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RACE, RISK, AND PERSONAL RESPONSIBILITY IN THE RESPONSE TO COVID-19

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The COVID-19 crisis has tragically revealed the depth of racial inequities in the United States. This Piece argues that the disproportionate impact of the pandemic on racial minorities is a symptom of a failing approach to public health, one that privileges individual behaviors over the structural conditions that generate vulnerability and inequitable health outcomes. Despite clear racial disparities in illness and deaths, the neoliberal ideology of personal responsibility shifts the onus for mitigation of risk away from the social and legal determinants of health and onto the individual. To understand how and why these disparate racial outcomes arise, this Piece offers an account of the theoretical frameworks that underpin the personal responsibility approach to public health and argues that it is necessary to foreground the social determinants of health in the response to the pandemic.

INTRODUCTION

As SARS-CoV-2 began to spread through the American population, a seemingly simple piece of public health advice took center stage: Wash your hands for twenty seconds.[1] Public health officials offered a tip for counting out twenty seconds: Sing the "Happy Birthday" song twice.[2] Yet what might have seemed like an easy individual behavior change exercise

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1. See, e.g., Coronavirus Disease (COVID-19) Advice for the Public, WHO, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public [https://perma.cc/H2ZT-72WN] (last updated Mar. 3, 2021); COVID-19: How to Protect Yourself & Others, CDC, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html [https://perma.cc/7P6X-7X6H] [hereinafter CDC, How to Protect Yourself] (last updated Feb. 4, 2021) ("Wash your hands often with soap and water for at least 20 seconds . . . .").

2. When and How to Wash Your Hands, CDC, https://www.cdc.gov/handwashing/when-how-handwashing.html [https://perma.cc/8W7M-RK2S] (last updated Nov. 24, 2020).

to many in fact constituted a significant structural burden for some. This included the predominantly Black community in Flint, Michigan that was still struggling to get access to clean water years after a contamination crisis.[3] The crisis stemmed from the decision to switch Flint's drinking water supply from Detroit's safe water system to the polluted Flint River.[4] This drastic cost-cutting measure reflected a tragic combination of neoliberal municipal governance and criminal negligence by the former Governor of Michigan and other city and state officials.[5] For this community, the options were: wash your hands frequently and increase exposure to contaminants, or minimize handwashing to save the costs of bottled water and increase risk of exposure to SARS-CoV-2.[6] As the case of Flint suggests, people's abilities to alter their individual behaviors to mitigate public health risk are directly shaped by the structural conditions under which they live, and in the case of Flint residents, by the conditions that generated a systemic crisis around access to clean water.

The water crisis in Flint, Michigan is a stark example of how the focus on individual behavior change ignores deep-seated structural inequalities that place disproportionate burdens on lower-income populations of color in the context of a public health crisis. As such, the individual-behavior approach misdirects policy attention and misallocates scarce resources in

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3. Mitch Smith, Julie Bosman & Monica Davey, Flint's Water Crisis Started 5 Years Ago. It's Not Over., N.Y. Times (Apr. 25, 2019), https://www.nytimes.com/2019/04/25/us/flint-water-crisis.html (on file with the *Columbia Law Review*) (reporting continued consumption of bottled water as residents fear lead poisoning from the city's pipes).

4. Id.

5. The Natural Resources Defense Council (NDRC) describes how the Flint River has for decades been a waste-disposal site for treated and untreated industrial waste from meatpacking plants, auto factories, lumber yards, and paper mills, as well as toxins from leaching landfills and raw sewage from the city's waste-treatment plant. For a description of the roots of the crisis, including the role of municipal cost-cutting, see, e.g., Melissa Denchak, Flint Water Crisis: Everything You Need to Know, NRDC (Nov. 8, 2018), https://www.nrdc.org/stories/flint-water-crisis-everything-you-need-know [https://perma.cc/SK52-GJKH]. For an analysis of cost-cutting as neoliberal municipal governance generally, see Bob Jessop, Liberalism, Neoliberalism, and Urban Governance: A State-Theoretical Perspective, 34 Antipode 452, 454–55, 459 (2002). For a discussion of the role of neoliberal governance in the Flint water crisis specifically, see David Fasenfest, A Neoliberal Response to an Urban Crisis: Emergency Management in Flint, MI, 45 Critical Socio. 33, 34–35 (2019). The mishandling of the crisis resulted in charges of criminal negligence against former Governor Rick Snyder and other officials. See Former Michigan Governor Charged in Flint Water Crisis, Along with 8 Others, NPR (Jan. 14, 2021), https://www.npr.org/2021/01/14/956927651/former-michigan-governor-charged-in-flint-water-crisis-along-with-8-others [https://perma.cc/U7WE-B4WL].

6. This was not the only problem. The combination of contaminated water and a lack of water had led the local population to develop some of the underlying health conditions that made the SARS-CoV-2 virus more hostile. See Leonard N. Fleming, COVID-19 Compounds Flint's Woes After Contaminated Water Crisis, Detroit News (June 2, 2020), https://www.detroitnews.com/story/news/local/michigan/2020/06/02/covid-19-compounds-flints-woes-after-contaminated-water-crisis/5221851002 [https://perma.cc/D5BQ-MVPW] (last updated June 15, 2020).

the midst of a pandemic. This approach has been critiqued by scholars and practitioners who argue that health outcomes are not only products of individual-level factors, whether behavioral or genetic, but rather are shaped by social risks and conditions that individuals, households, and communities face at home, school, and work.[7] This insight can be dated back to the early twentieth-century work of W.E.B. DuBois, who identified the relationship between poverty, racism, and health inequities, arguing that "[t]he Negro death rate and sickness are largely matters of [social and economic] condition[s] and not due to racial traits and tendencies."[8]

These social and economic conditions are referred to as "social determinants of health."[9] They encompass a range of social and environmental factors that shape inequitable health outcomes, including income and social protection, employment, housing and physical insecurity, discrimination and social exclusion, and access to health services.[10] Structural causes of health inequities, however, are not only socioeconomic and environmental. The legal system has also contributed to the production of the background conditions that lead to extreme health disparities and lay the foundation for poor health outcomes among vulnerable populations, particularly racial minorities. Legal rules shape access to decent housing and clean water as well as employment relations and working conditions, all of which have a direct relationship to people's exposure to the virus and their ability to combat it. Yet, rather than addressing these social determinants of health and the laws that underpin them, the COVID-19 response has exacerbated the problem. Structural causes of risk and vulnerability have been ignored while individual behavior changes such as handwashing, wearing masks, maintaining physical distance in public, and staying at home have been promoted as the solution to mitigating the risk of contracting SARS-CoV-2.[11] Crucially, this individual-behavior approach to public health is not idiosyncratic—it is part of a broader shift toward neoliberal modes of public policy and societal governance.[12] Yet the staggering death toll of the past thirteen months that has been concentrated

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7. See, e.g., Paula Braveman & Laura Gottlieb, The Social Determinants of Health: It's Time to Consider the Causes of the Causes, Pub. Health Reps., Jan.–Feb. 2014, at 19, 20–22 ("A large and compelling body of evidence has accumulated, particularly during the last two decades, that reveals a powerful role for social factors—apart from medical care—in shaping health across a wide range of health indicators, settings, and populations.").

8. Gilbert C. Gee & Chandra L. Ford, Structural Racism and Health Inequities: Old Issues, New Directions, 8 Du Bois Rev. 115, 116 (2011) (second alteration in original) (quoting W.E. Burghardt DuBois, The Health and Physique of the Negro American, 93 Am. J. Pub. Health 272, 276 (2003)).

9. For an overview of the theoretical and empirical foundations of the social-determinants-of-health approach, see Nancy Krieger, Epidemiology and the People's Health: Theory and Context 163–201 (2011).

10. See id. at 166.

11. See supra notes 3–4 and accompanying text.

12. Neoliberalism is an often used though rarely defined term. See Philip Mirowski, Postface: Defining Neoliberalism, *in* The Road from Mont Pèlerin: The Making of the

amongst people of color has tragically shown that this individual-behavior approach cannot alleviate the deep health disparities caused by structural inequities across both race and socioeconomic class.

