



**Nadine Ehlers and Leslie R. Hinkson (eds)**, *Subprime Health: Debt and Race in U.S. Medicine*, Minneapolis: University of Minnesota Press, 2017. ISBN: 9781517901493 (cloth); ISBN: 9781517901509 (paper)

*Subprime Health: Debt and Race in U.S. Medicine* is a timely and interdisciplinary look into the politics of race, health, and economy in the contemporary United States. Comprising seven fulsome empirical chapters, the volume explores the imbrication of race with ideas of debt and indebtedness in the practice of healthcare provision in the U.S. Cases range from stem cell trial recruitment, to the targeting of pharmaceutical products to specific racial groups, to medical “hot spotting” (to name just a few examples). In the introduction, editors Nadine Ehlers and Leslie Hinkson lay out a broad definition of race-based medicine, as “the systematic targeting of racial groups for special consideration when diagnosing certain ailments or treating certain diseases”, the “practices in clinical encounters, treatment, and diagnosis”, and “an entire system of health and medical care delivery that uses race as a primary means of rationing and rationalizing care” (p.xvii). This last component of the definition is particularly important in that it helps to historicize how novel developments in medicine are embedded within broader frameworks that sculpt the provisioning of healthcare in the United States. *Subprime Health* is unique in that it brings studies of racial health inequities into direct conversation with STS scholarship on biomedical research.

Linking these two areas of academic inquiry together is the concept of debt, both monetary and moral. As Ehlers and Hinkson explain, “one key benefit to viewing race-based medicine through the lens of debt is that it brings into focus the moral, ethical, and even efficiency debates surrounding the issue [of race-based medicine]...it compels us to move beyond thinking about race-based medicine within a specifically bioscientific/biomedical framework to instead think about it as a sociopolitical phenomenon” (p.xix-xx). Much of what follows operates around these interlaced conceptions of debt. The first four chapters document

some of the monetary costs incurred to racialized communities through different forms of race-based medicine. The final three examine different aspects of indebtedness, understood here as states of owing and dependency. Critically framed through a discussion of slavery as the foundation of health inequality, the book focuses predominantly on Black communities but notes how this work could be extended.

As its title suggests, the 2008 financial crisis—in which imaginaries of debt violently resurfaced in public discussion—haunts the pages of *Subprime Health*. The first chapter, Hinkson’s “The High Cost of Having Hypertension While Black in America”, fleshes out the parallels between the subprime crisis—in which predatory loans were disproportionately targeted towards Black and Brown Americans—and the expansion of race-based medicine. At a time when racialized lending practices were laying groundwork for the 2008 crisis, bioscience and medicine and were becoming increasingly oriented to the extraction of profit by targeting specific racial and ethnic groups as “specialized markets”. Here, the development of race-specific pharmaceuticals (e.g. BiDil, on which more later) is key. So too is a related phenomenon of drug prescription practices in “racialized patterns that are inconsistent with treatment guidelines” (p.5). Through a study of the prescription of hypertension drugs, Hinkson shows how Black women are consistently prescribed the highest-cost drug, despite being the group “least financially able to absorb the cost” (p.18). In medicine, as in the housing market, a person’s perceived race is treated as more important than other conditions that shape their suitability for a specific drug (or loan).

The parallels with housing are at work in Chapter 2, in which Ehlers and Shiloh Krupar discuss the spatial ontology of “medical hot spotting” as a potential form of “medical redlining” (p.43). Briefly, medical hot spotting is an emergent practice that uses GIS to spatially identify “super utilizers” of the U.S. healthcare system in order to enable targeted, preemptive medical interventions that will reduce healthcare debts. Krupar and Ehlers show how a seemingly race-blind practice aimed at extending health services ultimately re-inscribes anti-blackness: “The

spatial ontology at work in this targeting operation stipulates that where you are reveals who you are, as collected, assessed, and defined by marketers, governments, the police, or clinics. Racialised spaces and bodies become re-inscribed as knowable, measurable geotags and data of a population, even when medical hot spotting does not explicitly involve racial profiling. In other words, medical hot spotting ontologizes structural racism in/as space” (p.43). Driven by concerns over the overtaxed American healthcare system, they warn that this practice medicalizes urban marginality by positioning low-income, Black Americans as “debt producing subjects” (p.44).

