



Illustration by Jamiel Law

OUR COLUMNISTS

THE BLACK PLAGUE

Public officials lament the way that the coronavirus is engulfing black communities. The question is, what are they prepared to do about it?

By Keeanga-Yamahtta Taylor

April 16, 2020

0:00 / 26:06

Audio: Listen to this article. To hear more, download Audm for iPhone or Android.

The old African-American aphorism “When white America catches a cold, black America gets pneumonia” has a new, morbid twist: when white America catches the novel coronavirus, black Americans die.

Thousands of white Americans have also died from the virus, but the pace at which African-Americans are dying has transformed this public-health crisis into an object lesson in racial and class inequality. According to a Reuters report, African-Americans are more likely to die of COVID-19 than any other group in the U.S. It is still early in the course of the pandemic, and the demographic data is incomplete, but the partial view is enough to prompt a sober reflection on this bitter harvest of American racism.

Read *The New Yorker's* complete news coverage and analysis of the coronavirus pandemic.

Louisiana, with more than twenty-one thousand reported infections, has the largest number of coronavirus cases outside of the Northeast and the Midwest. When the state’s governor, John Bel Edwards, announced recently that it would begin to provide data about the racial and ethnic breakdowns of those who have died, he included the grim acknowledgement that African-Americans, thirty-three per cent of Louisiana’s population, comprise seventy per cent of the dead.

The small city of Albany, Georgia, two hundred miles south of Atlanta, was the site of a heroic civil-rights standoff between the city’s black residents and its white police chief in the early nineteen-sixties. Today, more than twelve hundred people in the county have confirmed COVID-19 cases, and at least seventy-eight people have died. According to earlier reports, eighty-one per cent of the dead are African-American.

In Michigan, African-Americans make up fourteen per cent of the state’s population, but, currently, they account for thirty-three per cent of its reported infections and forty per cent of its deaths. Twenty-six per cent of the state’s infections and twenty-five per cent of deaths are in Detroit, a city that is seventy-nine per cent African-American. COVID-19 is also ravaging the city’s suburbs that have large black populations.

The virus has shaken African-Americans in Chicago, who account for fifty-two per cent of the city's confirmed cases and a startling seventy-two per cent of deaths—far outpacing their proportion of the city's population.

As many have already noted, this macabre roll call reflects the fact that African-Americans are more likely to have preexisting health conditions that make the coronavirus particularly deadly. This is certainly true. These conditions—diabetes, asthma, heart disease, and obesity—are critical factors, and they point to the persistence of racial discrimination, which has long heightened black vulnerability to premature death, as the scholar Ruthie Wilson Gilmore has said for years. Racism in the shadow of American slavery has diminished almost all of the life chances of African-Americans. Black people are poorer, more likely to be underemployed, condemned to substandard housing, and given inferior health care because of their race. These factors explain why African-Americans are sixty per cent more likely to have been diagnosed with diabetes than white Americans, and why black women are sixty per cent more likely to have high blood pressure than white women. Such health disparities are as much markers of racial inequality as mass incarceration or housing discrimination.

It is easy to simply point to the prevalence of these health conditions among African-Americans as the most important explanation for their rising death rates. But it is also important to acknowledge that black vulnerability is especially heightened by the continued ineptitude of the federal government in response to the coronavirus. The mounting carnage in Trump's America did not have to happen to the extent that it has. COVID-19 testing remains maddeningly inconsistent and unavailable, with access breaking down along the predictable lines. In Philadelphia, a scientist at Drexel University found that, in Zip Codes with a “lower proportion of minorities and higher incomes,” a higher number of tests were administered. In Zip Codes with a higher number of unemployed and uninsured residents, there were fewer tests. Taken together, testing in higher-income neighborhoods is six times greater than it is in poorer neighborhoods.

