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Racism and the Political Economy of COVID-19: Will We Continue to Resurrect the Past?

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Abstract

COVID-19 is not spreading over a level playing field; structural racism is embedded within the fabric of American culture, infrastructure investments, and public policy, and fundamentally drives inequities. The same racism that has driven the systematic dismantling of the American social safety-net has also created the policy recipe for American structural vulnerability to the impacts of this and other pandemics. The Bronx provides an important case study for investigating the historical roots of structural inequities showcased by this pandemic; current lived experiences of Bronx residents are rooted in the racialized dismantling of New York City's public infrastructure and systematic disinvestment. The story of the Bronx is repeating itself, only this time with a novel virus. In order to address the root causes of inequities in cases and deaths due to COVID-19, we need to focus not just on restarting the economy, but on reimagining the economy, divesting of systems rooted in racism and the devaluation of Black and Brown lives.

Keywords COVID-19, racism, structural inequities, political economy

In the United States, the 3-month period between the first reported cases of "a pneumonia of unknown cause" in Wuhan, China, and the World Health Organization's declaration of COVID-19 as a pandemic was characterized by inaction, xenophobia, and government gaslighting of the public health community (Adolph et al. 2020; Lipton et al. 2020; Tellis, Sood, and Sood 2020; World Health Organization 2019). In official communications, the president dubbed COVID-19 the "Chinese Virus," but only after labeling it as a Democratic hoax or just the flu (Devakumar et al. 2020; Rogers, Jakes, and Swanson 2020; Yamey and Gonsalves 2020). This bigoted and denialist rhetoric set the stage for the nation's disjointed and sophomoric response to this public

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health threat. In the time since, the rhetorical racialization and politicization of the COVID-19 pandemic has transitioned into our lived realities. And we continue to mourn the dead and dying within the vacuum of federal leadership.

The U.S. has swiftly become the global epicenter of this pandemic—and the slow and anemic response of the current administration magnifies and lays bare deeply embedded structural inequities, namely racism (Bailey et al. 2020; Bailey et al. 2017; Chowkwanyun and Reed 2020). This same racism has driven the systematic dismantling of the American social safety net and created the policy recipe for American structural vulnerability to the impacts of this and other pandemics. As of May 9, 2020, the U.S. accounts for over 30% of the world's cases and over 28% of the world's deaths due to this pandemic thus far ("COVID-19 Coronavirus Pandemic" 2020). While there is likely vast underreporting in countries with less-developed public health infrastructure and testing capacity, this represents the abject failure of American public policy to ensure our national security.

COVID-19 Response Basics

To combat the pandemic, a basic Public Health 101 curriculum would advise pursuing a strategy of containment and, if needed, mitigation (Mack et al. 2007). For containment, you need to act fast when there are few cases, testing, isolating, contact tracing, and quarantining. However, our administration failed to do that—we squandered our containment window on deliberate inaction and scapegoating motivated by racism and politics (Devakumar et al. 2020; Lipton et al. 2020; Tellis, Sood, and Sood 2020; Yamey and Gonsalves 2020). In the absence of swift containment and severe inadequacies in testing, surveillance, and isolation, we have had to move on to

mitigation measures of physical distancing (e.g., stay-at-home orders) and personal preventive measures (e.g., masks, handwashing).

However, access to mitigation strategies are structurally constrained. People in marginalized racial/ethnic groups are overrepresented in racially and economically segregated communities with substandard housing conditions, unsafe or limited water, and crowded housing that make hand hygiene and self-quarantine challenging, if not impossible (Bailey et al. 2020; Bailey et al. 2017). These communities are also disproportionately experiencing chronic conditions, like diabetes, hypertension, and renal diseases, all of which put them at heightened risk of COVID-19 fatality. Furthermore, although not always luxurious, staying at home and self-isolation is a luxury not afforded to essential workers. The essential workers with the most frequent proximity to others are low-wage workers of color who are less visible than doctors, nurses, and firefighters (Tomer and Kane 2020). Thus, COVID-19 is not spreading over a level playing field—structural racism is embedded within the fabric of American culture, infrastructure investments, and public policy, and drives health inequities (Bailey et al. 2017). Despite the reluctant and incomplete release of data disaggregated by race/ethnicity, Black and Latinx Americans across the country are consistently overrepresented among COVID-19 hospitalizations and/or deaths (APM Research Lab Staff 2020; Laurencin and McClinton 2020). The pandemic highlights the disproportionate economic burden on people of color (e.g., unemployment, loss of access to employer-sponsored health insurance and benefits, lack of safety net), especially in states that have rejected Medicaid expansion. The need to pair public health efforts with a "commitment to dismantling the [real] structural and institutional drivers of health inequity" (Bailey et al. 2020) is made more clearly than ever.

