

Target: Biomedicine and Racialized Geo-body-politics

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Over time, providers who work with high utilizers are able to categorize patients into distinct groups... [one of which is described as] “socially disintegrated,” [that is, those] who tend not to engage in self-care, have few family resources and display dependent personalities.

—Hayden Bush, “Health Care’s Costliest 1%” (2012)

The student must ignore... these extreme statements and seek to extract from a complicated mass of facts the tangible evidence of a social atmosphere surrounding Negroes, which differs from that surrounding most whites; of a different mental attitude, moral standard, and economic judgment shown toward Negroes than most other folk.

—W. E. B. Du Bois, *The Philadelphia Negro: A Social Study* (1899)

ON AUGUST 1, 1896, W. E. B. Du Bois began a fifteen-month sociological study of “forty thousand or more people of Negro blood... living in the city of Philadelphia.”¹ Commissioned by the University of Pennsylvania and eventually published as *The Philadelphia Negro: A Social Study* (1899), this work is widely recognized as the first great empirical book on black life in American society. Part of Du Bois’s study included an analysis of the health conditions of Philadelphia’s black population and might be seen as an example of a *race-specific biopolitics of health*. For Michel Foucault, biopolitics is that form of power arising in the late eighteenth century that deals “with the population as a political problem” and focuses on “taking control of life and the biological processes of man-as-species” in order to achieve a state of equilibrium within that population.² To achieve this, “security mechanisms have to be

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¹ W. E. B. Du Bois, *The Philadelphia Negro: A Social Study* (New York: Lippincott, 1899), accessed June 10, 2013, <http://media.pfeiffer.edu/Iridener/dss/DuBois/pntoc.html>.

² Michel Foucault, *Society Must Be Defended: Lectures at the Collège de France, 1975–1976* (New York: Picador, 2003), 245, 246–47.

installed around the random element inherent in a population of living beings so as to optimize a state of life.”³ The biopolitics of health made the population a target of social welfare via the administration of public health. The aim of such administration was to regulate the processes of life, to affirm and proliferate the life of the population, to make the “biological citizens” of the nation *live more*.⁴ What Du Bois makes clear, however, is that this administration of biological life and health—the biopolitics of health—has been “cut” by racism and entrenched racial disparities.⁵ Different segments of the population have been governed in distinct ways, and white lives have been *affirmed* and *made to live* in ways that black lives have not. Black subjects, indeed, have been exposed to what Henry A. Giroux has named a “biopolitics of disposability”—where entire populations are marginalized by race and are socially and environmentally excluded from the attainment of health and from the arena of a pastoral public health.⁶

Du Bois’s investigation highlights that the city of Philadelphia—by way of the University of Pennsylvania study—was engaged in a form of race-specific biopolitics that sought to better manage and secure the potentially dangerous problems of the African American population. Here, black life (and blackness itself) was articulated as an ontological problem to be studied, measured, and ultimately governed in specific ways.⁷ The state and white society more generally

³ Ibid., 246.

⁴ On biological citizenship, see Nikolas Rose, *The Politics of Life: Biomedicine, Power, and Subjectivity in the Twenty-First Century* (Princeton, NJ: Princeton University Press, 2007), 24–25.

⁵ According to Foucault, the fostering of life is fragmented by race or, we could say, racism has been used as a functional mechanism to control the population en masse: the first function of racism, Foucault tells us, is “to fragment, to create caesuras within the biological continuum addressed by biopower” (*Society Must Be Defended*, 255). Michael Dillon and Andrew W. Neal have noted: “Race is one of the markers which biopolitically adjudicates. It does not only specify life’s eligibilities for this or that good it ultimately specifies whether or not a life is to be considered eligible for life as such.” Michael Dillon and Andrew W. Neal, *Foucault on Politics, Security and War* (Hampshire: Palgrave Macmillan, 2008), 168.

⁶ Henry A. Giroux, “Reading Hurricane Katrina: Race, Class, and the Biopolitics of Disposability,” *College Literature* 33, no. 3 (2006): 171. By “pastoral power,” we refer to Foucault’s idea that the modern state consists of the convergence of techniques, rationalities, and practices that work to *govern* (or direct) the conduct of individuals—as members of a population—and also to *organize* those individuals as a political and civil collective in the same way as a shepherd who cares for his flock. African Americans have been excluded from the pastoral aspect of health care. This exclusion has occurred in the form of lack of access to care and health insurance, inequities in caregiving, the medical abuse of black bodies (from grave robbing of black bodies for medical experimentation, to the Tuskegee syphilis experiments, to the appropriation of the Henrietta Lacks cell line). Indeed, black lives have been consistently imperiled in and through the biomedical encounter. For a wide-ranging study, see Harriet A. Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* (New York: Anchor, 2008). Also see Troy Duster, *Backdoor to Eugenics* (New York: Routledge, 2003); Alondra Nelson, *Body and Soul: The Black Panther Party and the Fight against Medical Discrimination* (Minneapolis: University of Minnesota Press, 2011); Dorothy Roberts, *Fatal Invention: How Science, Politics, and Big Business Re-create Race in the Twenty-First Century* (New York: New Press, 2012); and Michelle van Ryn and Steven S. Fu, “Paved with Good Intentions: Do Public Health and Human Service Providers Contribute to Racial/Ethnic Disparities in Health?,” *American Journal of Public Health* 93, no. 2 (2003): 248–55. For reports on racial health disparities, refer to the Institute of Medicine’s report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, 2002, accessed May 20, 2012, <http://www.iom.edu/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx>; and the American Medical Association’s report *Health Disparities*, accessed May 20, 2012, http://www.ama-assn.org/resources/doc/mss/ph_disparities_pres.pdf.

⁷ This form of governing began almost immediately after the formal end of slavery. For instance, the Freedman’s Bureau and early postslavery law are familiar examples of how black “freedom” was built on constraint. As Katherine Franke has argued, “the containment of African-American liberty within a ‘space of regulated freedom’ became one of the principal techniques used by the U.S. government to create particularly governable

had historically deemed this political problem of black life as a *product* of supposed inherent black difference—as the ontological *condition* of blackness itself. Du Bois both refused and inverted this logic, instead reframing what he called the “Negro problem” as “certain peculiar social problems affecting the Negro population” that had too long been ignored.⁸ Such problems might be thought of as the risks of black life in the United States that, for Du Bois, needed to be recognized as symptomatic of environmental factors and relentless historical disenfranchisement.⁹ His study showed that African American problems regarding health were “largely a matter of the condition of living,” and he insisted that, as a problem produced through social conditions, black health—or lack thereof—needed to be attended to and normalized in line with “the cultivated [white] race about it.”¹⁰ Such a proposition suggested that black life needed to be administered more, via attention to illness—toward more life.¹¹ We might say, then, that the Du Boisian study was a demand that the “cut” in the biopolitical fostering of life—along the color line—be remedied.

Contemporary biomedical technologies that target race seem to be attempting to do just this: target supposedly race-specific health factors in order to alleviate racialized health disparities. Targeting operations such as raced-based medicine and medical hot-spotting, for instance, are deployed ostensibly to affirm life: they are said to redress past forms of biomedical neglect and enable the tailoring of biomedical intervention into vulnerable racial communities, and they are advocated as the means by which to foster the health of those populations—through attention, through targeting. Such efforts highlight general changes to the biopolitics of health in neoliberal times. Where the governing of health had previously attended to illness and managed (or failed to manage) populations toward standardized norms of health (through standardized biomedicine), the neoliberal biopolitics of health is increasingly focused on *customizing* health, the body, and life itself through targeted biomedical practices.¹² But in neoliberal times, health and health care have also become ever more financialized and commodified, as we witness an increased economic logic to health.¹³ Such a move is coupled with the decline of the welfare or pastoral state—and public-health focus—and a simultaneous rise of the individualization of illness and health, which, in turn, places an increased emphasis on personal responsibility for

subjects.” Katherine Franke, “Not Quite White,” accessed May 26, 2013, http://www.law.columbia.edu/faculty/faculty_writing/facpubs/franke. Such governing continues in a myriad of ways, from the relentless incarceration of black bodies, to the racialization of space, to the topic of this essay—inequitable and endangering forms of biomedical administration.

⁸ Du Bois, *Philadelphia Negro*.

⁹ Ibid. Du Bois explicitly names these problems as “poverty, ignorance, crime and labor.”

¹⁰ Ibid. We might read “cultivated race” here to mean that the lives of white subjects have historically been cultivated—tended, fostered, and improved—in the United States in ways that the lives of minority citizens have not.

¹¹ A racialized biopolitics of health is that modality of governing that administers (in this case) black life via attention to health.

¹² See Adele E. Clarke, Janet K. Shim, Laura Mamo, Jennifer Ruth Fosket, and Jennifer R. Fishman, “Biomedicalization: Technoscientific Transformations of Health, Illness, and U.S. Biomedicine,” *American Sociological Review* 68, no. 2 (2003): 181–82.