Inconsistent testing, in combination with steadfast denials from the White House about the threat of the virus, exacerbated the appalling lack of preparation for this catastrophe. With more early coordination, hospitals might have procured the necessary equipment and staffed up properly, potentially avoiding the onslaught that has occurred. The consequences are devastating. In the Detroit area, where the disease is surging, about fifteen hundred hospital workers, including five hundred nurses at Beaumont Health, Michigan's largest hospital system, are off of the job with

symptoms of COVID-19. Early in the crisis, at New York City's Mount Sinai Hospital, nurses were reduced to wearing garbage bags for their protection. Across the country, health-care providers are being asked to ration face masks and shields, dramatically raising the potential of their own infection, and thereby increasing the strain on the already overextended hospitals.

The early wave of disproportionate black deaths was hastened by Trumpian malfeasance, but the deaths to come are the predictable outcome of decades of disinvestment and institutional neglect. In mid-March, Toni Preckwinkle, the president of the Cook County Board in Illinois, which encompasses Chicago, lamented the COVID-19 crisis and proclaimed that "we are all in this together," but, weeks later, she closed the emergency room of the public Provident Hospital in the predominantly black South Side. Preckwinkle claimed that the closure would last for a month and was a response to a single health-care worker becoming infected with the virus. Leave aside the fact that nurses, doctors, and other health-care workers have been testing positive for COVID-19 across the country, and their facilities have not been shuttered. It is a decision that simply could not have been made, in the midst of a historic pandemic, in any of the city's wealthy, white neighborhoods on the North Side.

Meanwhile, in Cook County Jail, three hundred and twenty-three inmates and a hundred and ninety-six correctional officers have tested positive for COVID-19. Not only have officials not closed the county jail as a result but they also have yet to release a significant number of jailed people, even though the facility has the highest density of COVID-19 cases in Chicago. These are the kinds of decisions that explain why there is a thirty-year difference in life expectancy—in the same city—between the black neighborhood of Englewood and the white neighborhood of Streeterville. They are also just the latest examples of the ways that racism is the ultimate result of the decisions that government officials make, regardless of their intentions. Preckwinkle is African-American, and the chairperson of the Cook County Democratic Party, but her decisions regarding Provident Hospital and Cook County Jail will still deeply wound African-Americans across Chicago.

The rapidity with which the pandemic has consumed black communities is shocking, but it also provides an unvarnished look into the dynamics of race and class that existed long before it emerged. The most futile conversation in the U.S. is the argument about whether race or class is the main impediment to African-American social mobility. In reality, they cannot be separated from each

other. African-Americans are suffering through this crisis not only because of racism but also because of how racial discrimination has tied them to the bottom of the U.S. class hierarchy.

Since emancipation, racism has underwritten black economic hardship. That hardship is expressed through the concentration of African-Americans in low-wage jobs—many of which are now ironically designated “essential.” According to a report in the *Times*, Annie Grant, a fifty-five-year-old black woman who worked at the Tyson Foods poultry plant in Camilla, Georgia, said that she was suffering from fevers and chills, and she told her children that she was ordered to return to work despite exhibiting symptoms of the virus. Earlier this month, she died from COVID-19. Two more workers at the plant have died, and others have complained about the lack of protective equipment and the difficulty of social distancing there, but Tyson has kept it open. (A spokesperson for Tyson Foods has said that the company has instituted safeguards for employees, including “an adequate supply of protective face coverings for production workers.”) When Vice-President Mike Pence spoke about the role of low-wage, essential work amid a widening outbreak in food-processing plants, he said, “You are giving a great service to the people of the United States of America, and we need you to continue, as a part of what we call critical infrastructure, to show up and do your job.”

The intersecting threats of hunger, eviction, and unemployment drive poor and working-class African-Americans toward the possibility of infection. Fewer than twenty per cent of African-Americans have jobs that allow them to work at home. Black workers are concentrated in public-facing jobs, working in mass transit, home health care, retail, and service, where social distancing is virtually impossible. And then there is the concentration of African-Americans in institutions where social distancing is impossible, including prisons, jails, and homeless shelters. African-Americans make up the majority of the incarcerated and the homeless. Forty-six per cent of African-Americans perceive COVID-19 as a “major threat” to their health, and yet race and class combine to put black people in danger. These numbers are the crisis wrapped inside of the pandemic.

