Postscript: COVID-19 and the Path Forward

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From legacies of enslavement to legal segregation; white terrorism; hyperincarceration; lethal policing; and ongoing discrimination in housing, employment, education, credit markets, and healthcare, this collection of essays has traced the major structural determinants of disproportionate COVID-19 incidence and mortality among people of color in the United States. It has also highlighted a number of reparative and redistributive policies to ameliorate such disparities in future pandemics.

Many of these calls for social justice are not novel. As such, how is it that our ability to imagine social alternatives to the racist status quo in this country has been so stunted over centuries of struggle? In a word: ideology.

Ideology can be thought of as "the distortion of knowledge to conform with an inequitable social structure" (Hamilton 1974). Since time immemorial—from the caste system in India to the evolution of racial capitalism across the Atlantic (Yengde 2019; Robinson 2000)—groups of people have been effectively dominated by the control, through knowledge production, of how they perceive themselves and their relationship to the world (wa Thiong'o 1986).

If we understand the enslavement of black people as foundational to American capitalism, the country's subsequent development can be depicted as an extension of this oppressive social order (Lemman 2020; Johnson 2020)—and as Charles Mills teaches, "If exploitative socioeconomic relations are indeed foundational to the social order, then this is likely to have a fundamental shaping effect on social ideation" (Mills 2017).

White supremacy has been the effective ideology of the United States since prior to its founding (Fields 1990), and it has dominated dialectically the ideation of politicians, jurists, religious leaders, philosophers, academics, artists, and other intellectuals whose work involves interpreting social phenomena (Rehmann 2014). Economists have been key in this epistemic effort; as Rubinstein explains, "Economics [is] an academic field that tends toward conservatism and helps the strong in society maintain their dominance. . . . Economic

models generally ignore the aspiration of individuals to gain power and control over other people . . . [and] economic questions that ought to be decided democratically via the political system are treated there as if they were professional matters and are deferred to experts to decide. . . . [This] is a ploy that serves the stronger members of society (including, just by chance, the community of experts)" (Rubinstein 2012).

The $10–12 trillion racial wealth gap in the United States is in no small part a result of the efforts of economists (Darity and Mullen 2020). When analyzed globally, the $152 trillion net appropriation by high-income countries from the Global South can also be tied to the work of this cadre of so-called experts, who are essentially the organic intellectuals—or status-quo propagandists—of racial capitalism (Gramsci 1971; Richardson 2020; Hickel, Sullivan, and Zoomkawala 2021; Marglin 2008; Amin 1973; Rodney 1972; Wilson Gilmore 2003).

With respect to COVID-19 and other diseases that disproportionately affect the marginalized, epidemiologists have taken on these reins by translating pandemic data into thought forms that actively delimit—through their exaggerated precision and acceptance of government interventions as status quo—the public's ability to imagine social alternatives (Graeber 2007). As we move from the superstructure of social science to the base of racial capitalism, we begin to see how the former colludes in the material deprivation and physical oppression of people of color.

Take, for example, the COVID-19 forecasts developed by the Institute for Health Metrics and Evaluation (IHME) at the University of Washington.[1] The models it developed in the spring of 2020 varied wildly over a matter of weeks, and the true number of next-day deaths from COVID-19 in the United States fell outside their prediction intervals as much as 70 percent of the time (Jewell, Lewnard, and Jewell 2020; Marchant et al. 2020). In addition, their plunging estimates were used to endorse the Trump administration's COVID-19 response as competent and effective (Richardson 2020).

But of greater consequence, they made no recommendations about risk structure—that is, the way people are enabled or constrained in their associations with others (Richardson et al. 2021). As such, they could also be deemed racist (Kendi 2017), since their analyses endorse a future where COVID-19 disparities continue to exist, institutionalized racism is rampant, hyperincarceration is ongoing, and universal health coverage is denied. In other words, their supposedly value-free epidemiology espouses valuations peculiar to racial capitalism (Marcuse 2009), preventing the measures and interventions outlined in this volume from being considered in the social imaginary. Indeed, such work

filters out information vital to demonstrating the ways white supremacy generates health inequities in the United States.

The IHME aims to improve the health of the world's populations by providing the best information on population health, which is somewhat like saying they could have improved the health of people enslaved in the United States in the seventeenth to nineteenth centuries by counting and reporting how many died from strokes, heart attacks, and malnutrition. There is, in short, no analysis of power (Richardson 2020; Honneth 1991; Farmer 2005; Fanon 1967).

For the most part, public-health data and forecasting are curated in a manner that occults "administered dehumanization and dispossession" (Kabel and Phillipson 2020), thus furthering status-quo relations of inequality (Richardson 2021). The hegemonic status achieved by such knowledge production disciplines us. It shields structural determinants from political contestation (Fraser 1989) and helps ensure—under a pragmatist notion of truth (Rorty 1999; Denzin 1996)—that we do not come to compromise on reparative action when presented with the evidence of disparities by race. In doing so, it coproduces white supremacy (Jasanoff 2004).

The ideological work done by such forecasting is strengthened by its designation as "outbreak science" (Rivers et al. 2019). This coding imparts epistemological currency to a variety of racist discourses so as to invest them with authority and legitimacy (Foucault 1979).

To interpret COVID-19 in an antiracist, relational fashion (Pohlhaus 2012; Emirbayer 1997; Kivinen and Piiroinen 2006; Kendi 2019; Krieger 1999), we could view it not as a *thing*—that is, not a physiological response to viral RNA—but rather as a hub of social distrust, othering, predatory accumulation, and flaunting of evidence (Marx 1976). That a country like Taiwan, with 23.6 million people, can count deaths from COVID-19 in the hundreds—instead of hundreds of thousands as in the United States, Russia, Brazil, and India[2]—demonstrates that the devastating lethality found in these comparatively inegalitarian nations is not a biological inevitability, but rather a socially constructed, reticulate health phenomenon (Berger and Luckmann 1967; Geertz 1973; Mayer 1996; Turshen 1977; Packard 1989; Laster Pirtle 2020).

Consequently, in order to dismantle the inherited ideologies of white supremacy that undergird health disparities in the United States, we must foment a changing of minds—a metapolitics—to enable real cultural reconstruction. The #BlackLivesMatter global movement is showing the way—how struggle in the streets, in the media, in academia, and interpersonally can lead to transformations in how we "capture, orient, determine, intercept, model, control, or secure the gestures, behaviors, opinions, or discourses of [human] beings"

(Agamben 2009). But to reach the ultimate fulfilment of these transformations, we must enact, globally, sweeping material and symbolic reparations programs (Darity Jr. and Mullen 2020; Beckles 2013; Richardson 2020).

NOTES

1. The IHME has been called "the world's premier center for health metrics—the science of measuring and analyzing global health problems" (Butler 2017). It has received more than $600 million from the Gates Foundation alone, which raises the question whether "Gates's billions [are] distorting public health data" (Schwab 2020).

2. As of 2021 (COVID-19 Dashboard by the Center for Systems Science and Engineering at Johns Hopkins University).

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