¹³ On the financialization of health and health care, see Edward J. O’Boyle, “Delivering Health Care in a Financially Broken System,” *Personally Speaking* 32 (2007), accessed May 25, 2013, <http://www.mayoresearch.org/files/FINANCIALIZATION32.pdf>.

health and self-care.¹⁴ Moreover, rather than attending to illness once it has presented, there is a heightened emphasis on preventive efforts that seek to preempt disease.¹⁵

This article focuses on the neoliberal biopolitics of health in relation to two target technologies that have recently received considerable public attention and their relation to race. First, we consider BiDil, a pharmaceutical approved by the Food and Drug Administration (FDA) in 2005 and subsequently marketed as a race-specific drug for self-identified African Americans suffering from heart failure. Second, we turn to what is known as “medical hot-spotting,” a practice that began in Camden, New Jersey, in 2007 and that uses Geographic Information Systems (GIS) technologies and spatial profiling to identify populations that are medically vulnerable (“health care’s costliest 1%”) in order to provide preemptive care at home and lower hospital admissions and health care costs. Individuals within these communities, as the opening quotation of this article testifies, are often classified as “socially disintegrated,” as dependent, and as unable to self-care, highlighting the enduring attitudes that Du Bois was working against. Additionally, both technologies demonstrate the individualization, customization, and financialization of health in neoliberal times and show that African Americans are still largely subjected to what Du Bois named as a “social atmosphere . . . which differs from that surrounding most whites.”¹⁶ Both of these target technologies demarcate populations, with supposedly distinct bodies, and name them as a political problem in need of specific health governance. Thus, a *geo-body-politics* is at work: race remains a central dimension of the administration of life *now imagined as a form of biosecurity*, wherein black bodies and racialized spaces are targeted in order to manage the life of the population as a whole. While both technologies offer the potential to address past health inequalities, BiDil might be seen to ontologize blackness as a corporeal truth for market accumulation, while medical hot-spotting can be said to ontologize structural racism in order to secure cost efficiencies of the health care system. Such operations ultimately reestablish dominant racial logics and threaten to make health and other social inequalities even worse. Indeed, the ontologizing function of these technologies presents what might, in a Du Boisian understanding, be seen as the new “problems” or risks of black life in the United States—ones that are open to ever more heightened administration, financial exploitation, and securitization under neoliberal biopolitics.

“FOR BLACKS ONLY”: RACE DRUGS AND THE NEW HEALTH GOVERNANCE

On June 24, 2005, the *New York Times* announced: “The Food and Drug Administration took a controversial step toward a new frontier of personalized medicine yesterday, approving the first drug ever intended for one racial group, African Americans.”¹⁷ This new pharmaceutical, marketed as BiDil, targeted racial health and promised to both revolutionize biomedical attention to racial disparities and pave the way toward pharmacogenomics—where drugs and drug combinations will be optimized for each individual’s unique genetic makeup.¹⁸ According to the pharma-

¹⁴ Rose, *Politics of Life*, 64.

¹⁵ On contemporary neoliberal trends in biomedicalization, see Clarke et al., “Biomedicalization.”

¹⁶ Du Bois, *Philadelphia Negro*.

¹⁷ Stephanie Saul, “F.D.A. Approves a Heart Drug for African-Americans,” *New York Times*, June 24, 2005, accessed May 26, 2013, www.nytimes.com/2005/06/24/health/24drugs.html?_r=0.

¹⁸ It is important to note, here, that BiDil is *not* a pharmacogenomic drug. While both the application for the drug’s patent and subsequent marketing stressed biological causes for the drug’s effectiveness in African

ceutical company NitroMed, which owned the patented drug at the time of its approval, BiDil is “for use in addition to routine medicines to treat heart failure in African American patients, to extend life, improve heart failure symptoms, and help heart failure patients stay out of the hospital longer.”¹⁹ In the years since BiDil first appeared, many debates have been waged regarding both its efficacy and the ethics of a race-specific drug. Despite the controversy, and the fact that BiDil was proclaimed as the “most cutting edge biomedical advance of the twenty-first century,” the drug has largely disappeared from the public arena: it failed to yield the projected market profits, it saw poor success in doctor and patient take-up, and it is no longer actively marketed.²⁰ It is still imperative to consider the significance of BiDil, however, precisely because of its role in race-based biomedicine and a new articulation of health governance along the color line. This new health governance locates disparities in health in the space of the black body, affirms racially segmented health care, and reconstitutes the supposed ontological racial space of the black body as a market opportunity.

BiDil did not begin as a race-specific drug but, rather, became one, through what Jonathan Kahn has called “a complex array of legal, commercial, and medical circumstances that transformed the drug’s identity.”²¹ The drug was first developed in the 1970s, when the University of Minnesota cardiology professor Dr. Jay Cohn combined two generic drugs, hydralazine and isosorbide dinitrate (H-I), to create a therapy—in one pill—that could be taken orally. The drug combination seemed to improve heart function (and minimize heart failure) by helping the body make nitric oxide, a gas that widens the arteries to help blood flow more easily, reduce hypertension, and lessen the strain on the heart. In order to see if the drug would indeed reduce mortality, Cohn tested the combination on 132 white and 49 black patients in the Vasodilator Heart Failure Trial (V-HeFT-I).²² This study found that the drug did indeed reduce mortality from heart failure, and in the late 1980s a second study (V-HeFT-II) was conducted to further refine the H-I combination.²³ In 1986 Cohn patented the drug—with no mention made of race—and in 1996 he and a drug company, Medco (who would initially develop, manufacture, and market the drug), submitted a New Drug Application (NDA) to the FDA. Despite noting the drug’s clinical efficacy, the FDA rejected the application due to a problem with the data, and Cohn went back to the drawing board. Determined to find a way to have the drug approved, he returned to the previous data (now fifteen years old) and analyzed it by race. Cohn and his lead researcher, Peter Carson, reported in a 1999 paper that, on this retrospective analysis, “the H-I combination appears to be

Americans, the various clinical studies never tested genes. Instead, as the FDA advisory committee chair, Steven E. Nissen, stated: “We’re using self-identified race as a surrogate for genetic markers” (cited in Roberts, *Fatal Invention*, 178). Race, then, was used as a *proxy* for (supposed) genetic difference.

¹⁹ See the NitroMed BiDil homepage, accessed May 26, 2013, http://www.nitromed.com/pnt/about_bidil.php.

²⁰ Roberts, *Fatal Invention*, 162. Shares in BiDil dropped in one year from a high of \$27 per share to \$2.50. Refer to Anne Pollock, *Medicating Race: Heart Disease and Durable Preoccupations with Difference* (Durham, NC: Duke University Press, 2012), 165.

²¹ Jonathan Kahn, “How a Drug Becomes ‘Ethnic’: Law, Commerce, and the Production of Racial Categories in Medicine,” *Yale Journal of Health Policy, Law, and Ethics* 4, iss. 1, art. 1 (2004): 11, accessed May 26, 2013, <http://digitalcommons.law.yale.edu/yjhple/vol4/iss1/1>.

²² Roberts, *Fatal Invention*, 171.

²³ On the specifics of the drug combination, see Pamela Sankar and Jonathan Kahn, “BiDil: Race Medicine or Race Marketing,” *Health Affairs* 24 (2005): 456–63. The second clinical trial studied the effects of the drug in 282 white and 109 black patients (see Roberts, *Fatal Invention*, 171).

particularly effective in prolonging survival in black patients.”²⁴ In this same year, Cohn relicensed BiDil to a biotechnology company, NitroMed, and in 2000 Cohn and Carson applied for a race-specific methods patent. With this article and the race-specific methods patent for the drug in hand, NitroMed approached the FDA again for another NDA. Following a subsequent FDA-required clinical trial—that tested the drug on *only* African Americans (the African American Heart Failure Trial, or A-HeFT)²⁵—the FDA approved BiDil *only for use in black patients*.²⁶ Thus, the first race-specific drug target technology was born.

BiDil can be said to operate as a target technology in that it identifies, names, localizes, and depicts African Americans as a distinct group—that can be clearly demarcated—in order to make that group into an accessible target for the drug’s development, approval, marketing, and consumption. Such targeting was widely supported, particularly among many black community organizations, such as the National Association for the Advancement of Colored People, the Congressional Black Caucus, the National Minority Health Month Foundation, and the Association of Black Cardiologists. These groups saw the drug as marking a recognition of the specific health needs of African Americans and a means through which to address enduring health disparities. At the same time, however, many other black organizations and critics were wary of racial profiling in medicine, and many of their concerns highlight that the new health governance—represented by the existence of BiDil—brings its own risks: ones that are largely punitive or, at the very least, neglectful.²⁷

The first element in this new health governance, as evidenced through BiDil, is that racial difference is reaffirmed and ontologized in the space of the black body as a biological truth—but now at the genetic level. As Kahn has argued: “Underlying the [BiDil] trial design is a race-specific patent that is premised on a genetic conception of race.”²⁸ The FDA approval for BiDil was also ultimately predicated on this idea, as the organization gave its (and thus the state’s) imprimatur to the claim on which the patent and NDA was based: that African Americans had a different—and, implicitly, substandard²⁹—physiology of the heart, attributable to some unknown but ontological biological factor.³⁰ NitroMed did not *explicitly* claim that African Americans had a distinct

²⁴ Cited in Roberts, *Fatal Invention*, 170.

²⁵ The A-HeFT trial ended early because of the strengths of its results: morbidity was decreased by 43 percent using BiDil, and hospitalization was decreased by 39 percent. It is important to stress here that the trial enrolled only black patients (a total of 1,050 self-identified black patients with class III or IV heart failure). See H. A. Taylor Jr., J. G. Wilson, D. W. Jones, D. F. Sarpong, A. Srinivasan, R. J. Garrison, C. Nelson, and S. B. Wyatt, “Toward Resolution of Cardiovascular Health Disparities in African Americans: Design and Methods of the Jackson Heart Study,” *Ethnicity and Disease* 15, S6 (2005): 4–17. Also see the BiDil packaging label (of 2005), accessed May 26, 2013, http://www.accessdata.fda.gov/drugsatfda_docs/label/2005/020727lbl.pdf.

²⁶ George T. H. Ellison, Jay S. Kaufman, Rosemary F. Head, Paul A. Martin, and Jonathan D. Kahn, “Flaws in the U.S. Food and Drug Administration’s Rationale for Supporting the Development and Approval of BiDil as a Treatment for Heart Failure Only in Black Patients,” *Journal of Law, Medicine, and Ethics* 36, no. 3 (2008): 449.

