she argues that such struggles end up “dividing the worthy and unworthy along racial and class lines,” which reveals how “some people’s premature deaths can accumulate for others as wealth, health, and political power” (58). While correlating the debts and deaths for some with wealth and accumulation for others would seem
to reveal an imbalanced ledger, it accords with accounting logics in which so long as debts are paid, it does not matter who is held to account.

Actuarial Remainders

Ultimately, this division between worthy and unworthy is not only mapped onto individual bodies. Instead, as Ehlers and Hinkson argue, “In a circular operation, this set of choices regarding health care feeds into and compounds the history and present of racial inequality formed by the workings of structural racism and practices of neglect, dispossession, and abandonment” (xii). In other words, asymmetrical, actuarialized histories of health and wealth emerge in differentiated access to and care for individuals who are, in turn, required to demonstrate health and financial literacies to best predict their (individuated) needs. The gulf between need and care is cast as a problem of individual financial planning and bridged by medical debt.

Whereas accounts of medical debt may represent it as the remainder in a calculation where money owed has not been squared with money paid, accounting for this rhetoric in debt considers the conditions of possibility for medical debt to emerge as an individual, mathematical calculation, directing analytic attention to interfacing histories and discourses that rhetorically manage risk, sticking it to the bodies and lives of the most precarious by way of economic rationality and health literacy. This is a rhetoric not only of medical debt but in debt, insofar as histories of actuarial technologies, medical subjectivities, and economic responsibilities map rhetorical possibilities and futures writ large. In the conclusion, then, and supported by this and previous chapter case studies that lay bare the consequences of rhetoric in debt, I pursue this argument more directly, considering how it might be leveraged to reenergize and remap relations among economics and rhetoric to offer more complex accounts of differential debt and to intercede in its insidious work.
Conclusion | Rhetorical Futures in Debt

My internet-assisted research and writing practices mean that I am daily sent Google alerts of debt-related news articles, which paint a picture of an unprecedented global debt crisis emerging from the COVID-19–instigated market slowdown and resulting stimulus packages. Targeted social media ads that algorithmically interpret my interest in debt also mean that I am daily offered debt-relief advice, products, and services. My favorites are headed by narratives of individuals or couples paying off incredible amounts of debt in just a few months by following “one simple rule” (I am not yet sure what that rule is: it is kept behind a paywall). My Amazon algorithm offers me critical social theories and popular press publications that range from explaining finance concepts to selling financial advice, the latter of which is heavily geared toward making smart investments and avoiding debt. During the writing of this book, I engaged with my medical provider a number of times to resolve what appeared to be unpaid bills but represented merely the fiscal difference between what the medical provider calculated as my share of costs versus what my insurance plan was willing to pay. Via my institutional email address, I was sent a survey requesting my input on the design for a new “gateway to campus” bond funded to the costs of $1 million, while my college was asked to reduce its operating budget by the same amount. Meanwhile, my state’s balanced-budget requirement was used by the state congress to justify pulling funding from my university’s permanent budget, the amount removed equal to that awarded from a one-time Coronavirus Aid, Relief, and Economic Security (CARES) Act payment at the beginning of the COVID-19 pandemic (in spring 2020). The combined effect: I am surrounded by debt, swimming in debt, and yet, as my university faces another budget crisis (in a long line of them) threatening jobs, programs, and research, inevitably meted out on the most vulnerable on campus—staff, part-time instructors, graduate students—we are denied debt.
As I have argued throughout this book, debt does not merely exist as a line of credit available to the financially worthy and literate. Rather, debt, credit, worth, and financial literacy emerge in relation, sticking to bodies and confirming subjectivities in normative ways and across levels of scale. And yet, framed by a commonplace rhetoric of debt-as-existing, as an individual, moral, and calculable choice, a denial of credit to a university in a state whose primary tax revenue (oil and gas) was fundamentally compromised by a pandemic is interpreted as making good sense: it is the moral choice given the university’s designation as not for profit, where spending on credit might not pay off, where administrators should learn to live within their means, tighten their belts, or pursue private partnerships to fund worthy projects (my program in rhetoric and professional communication, for example, is being encouraged to find “revenue streams” that replace a graduate assistant model of graduate funding). It also suggests that we cannot be trusted with debt—our future is not secure enough to underwrite our current needs.