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The real drivers of the coronavirus are unjust policies and unhealthy settings, not people's genetic makeup, characteristics, or, necessarily, hygiene and social distancing behaviors (Bailey et al. 2020). The real drivers are the policies and practices that produce close living and working quarters, limited access to hygiene and personal space, limited access to health care, and disinvested segregated neighborhoods. These policies and practices operate through historically created *settings*, like prisons and jails that now serve as impromptu death row for caged Americans, substandard housing and crowding, migrant farmworker barracks, and homeless shelters. These settings are important for centering equitable efforts and reduce the risk of stigmatization; however, the measured and unmeasured impact is on *people and communities* (Berger et al. 2020; Haley et al. 2020; Nowotny et al. 2020; Tsai and Wilson 2020).

Embedded Racism in the Current American Health Infrastructure and Decision-Making

These inequities have been decades in the making. Across the United States, racism is built into the politics and structure of the health care system, public health infrastructure, and perceptions of the social safety net (Bailey et al. 2017). During the New Deal era when the vision of the "American people" as White Americans dominated public discourse, the idea of investing in public goods was largely supported and played out in the design and execution of public policy (Davies and Derthick 1997; Quadagno 1994). For instance, the Social Security Act of 1935 explicitly excluded farmworkers and domestic workers—occupations primarily held by Black people—from access to old-age and unemployment insurance (Davies and Derthick 1997). The 1946 Hill Burton Act, which aimed to address hospital shortages after the Great Depression and World War II, had "separate-but-equal" provisions that sanctioned institutional racism in the "revitalized" health care system (Largent 2018).

The rollout of Civil Rights legislation expanded the perception of who constituted the "public" and seemingly triggered White backlash against "public goods" and welfare programs (Boyd 1970; Haney-López 2015; Quadagno 1994). In 1964, when Lyndon Johnson declared an "unconditional war" on poverty, aimed at "curing" poverty, the incorporation of hard-won civil rights for people of color into its implementation tainted how its key legislative acts, namely the establishment of Medicare, were consequently received (Matthews 2014). The Johnson administration, under pressure from and in coordination with civil rights leaders, utilized the implementation of the Social Security Amendments of 1965 (establishing Medicare) to force the racial/ethnic integration of segregated hospitals, conforming to Title VI of the 1964 Civil Rights Act and improving the health care access and health outcomes for Black people for generations (Smith 2016). Following the legislative changes, Black infant mortality fell precipitously, especially in former Jim Crow states (Hahn, Truman, and Williams 2018; Krieger et al. 2013). Unfortunately, together with divided reactions to the Vietnam War and the political tumult of the 1970s and 1980s, the war on poverty also helped trigger a backlash against government social welfare programs and a turn to conservatism (Laurent 2015). This conservatism takes the form of increased privatization, disinvestment in public systems, and the rhetorical understanding of "public" as subpar and designated for the (potentially undeserving) poor people of color.

The trope of the underserving person of color was never more visible than in Reagan's fabrication of the "welfare queen," a contemptible Black woman who took Whites' hard-earned money through her access to welfare programs. Reagan's denigration and scapegoating of Black women personified the key conclusions of the 1965 Moynihan Report, which denied the role of structural factors and racism in driving Black poverty, in favor of highlighting Black families' "pathologies" (Geary 2015). People of color were painted as pathological abusers of public

goods and freeloaders of deserving, productive Whites. The Reagan era spurred on the dismantling of the social safety net in favor of a neoliberal shift to private sector alternatives, which failed to guarantee comprehensiveness or equity in coverage, which directly impacted the health of communities of color. While Medicare and Social Security remained largely unchanged and Medicaid eventually expanded, Black/White disparities in premature death and infant mortality decreased between 1966 and 1980, but began to rise again in the 1980s during the time of the neoliberal erosion of the social safety net (Krieger et al. 2008). Simultaneously, American life expectancy rates have been falling further behind from those of other wealthy peer nations (Ho and Hendi 2018).

Since then, privatized managed care, cost containment, and differential reimbursement rates by public and private payers have led to closures that disproportionately affect safety-net hospitals, which primarily serve communities of color (Bazzoli et al. 2012; Hung et al. 2016; Lindrooth et al. 2018). The Trump administration is rooted in this racialized, neoliberal tradition, exacerbating the structural racism built into decision-making around health care and social policy. The vision of the "American people" is again being redefined to refer to White Americans, and is at odds with social safety-net policies and, even, the Affordable Care Act, which may benefit the "undeserving poor," namely Black, Latinx, and/or immigrant communities (McCabe 2019; McGregor, Blendon, and Zaslavsky 2019; Michener 2020; Tesler 2012). In the last few years, with the unprecedented attention and mobilization of select resources toward addressing White "deaths of despair" as well as a transformation of drug policies, the suffering of Black, Native American, and Hispanic/Latinx people in the U.S. has been normalized, and White lives are implicitly valued more highly, the very definition of racial capitalism.

