Recent work tracing the rise of the health-care sector in the postindustrial United States emphasizes interconnections between health-care economics, racial capitalism, neoliberalism, and financialization to account for the paradox of Americans’ worsening health amid a great profusion of medicine. Shiloh Krupar’s *Health Colonialism: Urban Wastelands and Hospital Frontiers*, part of the theory-driven Forerunners: Ideas First series from the University of Minnesota Press, makes a critical intervention in this emerging field from the perspective of political geography. While critics have long evoked colonialism to describe the exploitation of impoverished communities for the benefit of expanding medical institutions, Krupar’s focus on specific colonial land practices and spatial relations provides an important conceptual layer to this critique.

Calls from practitioners, activists, and scholars to decolonize medicine and public health are Krupar’s point of departure for *Health Colonialism*. These calls often focus on biomedical epistemologies and practices, legacies of race science that continue to reproduce violence and inequity. Krupar foregrounds the land-based mechanics of colonization and asks us to start from a spatial understanding of how medical institutions acquire property, amass capital from land and labor, and produce both health and sickness as commodities. The insistence that land is empty, blighted, wasted, and underutilized by the local population justifies imperial conquests on the geopolitical stage; Krupar sees a similar racialized ideology at work in cities that house academic medical centers and universities. For Krupar, the land practices and political economy of these institutions are inextricable from the problem of health inequity. While institutions increasingly recognize and seek to address social or structural determinants of health, they are themselves powerful structural determinants as they consolidate land and resources under the guise of a charitable mission.

Chapter 1 establishes an environmental justice analysis of politically created “wastelands” in urban real estate contexts. Urban spaces figured as wasteland may be contaminated with
toxic materials from industrial use, but this figuration also extends to states of “blight” or “decay” produced by social policy and to the mere presence of non-white and poor residents seen as insufficiently profitable. Under the protocols of mid-twentieth-century urban renewal, the state’s designation of blighted areas precedes eminent domain seizures and the transfer of land to private developers in the name of the public good. Krupar argues that brownfield policies enacted by the Environmental Protection Agency (EPA) since the 1990s operate similarly, turning polluted areas into a “settler-colonial property frontier” (p. 8). She details how subsidies, lax remediation standards, and the equation of public good with maximal economic productivity have enabled massive land transfers and private wealth accumulation.

In the world of brownfield redevelopment, facilities that serve public health needs are seen as especially desirable and are promoted under the banner of “healthfields” (p. 28). These include medical centers as well as grocery stores, parks, and affordable housing, all intended to address legacies of racism and inequity by bringing resources to disinvested communities. Krupar presents examples of medical facilities built on remediated brownfields that resulted from community activism and participation, including the adaptive reuse of a historic Black hospital site in St. Petersburg, Florida. While communities sought out these resources through the EPA brownfields process, Krupar maintains that the market logic of redevelopment and its lax environmental standards still represent an extractive project, potentially associated with greenwashing, gentrification, and tax evasion by elite institutions. Given the challenges that communities face in cleaning up contaminated sites within the narrow confines of neoliberal austerity, a discussion of non-extractive approaches to remediation would also have been helpful.

The second chapter reviews a more familiar story of twentieth-century hospital expansion through public financing of private universities and medical centers (often termed “Eds and Meds”), again foregrounding the mechanics of land acquisition and development. As segregation, redlining, and disinvestment produced blighted neighborhoods and deindustrialization drained urban economies, the state sought to develop new economic resources through private means. It is worth noting that this choice was a conscious ideological rejection of such public approaches as national health care and public housing; the condensed nature of this book means that Krupar does not discuss historical contention over alternatives. The perceived public-service function of hospitals made them the perfect vehicle for private development with a premise of social benefit. Federal funding withered in the 1970s, forcing both hospitals and cities to adopt debt financing. Speculative instruments, such as tax increment financing (TIFs), transferred municipal revenue into private hands while increasing the tax burden on residents, in the expectation of trickle-down benefits.

