COVID-19: Politics, Inequalities, and Pandemic

Disaster Preparedness and Social Justice in a Public Health Emergency

Harold A. Pollack
University of Chicago

Abstract The United States is now experiencing public health catastrophe on a scale not seen for more than a century. COVID-19 puts into stark relief the mutual obligations that reflect interdependence among participants in a common society. Drawing on the work of Amartya Sen concerning famine and related challenges, the author discusses the accompanying implications for social justice. Social justice in catastrophe requires strong social insurance structures and legal protections for the most vulnerable people, who would otherwise lack economic resources and political influence to protect their essential interests. Social justice also requires greater and more sustained attention to disaster preparedness and public health infrastructure—both of which are characteristically neglected, in part because the public health enterprise is identified with politically weak and often stigmatized populations.

Keywords COVID-19, public health, disaster preparedness, social justice

In April 2020, MSNBC journalist Chris Hayes posted a sardonic tweet:

> Tyranny is the government telling you you can't go to a hair salon because there's a plague. Freedom, on the other hand, is the government telling you you have to go back to work at your plague-stricken pork processing plant alongside workers who might be sick. (Hayes 2020)

One might assume Hayes was joking. He wasn't. He was providing a succinct meditation on the relationship between positive and negative freedom in defending our most essential interests in the midst of a public health catastrophe.

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Thus far in America, the COVID pandemic has taken more than 130,000 lives and caused trillions of dollars of economic damage, with no certain end in sight.

Aspects of the catastrophe could not have been predicted. Yet comparing America's body count and economic devastation to that experienced by Germany or South Korea, it's clear that our poor immediate response and weak public health infrastructures hastened disease spread. Weak social insurance compounded the damage; the lack of social protections for workers and a safety net for those in deepest need made the resulting economic, social, and health harms even worse than they would otherwise be.

The most devastating harms fall on the most vulnerable. As of this writing, African Americans account for almost two-thirds of known fatalities in Chicago. Five of Chicago's six zip codes with the highest COVID mortality rates are segregated South Side communities that are almost entirely African American. Nursing home residents account for a vastly disproportionate number of fatalities (Nadolny and Kwiatkowski 2020). Individuals living with physical or intellectual disabilities, in correctional institutions, and in congregate living sites have also experienced greatly elevated risk.

Some unknowable fraction of these deaths were caused by immediate mismanagement by officials at every level of government. The possibility of flu pandemic was widely predicted, indeed specifically feared by Presidents Clinton (Rove 2020), Obama (Burdryk 2020), and George W. Bush (Charatan 2005; Rove 2020). Nonetheless, our nation failed to adequately stockpile required equipment and was too late in enacting required emergency measures.

During the past decade, congressional Republicans opposed and cut spending on influenza preparedness and general public health (Dennis 2009; Torbati and Arnsdorf 2020). Governors and mayors from both political parties made critical early errors (Goodman 2020). New York's delayed implementation of distancing measures proved particularly costly, fueling disease spread both locally and across the nation (Carey and Glanz 2020). President Trump downplayed initial intelligence community warnings (Miller and Nakashima 2020; Shear et al. 2020) and weakened regulatory protections against infections in nursing homes (Drucker and Silver-Greenberg 2020). The Centers for Disease Control and Prevention lost irreplaceable time through manufacturing errors in its testing kits (Shear et al. 2020).

We won't know the full extent of such mismanagement until a rigorous policy autopsy is performed (Leveton, Sox, and Stoto 1995). In an

atmosphere of recrimination and mourning, we will be challenged to find the right balance of accountability and forgiveness given tens of thousands of lives lost. We will understandably focus on the most visible sins of omission or commission by specific officials. Any reasonable autopsy must confront the reality that public health is boring until it's not. The systematic imbalance in American health care leads us to privilege identified lives over statistical lives, favor acute medical treatment (and, in the moment, emergency response) over prevention and preparedness. When this goes visibly wrong, mistakes are always more obvious in retrospect than they are when the decisions are made.