I have also argued throughout this book that the effects of imagining rhetoric and debt separately, where the former merely describes the latter and the latter is assumed to exist independently, are distributed in radically inequitable ways—across bodies and lives, across cities and states, across whole nations. Following colonial, racialized, and gendered histories of value, debt signifies as the extension of credit for the financially literate, those who have significant wealth holdings, historical wealth accumulation, and normed financial practices. Although offered as an indication of worthiness and trust in financial decision-making of individuals, then, debt simultaneously confirms (and reaffirms) acceptable subject positions and practices—who and what matters—legislating and moralizing normative economic relations across levels of scale. Debt serves up “choices” required for economic participation and advance: student loans sponsor employment opportunities; bail bonds are often the only available option to avoid being jailed before a court date; mortgages pave the way for home ownership and wealth accumulation; municipal bonds distribute city amenities and services to its residents; medical bills accompany urgent, emergent, and planned medical services. But its moralistic backhand can be toxic. The onetime student with significant student loan debt and unstable employment should not have taken it out; the family who needs bail bonds to release a loved one from jail should have a savings account (and the loved one should make better life choices); the home owners whose mortgage is higher than the
market value of their home should have known better; the city whose residents could not pay their property taxes should not have proposed new capital projects; the person whose body needs medical attention and care should have money set aside in an HSA.

More than just evaluating these so-called choices, these rhetorical rebukes are meted out in terms of affective discipline and livability. In other words, when debt is reduced to a moral calculation of risk made through rational cost-benefit analysis and normative financial literacy, austerity measures become the appropriate response to significant debt. According to this logic, individuals with debt should not only live with the consequences of debt but *feel* the weight of their choices—shamed in segregated lunch lines at school, required to prove worthiness for public assistance, stripped of public and social services. The affects of debt do not only stick punitively, however, reinforcing the immorality of what Darrick Hamilton and William A. Harity Jr. call “bad debt,” but buttress credit, or “good debt,” as the required means for economic participation. As Maurizio Lazzarato succinctly puts it, “Debt is the technique most adequate to the production of neoliberalism’s *homo economicus*” (Governing 70).

The persuasive and encompassing rhetoric of debt as an individual and moral choice, I have further argued throughout this book, emerges through technologies and practices of accounting that reduce debt to a numerical and mathematical calculation. In other words, when debt is conceptualized numerically, it can be accounted for mathematically, a simple calculation of money lent and money due. By reducing debt to a matter of calculation, however, such accounting practices ignore its complex and violent histories in colonization, slavery, segregation, discrimination, and oppression. Under the rubric of financial accounting as a rational, positivist calculation, debt is simple, merely extant. In order to reframe and intercede in this reductive logos and its violent effects, then, I have proposed and mobilized a methodology capable of accounting for rhetoric in debt. Surfacing the enthymematic reasoning that leads to the conclusion that debt merely exists, I have followed scholars of rhetoric, affect, risk, and scale to offer a counterproposal: it emerges across spatial and temporal scales, entangled with normative rhetorics of individuality and morality, numeracy and rationality. With this inverted premise, I have theorized a methodology capable of tracking the emergence of debt across scales and exposing its differential effects. Mobilizing this methodology as a method has allowed me not only to wrestle debt from some of its commonplaces and resituate it temporally and spatially
but to identify avenues for intervention, which I pursue in more detail in this conclusion, because, as discussed in the introduction, technologies (or methodologies) do not merely record who and what matters but fundamentally participate in and sponsor terms of materiality.

Alternative Debts

To be sure, there are other ways to talk about debt that shift attention away from economic exchange and toward more affirmative relations. Indebtedness often bespeaks relations irreducible to economic exchange: a debt that can be neither paid off nor expressed in monetary terms. It would seem vulgar, for example, to attempt to express my indebtedness to academic mentors using a monetary calculation. Whereas I probably could identify a percentage of their salary or perhaps a percentage of mine to “repay” the time they spent on me, no dollar amount could accurately express what their “investment” made possible (my student loan payments, my mortgage, my career, this book, my sense of self, my own mentoring practices). Nor would I want it to. To represent such relationships with a dollar amount would, ironically, cheapen them; to calculate the hourly rate of this labor would misrecognize its nonmonetary qualities and value. Yet my graduate school experience—like many others—was also sponsored in part by student loan debt (my own and my mentors’), a risky choice for a humanities degree, a choice not guaranteed to “pay off,” economically anyway. And my time in a doctoral program was during the worst economic downturn since the Great Depression, marked by municipal failings and ensuing austerity measures that ravaged state governments and public universities. While such economic debts do not change my feeling of (nonmonetary) indebtedness as fundamentally sponsoring my graduate work and future possibilities as a scholar in my own right (and, indeed, give me even more pause as I consider the complicated contexts in which my own mentors were working to support my peers and me), they do not, either, eliminate the ways in which economic debts sponsored and shaped the same experience. One does not replace the other. Nor does one exist independently of the other. Moreover, the idea that some labor cannot be reimbursed because it cannot be quantified reproduces economic disparities along normative lines. Emotional labor and care work, for example, are denied as labor but nonetheless inequitably required of people of color and women, sans compensation.
To categorically deny the economics of mentoring relationships by admitting that such work cannot be adequately represented in terms of money simultaneously denies any claims for financial compensation.

