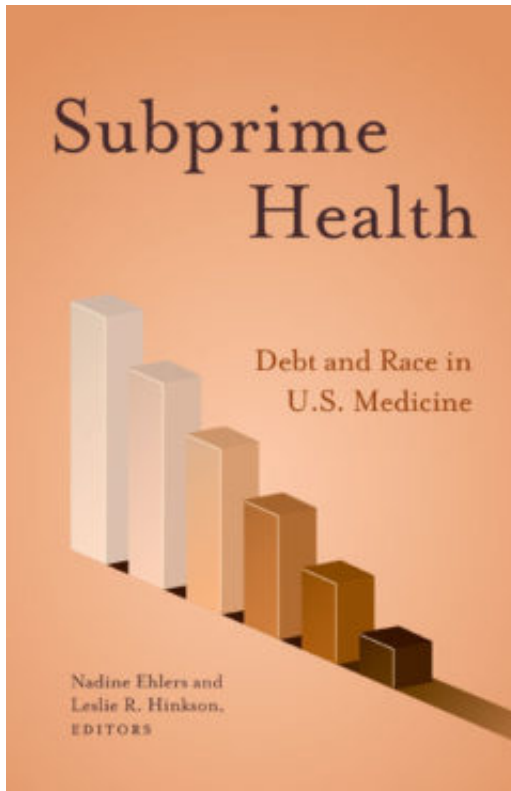


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## Nadine Ehlers and Leslie R. Hinkson's *Subprime Health: Debt and Race in US Medicine*

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By Naomi Zucker



[Subprime Health: Debt and Race in US Medicine](#)

[Nadine Ehlers](#) and [Leslie R. Hinkson](#) (editors)

University of Minnesota Press, 2017. 256 pages

“The focus on race in medicine and the hard sciences,” write Nadine Ehlers and Leslie R. Hinkson in their introduction to the new edited volume *Subprime Health: Debt and Race in US Medicine*, “creates unintended consequences—forms of debt” (2017:xxv). Putting into explicit conversation the already entangled, if not always directly theorized, relationships between race, health, and debt in the contemporary United States, they call on us to think through the ways in which access, obligation, and responsibility are constituted by, and might be reimagined

through, racialized forms of debt. Directly alluding to the subprime mortgage crisis which, while wreaking havoc on the broader economy, was disproportionately built on bad loans to minority households, they foreground the entrenched imbalances of power that unequally distribute bodily, economic, and social health and harm.

Bringing together an interdisciplinary group of scholars in sociology, geography, public health, STS, and critical race studies, among others, the book centers around race-based medicine, which the authors take to include not only the clinical practices of racially-targeted treatment, prescription, and research, but also—crucially—the larger ecosystem of historical and present-day racial inequities and oppressions within and outside of the medical realm. It thus encompasses the differential medical treatment of specific racial groups for specific complaints due to assumed fundamental differences in biology, behavior, or culture; race-targeted pharmaceutical interventions, or “ethnopharmacogenomics”, which take race as a good-enough proxy for ancestry and genetic difference; and, finally, the imbricated infrastructures of health and society in which race largely determines what kind of care one receives. This definition, they write, “takes into account the differentiation of bodies within biomedicine, the question of who gets access to health coverage, what types of care are available, and how many doctors or what kinds of care are available in particular communities” (xviii). Race-based medicine, here, is not limited to the moment where doctors or scientists explicitly invoke race. It is, rather, an apt descriptor of the ways our social world, as well as the medical system, systematically discriminates against people of color—in a white supremacist country, all medicine is race-based.

The concept of debt is crucial to this expanded vision of race-based medicine. It moves us across scales, away from a too-narrow focus on genes and drug prescriptions which, while a hugely important domain of research and discussion, has come to overshadow other possible emphases. Instead, it directs our attention toward the social, economic, and political structures that inform the making up of bodies, lives, and social worlds. While race-based medicine is often figured by supporters, in its most benevolent iterations, as a means of addressing an existing debt by including those who had previously suffered under, or been excluded from, medical research and care, a core argument of this volume involves turning this logic on its head. If race-based medicine is often figured as a way of repaying debts to those who have been excluded from, underserved by, or subject to the violence of medical research and treatment, in what ways, this collection asks, might it in fact exacerbate these debts? Instead of repaying a (very real) social debt to racial minorities, these essays suggest, race-based medicine in fact all too often creates new debts—both monetary and moral. Inverting the relation between owers and owed, through false promises and questionable

race-science, it can shift responsibility from the social to the individual, from subjects of historical exclusion to risk-bearing subjects held accountable for their own behavior, turning broader reparative obligations to right past wrongs into a new set of responsibilities and burdens for already-vulnerable minority subjects.

The race-health-debt nexus taken up in this volume thus opens up an array of high-stakes questions about how we are to assess the landscape of scientific research, medical practice, and the broader political economic orderings that structure the social determinants of health. How might debt, as a capacious analytic, prove productive in thinking through the complex and multidirectional entanglements of race and health, and with what effects on the organization of science and society? How do public and scientific discourses around genetics, pharmaceuticals, and the meaning of race circulate, gain traction, and become entrenched, and what possibilities exist for challenging dominant commonsense? How does race-based medicine reconfigure risk and blame, care and disregard, responsibility and response-ability (Haraway 2007), and what would it look like to take seriously the possibility of meaningful reparations, or of repair? Most fundamentally: what, as a society, do we owe one another, and how are we to reckon these obligations?