This Piece argues that the enormous impact of the pandemic on racial minorities is a symptom of a failing approach to public health, one that privileges individual behavior over structural conditions that generate unequal health outcomes. The story of racial minorities in the COVID-19 crisis, and the inability of minority communities to mitigate the risk of contracting SARS-CoV-2, signals the broader public health crises afoot. Black, Indigenous, and people of color (BIPOC) have borne the brunt of the failed public health response.[13] BIPOC populations in the United States are dying at significantly higher rates and at younger ages than the white population.[14] According to the COVID Racial Data Tracker, Black

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Neoliberal Thought Collective 417, 421 (Philip Mirowski & Dieter Plehwe eds., 2009) [hereinafter The Road from Mont Pèlerin]. Professor Philip Mirowski notes that some legal scholars mistakenly see neoliberalism "as an ideological movement that disempowers the state." Id. This common understanding is deeply misleading, and the definition of neoliberalism as a mode of governance that privileges market-based logics and policies presents a more compelling approach. This Piece uses the term deliberately to refer to specific examples of "actually existing neoliberalism" in the context of the COVID-19 response, particularly the dimension of neoliberal thought that encompasses the "cultural trope" of individual responsibility. Loïc Wacquant, Crafting the Neoliberal State: Workfare, Prisonfare, and Social Insecurity, 25 Socio. F. 197, 213–14 (2010). See generally Neil Brenner & Nik Theodore, Cities and the Geographies of "Actually Existing Neoliberalism", 34 Antipode 349 (2002) (defining and describing the features of "actually existing neoliberalism"); James Ferguson, The Uses of Neoliberalism, 41 Antipode 166 (2009) (providing a sophisticated articulation of the usage of the term "neoliberalism"); Loïc Wacquant, Three Steps to a Historical Anthropology of Actually Existing Neoliberalism, 20 Soc. Anthropology 66 (2012) [hereinafter Wacquant, Three Steps] (describing individual responsibility as a cultural trope). For a discussion of neoliberalism in a legal context, see generally David Singh Grewal & Jedediah Purdy, Introduction: Law and Neoliberalism, 77 Law & Contemp. Probs. 1 (2014).

13. See, e.g., Richard A. Oppel Jr., Robert Gebeloff, K.K. Rebecca Lai, Will Wright & Mitch Smith, The Fullest Look Yet at the Racial Inequity of Coronavirus, N.Y. Times (July 5, 2020), https://www.nytimes.com/interactive/2020/07/05/us/coronavirus-latinos-african-americans-cdc-data.html (on file with the *Columbia Law Review*).

14. Ladan Golestaneh, Joel Neurgarten, Molly Fisher, Henny H. Billett, Morayma Reyes Gil, Tanya Johns, Milagros Yunes, Michele H. Mokrzycki, Maria Coco, Keith C. Norris, Hector R. Perez, Shani Scott, Ryung S. Kim & Eran Bellin, The Association of Race and COVID-19 Mortality, EClinicalMedicine, Aug. 2020, at 1, 5. There is also an issue of unequal enforcement. Beginning in May 2020, thousands of police officers were deployed in New York to enforce social-distancing and mask orders. Ashley Southall, Scrutiny of Social-Distance Policing as 35 of 40 Arrested Are Black, N.Y. Times (May 7, 2020), https://www.nytimes.com/2020/05/07/nyregion/nypd-social-distancing-race-coronavirus.html (on file with the *Columbia Law Review*) (last updated Nov. 30, 2020). Images of their enforcement attempts quickly went viral on Twitter. E.g., Zellie Imani (@zellieimani), Twitter (May 3, 2020), https://twitter.com/zellieimani/status/1257094389396054016 (on file with the *Columbia Law Review*). Observers noticed a stark contrast: While the police were caught on camera beating people of color in some parts of the city, in others—those densely populated by white people—police handed out masks. Press Release, Letitia James, N.Y. Att'y Gen., AG James Calls on the NYPD to Ensure Equal Social Distancing Enforcement in NYC

people have died at a forty-nine percent higher rate than white people, while Native American and Latinx death rates have been forty percent and twenty-three percent higher than that of the white population, respectively.[15] The data on mortality rates by age group tells an even more shocking story of racial disparity: Between February and July 2020, Black mortality rates were 7.1 times higher than white mortality rates for persons aged 25 to 34 years, 9.0 times higher for persons aged 35 to 44 years, and 7.4 times higher for persons aged 45 to 54 years.[16] Yet despite these clear racial disparities in deaths, the ideology of personal responsibility continues to animate the public health response to the COVID-19 pandemic, shifting the onus for mitigation of risk away from the social and legal determinants of health and onto the individual. This racialized impact of COVID-19 tells a tragic story about a fundamentally misguided approach to the pandemic response. The current response relies too heavily on changing individual behavior and has not taken into account the structural determinants of risk and vulnerability that are actually driving this pandemic.[17]

The rest of this Piece is organized as follows: As background, Part I offers a brief genealogy of the neoliberal origins of the personal-responsibility approach and of how changing individual behaviors became central to responding to public health crises. Part II then describes a counterproject in which advocates and experts have begun to highlight the social determinants of health as a superior approach to understanding why lower-income people of color experience poor health outcomes. This latter perspective helps us understand why communities of color have been unable to mitigate the risk of contracting SARS-CoV-2. Finally, Part III shows how the experiences of the BIPOC community in the context of

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Communities (May 13, 2020), https://ag.ny.gov/press-release/2020/ag-james-calls-nypd-ensure-equal-social-distancing-enforcement-nyc-communities [https://perma.cc/9VWF-9V86]. Class does not offer a protective effect—in the same higher wealth quintiles, Black people die at a higher rate than white people. Shirley Sze, Daniel Pan, Clareece R. Nevill, Laura J. Gray, Christopher A. Martin, Joshua Nazareth, Jatinder S. Minhas, Pip Divall, Kamlesh Khunti, Keith R. Abrams, Laura B. Nellums & Manish Pareek, Ethnicity and Clinical Outcomes in COVID-19: A Systematic Review and Meta-Analysis, EClinicalMedicine, Dec. 2020, at 1, 15.

15. The COVID Racial Data Tracker, COVID Tracking Project, https://covidtracking.com/race (on file with the *Columbia Law Review*) (last visited Mar. 7, 2021).

16. Mary T. Bassett, Jarvis T. Chen & Nancy Krieger, Variation in Racial/Ethnic Disparities in COVID-19 Mortality by Age in the United States: A Cross-Sectional Study, PLOS Med., Oct. 2020, at 1, 5. Mortality rates for Latinx populations relative to the white population were almost the same: 7.0 times higher in the 25 to 34 age cohort, 8.8 times higher in the 35 to 44 age cohort, and 7.0 times higher in the 45 to 54 age cohort. Id.

17. The focus on the individual is aligned with the broader trend toward personal responsibility in welfare and public health since the 1980s—a discourse that was furthered, in part, by racial narratives, including that of the "welfare queen." See Kaaryn S. Gustafson, Cheating Welfare: Public Assistance and the Criminalization of Poverty 15 (2011) ("The welfare queen serves as a vehicle—for those across the political spectrum—to discuss the proper role of government and to discuss individual behavior and personal responsibility.").

COVID-19 exemplify a tragic policy imbalance between individual-behavior and structural approaches to addressing public health amid the current pandemic.

I. THE TURN TO INDIVIDUAL RESPONSIBILITY IN THE RESPONSE TO PUBLIC HEALTH CRISES

The primary guidance from the CDC—the federal agency tasked with leading the COVID-19 response—focuses on individual behaviors rather than structural determinants of public health outcomes. A full year into the pandemic, the CDC website provides the following advice to mitigate the risk of contracting SARS-CoV-2: Wear a mask, social distance, avoid travel, wash your hands, and clean and disinfect surfaces.[18] The agency advises people to wear masks in public (noting that masks are not a substitute for social distancing); to avoid crowds; and for those living in shared living situations, to maintain at least a six-foot distance from household members who may be sick.[19] In other words, the CDC emphasizes individual actions over structural responses.[20] In doing so, the CDC ignores the lived realities of millions of Americans who live in multigenerational households, experience overcrowded housing or worse, face housing instability and outright homelessness, have no alternative transportation options besides public transit, and have little control over their working conditions.[21] The

18. CDC, How to Protect Yourself, supra note 1.

19. Id.

20. Ironically, the CDC has a section on its website about the social determinants of health, which it describes as "conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks [sic] and outcomes," with references to CDC research that employs the concept. Social Determinants of Health: Know What Affects Health, CDC, https://www.cdc.gov/socialdeterminants/index.htm [https://perma.cc/379M-X83B] [hereinafter CDC, Social Determinants of Health] (last updated Jan. 26, 2021).