²⁷ See, for example, Roberts’s discussion of these critics (*Fatal Invention*, 182).

²⁸ Jonathan Kahn, “Patenting Race in a Genomic Age,” in *Revisiting Race in a Genomic Age*, ed. Barbara A. Koenig, Sandra Soo-Jin Lee, and Sarah S. Richardson (New Brunswick, NJ: Rutgers University Press, 2008), 135.

²⁹ Roberts argues that “by approving BiDil, only for use in black patients, the FDA emphasized the supposedly distinct—and, it is implied, substandard—quality of black bodies” (*Fatal Invention*, 176).

³⁰ Susan Reverby argues: “The evidence appeared to make congestive heart failure seem almost a ‘different disease’ in ‘self-identified’ African-Americans at the level of population as ‘self-identified’ race became the surrogate marker for some other interactive, but unknown, biological and environmental process.” Susan Reverby, “‘Special Treatment’: BiDil, Tuskegee, and the Logic of Race,” *Journal of Law, Medicine, and Ethics* 36, no. 3 (2008): 480, accessed April 27, 2015, http://www.examiningtuskegee.com/Special_Treatment.pdf.

genetic makeup, and the participants in the A-HeFT trial were not genetically tested.³¹ However, without any other explanation for why BiDil would work differently in African Americans, the assumption has been that the cause or “mysterious mechanism” could be attributed to the genes.³² “Race,” then, was used as a marker and a descriptor—a proxy—for genetics in the case of BiDil. According to Kahn, this proxy is used instrumentally and more broadly in pharmacogenomics “as a surrogate to get at [supposed] underlying genetic variation.”³³ Moreover, the proxy, it is claimed, is “only” to be used until we are able to develop truly personalized medicine (for each individual based on genes). Problematically, however, using race as a proxy means that people with radically varying genetic realities are homogenized under the racial descriptor “African American.” This view also assumes that racial groups are biologically distinct (that there are clear lines between different races), that African Americans represent a unitary racial group, and that race itself is a biological, rather than a social, category.³⁴ In refutation of such ideas, Troy Duster has poignantly argued, “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. What’s generating my increased blood pressure are the social forces at play, not my DNA.”³⁵ The issue of black heart failure “was not biological or genetic in origin, but biological in effect due to stress-related outcomes of reduced access to valued social goods, such as employment, promotion, housing stock, etc. *The effect was biological, not the origins.*”³⁶

However, there is no denying that BiDil works to reduce heart failure. The issue or point of contention is that there was no clear evidence of a racial indication for this drug: the study enrolled only blacks, it did not compare blacks to whites, and it did not prove that BiDil works better for African Americans. It only proved, as Pamela Sankar and Jonathan Kahn have noted, “that (black) subjects given BiDil, along with their standard heart medication, did better than (black) subjects given a placebo. . . . A study of white patients. . . might have returned the same finding.”³⁷ The trial for BiDil became a self-fulfilling prophecy: the trial targeted only one racial group, the control group was only within this racial group, and, therefore, the trial would only ever establish the efficacy of the drug within the group. Without an external control group, it was impossible to determine the efficacy of BiDil based on racial specificity. Rather than addressing the social causes of racial health disparities, then, BiDil targets black subjects who are abstracted from material space and, instead, endorses both the idea that black health differences are an ontological biological problem caused by racial difference and the idea that this difference must be

³¹ The FDA highlights pharmacogenomic information regarding the biomarkers NAT1 and NAT2 for the clinical pharmacology of isosorbide dinitrate and hydralazine (BiDil). Refer to <http://www.fda.gov/Drugs/ScienceResearch/ResearchAreas/Pharmacogenetics/ucm236797.htm> (accessed May 26, 2013). However, the latest drug label available for BiDil (2005) does not specifically mention genetic or biomarker testing. See http://www.accessdata.fda.gov/drugsatfda_docs/label/2005/020727lbl.pdf (accessed May 26, 2013).

³² Roberts, *Fatal Invention*, 177.

³³ Kahn, “Patenting Race in a Genomic Age,” 135.

³⁴ It is widely accepted that there are no racial genes, no clear genomic divide between any of society’s socially constructed racial categories, and no stable cluster of biomedically relevant genes that is essentially linked with ancestry or skin color.

³⁵ Troy Duster, quoted in Robin Marantz Henig, “The Genome in Black and White (and Gray),” *New York Times*, October 10, 2004, accessed June 14, 2013, http://www.nytimes.com/2004/10/10/magazine/10GENETIC.html?_r=0.

³⁶ Troy Duster, “Medicine and People of Color: Unlikely Mix—Race, Biology, and Drugs,” *San Francisco Chronicle*, March 17, 2003, B7, our emphasis.

³⁷ Sankar and Kahn, “BiDil,” 460.

governed through specific forms of health administration—by way of customized, biomedical targeting technologies.

If the first key element of the biopolitical governance of health in neoliberal times is that difference is being cast as a biological truth attributable to the mystery of genetics, then the second key element is that this difference (and life itself) is being increasingly financialized. Such financialization is clearly seen in the case of BiDil, where purported difference became a *market opportunity*, enabled largely through processes of biomedical customization. Indeed, race—and specifically the supposed racial difference of African Americans—became the means through which to overturn the prior FDA rejection of BiDil and to create a niche market.³⁸ That the FDA supported BiDil on the basis of race might be attributable to a rising interest in health disparities, increased community agitation around health equity, and the recent building of the Human Haplotype Map (HapMap) and Human Genome Project (HGP), which, as Sankar and Kahn have noted, “put the relationship of race and genetics back on the table.”³⁹ Regardless of the possible reasons, race was a convincing means through which to gain FDA approval and enable the producer, NitroMed, to generate and subsequently target a new market for personalized medicine. Importantly, according to the 2008 President’s Council of Advisors on Science and Technology’s “Priorities for Personalized Medicine” report, personalized medicine is not literally about creating drugs that are unique to individual patients. Instead, personalized medicine refers to “the ability to classify individuals into subpopulations that differ in their susceptibility to a particular disease or their response to a specific treatment.”⁴⁰ If that group is too small, the treatment protocol or drug will not be profitable. Hence, the question is one of *where to draw the line between subgroups* so as to enable profit. As Dorothy Roberts has argued, race solves this problem, in that “it provides a large, identifiable group of consumers.”⁴¹ “Population aggregates [then] become the target market,”⁴² and nonwhite consumers represent an emerging growth market to be targeted by drug manufacturers precisely because of the high incidence rates of certain diseases *within* minority communities—diseases that are themselves largely caused by or exacerbated through operations of biopolitical neglect.⁴³

This BiDil marketing opportunity—located in the suffering black body—was spectacularly financialized: there was an estimated market of 750,000 black Americans out of a total

³⁸ “Race apparently *only* became relevant,” according to critics Pamela Sankar and Jonathan Kahn, “when it offered the means to revive the commercial prospects of BiDil” (Sankar and Kahn, “BiDil,” 457).

³⁹ *Ibid.*, 459.

⁴⁰ President’s Council of Advisors on Science and Technology, “Priorities for Personalized Medicine,” September 2008, accessed May 26, 2013 http://www.whitehouse.gov/files/documents/ostp/PCAST/pcast_report_v2.pdf.

⁴¹ Roberts, *Fatal Invention*, 164.

⁴² Duster, “Medicine and People of Color,” B7.

⁴³ For example, in 2004, the Fifth Annual Multicultural Pharmaceutical Marketing and PR Conference noted: “Major U.S. drug manufacturers are making it a high priority area to cultivate relationships with ethnic consumers, physician groups, community networks and other key stakeholder groups to uncover new market growth. Disproportionately high incidence of diabetes, obesity, heart disease, cancer, HIV/AIDS, asthma and other health conditions among these segments require[s] *many strategic and tactical moves* in pharmaceutical marketing and PR” (quoted in Kahn, “How a Drug Becomes ‘Ethnic,’” 25, our emphasis). At the same time, it is important to recognize the political demand for treatments for African Americans in the United States. As Anne Pollock (*Medicating Race*, 170–71) notes, BiDil’s racial specificity was “highly palatable” to many African Americans precisely because it was seen as an effort to address racial health inequities. However, the racial specificity of the drug was also what made it “unpalatable.”

five million people with heart disease who might benefit from a pill, and Wall Street analysts predicted “annual sales of US\$500 million, even \$1 billion by 2010.”⁴⁴ Stock prices promised to be equally impressive, and in the lead-up to the FDA approval, BiDil stock crested at \$29 per share.⁴⁵ The part of the revenue that would stem from sales of the drug was to be secured through BiDil’s pricing structure: each pill cost \$1.80, and patients would be required to take six pills per day. This meant that a regimen of BiDil would cost \$10.80 per day and \$3,942 per year, making the drug between four and seven times more expensive than the combined price for the generic drugs out of which it was made.⁴⁶ Despite the fact that BiDil represents the fostering of life—of African Americans and, indeed, all patients—it also clearly represents an exploitative accumulation strategy, enabled through customization, that would make money from black suffering. Neoliberal biopolitics, here, demonstrates a pernicious form of *bioeconomics*.