The dangers of this logic are evident in many care and service industries, where the requirements of affective labor are met with affective—rather than monetary—compensation: teachers, social workers, medical assistants, and day-care providers are compensated with feelings of pride in their work, social contribution, and moral uprightness rather than strong wages or benefits. This is not to say that affective labor is never met with monetary compensation. Lawsuits that pursue damages for “pain and suffering,” for example, lay claim to affective debts that must be serviced monetarily. Insurance providers likewise address pain and suffering monetarily. Here “pain and suffering” is not so much “repaid” as acknowledged by way of a monetary reward. Of course, the calculations for adequate compensation in such cases might feel dehumanizing as often as they feel appropriate: What is the appropriate award for loss of life or chronic pain? How can such debts be repaid?

Perhaps the starkest example invoking debt and financial repayment in the case of a debt wholly irreducible to money is the argument for reparations for slavery. Indeed, such arguments capitalize on the violent logics of capitalism itself to lay claim to the unpaid debts of slavery, which not only funded the historical and current wealth of the United States and its white citizens but undermine the wealth accumulation and well-being of Black persons and communities in the United States to this day. Although the atrocities of slavery and its afterlives can never be addressed in their entirety through money, which once again equates people with—or reduces people to—the exchange or market value of their labor, arguments for reparations invoke money as (one) necessary acknowledgment of the ongoing effects of slavery. In a popular and anthologized New Yorker essay, Te-Nahisi Coates affirms, “Perhaps no number can fully capture the multi-century plunder of black people in America. Perhaps the number is so large that it can’t be imagined, let alone calculated and dispensed” (207). While he continues by arguing that “wrestling with these questions matters as much as—if not more than—the specific answers that might be produced” and that such wrestling would be “more important than any single check cut to any African American” (207), others are more insistent that literal repayment cannot be supplanted by scholarly conversation or debate.

In Rethinking Racial Capitalism, Gargi Bhattacharyya summarizes “interrelated models” that ground debates about reparations as follows:
• A calculation of the contemporary value of the breached promises of forty acres and a mule for each freed slave
• A calculation of the value created by the forced labor of slaves, and a calculation of contemporary monetary value of this injection of free labor
• A calculation of the continuing economic loss represented by the impact of slavery on nations of the Caribbean
• A calculation of the continuing economic loss represented by the loss of human capital to countries of Africa
• A calculation of the “price” of the injury to enslaved peoples and a calculation of the contemporary value of such compensation for injury to feelings. (92)

Each of these calculations, Bhattacharyya argues, “suggests something of how we might account for the impact of past racialised dispossession and exploitation on the racialised patterns of economic life daily.” She continues, “Most interestingly, each approach suggests a method of calculation, with the strong implication that all such matters can be accounted for, despite the passing of time and the uncertainty of accounting processes” (92, emphasis added).

The uncertainty that Bhattacharyya indicts accords with Coates’s recognition that calculation itself is one significant obstacle in ongoing debates about reparations: the question of how atrocity and deprivation can be calculated proves a stumbling block to making the case for its possibility. This failure of imagination is directly linked, following Bhattacharyya, to a failure of accounting—or, to put it otherwise, to an overwhelming trust in accounting systems and technologies inadequate to the complexity and horror of the material. For Caitlin Rosenthal, by contrast, the inability of accounting to account for the horrors of slavery is unsurprising, given that slavery was itself “a laboratory for the development of accounting” (4). Whether a failure or a feature of accounting, however, debts of slavery cannot be calculated when the terms of calculation are inadequate to the complexity of the issue. Because slavery cannot (or should not, anyway) be represented in a double-entry system, calculation seems impossible. In this way, the case for reparations—as literal repayment of the debts of slavery—subverts logics of debt and accounting by dramatizing their failures. Slavery cannot be reduced to monetary debt and repayment. And yet refusing to discuss monetary claims denies the long-term economic impacts of slavery and the real, ongoing effects of economic privations. One does not replace the other. Nor does one exist independently of the other. They are entangled with each other. As Coates puts it, “We cannot escape our history. All
our solutions to the great problems of health care, education, housing, and economic inequality are troubled by what must go unspoken” (206).