21. See, e.g. Mariana C. Arcaya, Yael Nidam, Andrew Binet, Reann Gibson & Vedette Gavin, Rising Home Values and COVID-19 Case Rates in Massachusetts, Soc. Sci. & Med., Nov. 2020, at 1, 4–5 ("Crowding, doubling up, homelessness, and taking on part-time work in jobs that carry COVID-19 exposure risk may help explain how rapidly increasing home values and unaffordable housing create geographic and social disparities in COVID-19 outcomes."); Rebecca Bentley & Emma Baker, Housing at the Frontline of the COVID-19 Challenge: A Commentary on "Rising Home Values and COVID-19 Case Rates in Massachusetts", Soc. Sci. & Med., Nov. 2020, at 1, 1–2 ("This paper reminds us that our most important public health levers sit outside of primary health care . . . . In the absence of a vaccine, both our housing, and our housing systems, have an important role to play."); David Robinson & Justin Steil, Eviction Dynamics in Market-Rate Multifamily Rental Housing, Hous. Pol'y Debate, Dec. 2020, at 1, 3 ("[N]eighborhood-level findings [demonstrate] that the racial composition of the neighborhood is a stronger predictor of eviction filings than the economic characteristics of that neighborhood, which suggests that addressing evictions requires addressing the ways that structural racism, specifically anti-Black policies and attitudes, has pervaded housing markets and metropolitan neighborhood structures."). For potential strategies for using housing policy as a tool to mitigate COVID-19 risk, see Emily A. Benfer, David Vlahov, Marissa Y. Long, Evan Walker-Wells, J.L. Pottenger, Jr., Gregg Gonsalves & Danya E. Keene, Eviction, Health Inequity, and the Spread of COVID-19:

CDC guidance further conceals the role of state and private actors (including employers and landlords) in creating these housing, transportation, and employment environments that make it impossible to follow CDC guidance. The individual-behavior and personal-responsibility tenor of the COVID-19 response is not new: It is a product of the "neoliberal turn" that has transformed virtually all arenas of public policy since the 1970s.[22] It haunts the response to public health crises in the United States including epidemics that preceded COVID-19.[23]

In recent years, several scholarly works have dated the neoliberal turn to the postwar period.[24] By using the term "neoliberalism," we refer to the emergence of a market-oriented mode of societal governance coupled with the rise of the ideology of personal responsibility and the demise of broad-based, state-sponsored welfare provisions, including universal healthcare. The rise of neoliberalism was not accidental: It was the product of an intellectual movement that began in the 1930s and increasingly gained political and economic support through the postwar period, ultimately becoming hegemonic by the 1980s. The growing influence of the philosophical approaches of Friedrich Hayek and other members of the Mont Pèlerin Society laid the groundwork for a market-oriented

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Housing Policy as a Primary Pandemic Mitigation Strategy, J. Urb. Health, Feb. 2021, at 1, 8 ("Housing displacement and eviction prevention can be a key component of a comprehensive strategy to control the pandemic by reducing COVID-19 infection, transmission, illness, hospitalizations, and death and to address health inequity.").

22. Adam Gaffney, The Neoliberal Turn in American Health Care, 45 Int'l J. Health Servs. 33, 34 (2015); see also Harald Schmidt & Allison K. Hoffman, The Ethics of Medicaid's Work Requirements and Other Personal Responsibility Policies, 319 JAMA Viewpoint 2265, 2265 (2018) (describing the consideration of work requirements as a condition of receiving Medicaid benefits); Daniel Goldberg, The Problem with Individual-Level Interventions to Curb the COVID-19 Pandemic, Harv. L. Petrie-Flom Ctr.: Bill of Health (Dec. 9, 2020), https://blog.petrieflom.law.harvard.edu/2020/12/09/individualism-covid-pandemic-public-health [https://perma.cc/54NR-ARTJ] ("The failure to control the COVID-19 pandemic in the United States rests, in part, on the individualistic nature of our public health responses."); Allison K. Hoffman, The Unhealthy Return to Individual Responsibility in Health Policy, Harv. L. Petrie-Flom Ctr.: Bill of Health (Jan. 16, 2017), https://blog.petrieflom.law.harvard.edu/2017/01/16/the-unhealthy-return-to-individual-responsibility-in-health-policy [https://perma.cc/8S7H-J9WW] ("[Former Speaker of the House Paul] Ryan's assumption—a theme also echoed in the other major Republican proposals on the table—is that personal responsibility will serve as a salve to the wounds of the American healthcare system.").

23. Vicente Navarro, The Consequences of Neoliberalism in the Current Pandemic, 50 Int'l J. Health Servs. 271, 271–72 (2020).

24. See, e.g., Fred Block & Margaret R. Somers, The Power of Market Fundamentalism 19–22 (2014); David Harvey, A Brief History of Neoliberalism 39–63 (2005); Quinn Slobodian, Globalists: The End of Empire and the Birth of Neoliberalism 121–25 (2018); Daniel Stedman Jones, Masters of the Universe: Hayek, Friedman, and the Birth of Neoliberal Politics 85–133 (2012); François Denord, French Neoliberalism and Its Divisions: From the Colloque Walter Lippmann to the Fifth Republic, *in* The Road from Mont Pèlerin, supra note 12, at 45–55.

worldview that has since been applied to healthcare policy.[25] Neoliberals took specific aim at statist policies that relied on government technocracy to organize the economy and deliver public services. Hayek famously argued that state planners can never capture the amount of knowledge of individual preferences to effectively coordinate a large-scale economy: Only the market could accomplish such a complex task.[26] In the arena of health, Dr. Adam Gaffney argues that Hayek's views helped cement the idea that people's preferences for healthcare were relative to their other needs: There is nothing special about healthcare relative to any other good that an individual may desire. "In other words, crudely speaking, one person might prefer paying rent to having a mammogram, while another might take a needed heart surgery over a week on vacation."[27] Thus, following Hayek, there would be no way for the state to objectively determine the desired standard of healthcare services preferred by each individual person, but the market could accurately reveal individual preferences.

Despite ideological and policy battles over the ensuing decades, this view has largely prevailed and undergirds the consumerist model for healthcare that we have today. This model imagines healthcare users to be rational consumers of health services whose willingness to pay accurately represents their healthcare needs.[28] As a result, the prior distribution of resources that shaped an individual's inability to access care was essentially erased from this market-oriented perspective on healthcare. This included the role of the government in shaping the ability of racial minorities to "choose" care, as exemplified in the Hospital Survey and Construction Act of 1946 (also known as the Hill–Burton Act).[29] Hill–Burton earmarked

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25. Denord, supra note 24, at 45–55; Gaffney, supra note 22, at 36–37 (describing Hayek's view of healthcare neoliberalism and discussing the rise of such views as the basis of healthcare philosophy in the United States and Great Britain).

26. See F.A. Hayek, The Use of Knowledge in Society, 35 Am. Econ. Rev. 519, 519–20 (1945); see also Eugene F. Miller, Hayek's *The Constitution of Liberty*: An Account of Its Arguments 149–54 (2010) (describing Hayek's criticism of unitary state systems and preference for a state-assisted but decentralized model).

27. Gaffney, supra note 22, at 38. Gaffney describes Hayek's neoliberal argument against free state-provided healthcare on the philosophical point that people's healthcare needs did not have "an objectively ascertainable character" and thus should not be provided. See Miller, supra note 26, at 67–71. Note that in his earlier work, Hayek did seem to think that some basic social welfare system was necessary and possible. See F.A. Hayek, The Road to Serfdom: Text and Documents, The Definitive Edition 147–49 (Bruce Caldwell ed., 2007) ("But there is no incompatibility in principle between the state's providing greater security in this way and the preservation of individual freedom.").

28. Gaffney, supra note 22, at 37 ("Health care should therefore be distributed like other commodities: according to the tastes of the individual consumer, each of whom acts as a rational actor in electing to purchase the quantity and quality of health care goods that he or she desires."). For information on the economic model of rational calculating behavior, see generally Gary S. Becker, The Economic Approach to Human Behavior (1976).

29. Hospital Survey and Construction Act of 1946, Pub. L. No. 79-725, 60 Stat. 1040 (codified as amended at 42 U.S.C. §§ 291–291m (1946)). The Hill–Burton Program was

resources for healthcare modernization but allowed states to continue to segregate hospitals while receiving the federal funds under a separate-but-equal philosophy.[30]

Despite calls to expand access to healthcare through the 1970s, the election of President Ronald Reagan ushered in new support for a neoliberal perspective on issues of social welfare.[31] Reagan vilified people on welfare as the "undeserving poor"—unworthy recipients of government support.[32] He racialized the provision of welfare support through the caricature of the "welfare queen"—a Black woman defrauding the welfare system to live a life of luxury.[33] This myth proved remarkably effective as a rhetorical device to undo the welfare system.[34] It not only tied in with deeply entrenched racist stereotypes in a moment of post–Civil Rights race-based political realignment but also underscored what Loïc Wacquant has termed the neoliberal cultural trope of individual responsibility.[35] As welfare support was removed, people with low incomes suffered, particularly those in vilified communities of color.[36] Thus, while race was formally absent in the policies that promoted individual responsibility, it was fundamental to the underlying political logic that fueled the rise of the neoliberal approach.

It was in the midst of this assault against people on welfare that HIV/AIDS began its deadly journey through Black and brown bodies.[37] Although often ignored in the early part of the epidemic, intense advocacy efforts directed the attention of scientists and public health experts, including CDC officials, toward marginalized communities of color.[38] It was because of these activists' calls for greater attention to the epidemic, and a growing sense that the epidemic was far larger than was being

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updated in 1975. See Pub. L. No. 93-641, 88 Stat. 2268 (1975) (codified as amended at 42 U.S.C. §§ 300q–300t (1979)).

30. Emily A. Largent, Public Health, Racism, and the Lasting Impact of Hospital Segregation, 133 Pub. Health Reps. 715, 715 (2018).

31. See Block & Somers, supra note 24, at 198 (explaining the rise in the conservatism movement in the 1970s and its embrace of market freedom and hostility toward government intervention); Gustafson, supra note 17, at 35–41 ("From the first moment of his bid for presidential election in 1980s, Ronald Reagan used anecdotes about welfare queens to exemplify everything he believed wrong with government programs—excessive spending on domestic programs and misuse of government money.").