The third element in this new governance of racial health is that personalized care would be achievable only through the intensification of personal responsibility for health. As Nikolas Rose has noted more generally, the contemporary biocitizen is called on to “partake of the ethic of active citizenship that has taken shape in advanced liberal democracies.”⁴⁷ The idea—and attendant ethic—of active citizenship compels individuals to self-care as a *biological responsibility*. For Rose:

This is an ethic in which the maximization of lifestyle, potential, health, and quality of life has become almost obligatory, and where negative judgments are directed toward those who will not, for whatever reason, adopt an active, informed, positive, and prudent relation to the future.⁴⁸

Precisely because BiDil was approved and marketed as a heart-failure therapy “for blacks only,” it presented an opportunity—and a call—for African Americans to attend to their health by way of consuming the drug. Two key factors should be noted here. First, to attend to health—to assume this responsibility—required that a new form of biosociality be inaugurated. If biosociality refers to “new forms of collective identification,” BiDil compelled a further collective identification to be made by African Americans, one that was now predicated on the suggestion of genetic sameness.⁴⁹ The racial indication for BiDil required, then, that individuals claim race as a biological truth, target themselves on the basis of this supposed truth, and govern themselves accordingly in order to fulfill the imperative to attend to health. Moreover, African Americans could be said to have been required to “consume blackness” through using a designer black drug, which was itself predicated on reductive and biologically essentialist ideas of race. Second, the “problem” of black health would be borne by the affected individuals. This can be seen in the sense that black health was cast as a biological, rather than a social-spatial, product—for which there might be a general social responsibility. It can also be seen in that fact that the financial burden of BiDil

⁴⁴ See Saul, “F.D.A. Approves a Heart Drug for African-Americans.” According to the 2009 Securities and Exchange Commission 10K report filed by NitroMed, the company’s sales from BiDil were considerably lower than expected: “\$12.1, \$15.3, and \$14.9 million in 2006, 2007, and 2008, respectively.” See Sheldon Krimsky, “The Art of Medicine: The Short Life of a Race Drug,” *Lancet* 379 (2012): 114–15, <http://www.councilforresponsiblegenetics.org/page/Documents/GRKZJNMMRR.pdf>.

⁴⁵ Jonathan Kahn, *Race in a Bottle: The Story of BiDil and Racialized Medicine in a Post-genomic Age* (New York: Columbia University Press, 2012), 166.

⁴⁶ Saul, “F.D.A. Approves a Heart Drug for African-Americans.”

⁴⁷ Rose, *Politics of Life*, 25.

⁴⁸ *Ibid.*

⁴⁹ *Ibid.*, 23.

would not be shared. For, despite the fact that government, policy-makers, and much of the broader social arena recognized (and even agitated for) the need to address racial health disparities, in many states Medicaid did not cover the drug or did not require Medicare plans to include it. Private insurance companies also denied coverage.⁵⁰ This refusal to make BiDil available can be attributed to the fact that care providers and plans were reticent to pay brand-name prices for a drug that combines two inexpensive and already-covered generic medications. Ultimately, then, the drug was put out of reach for the majority of those people it purported to help. This operation suggests a continuation of state and now-privatized disinterest in African American health, and the case of BiDil can be seen as exposing African Americans to a now-neoliberal biopolitics of disposability: a drug that was ostensibly made to affirm black life was available but not *made* available. The irony is that such lack of availability, coupled with poor patient demand and the unwillingness of doctors to prescribe the drug, contributed to BiDil's failure to secure the projected revenue and led to its eventual demise.⁵¹

Inarguably, BiDil can be viewed as a drug that offered (and continues to offer) the potential to affirm black lives, not by virtue of the racial specification but by the simple fact that the drug has been shown to work. At the same time, we might frame the use of race in the case of BiDil as an instantiation of what Michael Omi and Howard Winant call a "racial project": "Simultaneously an interpretation, representation, or explanation of racial dynamics, and an effort to reorganize and redistribute resources along particular racial lines."⁵² Taken in this light, BiDil represents a way of realizing vital rights for black lives, a means to attend to racial health disparities, and a vehicle through which to materialize hope in communities affected by an excess burden of illness.⁵³ But BiDil also problematically reifies racism in biomedicine and society more broadly and shows that drug companies can and have profited at the expense of the suffering black body. The meanings presented in the case of BiDil are inherently polarized and, indeed, contradictory, and it is this slippage—between positive and negative aspects of the drug—that leads Anne Pollock to characterize BiDil as a pharmakon: as having "the capacity to be beneficial and detrimental *to the same person at the same time*."⁵⁴ Regardless of these various aspects to BiDil, however, the drug is ultimately an example of a new form of health governance. Through state sanction (by way of FDA approval), BiDil reaffirms a segmented racialized population that will have a separate form of health administration based on supposed innate difference. Under this new governance, racial difference is becoming financialized—testimony to this is that racial patents for drugs have risen exponentially since the approval of BiDil⁵⁵—and the responsibility for health is falling to individuals who must take responsibility for social problems that are positioned as biological ontology.

Through this analysis, BiDil can clearly be seen to operate as a biomedical targeting technology on several levels. First, BiDil targets at the level of the group: it targets African Americans as a collective that is supposedly clearly demarcated, unitary, and homogeneous. Second, the

⁵⁰ Roberts, *Fatal Invention*, 185–87.

⁵¹ See Pollock, *Medicating Race*, 165–69; Roberts, *Fatal Invention*, 185–89.

⁵² Michael Omi and Howard Winant, *Racial Formation in the United States: From the 1960s to the 1990s* (London: Routledge, 1994), 185.

⁵³ Jonathon Xavier Inda, "Materializing Hope: Racial Pharmaceuticals, Suffering Bodies, and Biological Citizenship," in *Corpus: An Interdisciplinary Reader on Bodies and Knowledge*, ed. Monica J. Casper and Paisley Currah (New York: Palgrave Macmillan, 2011), 61–80.

⁵⁴ Pollock, *Medicating Race*, 169, emphasis in original.

⁵⁵ Kahn, "Patenting Race in a Genomic Age."

drug targets at the level of the individual body: it targets particular bodies as raced, and this supposed “racial truth” must be embodied *by* the individual. The A-HeFT trial for BiDil targeted racial bodies in space—identifying raced bodies living in the world—but paid no attention to the social conditions that produced the materiality of those bodies. In this way structural racism was ontologized *in* the body. Lastly, there is a relation of targeting at work between health care professionals and pharmaceutical marketing that is tautological: on the one hand, health care professionals target race as a biological reality that supposedly exists outside culture in the very same moment that they have ultimately acknowledged that race is not genetic. On the other hand, pharmaceutical marketing—staged by NitroMed—requires that they claim race as a biological reality precisely in order to develop marketing strategies “aimed at blacks,” who will be the consumers of the drug.⁵⁶ Therein lies the BiDil “paradox”: “the need to justify the drug because of health disparities between black and white populations in the United States, by using race, and the need to promise that race is only the ‘best available proxy’ on the way to genetic individualized care, where race will not be used.”⁵⁷

MEDICAL HOT-SPOTTING: LOCATING THE 1 PERCENT AND THE RACIALIZED CUSTOMIZATION OF HEALTH CARE

The case of BiDil demonstrates how race explicitly remains a central organizing principle of the administration of life. Moreover, race-based medicine paradoxically promises to redress historical neglect and black suffering by targeting African Americans as consumers of a speculative black “designer drug.” While lack of accessibility and uptake has dampened the effort, BiDil shows how race and attendant group-differentiated vulnerabilities may be biologically essentialized in order to create new markets, reorganize and redistribute resources along color lines, and affirm racially segmented health care. A second, no-less-contradictory form of racial governing has appeared on the US health care reform scene: medical hot-spotting. The practice of medical hot-spotting is not explicitly a racial project, except in cases where practitioners claim to address social and environmental factors that are the result of the historical disenfranchisement and biomedical neglect of people of color. In this progressive sense, medical hot-spotting can be understood as a form of biomedical intervention into minority communities through new health care access and coordination. However, medical hot-spotting endeavors to reorganize health governance according to the economic logic of cost efficiency by targeting populations that are high utilizers—that incur high costs—in the corporatized US health care system. To achieve this, it relies on spatial profiling and biomedical metadata analysis that ultimately risk normalizing—indeed, spatially ontologizing—historical geographies of racial domination, such as housing segregation or environmental racism, as simply geodemographic “facts” on a map.

Although such interpretations draw out uncomfortable speculations about the racial operations of medical hot-spotting—given the stated intentions of its practitioners and the fact that programs are just getting off the ground—we take this opportunity to examine how structural forms of racial inequality persist via evolving neoliberal practices that reinforce the racial

⁵⁶ Refer to the following Kaiser Network article, accessed June 13, 2013: <http://www.kaiserhealthnews.org/dailyreports/2005/june/17/dr00030826.aspx?referrer=search>.

⁵⁷ Sandra Soo-Jin Lee, cited in Reverby, “Special Treatment,” 478.

structure of society while also modifying processes of racialization *in/through space*.⁵⁸ Medical hot-spotting not only has germinated within US neoliberal policy and the postreform health care landscape but also innovatively extends neoliberal logics through race-space relations that it contradictorily renders invisible. We are particularly interested in examining the way medical hot-spotting utilizes spatial targeting operations that can potentially intensify racial stratification and injustice. Giroux captures the rationale for our preliminary critique of the emergent biomedical practice of hot-spotting: “Racial justice in the age of market-based freedoms and financially driven values loses its ethical imperative to a neoliberalism that embraces commercial rather than civic values, private rather than public interests, and financial incentives rather than ethical concerns.”⁵⁹

Medical hot-spotting has been variously defined as “the ability to identify in a timely manner heavy users of the systems and their patterns of utilization so that targeted intervention programs can be instituted”⁶⁰ and “a problem-solving technique that targets the most expensive problems or in-need people by allocating resources to specific problem areas as revealed by the data.”⁶¹ The practice began in Camden, New Jersey, an economically depressed community across the Delaware River from Philadelphia. Following the collapse of its industrial base and decades of white flight, Camden is considered to be one of the most blighted areas of the northeastern United States, owing to heavy pollution from toxic industries, unsafe and abandoned structures, violent drug trade and crime, and a population of approximately 77,000 that is per capita one of the poorest in the nation.⁶² In 2006 the median household income in Camden City was \$18,007, the lowest of all US communities with populations over 65,000, and 52 percent of the city’s residents lived in poverty.⁶³ In 2009 the unemployment rate in Camden City was 19.2 percent, while the overall unemployment rate was 10 percent in Burlington, Camden, and Gloucester Counties and 8.4 percent in Philadelphia and the four surrounding counties in southeastern Pennsylvania.⁶⁴ These figures become particularly telling in light of the racial demographics of

⁵⁸ Lisa Duggan, *The Twilight of Equality? Neoliberalism, Cultural Politics, and the Attack on Democracy* (Boston: Beacon Press, 2003); David J. Roberts and Minelle Mahtani, “Neoliberalizing Race, Racing Neoliberalism: Placing ‘Race’ in Neoliberal Discourses,” *Antipode* 42, no. 2 (2010): 248–57; and Michael Omi, “‘Slippin’ into Darkness’: The (Re)Biologization of Race,” *Journal of Asian American Studies* 13, no. 3 (2010): 343–58.