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Focused and Sustained Racialized Disinvestment: The Story of the Bronx

The intersection of structural racism and inequities that shape both the impact of the COVID-19 pandemic and our responses to it are evident in the story of the Bronx. As of early May, data from New York City (the epicenter of the epicenter of the pandemic), where racial information is complete for 92% of COVID-19 deaths, Black/Latinx New Yorkers account for two-thirds of all fatalities, despite their accounting for only half of the population (New York City Department of Health and Mental Hygiene 2020; New York State Department of Health 2020). Meanwhile, preliminary analyses indicate that wealthier, whiter neighborhoods have disproportionately greater access to testing per capita (Hicks 2020). Low-income communities of color, particularly in western Queens and the South Bronx, bear heavier impacts of the pandemic, as they are hotbeds for not only COVID-19 deaths, but also concentrations of service workers and food-insecure, rent-burdened households (Afridi and Block 2020; Dickson 2020).

Consistently ranked the 62nd out of 62 counties in New York State in the Robert Wood Johnson Foundation's County Health Rankings ("Bronx County, New York" 2020), the Bronx provides an important case study for investigating the historical roots of the structural inequities showcased by this pandemic. The Bronx was in dire need pre-COVID, with: 76 years of life expectancy (compared to 81.2, the citywide average); 30% of residents below the Federal Poverty Line (compared to 11% U.S. average); 59% of residents enrolled in Medicaid; 22% of all of statewide asthma-related hospitalizations; 60% higher diabetes mortality than the state overall; the highest rate of potentially preventable inpatient Medicaid admissions; a severe shortage of primary care and behavioral health providers; and 31% of the population going hungry (Allen et al. 2016). Furthermore, the Bronx residents have not only the most

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overcrowding in the city, but the highest volume of households that are severely rent-burdened—where household members spend 50% or more of their incomes on rent (Institute for Children 2017). Such current lived experiences of Bronx residents are rooted in the racialized dismantling of New York City's public infrastructure and systematic disinvestment.

In the 1930s' post-Great Depression era, the U.S. Government set out to provide bonds for homeowners to refinance their mortgages as part of the New Deal. The Home Owner's Loan Corporation was formed to grade neighborhoods in about 250 cities into different "risk" categories based on racial composition and recruited mortgage lenders, developers, and real estate appraisers to create color-coded maps, ranging from green indicating "Best" with White dominance to red indicating "Hazardous" based on levels of "infiltration" of racial/ethnic minorities) ("Mapping Inequality: Redlining in New Deal America" 2020). Through redlining, the federal government and banks began diverting investments from low-income communities of color toward mixed-income white communities. This practice drove institutionalized racial segregation, devastating places like the Bronx, where landlords could not get financing to make large-scale renovations or sell their properties. Instead, many owners looking to get a return on their investment turned to arson to recoup fire insurance money or did not put time into preventing fires (Flood 2010). Consequently, flames engulfed entire neighborhoods, leaving families homeless and businesses destroyed in their wake.

The peak level of fires in the 1970s coincided with the loss of manufacturing jobs and the fiscal crisis of New York City. This led to the slashing of vital support services, including fire departments. In 1972, Mayor John Lindsay closed 13 fire stations in the South Bronx, following RAND Corporation's recommendation that incorporated a racially biased technocratic algorithm assuming that the poor Black/Latinx "fire-prone" communities exhibiting "social pathologies"

were "overserved" by the fire department (Flood 2010). With this faulty, racialized decision-making, response times rose while fire incidents quadrupled and fatalities doubled. Seven census tracts (out of 289) in the Bronx between 1970 and 1980 lost 97% of their buildings to fire and abandonment, while most lost more than 50% (Flood 2010).

All the while, the new Cross Bronx Expressway tore apart vibrant commercial and residential neighborhoods and expedited the flow of people and goods to the growing suburbs (Caro 1974). While suburbs around the Bronx were blooming, the Bronx was burning. Overall disinvestment has led to fewer resources to support health, including access to healthy foods, safe public space, clean streets, and quality housing, and amplified existing inequities, like concentrated poverty, overcrowding, dilapidated housing stock, and limited maintenance and inspections (Wallace 1990). New York City, as a whole, was struggling financially, and on October 29, 1975, Gerald Ford denied the near-bankrupt City a federal bailout, and the City was forced into severe austerity measures as a result of the subsequent bankruptcy filing (Van Riper 1975). What were considered "essential public services" were redefined, excluding police, fire services, sanitation, and public schools—Ford likened the City's public spending on its residents to an "insidious disease."