Catastrophes of this magnitude bear an inner logic that transcends the errors and misfortunes most apparent to us. The deaths that result are not inevitable or random results of epidemiological or meteorological surprises. Allan M. Brandt and Alyssa Bortelho (2020) remind us that there is no such thing as a perfect storm. The very language distracts attention from structural failures and policy errors. The most important institutional failings and mistakes occur long before a hurricane, earthquake, drought, or pandemic occurs.

Disasters lay bare the structures and priorities of the societies that endure them. They put into stark relief our obligations to one another that reflect our mutual dependence, the reality that tens of millions of people do essential work to maintain the impossibly complicated ecosystem of a modern society. The ranks of essential workers include leaders and decision makers, first responders, doctors, and nurses—and janitorial workers disinfecting doorknobs and flat surfaces in common spaces, hourly food preparation workers, call-center and warehouse workers, and a myriad of others performing mundane tasks we rely on yet so easily take for granted. Some of these men and women are being protected in this crisis. Others are discovering that they must fend for themselves.

Existing social arrangements leave some people well equipped to protect themselves, provide some people with the tools to resist challenges to their equal membership and common worth in provision of emergency rescue resources. State action, inaction, incapacity, group conflict, and economic and political inequality create and perpetuate existing vulnerabilities. These inequalities create a sense of urgency regarding threats to some people who hold a privileged place in the pecking order, and palpably less urgency regarding equally serious threats to others.

This was true during Freedom Summer, when Dr. Jack Geiger prescribed food to poor Mississippi Delta families, who suffered from malnutrition despite living in a region of lush agricultural production (Geiger

2016). This was also true during much of the HIV epidemic, when individuals and communities most at risk lacked access to critical prevention and treatment resources. This is true today for many Americans under threat from the COVID-19 pandemic.

Consider two stories. The first is one man's childhood memory of a hate crime committed during the 1943 Bengal famine:

> One afternoon, a man came through the gate screaming pitifully and bleeding profusely. He had been knifed in the back. He was a Muslim daily laborer, and his name, he said, was Kader Mia. He had come to deliver a load of wood to a neighboring house, for a tiny reward. As he was being taken to the hospital by my father, he went on saying that his wife had told him not to go into a hostile area during the communal riots. But he had to go out in search of work because his family had nothing to eat. The penalty of that economic unfreedom turned out to be death; he died later in the hospital. (Sen 1998)

Fast-forward to this March 4, 2020, *Time Magazine* account of San Francisco essential workers:

> There are many things that worry Fina Kao about working in a busy donut shop in an age of fear about a spreading virus. The elderly customer who shuffles across the brown linoleum floor of the shop, orders a glazed donut, and then coughs. The parents sitting at a table sharing a breakfast sandwich as their small child touches the tables and the floor and the drinks fridge with her dirty fingers. The regulars who come in and who Kao knows travel annually to China—one of whom proceeds to sit at the window and cut his fingernails. . . . But Kao and her fellow workers at All Stars Donuts in the Richmond district of San Francisco don't have much choice but to show up to work, their only shield from potential coronavirus carriers a 24-ounce bottle of aloe hand sanitizer they've put near the register. Kao works five days a week from 5 a.m. to 1 p.m. "If we don't work," says Kao, 31, "we don't get paid." (Semuels 2020)

In some obvious ways, these stories could hardly be more different. One involved a murder committed in British colonial India during a period of famine and Hindu-Muslim violence. The other involved a waitress going to work in her own San Francisco community 77 years later.

Yet these stories bear greater similarity than we might have guessed three months ago. Two people risked so much, one losing everything, because they needed the income from their low-wage jobs. Both performed

mundane work. Although the entire society benefitted from their work, it was poorly paid, conducted under conditions that failed to protect them against predictable risks. Both workers lacked the economic resources (and, in the background, political power) to demand something better.

Similar stories might be told about direct-care workers who serve individuals with disabilities at an average hourly wage of $11.57 (Indeed.com 2020), trying to protect patients and themselves from COVID-19; about jail and prison staff, detainees, and inmates trying to stay safe in physical structures not designed to permit physical distancing; about childcare workers reporting to work with sore throats and fevers because they lack paid sick leave. The people who perform this work might receive an N95 mask or a charity handout. They lack the economic, social, or political influence to demand better.