32. Block & Somers, supra note 24, at 175; Brian Steensland, Cultural Categories and the American Welfare State: The Case of Guaranteed Income Policy, 111 Am. J. Socio. 1273, 1274 (2006).

33. Gustafson, supra note 17, at 35–36.

34. Id.

35. Wacquant, Three Steps, supra note 12, at 72–74.

36. Gustafson, supra note 17, at 36, 40; Keith Wailoo, Pain: A Political History 1–12 (2014).

37. Cathy Cohen, Boundaries of Blackness: AIDS and the Breakdown of Black Politics 79, 86 (1999).

38. Id. at 20–24, 91–148; Deborah B. Gould, Moving Politics: Emotion and ACT UP's Fight Against AIDS 4–5 (2009).

documented by experts, that the government began to finally pay attention.

The increased attention to AIDS by the public sector rubbed scholars in the emerging field of law and economics the wrong way. This was most clear in the work of Professor Tomas Philipson and Judge Richard Posner. In a 1993 book, *Private Choices and Public Health: The AIDS Epidemic in Economic Perspective*, Philipson and Posner outlined a new way of thinking about the risk of AIDS and its transmission.[39] They began to advocate for a new mode of examining epidemics which they call economic epidemiology.[40] They challenged the idea that it was necessary to have governmental intervention in the HIV/AIDS pandemic. Instead, they offered a market-oriented approach that treated an "individual's choice between safe and risky sex . . . as a rational decision."[41]

Crucially, by conceptualizing human behavior as rational decisionmaking based on individual risk–reward calculus, Philipson and Posner's behavioral model makes room for incentives—and hence law and public policy—to guide the behavior of those who are in the position to make these decisions (such as getting tested for HIV).[42] They take specific aim at epidemiology as a field that, as they argue, assumes that individuals have to "expose themselves, or [have] to avoid exposing themselves" to risk of infection.[43] According to Philipson and Posner, epidemiologists do this through studies that assume one can use randomized groups of people to understand population health and welfare decisions at the individual level.[44] In doing so, epidemiologists ignore the mechanisms through which information and incentives impact behavioral change and individual choice. By centering the rational individual, Philipson and Posner argue that one can treat the decisions made in the AIDS pandemic in the same way as decisions made in any other market context that economists study.[45]

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39. Tomas J. Philipson & Richard A. Posner, Private Choices and Public Health: The AIDS Epidemic in Economic Perspective (1993).

40. Id. at 52. For a critical elaboration of the tendencies of neoclassical economists—such as Posner's Chicago School colleagues, particularly Gary Becker—to "colonize" other social science disciplines, including epidemiology and law, see generally Ben Fine & Dimitris Milonakis, From Economics Imperialism to Freakonomics: The Shifting Boundaries Between Economics and Other Social Sciences (2009).

41. Philipson & Posner, supra note 39, at 4.

42. Philipson and Posner's identification of the role of incentives is consistent with the conceptualization of neoliberalism as the mode of governance where states engage in the "marketcraft" that is advocated in this Piece. For information on neoliberalism as re-regulation and "marketcraft," see generally Steven K. Vogel, Marketcraft: How Governments Make Markets Work (2018); Jedediah Britton-Purdy, David Singh Grewal, Amy Kapczynski & K. Sabeel Rahman, Building a Law-and-Political-Economy Framework: Beyond the Twentieth-Century Synthesis, 129 Yale L.J. 1784, 1794–818 (2020); Greta R. Krippner, The Making of U.S. Monetary Policy: Central Bank Transparency and the Neoliberal Dilemma, 36 Theory & Soc'y 477, 477–513 (2007).

43. Philipson & Posner, supra note 39, at 5.

44. Id.

45. Id.

They argue that a person who is contemplating sexual intercourse, or sharing a hypodermic needle, takes "optimal measures to adjust to the risk of infection."[46] In addition to ignoring structural forces that drive people toward drug use, they do not acknowledge that a person sharing a needle might be high or driven by addiction and hence their capacity for "rational" decisionmaking may be impaired. By focusing on individuals as rational decisionmakers and treating the HIV/AIDS context like a market, Philipson and Posner argue that the role of the state in addressing the AIDS pandemic should be directed away from social-welfare provisions and health services and toward creating and enforcing background rules and incentives to shape behavioral outcomes.[47]

Philipson and Posner's approach was based on a neoclassical economic model of human behavior underpinned by strict—and unrealistic—behavioral assumptions.[48] This approach had long been criticized by heterodox economists, but it also came under internal attack as mainstream economists sought to explain real-world deviations from the neoclassical behavioral ideal.[49] As the subfields of information economics and behavioral economics grew in the 1980s and 1990s, so did the idea that an alternative approach to addressing public health crises, like obesity or diabetes,[50] would be to improve the decisionmaking ability of individuals.[51] Behavioral economics challenged the idea of a purely rational

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46. Id. at 6.

47. Id. They have two exceptions. Philipson and Posner permit the government to retain an active role in addressing the AIDS pandemic by administering a universal mandatory testing program and criminalizing nondisclosure of HIV status—i.e., disincentivizing risk of transmission through criminal law. Id.

48. Philipson and Posner assumed that humans were strictly rational and had perfect information, and they imposed high cognitive demands on individuals who were expected to make complex calculations quickly and consistently regardless of external social and institutional context. For an early and powerful internal critique, see generally Amartya K. Sen, Rational Fools: A Critique of the Behavioral Foundations of Economic Theory, 6 Phil. & Pub. Affs. 317 (1977).

49. Heterodox critiques came from a variety of perspectives, including feminist economists who made gender-based critiques and economists of race who highlighted the role of race as a structural variable—and racism as a systemic process of hegemony—in shaping behavior and socioeconomic outcomes. For information on feminist critiques, see generally Nancy Folbre, Who Pays for the Kids? Gender and the Structures of Constraint (1994). For information on race-based critiques, see generally Robert Higgs, The Question of Discrimination: Racial Inequality in the United States Labor Market: Essays (Steven Shulman & William Darity, Jr., eds., 1989).

50. See, e.g., Angela J. Jacques-Tiura & Mark K. Greenwald, Behavioral Economic Factors Related to Pediatric Obesity, 63 Pediatric Clinics N. Am. 425, 443–44 (2016) (applying behavioral economics to the policy framework for child obesity).

51. Richard H. Thaler & Cass R. Sunstein, Nudge: Improving Decisions About Health, Wealth, and Happiness 1–14 (2009) (advocating for targeted policy "nudges" to influence individuals' decisionmaking behavior in areas such as health); see also Russell Korobkin, Three Choice Architecture Paradigms for Healthcare Policy, *in* Nudging Health: Health Law and Behavioral Economics 15, 15–26 (I. Glenn Cohen, Holly Fernandez Lynch & Christopher T. Robertson eds., 2016). For information on how the economics of

individual, instead arguing that people were rational within certain bounds shaped by cognitive factors, including systematic bias or the interplay of psychological forces.[52] Taking behavioral economics seriously meant challenging the notion of a purely rational individual and rethinking the role of regulation in helping people make optimal decisions. As Professors Cass Sunstein and Richard Thaler famously put it, the state should occasionally "nudge" people into making the right decision for their health rather than simply designing incentives for rational individuals to assess risk and optimize outcomes, or more radically, addressing structural causes of behavior and health outcomes.[53] A person who has borderline diabetes, for example, might be encouraged to buy a smaller soft drink due to regulation mandating calorie labels or size restrictions.[54]

While behavioral economics acknowledged the important role of the state's regulatory capacity in shaping decisions, it is primarily a theory about how individuals make decisions.[55] The focus on the individual had a large impact on the study and practice of public health throughout the 1980s and 1990s.[56] For one, it inspired epidemiologists to ask new questions about the role of incentives in altering risky behavior.[57] But,

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information affects decisionmaking, see generally Joseph E. Stiglitz, The Contributions of the Economics of Information to Twentieth Century Economics, 115 Q.J. Econ. 1441 (2000). For information on the foundational work in behavioral economics, particularly on the role of insights from psychology, see generally Daniel Kahneman, Thinking, Fast and Slow (2011) (discussing the findings of Kahneman's research in collaboration with Amos Tversky). For information on the rise of behavioral economics as a subfield of economics, see generally Richard H. Thaler, Misbehaving: The Making of Behavioral Economics (2015).

52. See Pelle Guldborg Hansen, Laurits Rohden Skov & Katrine Lund Skov, Making Healthy Choices Easier: Regulation Versus Nudging, 37 Ann. Rev. Pub. Health 237, 238 (2016) ("[A]dvances in behavioral economics and cognitive and social psychology . . . have revealed how human behavior and decision making is boundedly rational, systematically biased, and unavoidably habitual owing to the interplay of psychological forces, with what ought to be, from the perspective of rationality, irrelevant features of complex decision-making contexts.").