Jenna Loyd’s chapter, “Obamacare and Sovereign Debt: Race, Reparations, and the Haunting of Premature Death”, examines the significance of race to the congressional debates over the Affordable Care Act (ACA). Grounded in an extensive history of health care reform, Loyd demonstrates how Republicans’ fear of sovereign debt was leveraged against the Black and Brown communities who would ultimately become the ACA’s primary recipients. Loyd examines the political geography of affordable healthcare, noting how representatives from Black majority southern states disproportionately voted against the ACA. If the previous two chapters detail efforts to include historically underserved populations within medicine, here we understand how white fear over sovereign debt provided a structural support for the self-serving belief that no debts were owed for the structural violence of U.S. racism, emphasizing instead social deservedness through marketability (p.63).

Anne Pollock’s chapter, “BiDil’s Compensation Relations”, takes on race-based medicine from a different angle, considering the drug BiDil—the first to receive a patent for a race-specific indication. Pollock asks why BiDil failed to generate substantive market value despite the hype about it. Her refutation of the commonsense claim “that marketing and compensation efforts are effective in getting the pharmaceutical company what it wants” (p.85) is instructive. Debt, Pollock argues, does not guarantee the ability to extract payment. Instead, Pollock directs our attention to the larger social and power relations in which debt is situated—from BiDil’s claims to cure racial inequality through medicine to the racial stratification of

health care delivery more broadly, including the costs associated with obtaining an initial prescription.

As noted, in the second half of the book the question of debt turns from the monetary to the moral. Catherine Bliss's chapter, "The Meaning of Health Disparities", will be particularly instructive to health geographers. Bliss tracks the changing meaning of "health disparities" in the United States, showing how the concept—which emerged out of public health debates over racial inequality in the 1980s—has changed with the expansion of genomic science. Earlier understandings of health disparities suggested that "payback for racial inequality required economic and political means targeted to advance the social standing of minorities" (p.107). But as bioscience gained favor in federally-funded research, "research inclusion by race came to be the predominant biomedical solution to solving the moral crisis of racial inequality" (p.108). Now more than ever before, Bliss argues, health disparities are studied through the inclusion of minorities within programs of genomic research, what she calls the "genomic racial redress framework". Once again, a convenient framing comes to ignore the political, economic, and social factors of race that have informed other orientations to the study of racial health disparities.

While Bliss offers a substantive overview of the history of genomic research, Ruha Benjamin and Hinkson work through the ethnographic in the sixth chapter, a study of "Moral Debts and Racial Mistrust in Experimental Stem Cell Science". This chapter examines the cultural practices through which researchers attempt to recruit minorities within stem cell research, arguing that "it is not only biologically reductive notions of race that are revived in stem cell recruitment discourse; culturally essentialist ideas about group traits—trusting versus nontrusting groups—also require critical attention" (p.131). Even though racial targeting in stem cell science is often portrayed as a project of "reparative justice", scientific norms and behavior reproduce notions of biological and cultural essentialism.

One thing that the volume does especially well is demonstrate how many scientific endeavors fail to operationalize what the editors, Ehlers and Hinkson, describe as a sociological understanding of race—thus leaving many of racism’s most insidious, invisible vectors unchallenged. The final chapter, Khiara Bridges’ “Lessons From Racial Medicine”, takes this one step further. Through a comparison of the Supreme Court’s arguments regarding race in college admissions and the logic of race in biomedicine, Bridges shows how race is differently conceptualized in each context. Whereas the Supreme Court sought to undo affirmative action programs that are based on ideas of racial redress, biomedicine has systematically attempted to *include* minorities within research programs. The main point here is that law and science both employ flawed conceptions of race in their treatment of the individual.

Overall, *Subprime Health* documents how the race-based medicine reframes race as a biological phenomena that organizes medical knowledge and practice along racial lines, and in ways that are both historically situated and profoundly novel. “Biomedicine”, Hinkson and Ehlers conclude, “needs to focus more on what is broken in bodies and the pathologies to be found in biological processes, rather than biologizing what is broken and pathological in our society” (p.186). Though many of its contributions are from outside of geography, *Subprime Health* leaves geographers some pressing questions: How is the racialized practice of biomedicine and bioscience made through geography? What geographical imaginaries are at work in these processes, and what geographical knowledges are necessary to contest them? Readers of *Subprime Health* will leave informed of the history and practice of race-based medicine, and its significance to Black health and life in the United States. The geography of this phenomenon certainly bears further scrutiny.



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