The case for reparations, then, marshals the unstated premises of debt—that it is individual, moral, calculable—to draw attention to the yet unacknowledged costs and consequences of slavery. To put it otherwise, it is when it is given that debt is conceptualized as the calculable responsibility of individuals to repay for past credits or advances that reparations must be repaid. By this logic, individuals must (collectively) repay the long-overdue debt: a financial and moral reckoning. Ironically, the call to equate and redress slavery with financial compensation exposes debt as wholly irreducible to money. But the goal of the call for reparations is not a simple identification or recognition of its irony because monetary compensation, no matter how inadequate, would help address the continuing legacies—including economic injustices—of slavery.

Leveraging the unstated premises of debt in this way, I submit, allows Coates, Bhattacharyya, Rosenthal, and others to surface its complex history and differential work. Unlike the increasingly popular demands to cancel debt, this argument for reparations acknowledges the messy imbrication of rhetoric in debt. A vocal proponent of the call to cancel debt for all, the late David Graeber justified it on the grounds that debt is “the perversion of a promise” (391). Framed in this way, promising is a moral act, its perversion immoral. The only appropriate response, according to Graeber, is thus to “wipe the slate clean,” which would allow us to reconceptualize how we make promises or “what we truly owe” each other (391). The appeal of starting over, so to speak, is that it ostensibly cancels the stranglehold of historical inequities on present and future opportunities and flourishing. The clean slate is promised as the great equalizer, allowing promises to become something different from a perverse relationship to credit, finance, and global capitalism writ large. Indeed, wiping the slate clean should dispel the disproportionate hold of debt on the flourishing and futures of racialized, minoritized, and otherwise-dispossessed groups.

But influenced by Coates, I submit that wiping the slate clean also, even if unwittingly, erases the histories of debt, denying its emergence and differential effects with the idealistic goal of erasing differences for all. And given that Graeber is so insistent on telling the (five-thousand-year) history of debt, tracing its forms across time and spaces, his proposal to cancel debt cannot but be read as
a cancellation of history. Erasing and denying history, ugly and implicated in violence as it is, does little to illuminate the unstated premises on which debt rests. Moreover, clearing the ledgers, wiping them clean, does not interrupt the accounting technologies and processes through which individuals (read: debtors) are produced, moralized, and managed. Individuals are not questioned as rational economic actors responsible for decisions about the future; rather, starting with a clean slate, individuals’ embodied actions and practices are once again misrecognized as pathological, disarticulated from the complex webs of meaning in which they emerge.

Lazzarato, offering his own critique of Graeber’s proposal, contends that “Graeber thinks that debt is merely exchange that has yet to come to an end, presupposing the equality of parties” (Governing 84). By contrast, Lazzarato insists that “in finance capitalism, debt is infinite, unpayable, inexpiable, except through political redemption . . . and never through monetary reimbursement” (84). Indeed, “political domination and economic exploitation” (88) are assured when debts are never ending, when credit is always required: “we go from one debt to another, take out credit and repay it, and so on” (89). In this context, given that “the debt of today’s capitalism is unpayable, unreimbursable, and infinite,” Lazzarato proposes, “we must change the sense of the unpayable by quite simply not paying” (89, 90, emphasis added). Despite the seeming similarities with Graeber’s call to “wipe the slate clean,” Lazzarato asserts a fundamental difference in their conceptualizations of debt; for him, it is “through a political act, a refusal, that we will break the relation of the domination of debt” (89, emphasis added). Rather than erasing history by wiping the slate clean or lamenting the apparent inescapability of debt, Lazzarato follows Deleuze to suggest that “there is no need to fear or hope, but only to look for new weapons” (qtd. in Lazzarato, Governing 90).