53. See Thaler & Sunstein, supra note 51, at 72–80 ("[P]eople will need nudges for decisions that are difficult and rare, for which they do not get prompt feedback, and when they have trouble translating aspects of the situation into terms that they can easily understand."); Steven J. Gonzalez, Assisting Personal Responsibility: Using Nudges to Reduce Sugar Consumption, Harv. L. & Pol'y Rev., https://harvardlpr.com/2017/03/17/assisting-personal-responsibility-using-nudges-to-reduce-sugar-consumption [https://perma.cc/QFA5-CA5J] (last visited Jan. 27, 2021).

54. Thaler & Sunstein, supra note 51, at 7, 43–44.

55. Id. at 72–80 (examining psychology to predict decisionmaking).

56. Howard M. Leichter, "Evil Habits" and "Personal Choices": Assigning Responsibility for Health in the 20th Century, 81 Milbank Q. 603, 603–04 (stating that by the end of the 20th century, experts and policymakers "placed much of the blame for seemingly avoidable morbidity and premature mortality on Americans' alleged personal careless and imprudent lifestyle choices").

57. See, e.g., Jill Luoto & Katherine Grace Carman, Inter-American Development Bank, Behavioral Economics Guidelines with Applications for Health Interventions 20–39

perhaps more importantly, it drilled down on an individual and the choices that person makes that increase the risk of that person becoming sick.[58] The idea that individuals made the decisions that controlled their health and destiny dovetailed with the market-oriented political and economic ideology of neoliberal governmentality that, through the 1980s and 1990s, was slashing public services funding across the board while promoting progress through individual entrepreneurship, hard work, and personal responsibility.[59]

II. THE SOCIAL DETERMINANTS OF HEALTH

Despite the rising influence of economics in the discussions about healthcare, social movements seeking access to better health services long highlighted the role of social and economic conditions that affected access to healthcare, including racism.[60] From the 1960s through today, there have been many movements that have called for closer examination of the structural factors that contribute to inequitable health outcomes.[61] These include small and large organizations, such as the Boston Women's Health Collective, the Black Panthers, the Black Women's Health Imperative, Gay Men's Health Crisis, ACT-UP, and Life Force.[62] These groups often focused on the health needs of particular communities (e.g., women, gay men, and Black women). In response to state retrenchment during the

(2014) (noting that many chronic diseases stem from individual behaviors, and applying behavioral economics to health policy design).

58. See id. at 1–4 (suggesting that individual lifestyle choices can affect susceptibility to noncommunicable diseases, such as cardiovascular diseases, cancers, chronic respiratory diseases, and diabetes).

59. See Linda Lobao, Mia Gray, Kevin Cox & Michael Kitson, The Shrinking State? Understanding the Assault on the Public Sector, 11 Cambridge J. Regions, Econ. & Soc'y 389, 390, 399–401 (2018) (describing how neoliberalism across the world led to a decline in public services throughout the 1980s and 1990s).

60. See Beatrix Hoffman, Healthcare Reform and Social Movements in the United States, 93 Am. J. Pub. Health 75, 75 (2003) ("Many grassroots movements, including the civil rights and women's movements and those on behalf of people with particular diseases like AIDS, have demanded changes in the health care system.").

61. See, e.g., Donna Cooper Hamilton & Charles V. Hamilton, The Dual Agenda: Race and Social Welfare Policies of Civil Rights Organizations 155–56 (1997) (explaining how Medicare was endorsed by many civil rights organizations, such as the NAACP); Judy Norsigian, Our Bodies Ourselves and the Women's Health Movement in the United States: Some Reflections, 109 Am. J. Pub. Health 844, 844 (2019) (discussing how the women's health movement in the 1960s expanded to cover other health issues).

62. See, e.g., Mary T. Bassett, Beyond Berets: The Black Panthers as Health Activists, 106 Am. J. Pub. Health 1741, 1741 (2016); Norsigian, supra note 61, at 844; David France, How ACT UP—the Coalition that Fought Against AIDS Stigma and Won Medications that Slowed the Plague—Forever Changed Patients' Rights, Protests and American Political Organizing as It's Practiced Today, N.Y. Times (Apr. 13, 2020), https://www.nytimes.com/interactive/2020/04/13/t-magazine/act-up-aids.html (on file with the *Columbia Law Review*); History, Gay Men's Health Crisis, https://www.gmhc.org/history [https://perma.cc/C8EC-XNZN] (last visited Jan. 25, 2021); Our Story, Black Women's Health Imperative, https://bwhi.org/our-story [https://perma.cc/7FTY-FU4Q] (last visited Jan. 25, 2021).

neoliberal turn, their range of demands expanded to include issues initially considered to be beyond the scope of immediate health service delivery in an acknowledgement that these broader factors also had an impact on people's health outcomes. This was exemplified in the movement to provide housing to AIDS patients in the 1980s—resulting in the organization Housing Works, founded by ACT-UP advocates.[63]

While the need to consider the structural drivers of health outcomes has long been a point of discussion,[64] the idea began to take shape as an institutional response to health inequalities, at least since the 1980s.[65] Experts began to weigh in on the question of how social factors shape individual health outcomes under a new approach called the social determinants of health.[66] The social determinants of health offered a sharply contrasting position to individual behavior and rational choice. It highlighted issues of inequality and structural forces by showing how health outcomes are often set into motion by larger sets of upstream factors, including where a person lives, works, and engages in leisure.[67] In the 2000s, the social-determinants-of-health approach began to enter global public health discourse and practice. Around 2003, the WHO convened experts to form the Commission on the Social Determinants of Health in the "spirit of social justice."[68] The aim was to give support "in tackling the social causes of poor health."[69] The Commission was focused

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63. About Us, Hous. Works, https://www.housingworks.org/about-us [https://perma.cc/K3K9-5S3Z] (last visited Jan. 9, 2021) (describing the organization's "mission to end the dual crises of homelessness and AIDS through relentless advocacy, the provision of lifesaving services, and entrepreneurial businesses that sustain our efforts").

64. For a longer history dating back to the nineteenth century, see generally Dennis Raphael, Social Determinants of Health: Present Status, Unanswered Questions, and Future Directions, 36 Int'l J. Health Servs. 651 (2006) (tracing the phrase "social determinants" to Alvin Tarlov's analysis in Health and Social Organization: Towards a Health Policy for the 21st Century 71–93 (David Blane, Eric Brunner & Richard Wilkinson eds., 1996)). W.E.B. DuBois also wrote about addressing social concerns to better the health of the Black community. See W.E. Burghardt DuBois, The Health and Physique of the Negro American, 93 Am. J. Pub. Health 272, 276 (2003).

65. For a history on the rise of focus on the social determinants of health, see generally Paula Braveman, Susan Egerter & David R. Williams, The Social Determinants of Health: Coming of Age, 32 Ann. Rev. Pub. Health 381, 382 (2011).

66. NCHHSTP Social Determinants of Health, CDC, https://www.cdc.gov/nchhstp/socialdeterminants/index.html [https://perma.cc/K4SY-WC9C] (last updated Dec. 19, 2019).

67. CDC, Social Determinants of Health, supra note 20 ("Differences in health are striking in communities with poor SDOH such as unstable housing, low income, unsafe neighborhoods, or substandard education. By applying what we know about SDOH, we can not only improve individual and population health but we can also advance health equity.").

68. Comm'n on Soc. Determinants of Health, Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health—Final Report of the Commission on Social Determinants of Health (2008) [hereinafter Closing the Gap].

69. Commission on Social Determinants of Health—What, Why and How?, WHO, https://www.who.int/social_determinants/thecommission/finalreport/about_csdh/en [https://perma.cc/EW8S-XN69] (last visited Jan. 25, 2021).

largely on the health inequalities seen between rich and poor countries on the global scale, highlighting a range of structural issues that impact individual health, from the economic aid provided in bilateral assistance to intrahousehold dynamics that leave some family members unable to address health issues.[70] The report concludes, in sum, that "social injustice is killing people on a grand scale."[71] Around the same time, the CDC was also turning toward considerations of social determinants of health, as illustrated by a special issue of the *American Journal of Preventive Medicine* in 2003 that describes the need to focus on social determinants in addressing health concerns.[72] By 2010, the public health institutions of the U.S. federal government at large had begun to center the social determinants of health in their thinking about responding to pandemics, noting that five key determinants of health are: "economic stability, education, social and community context, health and health care, and neighborhood and built environment."[73]

Since the development of the literature on the social determinants of health, scholars have expanded the frame to better understand the role of law in producing and creating the various factors that shape population health.[74] While those focused on a mainstream neoclassical-economics framing considered how to understand actors as rational, and behavioral economists designed interventions to "nudge" individuals toward optimal behaviors, legal scholars who focused on the social determinants of health honed in on the role of the legal and regulatory environment in shaping the background socioeconomic structure, and in turn, health outcomes.[75] Scholars and advocates, for example, would question how landlord–tenant

70. Closing the Gap, supra note 68, at 3–5.

71. Id. at 36.

72. See, e.g., Laurie M. Anderson, Susan C. Scrimshaw, Mindy T. Fullilove, Jonathan E. Fielding & the Task Force on Community Preventive Services, Culturally Competent Healthcare Systems: A Systematic Review, 24 Am. J. Preventive Med. 68, 69–70 (2003); Laurie M. Anderson, Susan C. Scrimshaw, Mindy T. Fullilove, Jonathan E. Fielding & Jacques Normand, The *Community Guide*'s Model for Linking the Social Environment to Health, 24 Am. J. Preventive Med. 12, 18–19 (2003); David E. Hayes-Bautista, Research of Culturally Competent Healthcare Systems, 24 Am. J. Preventive Med. 8, 8–9 (2003) (noting that the promotion of cultural competence in healthcare system is critical for effective health care); G. Thomas Kingsley, Housing, Health, and the Neighborhood Context, 24 Am. J. Preventive Med. 6, 6–7 (2003) (discussing the need for housing, public safety, and workforce development in order to address certain health issues).