⁵⁹ Henry A. Giroux, “Spectacles of Race and Pedagogies of Denial: Anti-Black Racist Pedagogy under the Reign of Neoliberalism,” *Communication Education* 52, no. 3/4 (2003): 195–96.

⁶⁰ J. Hu, F. Wang, J. Sun, R. Sorrentino, and S. Ebadollahi, “A Healthcare Utilization Analysis Framework for Hot Spotting and Contextual Anomaly Detection,” *American Medical Informatics Association Annual Symposium Proceedings* (2012), 360.

⁶¹ Dylan Ratigan, “Hot-Spotting: It’s How, Not How Much,” *Huffington Post*, November 28, 2011, accessed November 28, 2011, http://www.huffingtonpost.com/dylan-ratigan/hotspotting-its-how-not-h_b_1116765.html.

⁶² Camden population data available at <http://www.census.gov/quickfacts/table/PST045214/3410000,00> (accessed February 15, 2015).

⁶³ Legal Services of New Jersey, Poverty Research Institute, “Poverty in the City of Camden,” April 2007, accessed February 15, 2015, <http://www.lsnj.org/PDFs/budget/PovertyCityOfCamden041107.pdf>; Karen Fahim, “Rethinking Revitalization; in *Crumbling Camden, New Challenges for a Recovery Plan*,” *New York Times*, November 5, 2006, accessed February 15, 2015, <http://query.nytimes.com/gst/fullpage.html?res=9C04E2DF113FF936A35752C1A9609C8B63>.

⁶⁴ https://en.wikipedia.org/wiki/Camden,_New_Jersey (accessed February 15, 2015); “S. Jersey Fairing Worse on Jobs than Phila. Area,” *Philadelphia Inquirer*, November 29, 2009, D02.

the city. According to the 2010 census, half of the city's residents were black or African American and more than a third of the residents were Latino.⁶⁵

Alongside these statistics, it is also important to note that a distinctive operation of regional racialization is at work in Camden. This is the topic of Howard Gillette Jr.'s *Camden after the Fall: Decline and Renewal in a Post-industrial City*, which chronicles the endemic disinvestment that has haunted Camden throughout the twentieth century.⁶⁶ Historically, like many urban centers, Camden experienced deindustrialization, with white flight and devastating economic and social disinvestment. Spatial tools and policies—planning and zoning laws, development schemes, rental and mortgage structures, and so on—were explicitly used to racialize the demographic layout of the region. In the 1960s nearby suburbs and townships used financial and zoning powers to exclusively attract middle- to upper-class white families away from Camden; at the same time the power of eminent domain was used to remove poor and black residents from those areas. As a result, the city of Camden effectively became a container of poverty, with declining interior infrastructure and minimal access to outlying areas, where services were being elevated and communities cultivated. Added to these various factors, the presence of toxic industries, poverty, and escalated violent crime all have contributed to a dire public-health problem in Camden. With 29.5 percent of the population unable to afford prescription drugs, the city's residents clearly experience disproportionate levels of ill health.⁶⁷

Medical hot-spotting cannot be divorced from the racial geography that informed its inception; it emerged in this racialized context as a means to lower exorbitant health care spending on the medically indigent by coordinating intensive outpatient care for complex- and high-needs patients. The practice is attributed to Dr. Jeffrey Brenner, who founded the “Camden healthcare providers breakfast group” in 2002 and later the Camden Coalition of Healthcare Providers, where he serves today as full-time executive director.⁶⁸ His personal and professional interest in addressing violence in Camden led him to apply policing strategies to health care, namely CompuStat, a program that tracks and maps crime statistics and, by doing so, allows police to target areas where crimes are committed and direct resources toward controlling these “hot spots.”⁶⁹ Just as such law enforcement compiles data and employs GIS technologies to identify and give special attention to areas of high crime rates, Dr. Brenner figured that a medical application—medical hot-spotting—could similarly identify populations that are medically vulnerable/indigent and high utilizers of the health care system (i.e., patients who use health care resources at abnormally high rates) in order to facilitate preemptive care and cut down the number of medical crises requiring expensive hospitalization and treatments. He obtained massive amounts of data from hospitals in the area to map medical information and found that 1 percent of patients

⁶⁵ Refer to <http://www.census.gov/quickfacts/table/PST045214/3410000,00> (accessed February 15, 2015).

⁶⁶ Howard Gillette Jr., *Camden after the Fall: Decline and Renewal in a Post-industrial City* (Philadelphia: University of Pennsylvania Press, 2006).

⁶⁷ Figure quoted from CamConnect's 2008 “Camden Facts,” accessed February 15, 2015, http://www.camconnect.org/datalogue/Camden_Facts_08_3-20-08_health.pdf.

⁶⁸ There are numerous short biographies of Dr. Brenner and popular accounts of the development of medical hot-spotting. See, e.g., Atul Gawande, “The Hot Spotters,” *New Yorker*, January 24, 2011, accessed November 30, 2012, http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande.

⁶⁹ Bryce Williams, “Medical Hotspotting: When Treating Patients like Criminals Makes Sense,” *Fast Company Exist* blog, November 23, 2011, accessed May 30, 2013, <http://www.fastcoexist.com/1678856/medical-hotspotting-when-treating-patients-like-criminals-makes-sense>.

in Camden were driving 30 percent of medical costs⁷⁰ and that people with the highest medical costs and the greatest number of emergency room visits were usually receiving the worst care. For example, one single public-housing development was alone responsible for \$12 million in health care costs from 2002 to 2008.⁷¹ High utilizers of health care in Camden visited overburdened local clinics, were uninsured or otherwise remiss about seeing a primary-care doctor for preventive care, were on welfare and otherwise poor, and were making detrimental lifestyle choices with little capacity for change, such as cycles of prescription medicine and other treatments that dealt with superficial symptoms rather than root causes of health problems.⁷²

In addition to sophisticated medical data mapping, medical hot-spotting also entails directing more efficient and effective care toward these medical hot spots of high utilizers.⁷³ Medical hot-spotting coordinates and tailors care management through numerous techniques that restructure the organization, delivery, accountability, and doctor-patient relations of health care. These strategies include interdisciplinary teamwork, house calls and personalized follow-ups, practical preventive care rather than ER visits, medical escorts and transition nurses, community assistance programs, and behavioral modification techniques—all focused on the individual patient over a period of up to six months.⁷⁴ A promising aspect of medical hot-spotting, then, is to alleviate health inequities, through stabilizing both the medical conditions *and* the social environment of patients as a means to health. This might range from health and wellness promotion, behavioral modification, and psychosocial counseling to helping patients apply for government assistance programs, secure better housing or temporary shelter, enroll in medical day programs, and adapt to home life and a responsible routine after hospital discharge.⁷⁵ Collaboration and delivery of such services might also reconfigure the relationships among medical professionals in innovative ways, involving primary-care physicians, nurses, social workers, and the more recent field of health coaches. From Camden, medical hot-spotting has gained traction across the health care system. The Aetna Foundation awarded \$175,000 to the Camden Coalition of Healthcare Providers to establish a new fellowship program to train primary-care doctors in the practice of medical hot-spotting.⁷⁶ Similar practices are now at work in Trenton, Newark, West Philadelphia, York, Scranton, Allentown, the Bronx, Queens, Atlantic City, Boston, Anchorage, Chicago, Seattle, and Las Vegas.⁷⁷

⁷⁰ Peter Bronski, “The Doctor on a Medical Mission,” *Vassar: The Alumnae/i Quarterly*, accessed May 30, 2013, <http://vq.vassar.edu/issues/2012/02/pushing-boundaries/the-doctor-on-a-medical-mission.html>.

⁷¹ Hayden Bush, “Health Care’s Costliest 1%,” *Hospitals and Health Networks*, September 2012, accessed May 30, 2013, <http://www.hhnmag.com/hhnmag/features/1Percent/OnePercent.shtml>.

⁷² Bronski, “The Doctor on a Medical Mission.”

⁷³ Dr. Brenner has also emphasized the importance of garnering qualitative data from doctors and providers in the process of locating high utilizers.

⁷⁴ Aetna Foundation press release, “Aetna Foundation Awards \$325,000 in Grants to Train Doctors for 21st-Century Health Care,” March 5, 2013, accessed May 30, 2013, <http://news.aetnafoundation.org>.

⁷⁵ John Blair, “Universal Hot Spotting: The Future of American Medicine in the Face of a Novel Healthcare Delivery Approach,” *The Triple Helix* blog (Arizona State University), accessed May 30, 2013, <http://asutriplehelix.org/node/185>. Also see the *Frontline* video “Doctor Hotspot,” accessed June 13, 2013, video.pbs.org/video/2070853636/.