Building on Lazzarato’s call for a political act rather than an economic reimbursement—or even a clean slate—I suggest that it must also be a rhetorical act. Or, rather, to conceptualize the political acts of refusal necessary to divest from logics of and (following Lazzarato) governmentality by debt, we need methodologies capable of accounting for rhetoric in debt. In the remainder of this conclusion, then, I discuss how the methodology of accounting that I propose and practice in this book can both facilitate more just material practices of rhetorical inquiry and contribute to more equitable economic and accounting theories and practices.
More than a Metaphor: Rhetoric in Debt

Articulating a methodology of accounting for rhetoric in debt at the interdisciplinary crossroads of social, cultural, and critical theories of rhetoric, economics, and accounting and the conceptual crossroads of affect, risk, and debt ostensibly invites an almost ready-made genealogy in the Western canon. Who better to drive inquiry into the emergence and effects of debt than Marx, Derrida, Deleuze and Guattari, and Lazzarato? And indeed, my own education and citation practices are indebted to this work, “reverberating,” as Kyle P. Vealey and Alex Layne put it, with their profound influence on rhetoric, economics, and the humanities writ large (54). While the conceptual affordances and provocations of this genealogy are vast, however, they simultaneously elide key questions of the imbrication of debt in conquest, colonization, and racialized and gendered oppression, which more explicitly invoke histories of trade and development grounded in people and land as colonial property, always already available to fund capital projects.

Motivated by a feminist commitment to differential embodiment, then, I sought out the theories and scholarship from a variety of disciplines responsive to questions of how and for whom debt emerges and matters, where and how it sticks. Moreover, reminded by Vealey and Layne that “the reverberations of scholarly work not only shape the future but also construct a comprehendible narrative of the past through our practices of citation” (70), I considered how the enthymematic analysis I conducted, the methodology I theorized and mobilized, and the interdisciplinary scholarship I relied on to parse (some of) the complexities of debt might highlight its uneven emergence, its sticky attachments, its differential work. The reverberations of this research compelled me to consider how the case studies of debt I centered in this project must contextualize the discourses of debt across temporal and spatial scales, marking their emergence within histories of credit (and debt) allocation and denial. In other words, by considering the emergence of rhetorics of debt, I identified rhetoric as always already in debt, not only coincident but coemergent—not merely a vehicle to describe differential debt but intimately entangled in the production and work of debt to authorize who and what counts, who and how they matter.

My selection of three US-centered case studies both constrains the implications of this work and invites further study. As demonstrated by each chapter, materializing the scalar boundaries through which debts emerge is paramount to my articulation of accounting for rhetoric in debt; thus, articulating my own
cases vis-à-vis national boundaries was productive—in surfacing certain kinds of debts and debtors, histories and elisions—as well as limiting, insofar as I mostly partitioned off questions of transnational finance and trade that are so fundamental to contemporary issues of debt and differential mattering. And indeed, temporal and spatial scales through which debt emerges can hardly be contained by national boundaries. As I suggested in the introduction to this book, however, working to “generate descriptions of localized interaction” (Jung) renders accounts of debts that are otherwise unavailable and, I further propose here, invites additional research that articulates and uses different boundaries to continue to better understand and track rhetoric in debt. As scholars in rhetoric and critical and financial accounting and debt studies take up the charge to consider rhetoric in debt, then, I see opportunities to track debt and its affects across national boundaries, in order to better account for the transnational flows of monies, peoples, resources, credit, and debt that participate in differential conditions of possibility. This work would be well supported, too, by reducing scalar boundaries to focus on local interactions: within specific regions, cities, and even institutions.

As scholars of rhetoric seek to interrupt and intervene in patterns and practices of differential mattering, it is imperative that our methodologies build in accounting practices adequate to the complexity of our debts and our (rhetorical) complicity with those debts. It is equally important that they foreground the inequitable distribution of rhetoric and debt, sensitive not only to theoretical and technological accounts of debt but to their uneven effects on communities, bodies, and lives. Accounting for differential mattering, in other words, cannot be conducted through the expansion of rhetorical theory or the refining of accounting technologies but through methodologies that center histories and realities of debt for all, when it is only good for some. Further, such methodologies cannot, as suggested earlier, ignore, deny, or erase the push politics (Peck) or ideological pull of calculation and equivalency but must imagine our rhetorical and economic inheritances as fundamentally entwined in order to imagine them otherwise. In short, rhetoric cannot be cast as a critical heuristic independent of the historical, social, cultural, and economic relations in which it emerges. Indeed, as discussed in the introduction to this book, accounting itself is neither ahistorical or arhetorical but the product of histories, discourses, and relations that produce rhetorical equivalencies compressed into numerical equivalencies. Likewise, rhetoric is neither afinancial nor aeconomic but emerges always already in relation to both (Hanan). Erasing this entanglement only denies
its history and consequences. To contend with these relations, by contrast, invites a form of interdisciplinary rhetorical accounting that is sensitive to history, to complicity, and to interanimations. This form of accounting not only highlights the construction of our ledgers but materializes our suppressed premises, seeking out the sticking points through which individuals—people, numbers, debts—emerge as stand-ins for rhetoric in debt.