Poverty, in turn, reinforces ideological assumptions about race. When working-class black neighborhoods have high rates of substandard housing and poor maintenance, and black communities suffer from poor diets and widespread obesity, these characteristics are conflated with race. Racializing poverty helps to distract from the systemic factors at the foundation of both racial and economic inequality. Instead, there is an overabundance of attention placed on the diagnosis and repair of supposedly damaged African-Americans. On April 10th, Trump’s Surgeon General, Jerome

Adams, who is black, instructed African-American and Latino communities to avoid alcohol, tobacco, and drugs during the pandemic. In a familiar paternalistic ode, Adams advised, “We need you to do this, if not for yourself, then for your *abuela*. Do it for your granddaddy. Do it for your big mama. Do it for your pop-pop.” He added, “We need you to step up.”

These remarks were a reminder of how the focus on the comorbidities accompanying COVID-19, such as diabetes and hypertension, can be easily transformed into discussions about the dietary and exercise habits of the black working class. But that is an irresponsibly one-sided discussion, one that ignores the comorbidities of food deserts, the diminishing returns of food stamps, and the depression and alienation that blanket poor and working-class black neighborhoods. It is not the absence of willpower that is fuelling the pandemic’s deadly effects in black communities. And the disproportionate impact of the virus is not caused by a language barrier requiring that African-Americans be spoken to with “targeted language,” as Adams later explained.

Adams’s remarks were also a reminder that, even when poverty is not the issue, racism or racially inflected assumptions about African-Americans influence the ways that they are cared for within the health-care industry. Not only are black women three times more likely to die in childbirth than white women are but college-educated black women’s mortality rates in childbirth are higher than those of white women with just a high-school degree. The stereotypes of African-Americans as fat and lazy, carefree and reckless, impetuous, irresponsible, and ultimately undeserving, are absorbed into the consciousness of the general public, health-care providers among them. These stereotypes are rooted in misperceptions of poor and working-class black life, but, because race is widely seen as biologically based in our society, including by doctors, they are assumed to be characteristics inherited by all black people. In a series of studies published in 2017, researchers found “an implicit preference for white patients, especially among white physicians.” Another study found that doctors believed that white patients were more medically cooperative than African-American patients. A 2016 study of medical students and residents found that almost half of them believe that there are biological differences between black bodies and white bodies—including the false notion that the nerve endings of black people are less sensitive than those of whites. These findings may give some insight into a more recent study that showed that black patients were forty per cent less likely to receive medication to ease acute pain.

Discrimination against African-American patients is so embedded in health-care practices that a national study found that, even when hospitals and insurers relied on an algorithm to manage care, African-American patients received on average eighteen hundred dollars less of care per year than white patients with the same chronic health conditions. African-Americans had to be sicker than whites before they were referred for more specialized help. It's not just poverty that leads to misdiagnoses and inconsistent care; it is also deeply embedded assumptions that black bodies are damaged and, thus, disposable.

It's not just Trump appointees who make condescending or ignorant statements. Even a liberal stalwart like Chicago's mayor, Lori Lightfoot, is not immune to fixating on perceptions of black complicity in poor health outcomes. In response to the reporting on black deaths from the coronavirus, Lightfoot said, "Now, we're not going to be able to erase decades of health disparities in a few days or a week, but we have to impress upon people in these communities that there are things they can do—there are tools at their disposal that they can use to help themselves, but we have to call this out as it is and make sure we've got a very robust, multitiered response now and going forward, and we will."

What are the "tools" at the disposal of black communities in Chicago that would allow them to "help themselves" out of the COVID-19 crisis? Lightfoot did not elaborate, but this sounds like loaded language that shifts the blame for black health disparities onto the segregated black neighborhoods of Chicago. Lightfoot's comments underestimate the difficulty of achieving good health and wellness while also combatting the forces of underemployment, evictions, and police violence—all of which define much of working-class black life in Chicago. The over-all unemployment rate for young black men and women in Chicago is thirty-seven per cent, compared with six per cent for their white peers. It is certainly easier to promote these mysterious "tools" than it is to confront the decades-long crisis of disinvestment and unemployment in the city, but that is actually what is necessary to change these circumstances.