73. Social Determinants of Health: Interventions and Resources, Healthy People, https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources [https://perma.cc/7V97-5SJP] (last visited Jan. 25, 2021).

74. Scott Burris, Law in a Social Determinants Strategy: A Public Health Law Research Perspective, 126 Pub. Health Reps. 22, 23 (2011).

75. Id.; Abraham Gutman, Katie Moran-McCabe & Scott Burris, Health, Housing, and the Law, 11 Ne. U. L. Rev. 251, 255–66 (2019).

laws might impact evictions, and in turn homelessness, a contributing factor to many people's poor health.[76] Or how repeat exposure to environmental toxins caused by landlords' failures to maintain decent housing standards, often due to legal and illegal racial discrimination in the housing market, causes increased rates of cancer.[77]

Unlike the law-and-economics focus on the individual, the literature on the social determinants of health focuses on structural constraints to good health, including the mechanisms through which the upstream legal regime produces poor health outcomes. This approach emphasizes the point that the idea of risk is not about a rational individual making a calculated choice, nor is it about access to information. Instead, people's poor health outcomes are often the result of structural factors well outside of their control. To go one step further, the social-determinants-of-health literature helps to highlight how the idea of choice can be dangerous, making it seem as though people have willfully taken up habits or taken risks with agency. This notion of choice allows society to blame individuals' health on their "bad decisions," rather than considering the structural factors that shape health outcomes.

III. COVID-19: STRUCTURAL CONSTRAINTS TO RISK MITIGATION FOR RACIAL MINORITIES

This section turns its focus specifically to the dangers of the individual-responsibility approach to public health and the COVID-19 pandemic, particularly for BIPOC. This Piece argues that, from the moment SARS-CoV-2 was discovered, the response to the COVID-19 pandemic has emphasized the individual behaviors that should be adopted in order to effectively mitigate transmission of the virus.[78] This has included washing your hands for twenty seconds, staying at home, being "socially distant" or six feet apart from another person,[79] and always wearing a mask. As the spread of the virus accelerated through broader swathes of the population and the numbers of people infected and deaths began to spike, states also began to issue public health orders: They announced stay-at-home orders, capacity restrictions in restaurants, general reductions in service industry operations, and "nonessential" business closures to prevent person-to-

76. See, e.g., Arcaya et al., supra note 21, at 4–5; Clare Bambra, Ryan Riordan, John Ford & Fiona Matthews, The COVID-19 Pandemic and Health Inequalities, 74 J. Epidemiology & Cmty. Health 964, 965–66 (2020); Robinson & Steil, supra note 21, at 4.

77. Gutman et al., supra note 75, at 254.

78. See supra notes 1–2 and accompanying text.

79. The six-feet rule is outdated and is now being disproven. See Nicholas R. Jones, Zeshan U. Qureshi, Robert J. Temple, Jessica P.J. Larwood, Trisha Greenhalgh & Lydia Bourouiba, Two Metres or One: What Is the Evidence for Physical Distancing in COVID-19?, BMJ, Aug. 2020, at 1 ("Rules that stipulate a single specific physical distance (1 or 2 metres) between individuals to reduce transmission of SARS-CoV-2, the virus causing covid-19, are based on an outdated, dichotomous notion of respiratory droplet size.").

person spread.[80] Exempt from these rules were "essential services" and "essential workers." Most of these essential services and workers fell into a few specific categories: healthcare; food and agriculture; and certain industrial, commercial, and residential services.[81] The impact of the pandemic on BIPOC communities demonstrates several pathways by which structural inequality impacts the ability of individuals to mitigate their risk of exposure to the virus. The consequences for BIPOC also reveal how social determinants of health have been ignored in the response.

This was most evident in the inability of individuals to control their risk of exposure. For many BIPOC, controlling risk of exposure was nearly impossible, since both places of employment, necessary for financial stability, and the home, necessary for survival, became key sites of risk of exposure. This began early in the pandemic when scores of essential workers—many of whom were already struggling financially as members of the "working poor"—continued to provide essential services, thus facing repeated exposure to the virus.[82] This vulnerability through work is racialized, and it persisted through the winter surge. For example, Latinx mortality rates in hard-hit Los Angeles County have skyrocketed in recent weeks and are now 263 per 100,000 compared to 92 per 100,000 for white county residents as of February 7, 2021.[83] Latinx households are particularly vulnerable to work-related risk: Data shows that Latinx households have "1.6 wage earners per household compared to 1.2 in non-Hispanic households."[84] The second is the relationship between SARS-CoV-2 and underlying health conditions once a person has contracted the virus. These underlying health conditions are often the outcome of a person's

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80. Amanda Moreland, Christine Herlihy, Michael A. Tynan, Gregory Sunshine, Russell F. McCord, Charity Hilton, Jason Poovey, Angela K. Werner, Christopher D. Jones, Erika B. Fulmer, Adi V. Gundlapalli, Heather Strosnider, Aaron Potvien, Macarena C. García, Sally Honeycutt & Grant Baldwin, Timing of State and Territorial COVID-19 Stay-at-Home Orders and Changes in Population Movement—United States, March 1–May 31, 2020, 69 Morbidity & Mortality Wkly. Rep. 1198, 1198 (2020).

81. Celine McNicholas & Margaret Poydock, Who Are Essential Workers?: A Comprehensive Look at Their Wages, Demographics, and Unionization Rates, Econ. Pol'y Inst. (May 19, 2020), https://www.epi.org/blog/who-are-essential-workers-a-comprehensive-look-at-their-wages-demographics-and-unionization-rates [https://perma.cc/2ESV-MV9G].

82. Molly Kinder & Martha Ross, Reopening America: Low-Wage Workers Have Suffered Badly from COVID-19 so Policymakers Should Focus on Equity, Brookings Inst. (June 23, 2020), https://www.brookings.edu/research/reopening-america-low-wage-workers-have-suffered-badly-from-covid-19-so-policymakers-should-focus-on-equity [https://perma.cc/HEL2-F9N3].

83. LA County Daily COVID-19 Data, L.A. Cnty. Dep't of Pub. Health, http://publichealth.lacounty.gov/media/coronavirus/data/index.htm [https://perma.cc/2YGG-LD26] (last updated Feb. 7, 2021) (tracking the "age-adjusted death rates due to COVID-19 per 100K" (cleaned up)).

84. Vivian Ho, Number of Latinos Dying Daily from COVID Soars 1,000% in Los Angeles, Guardian (Jan. 30, 2021), https://www.theguardian.com/us-news/2021/jan/30/los-angeles-coronavirus-latino-deaths-increase-1000 [https://perma.cc/7C78-GHXU].

repeated exposure, sometimes generational exposure, to toxins, stress, and lack of access to adequate healthcare services.[85] Underlying health conditions are more prevalent among the poor, and the pandemic impacts are compounded for racial minorities, for whom formal and informal discrimination results in poor housing conditions, exposure to toxins (including lead), and unstable employment.[86] And yet, the response from public-health agencies emphasized individual behavior change and personal responsibility. For many BIPOC, the home itself became a site of potential transmission. This was particularly true where there were essential workers in the family. For these communities, "stay-at-home" did not translate to staying away from exposure.

Exemptions for essential workers immediately raised red flags for scholars and advocates who recognized the disproportionate risks stemming from the social determinants of health. In many of the industries that remained, such as meat-processing plants and public transportation, employees could not socially distance from coworkers, or they carried out tasks that brought them into close and often repeated contact with strangers.[87] Further, because of the racialized structure of the labor market, many of these employees were Black and Latinx, especially in food and agriculture, and many were women of color, as in healthcare.[88] The

85. Lack of access to adequate healthcare services comes in two forms: (1) dearth of actual services and (2) racism in healthcare settings that impedes access. For a discussion on racism against healthcare providers, see Kimani Paul-Emile, Alexander K. Smith, Bernard Lo & Alicia Fernández, Dealing with Racist Patients, 374 New Eng. J. Med. 708, 708–11 (2016) (discussing the tension between a patient's right to refuse medical treatment and a physician's right to a workplace free from discrimination).