No one pondered these issues with greater acuity than Amartya Sen, whose childhood memory provides that first anecdote, whose father tried in vain to rescue Kadar Mia. As Sen observed decades later, such stories reflect continuing inequalities and imbalances in state capacities that make natural and man-made disasters so much more punishing to some communities and groups than to others. Disasters almost always include epidemiological, meteorological, or seismic challenges. They are almost always more than that.

In the Bengal famine and so many others, Sen (1983: 90–93) found that there is generally sufficient food for everyone. Rapid changes in relative wages and prices, not gaping shortages, cause particular communities and people in colonial India to suffer or starve. An urban wartime manufacturing boom created an accompanying boom in urban wages, which increased the demand for food. Given inelastic supply, this produced a corresponding increase in food prices. Although the overall food supply was adequate, rural workers could not afford to buy that food, because rural agricultural wages failed to keep pace. Advantaged constituencies effectively outbid others for an essential resource.

An active, democratically accountable government might have ameliorated this process. It might have distributed food in rural areas, might have allowed rural workers greater access to manufacturing employment, might have taken other steps to raise the earning power of vulnerable populations in an emergency. India's lethargic colonial rulers, occupied on other fronts in a world war, failed to take these steps, costing an estimated three million lives (Sen 1983: 202). Facing other natural disasters and threats, similar authoritarian governance failures occurred in China, Sudan, Ethiopia, and North Korea.

The faltering COVID-19 response in the United States, Great Britain, and elsewhere reminds us that democratic governance does not guarantee an effective pandemic response. Still, in a time of crisis, protecting every member of the community is the most basic obligation of democratic governance. No less important is the obligation to prepare beforehand, to create and sustain state capacity to address predictable threats to the well-being of everyone, especially those who face characteristic vulnerabilities that might cause their needs to go unaddressed.

Seven characteristic interests (and corresponding vulnerabilities) should command our attention as we seek to learn from these experiences. Each is important to assure every US resident with the means to address his or her basic needs in the face of a serious public health threat.

Attention to prior health status and disparities. COVID-19 underscores the role of prior health challenges, such as diabetes, hypertension, and obesity, that heighten the risk of death or serious illness if one becomes infected (Richardson et al. 2020). Most Americans who have died or required intensive care experience one or more of these comorbidities. African Americans older than age 50 face sharply elevated risks, which is a key reason African Americans have experienced elevated mortality. Minoritized populations may bear an additional burden because their prior experience provides reason to distrust public health and medical authorities, which may render public health messaging and risk communication less effective in a crisis (Alsan and Wanamaker 2018).

Basic services. Everyone requires access to basic public services. Although these services help everyone, they are especially critical for vulnerable individuals and groups. Access to safe housing is one example. As the emerging threat of COVID-19 became obvious, many American cities included thousands of vacant hotel rooms and apartments. Meanwhile, thousands of precariously housed men and women crowded together, sleeping cheek by jowl, barracks style, in overburdened homeless shelters that pose especially serious threats to physical and mental health.

Basic economic resources. Every resident must command required economic resources to purchase emergency goods and services. When individuals put their lives at risk because they need a paycheck, this is a basic social insurance failure.

Political power and social standing. Every resident must command sufficient political resources to demand an urgent response when their most basic needs are put at risk. Many citizens in Bengal lacked such resources 77 years ago. Americans vulnerable to HIV lacked these resources two generations later. It's not that most Americans or their elected officials

were happy that people were dying of AIDS. It was the lack of urgency and priority in response. The band played on (Shilts 2007).

A similar pattern could be observed in Michigan that allowed Flint residents to be poisoned by their tap water. Before Flint water was found to contain lead,

> Flint residents were told to boil their water several times because of the presence of e-coli. Then, residents started complaining about skin rashes and their hair falling out, likely caused by the chlorine used to kill the e-coli. (Carmody 2015)

Leaving aside lead-related harms, it strains credulity to imagine that a more powerful or more broadly valued constituency would have been forced to endure such a basic failure for so long. As this essay goes to press, poorly compensated workers lack paid sick leave or basic protective equipment to avoid infection. Meatpacking workers and those in other economically sensitive industries may be denied unemployment benefits if they don't appear for work that exposes them to COVID-19 risks (Romm 2020).