The impact of the disinvestment was felt disproportionately in the outer boroughs that were slated for "planned shrinkage," namely the Bronx. Further, Reagan's budget reform plans unraveled much-needed social safety-net programs, contributed to the well-known crack epidemic, and increased domestic violence, child abuse and neglect, hyperincarceration, and further disinvestment. Lasting health implications persist to this day (Hinterland et al. 2018). It seems that the same story of the Bronx is repeating itself, only this time with a novel virus.

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Lessons (Potentially) Learned

If we can learn from our history—and, perhaps, Singapore, a country that is fighting a second, brutal wave of COVID-19 after a "successful" containment amongst its citizens—the blatant disregard for marginalized people impacts us all (Ang 2020). In the U.S., our reliance on prisons and jails makes us more vulnerable to the next pandemic. Overcrowded housing makes us more vulnerable to the next pandemic. Severe food insecurity makes us more vulnerable to the next pandemic. Inadequate protection for *all* our essential workers makes us more vulnerable to the next pandemic. The absence of paid sick leave and job insecurity make us more vulnerable to the next pandemic. The systematic mismatch between increasing vacant luxury housing and increasing houselessness in absence of universal health insurance makes us more vulnerable to the next pandemic. Our disjointed, profit-focused health systems make us more vulnerable to the next pandemic. Our immigration policy makes us more vulnerable to the next pandemic. Our inadequate provisions for the elderly make us more vulnerable to the next pandemic. Deep inequities make us more vulnerable to the next pandemic.

Recommendations

When we think about where we go from here, it is important for us not to repeat the mistakes of the past—venturing down the well-trodden tracks of racial capitalism, structural racism, classism, and philanthropic self-congratulation. In the vacuum of appropriate leadership as the pandemic ravages American communities, organizations, foundations, and individuals are stepping up, securing personal protective equipment, donating food, advocating for testing, and funding new projects. However, this coming-together does not negate the need for investment in the fundamental reimagining of systems rooted in racism and the devaluation of Black and

Brown lives. Physicians take an oath to "do no harm"—an oath that must extend to public health professionals, economists, elected officials, law enforcement, and the philanthropic sector. This work aims to mitigate the real-life impact of natural and man-made disasters, but often creates stopgaps to patch the deficiencies and absolve our federal, state, and local governments and public health systems from *their* true "essential" work—ensuring the health and security of our residents. In most cases, it is hubris to think we are transforming communities without addressing the root causes of undue racialized, gendered, and class-based suffering.

Addressing root causes does not mean investing in law enforcement, correctional facilities, and homeless shelters. It does not mean funding another series of 5-year projects. It does not mean repeating history by hiring yet another technocratic consulting company to find "apolitical" solutions (Bowden 2020). It does not mean "going back to normal." We need to focus not just on restarting the economy, but on *reimagining* the economy. Maybe employment can be based not in the construction of luxury high-rise developments that fuel a supply–demand mismatch, but in the construction of truly affordable housing that upholds human dignity. Maybe security can be based not in jails and prisons, but in quality schools and community health services. Maybe recovery can be based not in the gig economy and new low-wage work, but in building our public health and social service infrastructure, perhaps with community health workers who are paid a living wage and have access to occupational protections.

Instead of slashing the budget, we should invest in our local health departments as assets in contact tracing and health care coordination as well as connecting with community health centers, established community-based organizations, and long-standing local leaders and organizers in our neighborhoods. We should invest in a more independent and well-funded Centers for Disease Control and Prevention. We should invest more in Medicaid and health care

for all. We should invest in the Indian Health Service, which should be an entitlement for the native residents of this land, not a discretionary expense. We should invest our resources in behavioral health services, especially as the trauma of this pandemic drives our collective and individual mental health and/or substance use. People with disabilities need more reimbursement for care and survival. Furthermore, we should not give in to the "shiny object syndrome" posed by the COVID-19 pandemic, but also prioritize addressing the symptoms of our systemic issues—the disproportionate distribution of chronic illnesses across different communities. In short, we need to invest in public physical and mental health and transform the places and policies that are breeding grounds for inequities.

Public health is rooted in social justice and advocating for our joint, interconnected humanity. Rudolf Virchow, the father of modern pathology and founder of social medicine, said: "Medicine is a social science, and politics nothing but medicine at a larger scale" (Mackenbach 2009). Investing in existing, capable, and dedicated community leaders and entities, and strengthening the foundation of our welfare systems, may be the most expedient and effective approach towards a sustainable and equitable future.

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