86. See Gutman et al., supra note 75, at 253–55; Sherita Hill Golden, Coronavirus in African Americans and Other People of Color, Johns Hopkins Med. (Apr. 20, 2020), https://www.hopkinsmedicine.org/health/conditions-and-diseases/coronavirus/covid19-racial-disparities [https://perma.cc/C5LH-H7SA].

87. Jasmine Kerrissey & Clare Hammonds, About Two-Thirds of Low-Wage Essential Workers Can't Practice Social Distancing—And They're More Likely to Lack Protections from Coronavirus, Bus. Insider (June 5, 2020), https://www.businessinsider.com/low-wage-essential-workers-cant-social-distance-less-protections-2020-6 [https://perma.cc/4CYS-B8MB]; see also Veena Dubal & Meredith Whittaker, Uber Drivers Are Being Forced to Choose Between Risking COVID-19 or Starvation, Guardian (Mar. 25, 2020), https://www.theguardian.com/technology/2020/mar/25/uber-lyft-gig-economy-coronavirus [https://perma.cc/X2VB-XF53].

88. Charles A. Taylor, Christopher Boulos & Douglas Almond, Livestock Plants and COVID-19 Transmission, 117 Proc. Nat'l Acad. Scis. 31,706, 31,706 (2020) ("[This] study suggests that, among essential industries, livestock processing poses a particular public health risk extending far beyond meatpacking companies and their employees."); Michelle A. Waltenburg, Tristan Victoroff, Charles E. Rose, Marilee Butterfield, Rachel H. Jervis, Kristen M. Fedak, Julie A. Gabel, Amanda Feldpausch, Eileen M. Dunne, Connie Austin, Farah S. Ahmed, Sheri Tubach, Charles Rhea, Anna Krueger, David A. Crum, Johanna Vostok, Michael J. Moore, George Turabelidze, Derry Stover, Matthew Donahue, Karen Edge, Bernadette Gutierrez, Kelly E. Kline, Nichole Martz, James C. Rajotte, Ernest Julian, Abdoulaye Diedhiou, Rachel Radcliffe, Joshua L. Clayton, Dustin Ortbahn, Jason Cummins, Bree Barbeau, Julia Murphy, Brandy Darby, Nicholas R. Graff, Tia K.H. Dostal, Ian W. Pray, Courtney Tillman, Michelle M. Dittrich, Gail Burns-Grant, Sooji Lee, Alisa Spieckerman,

ability to limit risk was directly tied to a person's employment and their overall financial stability. Employment was a key cause of exposure to SARS-CoV-2 for racial minorities, particularly Black and Latinx women, who make up approximately forty to fifty percent of the employees in healthcare settings and nursing homes. [89] For Latinx workers in particular, agricultural work and the meatpacking plants became active hotspots.[90] Eighty-seven percent of the people infected with SARS-CoV-2 in meatpacking plants were racial minorities.[91] Where people were employed in nonessential services—the service industry more broadly, which includes restaurants[92] and nail salons[93]—the pandemic and business closures resulted in financial ruin.[94] This had grave effect on single-parent households and resulted in a boom in housing instability and rising eviction rates.[95]

Kashif Iqbal, Sean M. Griffing, Alicia Lawson, Hugh M. Mainzer, Andreea E. Bealle, Erika Edding, Kathryn E. Arnold, Tomas Rodriguez, Sarah Merkle, Kristen Pettrone, Karen Schlanger, Kristin LaBar, Kate Hendricks, Arielle Lasry, Vikram Krishnasamy, Henry T. Walke, Dale A. Rose & Margaret A. Honein, Update: COVID-19 Among Workers in Meat and Poultry Processing Facilities—United States, April–May 2020, 69 Morbidity & Mortality Wkly. Rep. 887, 887 (2020); Jocelyn Frye, On the Frontlines at Work and at Home: The Disproportionate Economic Effects of the Coronavirus Pandemic on Women of Color, Ctr. for Am. Progress (Apr. 23, 2020), https://www.americanprogress.org/issues/women/reports/2020/04/23/483846/frontlines-work-home [https://perma.cc/WK4D-5PEF]; McNicholas & Poydock, supra note 81.

89. Frye, supra note 88.

90. See Taylor et al., supra note 88, at 31,706–07.

91. Waltenburg et al., supra note 88, at 887.

92. See, e.g., Yuki Noguchi, Closed All at Once: Restaurant Industry Faces Collapse, NPR (Mar. 22, 2020), https://www.npr.org/2020/03/22/819189939/closed-all-at-once-restaurant-industry-faces-collapse [https://perma.cc/KCD8-VQP7] ("Rapid shutdowns in cities and states to stem the coronavirus have thrown restaurants across the country into sudden and complete disarray."); Anjali Sundaram, Yelp Data Shows 60% of Business Closures Due to the Coronavirus Pandemic Are Now Permanent, CNBC (Sept. 16, 2020), https://www.cnbc.com/2020/09/16/yelp-data-shows-60percent-of-business-closures-due-to-the-coronavirus-pandemic-are-now-permanent.html [https://perma.cc/5PYR-HVKM] (last updated Dec. 11, 2020) ("Throughout the past six months, restaurants, bars and nightlife venues have been hit the hardest by the restrictions brought by the pandemic: 32,109 restaurants have closed, as of Aug. 31. The number of restaurants forced to permanently close is slightly above Yelp's total average, at 61%.").

93. See, e.g., Juliana Kim, Nail Salons, Lifeline for Immigrants, Have Lost Half Their Business, N.Y. Times (Nov. 23, 2020), https://www.nytimes.com/2020/11/23/nyregion/new-york-city-nail-salons-coronavirus.html (on file with the *Columbia Law Review*) ("Nail salon visits in the state have dropped by more than 50 percent, and sales have fallen by more than 40 percent, according to an October survey of 161 salon owners conducted by the Nail Industry Federation of New York.").

94. See, e.g., Gal Tziperman Lotan, Day Care, Already in Short Supply, Becomes Scarcer During the Pandemic, Bos. Globe, https://www.bostonglobe.com/2020/11/17/metro/covid-19-pandemic-has-further-cut-into-bostons-childcare-shortage (on file with the *Columbia Law Review*) (last updated Nov. 17, 2020) (discussing financial instability for childcare workers).

95. See Emily Benfer, David Bloom Robinson, Stacy Butler, Lavar Edmonds, Sam Gilman, Katherine Lucas McKay, Zach Neumann, Lisa Owens, Neil Steinkamp & Diane

Staying at home did not mean living and working in a risk-free environment. For this subset of people, it remained impossible to control the risk of exposure even at home. For those living with essential workers, the home that public health agencies, including the CDC, posited as a safe space was transformed into a risky environment. This was particularly so for the elderly residing with multiple generations, as is disproportionately the case in lower-income households of color.[96] Again, this resulted in racially disparate health outcomes in the context of the pandemic.[97] A recent study in *JAMA: The Journal of the American Medical Association* utilized data from the universal testing of pregnant women in New York City to find that the building-level variables measured by household membership, household crowding (greater than one person per room), and low socioeconomic status were associated with a higher prevalence of SARS-CoV-2.[98] The combination of housing conditions and being an essential worker has now also been directly connected to the vulnerability of children contracting SARS-CoV-2. Black and Latinx children are dying at higher rates in the pandemic.[99] This is because, as the CDC notes in the *Morbidity and*

Yentel, The COVID-19 Eviction Crisis: An Estimated 30–40 Million People in America Are at Risk, Aspen Inst. (Aug. 7, 2020), https://www.aspeninstitute.org/blog-posts/the-covid-19-eviction-crisis-an-estimated-30-40-million-people-in-america-are-at-risk [https://perma.cc/37VY-94Y6]. The CDC responded to this by issuing an order to halt residential evictions as a means to prevent the further spread of SARS-CoV-2. See Temporary Halt in Residential Evictions to Prevent the Further Spread of COVID–19, 85 Fed. Reg. 55,292, 55,292 (Sept. 4, 2020) ("Under this Order, a landlord, owner of a residential property, or other person with a legal right to pursue eviction or possessory action, shall not evict any covered person from any residential property in any jurisdiction to which this Order applies during the effective period of the Order." (footnote omitted)).

96. Thomas M. Selden & Terceira A. Berdahl, Risk of Severe COVID-19 Among Workers and Their Household Members, 181 JAMA Internal Med. 120, 121 (2021) ("Between 56.7 and 74.3 million increased-risk US adults lived with or were themselves essential workers who could not [work at home] . . . . Policy makers seeking to make efficient and equitable decisions . . . should consider the health risks not only of workers, but also of those with whom they live.").

97. See Lauren M. Rossen, Amy M. Branum, Farida B. Ahmad, Paul Sutton & Robert N. Anderson, Excess Deaths Associated with COVID-19, by Age and Race and Ethnicity—United States, January 26–October 3, 2020, 69 Morbidity & Mortality Wkly. Rep. 1522, 1523 (2020) (highlighting the "disproportionate increases among certain racial and ethnic groups" as being "consistent with noted disparities in COVID-19 mortality").