Public health infrastructure. As Sen notes in *Development as Freedom*,

> protection against starvation, epidemics, and severe and sudden deprivation is itself an enhancement of the opportunity to live securely and well. The prevention of devastating crisis is . . . part and parcel of the freedom that people have reason to value. (Sen 1998)

The lack of public health infrastructure itself reflects and expresses a social injustice. The United States spends $3.6 trillion on personal health care services every year. Yet we lack basic materials for pandemic preparedness and basic capacity for testing and contact tracing. Local health departments have faced continual budget cuts during the past decade. They rely on uncertain annual appropriations from state, city, and county governments. (Many states with the lowest per capita public health expenditures also rejected the Affordable Care Act's Medicaid expansion [SHADAC 2020], which provides key prevention and treatment resources for addiction treatment, mental health, and other matters of public health concern.)

No one explanation suffices for these imbalances in the American medical political economy. Rick Mayes and Thomas R. Oliver (2012) note that powerful, organized constituencies benefit from the supply and receipt of traditional medical care, while the benefits of population health measures are often delayed and easily taken for granted.

Given the public-good aspect of vaccination and other public health efforts, the constituency that favors public health is more diffuse. The public health enterprise is a victim of its own success as well. When public health authorities effectively reduce pollution, provide safe drinking water, or reduce injuries and death, the people who benefit from such measures often have no way to know that they benefitted from public health interventions (Brown 2010: 161).

Brown notes another obstacle, too. Political opportunities to mobilize public health measures can be intense during a crisis, but then public interest wanes when the immediate crisis seems to pass away (Fee and Brown 2002: 42). This is not a dynamic that promotes methodical planning; nor does this promote creation and maintenance of the public health infrastructure required to meet the next crisis.

Part of the explanation also reflects deeper inequalities. Public health services have traditionally served politically weak, stigmatized, or socially marginalized individuals and groups. Syphilis, HIV, hepatitis C, and substance use disorders are not randomly distributed across the population. Rightly or wrongly, millions of Americans regard themselves as personally distant from these risks. The public health enterprise, charged to address such challenges, inherits the political weakness and social stigma associated with the populations it serves. Indeed, randomized survey research trials suggest that messaging that emphasizes social determinants strengthens ideological polarization and can actually reduce support for public health initiatives within key constituencies in the United States. (Gollust, Lantz, and Ubel 2009).

Statutory protections for the equal worth of everyone. The COVID-19 crisis also raises uncomfortable questions about the role of quality-of-life calculations in emergency triage. During a pandemic that stresses the capacity of intensive care and other acute services, individuals with stable disabilities require effective protection against forms of triage that would assign lower worth to their lives, deeming them less qualified for emergency resources based on their supposed lower quality of life as evaluated by others (Silverman 2020).

Global public health structures to protect vulnerable populations across boundaries. Each nation faces distinctive COVID-19 challenges, which reflect local capacities, values, and epidemiological realities. Still, the challenges of infectious disease prevention and control are now global. Given interconnected supply chains, commerce, travel, and population flows, epidemiological conditions in one country or local area have important consequences across the world.

Some local patterns Sen lamented in the Bengal famine remain globally pertinent. Around the world, there are (or will soon be) sufficient quantities of protective equipment to protect medical workers and first responders, and sufficient quantities of cloth masks and other equipment for broad population protection. Yet as the *New York Times* reports, there is currently a bottleneck. Wealthy societies are outbidding African and Latin American nations and global aid organizations for masks, test equipment, and other essential supplies (Bradley 2020).

Such competition raises profound ethical concerns, and practical questions, too. This resource imbalance threatens to accelerate COVID-19 spread in societies that are the least equipped to provide proper treatment or to endure the resulting economic loss. North and Central America is an integrated ecological, epidemiological, and demographic system. Millions of human beings, wildlife, and agricultural goods move across our borders every year. We cannot contain COVID-19 in the United States and Canada without effective measures to contain disease spread south of our borders.