There is an additional consequence of letting the coronavirus crisis lapse into a narrow focus on the personal choices of African-Americans. The assumption that if African-Americans just change their personal behavior then they can join the ranks of the fit and healthy ignores the systemic issues that have created a general crisis of health and wellness and access to medical care in the United States. The problem that black people face is not just one of exclusion from adequate health

care, with inclusion as the cure. Simply calling for “equal access” can reinforce the perception that the problem is one of exclusion alone, when the deeper problem is U.S. society itself.

When James Baldwin, in his searing 1963 book “The Fire Next Time,” posed the question of whether African-Americans should integrate into the “burning house” of the United States, he argued that the question demanded a deeper look into U.S. society. Baldwin wrote, “White people cannot, in the generality, be taken as models of how to live. Rather, the white man is himself in sore need of new standards, which will release him from his confusion and place him once again in fruitful communion with the depths of his own being. And I repeat: The price of the liberation of the white people is the liberation of the blacks—the total liberation, in the cities, in the towns, before the law, and in the mind.”

Racism has meant that most African-Americans suffer to greater degrees than most white Americans. But, in the past several years, there have been multiple reports showing that the life expectancy for the average white person has gone in reverse. This does not normally happen in the developed world. But, in this country, this phenomenon is driven by alcoholism, opioid abuse, and suicide. Far from white privilege, this is white pathos.

Unequal access to health care may be important in the immediate context of the pandemic, but this alone doesn’t tell us much about the general crisis with for-profit health care in the United States. It also doesn’t tell us much about the larger social crises in the U.S. that underwrite the particular health-care problems of African-Americans and white Americans. A glimpse into those larger crises was provided by the United Nations in 2017, when its investigators interviewed people in several cities about poverty in the United States. The report concluded that “the United States already leads the developed world in income and wealth inequality, and it is now moving full steam ahead to make itself even more unequal. . . . High child and youth poverty rates perpetuate the intergenerational transmission of poverty very effectively, and ensure that the American dream is rapidly becoming the American illusion.” The U.S. has the highest youth and infant mortality rates among wealthy countries. U.S. citizens live “shorter and sicker” lives than those of other prosperous democratic nations.

When public officials lament the way that COVID-19 is engulfing black communities, the larger question is, what are they prepared to do about it? The immediate answer should be the rapid

expansion of Medicaid and Medicare. But access to health care is only one small piece of the dynamic that compromises the health of African-Americans. Good health-care practice must also include relief from the threat and stress of evictions. Black women constitute about forty-four per cent of those who are evicted from their homes in urban areas; as a result, they disproportionately experience homelessness and depression and, in extreme cases, commit suicide. Good health care means higher-paying jobs that allow black women and their families to worry less about monthly bills and the costs of child care and education. Black women in Louisiana, the state where African-Americans face the highest mortality rates from COVID-19, make forty-seven cents to every dollar made by white men.

We periodically endure national crises that force us to look at the poverty and inequality that exist all around us. We hear those in power, including elected officials, breathlessly discuss the shameful conditions that produce these outcomes, but they pledge little in terms of specific policies and concrete actions to reverse them. Trump says that the higher rates of black death are “a tremendous challenge. . . . We want to find the reason to it.” Dr. Anthony Fauci, the director of the National Institute of Allergy and Infectious Diseases, who dutifully accompanies Trump to his press briefings, provided an explanation that included existing health problems, but, Fauci concluded, “There is nothing we can do about it right now except to give them the best possible care and to avoid complications.”

Expressions of concern, well wishes, and promises of “a very robust multilayered response” sound good at press conferences. But many elected officials who tell us that they mean well are so trapped by a prevailing hostility to spending in order to rebuild the public sector that they are unable to reach actual solutions. In the midst of this surging pandemic, the mayor of Philadelphia, Jim Kenney, a Democrat, recently announced a round of budget cuts and reduced services, saying, “It’s not going to be easy, and it’s not going to be pleasant . . . but, at the end of it, we need a balanced budget.”