⁷⁶ Aetna Foundation press release, “Aetna Foundation Awards \$325,000.”

⁷⁷ See Atul Gawande, “Seeing Spots,” January 27, 2011, accessed May 30, 2013, <http://www.newyorker.com/online/blogs/comment/2011/01/seeing-spots.html>; and Gawande, “Hot Spotters.” While we have specifically mentioned medical hot-spotting in Camden, New Jersey, there are numerous other pilot programs of patient-focused accountable care occurring across the country, such as the Special Care Program in Seattle

Such health care reforms and experimentations are needed *social projects*, which, we argue, are always *inherently racial projects*. Indeed, the well-documented institutional racism of biomedicine and pernicious and ongoing forms of structural racism that underpin US society and produce differential vulnerabilities to illness and disease are part of what universal access to health care endeavors to address and even rectify.⁷⁸ Yet “race” remains topically out of bounds in discussions about medical hot-spotting, in spite of the racially stratified society and health care system of the United States. Our intervention, then, is to consider what we might call the “racial hazards” of medical hot-spotting, specifically the spatial technologies involved, with respect to two neoliberal logics—“cost efficiency” and “self-care”—that operate in contemporary US health care reform. These logics and technologies work to *ontologize racialized spaces*—they ontologize structural racism *as space*, as transparent/self-evident, race-neutral, dehistoricized, undialectical space. In contrast to many of the intentions behind medical hot-spotting, this development in health governance potentially supports intensified racial dominance under the auspices of improved health intervention and coordinated care, such as the racialized rationing of resources through spatially customized health care; health care as punitive workfare for racialized bodies in targeted hot spots; and spatial profiling for the purposes of biosecurity and containment of minority populations. While these dystopic outcomes are not explicitly intended by medical hot-spotting practices, they draw attention to the horizons of US health care reform and experimentation—namely, *a new health governance along the lines of race*.

George Lipsitz incisively observes that “competition for scarce resources in the North American context generates new racial enmities and antagonisms, which in turn promotes new variants of racism.”⁷⁹ In the context of austerity policies and widespread panic about the over-taxed US health care system, “cost efficiency” amplifies a racist national opposition between those who are worthy of scarce resources—an imagined community of deserving Americans (i.e.,

for Boeing workers; CareOregon’s geomapping of high-cost users as part of its administration of a nonprofit health plan that serves Medicare and Medicaid patients; Southcentral Foundation’s health care system in Anchorage, Alaska, which targets Native Alaskans to coordinate care and cut costs; and the 2011 launch of the Center for Integrative Medicine, part of the Spectrum Health Medical Group in Grand Rapids, Michigan, which actively seeks out high-frequency patients for treatment of social and medical issues. Additional examples are listed in Blair, “Universal Hot Spotting.”

⁷⁸ The institutional racism of medicine includes lack of economic access to health care in relation to racial stratification of the economy; barriers to hospitals and health care institutions due to the closure, relocation, or privatization of hospitals that primarily serve minority populations; inequities in preventive care and treatment based on medical or biological differences, income, etc.; lack of culturally competent care and/or language accessibility; racial disparities in the provision of treatments and inclusion in research; unequal access to emergency care and excessive wait times; deposit requirements as a prerequisite to care; and the refusal of Medicaid patients. For an extended review, see Vernellia Randall, “Institutional Racism in U.S. Health Care,” Institute on Race, Health Care and the Law, accessed May 30, 2013, <http://academic.udayton.edu/health/07humanrights/racial01c.htm>. A practice of medical redlining that came to public notice in California was the requiring of physician “economic credentials” (in addition to professional credentials) in order to qualify to perform surgeries in a hospital; doctors who served costly patients could be rejected on the grounds of being “high risk” for financial loss. See Robert Weinman, “Medical Red-Lining: ‘Economic Credentials’ for Physicians,” *San Francisco Chronicle*, January 12, 1996, accessed April 27, 2015, <http://www.sfgate.com/news/article/Medical-red-lining-Economic-credentials-for-3153379.php>. In general, the corporate dominance in US health care has supported increasingly inequitable distribution of health care resources and thus has contributed to the declining public-health conditions of poor and minority urban communities. See David G. Whiteis, “Unhealthy Cities: Corporate Medicine, Community Economic Underdevelopment, and Public Health,” *International Journal of Health Services* 27, no. 2 (1997): 227–42, esp. 227.

⁷⁹ George Lipsitz, *American Studies in a Moment of Danger* (Minneapolis: University of Minnesota Press, 2001), 12.

white, suburban, healthy families)—and the despicable, leeching “high utilizers” and “high-risk” populations (i.e., categories that serve as proxy for racialized others).⁸⁰ Expressed concerns about competition for scarce health care dollars mobilize racism in the powerful rhetoric of statistics and unfair burden—for example, “there’s a small segment that is burning through 20 percent of our society’s wealth at a massive rate”⁸¹ or “because U.S. hospitals give billions of uncompensated care to the uninsured and underinsured each year, they pass costs along to insured users.”⁸² Such a picture presents the world as a grid of relationships of cost. The abstraction of this cost grid disregards the “richness” of space—the social-spatial relationships that contribute to high-cost usage of health care. And it circumscribes subjectivity within the market, ignoring the complex ways that subjects are embodied and situated. In the late 1990s David G. Whiteis sounded an early warning: “The current emphasis on ‘managing’ medical care for cost containment disregards the social and environmental genesis of many health problems.”⁸³ In this way, the logic of cost efficiency functions as a neoliberal technique of ignoring the structural reasons for ill health by giving epistemological primacy to cost relations. This operation has opened the door for racist language under the sign of “cost.” Indeed, “high utilizer” may join “welfare queen” and “gang-banger” in the pantheon of demonized subjects for “endangering our national health care budget and the health of worthy citizens who are not bringing health problems on themselves.”⁸⁴ Medical hot-spotting, then, could support the idea that hot spots are a serious threat to the nation and, by locating them, might encourage the transfer of blame and *placement of responsibility* on those who are already disadvantaged, disenfranchised, and civically disabled.⁸⁵

Although medical hot-spotting attempts to organize treatment modalities and infrastructure that are customized to vulnerable communities, there is, as of yet, little reflection on how discrimination may happen in such managed care and whether any civil rights protocol should inform medical hot-spotting. Without attending to these issues, the practice risks having a disparate and deleterious impact on minorities. Medical hot spots could serve as *a means to ration health care*, by drawing out and further entrenching social borders and spatial segregations—in essence, performing a kind of *medical redlining*. For example, while the poor are increasingly placed in managed-care programs, we will likely continue to see the use of tax-supported bonds for hospitals that terminate medical services for the poorest patients. Some managed-care organizations may limit the access

⁸⁰ The bottom line of US health care reform is cost reduction—the underlying rationale for targeting the costliest 1 percent and coordinating cost-saving interventions. A 2012 report released by the Agency for Healthcare Research and Quality found that 1 percent of patients accounted for approximately one-fifth of health care spending in the United States in 2009. According to the US Department of Health and Human Services, almost half of total health care spending can be attributed to 5 percent of the population, and the 15 percent most expensive health conditions account for 44 percent of total health care costs. See Bush, “Health Care’s Costliest 1%”; and Williams, “Medical Hotspotting.”

⁸¹ Doug Eby, MD, vice-president of medical services for the Southcentral Foundation health care system, Anchorage, Alaska, quoted in Bush, “Health Care’s Costliest 1%.”

⁸² See Ed Sealover, “‘Hot Spotting’ May Be Way to Cool Cost of Health Care,” *Denver Business Journal*, accessed June 13, 2013, <http://www.bizjournals.com/denver/print-edition/2012/07/27/hot-spotting-may-be-way-to-cool-cost.html?page=all>.

⁸³ Whiteis, “Unhealthy Cities,” 229.

⁸⁴ April Michelle Herndon, “Collateral Damage from Friendly Fire? Race, Nation, Class and the ‘War against Obesity,’” *Social Semiotics* 15, no. 2 (2005): 132.

⁸⁵ Andrew Dilts, “Incurable Blackness: Criminal Disenfranchisement, Mental Disability, and the White Citizen,” *Disability Studies Quarterly* 32, no. 3 (2012), accessed May 30, 2013, <http://dsq-sds.org/article/view/3268/3101>; and Herndon, “Collateral Damage,” 129.

of Medicaid patients to the full array of providers by sending those patients lists that contain only the names of providers who accept Medicaid, resulting in segregated provider lists.⁸⁶ Medical hot spots could lead to reduced access to specialized medicine and experts, and stricter definitions of medical necessity may be instituted within hot spots to decrease opportunities to receive a particular test or treatment (a twisted reversal of current profit-seeking methods that overprescribe to the poor, such as ordering unnecessary tests or visits). High utilizers in hot spots may be asked to undergo race-based genetic testing for insurance underwriting.⁸⁷ The intersections of medical hot spots with hot spots of another kind—waste sites and contamination—could initiate biomonitoring requirements, wherein social-environmental inequities in origin (i.e., reduced access to valued social goods, such as employment, housing, clean air and water) are monitored as race-based biological effects. Medical hot-spotting could also result in the “ghettoizing” of physicians or other types of providers that serve mainly poor minorities, restricting them to a particular managed-care network arranged for patients considered to be statistically “too costly.” Following the logic of cost efficiency to its limits, *medical hot-spotting potentially rationalizes racially segmented care* and, thusly, justifies the racialized rationing of medical resources under the terms of spatially customized care. For minority communities that have intimately experienced institutional racism in medicine, this simply means more of the same—a sad reminder that cost efficiency and austerity may not induce innovations that actually improve health equity, as currently averred.