Where Does This Leave Us?

Although the threat of infectious disease is universal, individuals, families, and communities possess unequal capabilities to protect themselves and to shield themselves from pandemics' worst effects. Such catastrophes proide a basic test of political and economic institutions to protect every member of our society. They shine a bright light on the successes and failures of our institutions, allowing us to see which segments of our society and our response reflect a sense of urgency and common fate.

Social justice in catastrophe requires an effective emergency response. Sen's work reminds that we also require something more: Greater and more-focused state capacity to address predictable threats to everyone's health and well-being. Some components of this response can be created and deployed in a crisis. Many cannot. They require development of institutional capacities and political commitments long before disaster strikes.

Effective emergency economic response must protect everyone's earning power and the main pillars of the macroeconomy. This entails social insurance structures such as paid leave that allow infected US residents to self-isolate to avoid infecting others, and that allow workers to care for themselves or their loved ones when illness strikes.

Such a response obviously includes aggressive public health measures from epidemiological surveillance and contact tracing to quarantine to provision of stockpiled protective equipment and diagnostic tests. Less

obvious are the ways that such measures require sustained institutional attention to supply chains for critical equipment, oversight of staff training, and the physical layout of jails, prisons, and long-term care facilities for infection control. These processes must attain the routine technical proficiency and vigilance now devoted to the supply chain at Walmart, Amazon, and McDonald's—not to mention the design and delivery of cancer treatment in elite academic medical centers.

Emergency public health response also requires a national and global public health enterprise, one that is funded and operated on a level commensurate with the financing and operation of personal health services. In 2018, the Centers for Disease Control and Prevention's $11 billion budget was notably below those of just one hospital system, Boston's Partners Healthcare, whose operating revenues exceeded $13 billion (Partners 2019). That same year, the World Health Organization spent one fifth as much, approximately $2.3 billion, in its efforts to address diverse health challenges facing billions of people (Moulds 2020). Given these disparities, it's not surprising WHO is sometimes less technically proficient than these other organizations.

Many actors made key errors in their initial failure to contain the pandemic and in subsequent efforts to slow disease spread (Shear et al. 2020). One must recognize these individual failures, but see past them, too, because the most important failures of the COVID-19 pandemic have been structural and institutional, not specific mistakes made in the moment by key decision makers.

The central task of democratic policymaking isn't a concrete leadership decision or legislative vote. Rather it is to set in concrete the resources and capacities to make these decisions and votes more likely to be successful, and less likely to be crucial factors when the nation faces an immediate crisis. The craft of policy making is the creation of effective organizations with skilled workforces, institutionalized expertise and infrastructure, channels of authority and accountability, regularized procedures to protect the vulnerable. These capacities are essential in a crisis, and cannot be created from scratch in the midst of disaster.

Many of these components of an effective emergency response are boring—until they are not, for at least some period; until they become interesting again. Our democracy finally pays attention when disaster strikes, only to discover that we have performed profound injustices by failing to protect our most vulnerable US residents, including some we rely on to perform our most essential work. That is a practical failure. It is also an injustice.

We can't turn back the clock to provide the proper COVID-19 response. We can still learn from this disaster, however. We can improve social insurance, and our national and global public health infrastructure. We can, while addressing the immediate crisis, begin the hard methodical work of preparing for the next national and global trial. We can implement large, permanent increases in national and global public health preparedness to address pandemics and other threats.

Given climate change, global migration, ethnic conflict, and more, we should be confident that other catastrophes will come, perhaps even more deadly and more daunting than COVID has been. Prudence and social justice require us to be better prepared next time around.

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Harold A. Pollack is the Helen Ross Professor of Social Service Administration and an affiliate professor in the Biological Sciences Collegiate Division and Department of Public Health Sciences at the University of Chicago. He is faculty codirector of the University of Chicago Health Lab. His current research concerns interventions to serve individuals living with substance use or psychiatric disorders who come into contact with law enforcement and correctional systems.
haroldp@uchicago.edu

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