The book unfolds across seven chapters by contributing authors, framed by Ehlers and Hinkson's introduction and conclusion, and is divided into two parts. The first, on "Race-Based Medicine and Monetary Debt," takes up debt in its financial sense, asking about the economic incentives structuring racialized health disparities and the financial burdens borne by individuals and communities of color. How, these chapters ask, are the costs of medical care distributed, and what kinds of debts are deemed acceptable or intolerable? Who ends up paying for race-based medicine—monetarily and otherwise?

In an essay on race and hypertension, sociologist Leslie Hinkson investigates how racialized prescription patterns for hypertension drugs can override evidence-based best practices leaving black patients both "underserved and overcharged" (24), more likely to receive either more expensive, or older and less effective, drugs for a condition of which they bear a disproportionate disease burden. Enacted under the guise of inclusion, such practices, she argues, in fact at once erase the social determinants of hypertension, reify biological definitions of race, and ultimately lead to worse and more expensive care for already vulnerable groups. Nadine Ehlers and Shiloh Krupar take on "medical hot spotting," a data-driven approach to health care allocation that seeks to map and target high-need patient populations. They explore how a practice designed to divert resources to the sickest and most underserved, while also using health care resources "efficiently" to minimize overall

expenditures, becomes a racialized (and racializing) project. Hot spotting, they suggest, ultimately stigmatizes the “high utilizers” it purports to serve by displacing the cost of “uncompensated medical debt” incurred by hospitals treating uninsured patients onto a moral debt and ontologized unworthiness carried by minority subjects and the neighborhoods in which they live. Geographer Jenna Loyd, in her essay on the Affordable Care Act, analyses political debates over extending health coverage through the concepts of slow death and haunting, tracing how certain kinds of debt—namely, US sovereign debt—have been wielded to obscure the harms of other, delegitimized forms of debt: the ongoing racial exclusion and violence that continue to constrain the possibilities of health and longevity for black Americans. Color-blind rhetoric, she shows, converges with neoliberal attacks on social spending to invisibilize both social debt and social responsibility. In the last chapter of this section, Anne Pollock focuses on the various “compensation relations” at stake in the making and marketing of BiDil, the first FDA-approved race-based drug, interrogating the regimes of value through which public and private actors mediate access between drugs and patients, and with what moral and financial consequences. The promotion and failure of BiDil, she argues, reveals how complex and often untenable relations between pharmaceutical companies, patients, insurers, and healthcare providers distribute costs and benefits in a racially and economically unequal society.

Where the first half of the book examines how monetary debt is made and distributed, the second part, on “Race-Based Medicine and Indebtedness,” more explicitly addresses a broader conception of moral and social debt, highlighting questions of dependency, citizenship, belonging, and obligation. How, these essays ask, do our understandings of what race is, and what it can tell us about individuals and groups, affect the kinds of accountability and justice we can imagine? In what ways do essentializing narratives around biology or culture obscure social and historical processes?

In “The Meaning of Health Disparities,” sociologist Catherine Bliss discusses how a focus on genomics in race-based medicine has engendered a large-scale shift in how racial health disparities are understood and, correspondingly, what forms of redress we imagine to be possible or desirable. Drawing on a notion of debt that “rests on a...capacious view of social obligation” (108), she questions the ways in which the biological has eclipsed the political-economic in the structuring of research and of care. Ruha Benjamin and Leslie Hinkson, in a chapter on biomedical recruitment in stem cell science, investigate how trust gets constructed as a cultural trait in a broader moral economy of scientific research. Ignoring the histories and contemporary structural dynamics that affect who is included in the medical sphere and how, they show how

discourses that blame trust-deficits for non-participation, even as they put forth a notion of race-based medicine as a kind of reparation, at once reify notions of inherent racial difference and turn those most owed into owing subjects responsible for sacrificing their bodies to science in the present. Finally, in an exploration of the equal protection clause through a comparative analysis of race-based medicine and affirmative action in college admissions, anthropologist and legal scholar Khiara M. Bridges asks what notions of race are at work in these two domains, and how they differentially figure the individual subject. How, she asks, can race, as it is varyingly mobilized, at times obscure, and at times reveal, crucial information at the level of the individual?

This book comes at a timely moment, published in 2017 in the midst of a troubling renewal of race science in the scholarly and public sphere (see, for example, Reich 2018). Rejecting biological notions of essential race, while remaining highly attuned to the ways in which, as anthropologists have persuasively argued, race *becomes* biology (Gravlee 2009), it insistently re-directs our attention to a social understanding of racial disparities in health that, instead of entrenching existing debts, asks us to consider what real repair would look like.

While the individual chapters vary in their depth of analysis and theoretical acuity, taken as a whole, the collection offers an important extension of conversations around race-based medicine, from its common reduction to genetics research and pharmaceutical development to a much broader social-historical perspective. It will be of interest to those working in public health, medical anthropology and sociology, the critical study of race, and American studies and, while focused primarily on African Americans in the US, also speaks more broadly to the ways in which histories of oppression and inequality enter, at all levels, into the workings of science, medicine, and care.

The focus on debt is the book's most valuable contribution, holding significant potential for making sense of the uneven distributions of accountability that shape relations between selves and society across entrenched imbalances of power (see also Joseph 2014). Debt, after all, enacts and creates social relations across time; it calls on us to attend to the workings of history and the constitution of obligations, and to think through what it would mean to imagine (and enact) more caring and more just social orderings. Tethering a past where something was taken or denied and a present in which these imbalances continue to be played out, it demands of us a reckoning with what a more equal future might look like.

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