A second neoliberal logic that underpins medical hot-spotting—“self-care”—undercuts the promise of *social* reform by enlisting the nation’s costliest health care consumers to participate in preventive care yet relegating “racially coded economic disadvantage and reassigning identity based biases to the private and personal spheres.”⁸⁸ In response to the decline of the welfare state, neoliberal self-care—as we saw in the case of BiDil—asserts that *individuals* are solely in charge of their health, absolving the state and corporations from such responsibility. Self-care entails a shift to biological citizenship, from one who possesses rights to services, to a manager of individual health risks in a context of enhanced social control and consumer access.⁸⁹ Self-care disciplines individuals—targeting individual behaviors—in line with normative models of health, despite any structural issues that might preclude good health. Agency is privatized, as social values are redefined in the terms of market-based interests.⁹⁰ The neoliberal assertion of race-transcendent agency eclipses the ongoing impacts of structural racism, such as social-economic disinvestment in minority neighborhoods and the political neglect of people of color. This is particularly deleterious to African Americans, who have received significantly less adequate care than white Americans in the United States, due to a host of financial, organizational, and social barriers.⁹¹

⁸⁶ This already happens; see Randall, “Institutional Racism in U.S. Health Care.”

⁸⁷ Genetic testing is already required by life insurance underwriting in the United States. See R. J. Pokorski, “Insurance Underwriting in the Genetic Era,” *American Journal of Human Genetics* 60, no. 1 (1997): 205–16; and Mark Rothstein, *Genetics and Life Insurance: Medical Underwriting and Social Policy* (Cambridge, MA: MIT Press, 2009).

⁸⁸ Dana-Ain Davis, “Narrating the Mute: Racializing and Racism in a Neoliberal Moment,” *Souls* 9, no. 4 (2007): 349; and Duggan, *Twilight of Equality?*

⁸⁹ Torin Monahan and Tyler Wall, “Somatic Surveillance: Corporeal Control through Information Networks,” *Surveillance and Society* 4, no. 3 (2007): 164; and Susanne Bauer, “Societal and Ethical Issues in Human Biomonitoring—A View from Science Studies,” *Environmental Health* 7, suppl. 1 (2008): 1, 8.

⁹⁰ Giroux, “Spectacles of Race,” 209.

⁹¹ Raj Bhopal, “Spectre of Racism in Health and Health Care: Lessons from History and the United States,” *British Medical Journal* 316, no. 7149 (1998): 1970–73, accessed May 30, 2013, <http://www.ncbi.nlm.nih.gov>

The historically accumulated suffering of the black body has meant that African Americans are at increased risk for acute and chronic diseases, including HIV/AIDS, tuberculosis, and mental illness.⁹² In the context of austerity and corporatized health care, the neoliberal logic of self-care enlists African Americans to participate as consumers of preventive care yet relegates any inability to do so to a private issue or racially grouped failure within a supposedly color-blind meritocracy enabled by the free market. As David J. Roberts and Minnelle Mahtani explain:

Race, specifically blackness, coupled with anti-market behaviors become intertwined in the construction of the antithesis of the ideal neoliberal citizen in the black ghetto resident. . . . [R]ace is mobilized to show that racialized subjectivities are essential in justifying certain impacts of neoliberalization that are experienced disproportionately within racialized communities.⁹³

Medical hot-spotting exhibits this tendency, in that the emphasis on individual behavioral change can lead to pathologizing those who are unsuccessful at self-care. Three types of patients are targeted by medical hot-spotting: the mentally ill, the medically fragile elderly, and, as mentioned in the opening quotation of this article, patients who are described as “socially disintegrated” (i.e., those “who tend not to engage in self-care, have few family resources and display dependent personalities”).⁹⁴ Another potential proxy for race or even “social death,” the category of “socially disintegrated” seemingly offers an opportunity to examine the race-specific neoliberal biopolitics of health. Indeed, anecdotal evidence and a short documentary about medical hot-spotting demonstrate the many ways that the practice *does* expand health care into social, environmental arenas and attempts to cultivate social infrastructure and stability through caregiving.⁹⁵ A network of transition nurses, doctors, social workers, escorts to follow-up medical appointments, and various other volunteers from AmeriCorps and college nursing programs attend to individual patients in their homes and neighborhoods in a series of visits over six months. These laudable efforts to establish new social relationships, however, are compromised by the focus on individual behavioral modification rather than broader social reform and responsibility. It is unrealistic (and unjust) to expect that social death and racism—what Ruth Wilson Gilmore has poignantly defined as “the state-sanctioned and/or extralegal production and exploitation of group-differentiated vulnerability to premature death”⁹⁶—can be resolved through neoliberal self-care.

Moreover, medical hot-spotting signals the punitive potential of race-based self-care practices. While BiDiI represents a case of targeting African Americans for a race-based drug market, the call to find the 1 percent heralds the social sorting of so-called excessive consumers of public and government health care resources—those who fail at/to self-care—from productive citizens who attend to the neoliberal imperative to maintain their bodies responsibly.⁹⁷ This allows

</pmc/articles/PMC1113412/>.

⁹² Whiteis, “Unhealthy Cities,” 229.

⁹³ Roberts and Mahtani, “Neoliberalizing Race, Racing Neoliberalism,” 249. Roberts and Mahtani are paraphrasing the arguments of David Wilson, *Cities and Race: America’s New Black Ghettos* (New York: Routledge, 2006).

⁹⁴ Bush, “Health Care’s Costliest 1%,” 32.

⁹⁵ See, e.g., *Frontline* video “Doctor Hotspot.”

⁹⁶ Ruth Wilson Gilmore, *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California* (Berkeley: University of California Press, 2007), 247.

⁹⁷ Monahan and Wall, “Somatic Surveillance,” 163; Herndon, “Collateral Damage,” 132.

for race to be understood as a marker of risky or dysfunctional social behaviors rather than as an indicator of racialized experiences that make one more vulnerable. The behaviorist emphasis functionally blurs welfare and penal policies and could signal an intensified form of health governance that medicalizes urban marginality and valorizes paternalistic managed-care units for segmented populations.⁹⁸ In line with Loïc Wacquant's important observation that neoliberalism does not necessarily involve the shrinking of the state, the self-care promoted by medical hot-spotting could progress into an aggressive deployment of in/voluntary programs stipulating personal responsibility, just as the state is withdrawing institutional supports that are necessary to shoulder illness, unemployment, indigence, and so forth.⁹⁹ Indeed, the logic of neoliberal self-care pushes medical hot-spotting in the direction of racially sorting and segmenting health care as *moralizing behavioral workfare*.

Such a possibility is further supported by exploring the spatial technologies that inform medical hot-spotting. These technologies can be seen to produce a racially stratified datascape of expectations that lead to the militarization of everyday life for the purposes of biosecurity. Medical hot-spotting is dependent on mining for data and the geographical processing of medical metadata—that is, the mass collecting, geographical networking, and commercial deployment of medical data. Set within the historical context of racialized dispossession and biopiracy in Western medicine, data mining and the metadata-processing industry have the potential to reproduce and amplify racial domination, in terms of both political economy and epistemological politics.¹⁰⁰ In the most general sense, metadata aggregates scale up and interrelate different data sets, providing more material to enhance our understanding of the larger social and environmental genesis of health problems. Yet with medical hot-spotting, the imperative to find high utilizers of the health care system entails a *self-fulfilling process of data analysis*: the sick and disenfranchised are always the population, never the control group, and those who are healthy among the population are statistically illegible, making the population always appear sicker than it might be.¹⁰¹ Medical hot-spotting could also be perceived as an auditing practice within a *self-fulfilling political economy*. Just as postindustrial development of infotechnology and “big data” was historically enabled by subverting capital from inner cities and people of color, medical hot-spotting risks contributing to this disinvestment. Medical intelligence and metadata analysis—at the core of medical hot-spotting—essentially represent a new division of labor of the management of the poor and industrial remains; the industry audits the effects and casualties of the process that gave rise to it. The danger is that data mining and auditing will operate in a kind of narcissistic feedback loop of racial domination that profits from producing a *racially stratified datascape of expectations*—basically, reproducing “what we already know.”

Furthermore, medical hot-spotting integrates GIS data and geodemographic techniques that target problem spaces and populations through spatial profiling and geosurveillance, thus militarizing everyday life. From crime mapping and policing, medical hot-spotting borrowed

⁹⁸ Loïc Wacquant forcefully argues that welfare and penal policies are (re)linked, “inasmuch as these two strands of government action toward the poor have come to be informed by the same behaviorist philosophy relying on deterrence, surveillance, stigma, and graduated sanctions to modify conduct.” Loïc Wacquant, “Crafting the Neoliberal State: Workfare, Prisonfare, and Social Insecurity,” *Sociological Forum* 25, no. 2 (2010): 199.

⁹⁹ *Ibid.*, 218.

¹⁰⁰ See n. 6.