Philadelphia is the poorest of the large American cities where African-Americans are suffering the most from the COVID-19 outbreak. And, at just the moment when many are highlighting the ways that inequality and our poor civic infrastructure are failing the public—especially the black public—the mayor has announced “unpleasant” budget cuts.

It’s not just Philadelphia. For decades, across the country, cities large and small have been committed to a development model that prioritizes attracting private corporations with promises of tax relief

while neglecting to invest heavily in public institutions. Instead, public hospitals have been closed, public housing has been detonated or left in disrepair, public schools have been starved of investment, and public health clinics have been shuttered. Even as the horrifying consequences of these political choices during the COVID-19 epidemic appear in news stories across the country, elected officials have no meaningful plans to change course.

Knowledge alone about these health disparities and the racism in which they are rooted will not be enough to inspire action by elected officials or government entities. When Hurricane Katrina exposed the brutal racism of the Gulf Coast, it did not lead to a new regime of robust investments in the public sector or an infusion of high-paying jobs to pull African-Americans out of poverty. Instead, corporate vultures and their public enablers forced the closure of nearly all of the city's public schools, which were "auctioned off" to charters. The New Orleans City Council voted unanimously to tear down public housing undamaged by the hurricane. And tens of thousands of black New Orleanians were given one-way tickets out of the city, and then disparagingly referred to as "refugees" in their own country. Unless public spending is restored and coupled with access to high-paying employment, preventive and emergency health care, and safe, secure, and affordable housing, then it is hard to take seriously the expressions of outrage at the poverty and racism in this country.

In the past month, we have seen that it is possible for local and national governments to act in ways that protect people. The federal government has suspended interest and collection of federal student-loan payments until September, and the Department of Housing and Urban Development has declared a moratorium on foreclosures and evictions of government-insured mortgages. Some cities and states have halted evictions from rental properties, and municipalities across the country have released thousands of people from jails and prisons. Local law enforcement has pledged not to make arrests for misdemeanor offenses. In Detroit, officials pledged to stop turning people's water off when they can't pay their bills. If all of these actions are possible in a national emergency, because we believe that they will mitigate people's vulnerability to disease and death, then why can't this always be the standard? After all, when is it ever a good time to turn off someone's access to potable water? One cannot continue to decry the rising rates of black death while preparing to change not a single thing about our failing political and economic systems.

The difficulty in making these decisions is not only about a lack of political will. In 1968, during another period of social upheaval, Martin Luther King, Jr., explained that the power of the black

movement lies not only its capacity to fight for the rights of African-Americans but in its revelation of the “interrelated flaws” of American society, including “racism, poverty, militarism, and materialism.” The “black revolution,” King continued, has the power to expose “the evils that are rooted deeply in the whole structure of our society. It reveals systemic rather than superficial flaws and suggests that radical reconstruction of society itself is the real issue to be faced.”

Even when the flaws in our society are so easy to point out, resolving them comes into immediate conflict with the very basic assumptions of governance in the country today. Repairing the deep, historical, and continuing harm done to black people will require deep, abiding transformations. It was true when King wrote these words, more than a half century ago, and it has never been truer than it is today. To fulfill the promise that black lives matter, the United States must change in systemic and not superficial ways.

A GUIDE TO THE CORONAVIRUS

- How to practice social distancing, from responding to a sick housemate to the pros and cons of ordering food.
- How the coronavirus behaves inside of a patient.
- Can survivors help cure the disease and rescue the economy?
- What it means to contain and mitigate the coronavirus outbreak.
- The success of Hong Kong and Singapore in stemming the spread holds lessons for how to contain it in the United States.
- The coronavirus is likely to spread for more than a year before a vaccine is widely available.
- With each new virus, we've scrambled for a new treatment. Can we prepare antivirals to combat the next global crisis?
- How pandemics have propelled public-health innovations, prefigured revolutions, and redrawn maps.
- What to read, watch, cook, and listen to under coronavirus quarantine.