Krupar surveys examples of Eds and Meds development in cities from Cleveland to Baltimore, where institutions have enclosed land, displaced residents, and profited from acute and specialty care while public health continues to suffer. Private police forces afford further control of movement and surveillance of space. Framing these activities as colonial (in addition to, for instance, neoliberal) underscores the racial dimension of the process whereby land and labor are extracted from BIPOC (Black, Indigenous, and people of color) communities and helps us to conceptualize health as a commodity produced from local resources that flows through a global financial system. Historical context for this critique would be helpful, as it appears among activist and community organizations at least since the 1970s in relation to academic medical center expansions.[1] The global flow of health as a commodity is the subject of chapter 3. This chapter offers pro-
vocative linkages that extend the implications of US hospitals’ spatial practices. Drawing on the work of Howard Waitzkin, Nic John Ramos, Andrew T. Simpson, and others, Krupar asserts that US medical institutions have leveraged their biomedical prestige—built through extraction from the public sphere—into overseas partnerships and contracts that parasitize foreign health systems.[2] Domestically, health systems with prestigious brands recruit medical tourists who pay out of pocket, entrenching segregation and austerity for the local population. Extending the discourse of technological innovation and philanthropic mission familiar from their domestic operations, they build overseas luxury outposts for high-end specialty care, while maneuvering to open new markets for profit-driven American insurance models.

Throughout the book, Krupar attends to hospitals’ paradoxical claims about environmental sustainability, and these contradictions reach their peak in the affinity of elite medical brands for wealthy petrostates. Johns Hopkins manages Saudi Aramco’s corporate health-care system, and both the Mayo Clinic and Cleveland Clinic built high-end hospitals in the United Arab Emirates, one of which won a Gold LEED (Leadership in Energy and Environmental Design) certification for sustainability. In this chapter, we see the importance of branding, aesthetics, and managerial expertise as health-care industry commodities in an environment of free trade and privatization and are reminded of these commodities’ material foundation in the enclosures of urban academic medical centers.

A brief but dense conclusion presents Krupar’s assessment of what decolonization could look like if we attend to the spatial and place-based process of health colonialism. This would entail promoting social medicine and political change over entrepreneurial biomedicine. Krupar mentions public medical education, land rematriation, the cancellation of medical debt, and an end to the “occupational segregation” of health-care labor (p. 99). While liberal notions of the public and of public goods are historically exclusionary, Krupar asserts the need for redistribution as the fundamental basis of any antiracist program in medicine. Perhaps this includes the redistribution of health care itself, as the book is a testament to the consequences of making health a financialized vehicle for wealth accumulation.

The usefulness of a robust theorization of health colonialism is evident in a growing body of work on the urban history and political economy of “Eds and Meds.” Davarian L. Baldwin’s In the Shadow of the Ivory Tower: How Universities Are Plundering Our Cities (2021) focuses on gentrification and the neoliberal real estate exploits of “Uni- verCities.” Guian A. McKee’s Hospital City Health Care Nation: Race, Capital, and the Costs of American Health Care (2023) traces how the financialization of the health-care industry drives urban policy. Marisela Gomez advances a similar analysis in her account of local resistance to Johns Hopkins Hospital’s redevelopment of East Baltimore, Race, Class, Power, and Organizing in East Baltimore: Rebuilding Abandoned Communities in America (2013). She observes how redlining and the racialized discourse of blight facilitated the planned decay of neighborhoods slated for hospital expansion. Health Colonialism offers a highly concentrated and forceful critique that introduces readers to this set of issues; acknowledging the need for brevity, the book could still benefit from a deeper engagement with local perspectives and historical context. In turn, Krupar’s formulation of health colonialism, with its foundation in local land practices and its extension to elite medical brands as a global export commodity, will be valuable for scholars and activists working in this area.

Notes


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