¹⁰¹ This is a critique directed toward statistical analysis; by no means do we wish to assert that the medically vulnerable and ill are not really very sick.

technologies that collect and use spatial data to model, monitor, and control criminal behaviors. “Crime hot-spotting” was first instituted by New York City police commissioner William Bratton in the mid-1990s and is credited with reducing crime by as much as 60 percent.¹⁰² The practice generates digital cartographic representations of high-crime areas by linking statistical information such as crime type and occurrence with zip code and neighborhood.¹⁰³ Police are then able to target and direct resources toward anticipated high-crime spaces and people, spatially customizing surveillance and control rather than supplying blanket police enforcement. This early “civilian” application of GIS demonstrates the role of digital electronic information, the production of electronic spatial representations of those data, and the operation of technology within a network of knowledge.¹⁰⁴ It also reveals a political rationality that calls forth the use of technology to surveil spaces and populations.¹⁰⁵ The seemingly innocuous agenda of fact gathering and documentation transforms a governing body into a field of perception and substantiates a militaristic conception of the world as a target, a vision of the world in terms of people and spaces as at-risk resources to be managed and surveilled.¹⁰⁶ Geosurveillance, then, is the logical outcome of the militarized interpretation of residents as risk factors that need to be logged, understood in a calculative statistical manner, mapped, modified, and controlled. While the GIS-backed development of geodemography and target marketing has powerfully combined information about locations with visual materials to create and capitalize on consumer audiences, geosurveillance in the case of criminal or medical hot-spotting secures target fields of information, spatial data, and geographical identification of high-risk people and spaces *for the purposes of biosecurity*—that is, managing health for the optimization of the population.¹⁰⁷ When the geosurveillance technologies of medical hot-spotting are considered, health promotion and disease prevention involve intensified and increasingly militarized preemption.

Whether for marketing purposes or biosecurity, *spatial profiling* measures and maps and, in doing so, sets up the possibility of expectations that can be linked to spaces and populations through the act of targeting. Targeting territorializes such expectations and involves place-particularizing metaphors, masculinist ideas about penetrating and mastering space, and a network logic (i.e., targets are under the purview of a larger, more encompassing gaze and database).¹⁰⁸ Part of the legacy of militarized visual culture, targeting dramatically translates military dreams of high-tech omniscience and rationality into the governance of urban civil society,

¹⁰² George L. Kelling and William J. Bratton, “Declining Crime Rates: Insiders’ Views of the New York City Story,” *Journal of Criminal Law and Criminology* 88, no. 4 (1998): 1217–31. Bratton is also the current NYC Police Commissioner. This is the second time he has held this position.

¹⁰³ Amy Proppen, “Critical GPS: Toward a New Politics of Location,” *ACME* 4, no. 1 (2006): 135.

¹⁰⁴ *Ibid.*, 132.

¹⁰⁵ Jeremy W. Crampton, “The Biopolitical Justification for Geosurveillance,” *Geographical Review* 97, no. 3 (2007): 389.

¹⁰⁶ Proppen, “Critical GPS,” 136.

¹⁰⁷ Crampton, “Biopolitical Justification,” 390; Rey Chow, *The Age of the World Target: Self-Referentiality in War, Theory, and Comparative Work* (Durham, NC: Duke University Press, 2006), 40; Caren Kaplan, “Precision Targets: GPS and the Militarization of U.S. Consumer Identity,” *American Quarterly* 58, no. 3 (2006): 693–713, esp. 694–95; and Samuel Weber, *Targets of Opportunity: On the Militarization of Thinking* (New York: Fordham University Press, 2005).

¹⁰⁸ Targeting in terms of “seeing-as-destroying” is beyond the scope of this essay; refer to Derek Gregory, “In Another Time-Zone, the Bombs Fall Unsafely . . . : Targets, Civilians and Late Modern War,” accessed May 30, 2013, http://geographicalimagination.files.wordpress.com/2012/07/gregory-in-another-time-zone_illustrated.pdf; Chow, *Age of the World Target*; and Kaplan, “Precision Targets.”

enhancing biosecurity through the extension of the military-industrial complex into everyday life.¹⁰⁹ Targeting promises powerful technological mastery via the longstanding martial and territorial aspects of mapping combined with the virtualizing of the world through technology-as-information. The truth-value that has been placed historically on sight in documentary, realist, and empirical traditions now underlines the superiority of contemporary information systems that privilege vision and visuals. An operation of targeting, medical hot-spotting creates hot spots (“targets”)—that is, territorialized expectations that are mapped and “located” for the purposes of spatially customizing care. The spatial ontology at work in this targeting operation requires that where you are reveals who you are, and who you are is a target, as collected, assessed, and defined by marketers, governments, the police, or clinics.¹¹⁰ The collection of medical data and spatial data analysis does not necessarily involve the explicit racial profiling of spaces. However, *medical hot-spotting risks ontologizing structural racism in/as space*: racialized spaces and bodies become ontologized in space as locationally removed, knowable, measurable geo-tags and data of a population, which, in essence, normalizes racism as just another map of everyday life. Accordingly, medical hot spots might be seen to *ontologize the ghetto*, reinforcing and reentrenching existing racialized segregations, including the historical geographies of urban renewal, redlining in housing and mortgage industries, environmental racism, and so forth.

Following this logic, we might say that medical hot-spotting *mobilizes the ghetto as a pre-emptive way of seeing, of knowing-as-containing*. Establishing medical hot spots could serve as a tautological spatial containment technique for the management of poverty and marginality, reinscribing an imaginative geography of atypical, high-cost, deviant, abnormal “others” inside the spaces of everyday life.¹¹¹ Targeting the medically indigent 1 percent could effectively result in “coordinated care camps” that punitively quarantine racialized segments of the population. Such targeting would spatially locate “problem” populations/bodies not only through physical separation, differentiation, and distancing but also through lowered expectations. Thus, customized care coordination would administer health care in the service of a biopolitical project of disposability. The neoliberal logics of cost efficiency and self-care might even, ultimately, translate medical hot-spotting into a *remote care delivery system* that somatically surveils the high utilizers of health care through cost-saving home monitoring, treats corporeal systems as information in order to mine data, positions bodies as nodes within a network of physiological and locational data connected to command centers, and relentlessly secures capital accumulation and military intervention.¹¹² Stephen Graham describes this neoliberal dystopia:

If contemporary power in the cities of both “homeland” and “war zone” is about attempting to separate the spaces, zones, privileges and mobility of the risk-free (who need protection) from risky surrounding populations and infiltrations, then the only possible way to do this is pre-emptively, digitally and with a high-degree of technological automation. As a result,

¹⁰⁹ Stephen Graham, *Cities under Siege: The New Military Urbanism* (London: Verso, 2011), xi; Matthew Sparke, “From Global Dispossession to Local Repossession: Towards a Worldly Cultural Geography of Occupy Activism,” in *The New Companion to Cultural Geography*, ed. Nuala Johnson, Richard Schein, and Jamie Winders (Oxford: Wiley-Blackwell, 2013), 387–408, also available at <http://faculty.washington.edu/sparke> (accessed June 13, 2013).

¹¹⁰ Kaplan, “Precision Targets,” 697.

¹¹¹ Wacquant, “Crafting the Neoliberal State”; Loïc Wacquant, “From Slavery to Mass Incarceration: Rethinking the ‘Race Question’ in the US,” *New Left Review* 13 (2002): 41–60.

¹¹² Monahan and Wall, “Somatic Surveillance,” 155.

militarized targeting becomes crucial, and the software algorithms that continually police the “data-sphere” of machine-readable information, searching for potentially hazardous behaviors, circulations, people, or presences, assume political and sovereign power.¹¹³

BIOFUTURES

The Du Boisian vision of alleviating the racial “cut” in the governance of life has clearly not been realized. Indeed, the new health governance (i.e., the neoliberal biopolitics of health) functions along racial lines. In this operation, black lives are especially imperiled in the very same moment that life is ostensibly affirmed. BiDil is said to affirm life in that it claims to target health issues that are supposedly particular to black bodies, and medical hot-spotting is predicated on the seemingly laudable pursuit of attending to vulnerable populations through spatial targeting operations. As we have shown, however, these biomedical technologies and interventions indicate a powerful geo-body-politics that secures race as a central dimension in the administration of life: black bodies and racialized spaces are targeted in order to manage the life of the population as a whole, according to neoliberal biosecurity. Such operations actually fortify the color line by ontologizing bodies and spaces as “*a problem*,” thus reinscribing the very same logic that Du Bois was working against. In designating bodies and spaces as “problems,” these examples of targeting fail to address the social problems of structural racism and ongoing political, civic, and corporeal disenfranchisement that condition black life in America.

BiDil and medical hot-spotting indeed raise confounding questions that remain central to racial health in the era of neoliberal biopolitics—with its pernicious individualization of health. First, how might it be possible to attend to racial health disparities without running the risk of racial reification at the level of the body, as is the case with BiDil? Second, how can racial disparities in health be alleviated if, as a society, we move toward a supposedly color-blind approach to health that is actually thoroughly imbricated in (and exacerbates) racial assumptions, stratification, and dominant racial logics, as is the case with medical hot-spotting? Where BiDil essentializes race in the space of the body (abstracted from material-spatial relations), medical hot-spotting invisibilizes historical geographies of race as self-evident space—outside of social life.

Race may not be biological, but racism, structural disadvantage, and the historical accumulation of suffering undeniably have biological effects that sediment in the black body. In this way, as Anne Pollock notes, race is “fixed enough for action,” and simultaneously, as Giroux reminds us, “the color line in America is neither fixed nor static.”¹¹⁴ Undeniably, racial health must be addressed as a distinct issue, but biomedical efforts that seek to organize reparative justice need to account for the ways health is inextricable from shifting forms of structural racism and the ongoing disinvestment in black life. They also need to tackle the potential false promises offered by biomedical target technologies and interventions and to *work against* reestablishing race as an ontology—at the very same moment that we labor toward alleviating those very real social disparities predicated on race. Ultimately, “the emphasis on . . . [the] socially and historically constructed nature [of race] offers hope because it suggests that what can be produced by dominant relations of power can also be challenged and transformed by those who imagine a more utopian and just world.”¹¹⁵ A

¹¹³ Graham, *Cities under Siege*, 99.

¹¹⁴ Pollock, *Medicating Race*, 179; Giroux, “Spectacles of Race,” 209.

¹¹⁵ Giroux, “Spectacles of Race,” 209.