98. Ukachi N. Emeruwa, Samsiya Ona, Jeffrey L. Shaman, Amy Turitz, Jason D. Wright, Cynthia Gyamfi-Bannerman & Alexander Melamed, Associations Between Built Environment, Neighborhood Socioeconomic Status, and SARS-CoV-2 Infection Among Pregnant Women in New York City, 324 JAMA 390, 392 (2020).

99. Danae Bixler, Allison D. Miller, Claire P. Mattison, Burnestine Taylor, Kenneth Komatsu, Xandy Peterson Pompa, Steve Moon, Ellora Karmarkar, Caterina Y. Liu, John J. Openshaw, Rosalyn E. Plotzker, Hilary E. Rosen, Nisha Alden, Breanna Kawasaki, Alan Siniscalchi, Andrea Leapley, Cherie Drenzek, Melissa Tobin-D'Angelo, Judy Kauerauf, Heather Reid, Eric Hawkins, Kelly White, Farah Ahmed, Julie Hand, Gillian Richardson, Theresa Sokol, Seth Eckel, Jim Collins, Stacy Holzbauer, Leslie Kollmann, Linnea Larson, Elizabeth Schiffman, Theresa S. Kittle, Kimberly Hertin, Vit Kraushaar, Devin Raman, Victoria LeGarde, Lindsey Kinsinger, Melissa Peek-Bullock, Jenna Lifshitz, Mojisola Ojo, Robert J Arciuolo, Alexander Davidson, Mary Huynh, Maura K. Lash, Julia Latash, Ellen H.

Mortality Weekly Report, essential workers are at higher risk for exposure and a higher risk of intra-household transmission. In some cases, the push toward risk mitigation bordered on the absurd.[100] Such was the case in Flint, Michigan, where handwashing was impossible given the ongoing challenges of accessing clean water.[101]

Not only was it more difficult for those with low incomes and for BIPOC to curb exposure, public health officials designed and implemented the virus response in arguably racially and socioeconomically neutral terms that assumed that all individuals were equally vulnerable to sickness and death. This turned out not to be true: The illness has been generally more severe in those with preexisting conditions, who are disproportionately people of color.[102] The literature on the social determinants of health paints a clear picture as to why it is that lower-socioeconomic-status and BIPOC populations disproportionately suffer from health conditions, including higher rates of asthma, diabetes, cancer, and heart disease.[103] These factors fall far outside of the control of an individual person and include structural and environmental issues, such as poor housing conditions; living in food deserts and food swamps; contaminated water; air pollution; and persistent stress due to employment and financial insecurity, poverty, and racial discrimination.[104] The tragic

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Lee, Lan Li, Emily McGibbon, Natasha McIntosh-Beckles, Renee Pouchet, Jyotsna S. Ramachandran, Kathleen H. Reilly, Elizabeth Dufort, Wendy Pulver, Ariela Zamcheck, Erica Wilson, Sietske de Fijter, Ozair Naqvi, Kumar Nalluswami, Kirsten Waller, Linda J. Bell, Anna-Kathryn Burch, Rachel Radcliffe, Michelle D. Fiscus, Adele Lewis, Jonathan Kolsin, Stephen Pont, Andrea Salinas, Kelsey Sanders, Bree Barbeau, Sandy Althomsons, Sukhshant Atti, Jessica S. Brown, Arthur Chang, Kevin R. Clarke, S. Deblina Datta, John Iskander, Brooke Leitgeb, Talia Pindyck, Lalita Priyamvada, Sarah Reagan-Steiner, Nigel A. Scott, Laura J. Viens, Jonathan Zhong & Emilia H. Koumans, SARS-CoV-2–Associated Deaths Among Persons Aged <21 Years—United States, February 12–July 31, 2020, 69 Morbidity & Mortality Wkly. Rep. 1324, 1328 (2020).

100. Id. at 1325–28.

101. See supra notes 3–7 and accompanying text.

102. See Bixler et al., supra note 99, at 1325 (finding that "75% of decedents had at least one underlying condition, and 45% had two or more underlying conditions").

103. Samantha Artiga, Rachel Garfield & Kendal Orgera, Communities of Color at Higher Risk for Health and Economic Challenges Due to COVID-19, Kaiser Fam. Found. (Apr. 7, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/communities-of-color-at-higher-risk-for-health-and-economic-challenges-due-to-covid-19 [https://perma.cc/57SJ-C53V].

104. Ashley M. Butler, Social Determinants of Health and Racial/Ethnic Disparities in Type 2 Diabetes in Youth, 17 Current Diabetes Reps. 1, 2 (2017) ("Given that racial/ethnic minority children and families in the general population also have disproportionate social, economic, and environmental disadvantages, it is possible that there are pervasive disparities in youth onset [type 2 diabetes]."); Rebekah J. Walker, Joni Strom Williams & Leonard E. Egede, Influence of Race, Ethnicity and Social Determinants of Health on Diabetes Outcomes, 351 Am. J. Med. Scis. 366, 369–71 (2016) ("[A]n important component that is often ignored is the role of social determinants of health on outcomes, and the possible role these determinants play in disparities.").

result is that BIPOC are dying at higher rates.[105] As noted above, Black Americans, for example, suffer a forty-nine percent higher mortality rate than white people.[106] The COVID-19 pandemic has harshly revealed the mechanisms through which race and structural inequality determine life and death.[107]

Finally, while we have shown how vulnerability to contracting SARS-CoV-2 is structurally determined, perhaps some of the disproportionate impact of COVID-19 could have been mitigated by access to care. Healthcare itself, however, is notoriously shaped by financial barriers and discrimination, and as a result, is fundamentally racialized. For example, African American and Latinx populations are less likely to be insured than other race groups.[108] In 2013, around forty percent of Hispanics and twenty-five percent of Black Americans were uninsured, compared to fifteen percent of white Americans.[109] Further, over the last several years, Latinx and Black children top the charts respectively for losing health insurance.[110] Latinx children, in particular, have been impacted by the Trump Administration's public-charge rule, which considers an immigrant's use of public benefits for over twelve months when determining admissibility.[111] The mere existence of the rule could discourage individuals from seeking care and treatment for SARS-CoV-2, lest they be penalized in the immigration process for being a public charge despite the fact that there have been efforts to encourage care by immigrants.[112] Treatment

105. See supra notes 15–16 and accompanying text.

106. See supra note 15 and accompanying text.

107. See Ruqaiijah Yearby & Seema Mohapatra, Law, Structural Racism, and the COVID-19 Pandemic, J.L. & Biosciences, Jan.–June 2020, at 1, 3–4.

108. See Thomas C. Buchmueller, Zachary M. Levinson, Helen G. Levy & Barbara L. Wolfe, Effect of the Affordable Care Act on Racial and Ethnic Disparities in Health Insurance Coverage, 106 Am. J. Pub. Health 1416, 1418–19 (2016) (emphasizing that large disparities in health insurance coverage are related to race and ethnicity).

109. Id.

110. See Margot Sanger-Katz & Abby Goodnough, Even as the Economy Grew, More Children Lost Health Insurance, N.Y. Times (Oct. 9, 2020), https://www.nytimes.com/2020/10/09/upshot/children-losing-health-insurance.html (on file with the *Columbia Law Review*) ("A report Friday by the Georgetown Center for Children and Families found that the ranks of uninsured children grew the most in Texas and Florida, and that Latino children were disproportionately affected.").

111. Hamutal Bernstein, Dulce Gonzalez, Michael Karpman & Stephen Zuckerman, Amid Confusion over the Public Charge Rule, Immigrant Families Continued Avoiding Public Benefits in 2019, Urb. Inst. (May 18, 2020), https://www.urban.org/research/publication/amid-confusion-over-public-charge-rule-immigrant-families-continued-avoiding-public-benefits-2019 [https://perma.cc/VGV6-F86R] (noting that the public-charge rule creates a "policy environment where immigrant families fear accessing critical health services for themselves or their children"); see also Public Charge, USCIS, https://www.uscis.gov/green-card/green-card-processes-and-procedures/public-charge [https://perma.cc/NHL5-QZN6] (last updated Sept. 22, 2020).

112. See Miriam Jordan, 'We're Petrified': Immigrants Afraid to Seek Medical Care for Coronavirus, N.Y. Times (Mar. 18, 2020), https://www.nytimes.com/2020/03/18/us/

and care for SARS-CoV-2, however, is not the only issue: The public-charge rule may mean that members of these populations are less likely to seek out health services for the preexisting conditions that make the virus particularly deadly. And, when people do seek out services, they must contend with health discrimination in the clinical setting that contributes to an already deep sense of distrust in the medical system and further reduces access to healthcare for vulnerable populations.[113]

CONCLUSION

In their well-known book, *The Miner's Canary: Enlisting Race, Resisting Race, Transforming Democracy*, Lani Guinier and Gerald Torres wrote of the phenomenon in which the difficulties experienced by racial minorities are indicators that "signal problems with the way we have structured power and privilege."[114] The barriers to care, high death rates, and exposure to risk that BIPOC face in the pandemic lay bare a world in which some people can survive because others will die. By minimizing the role of the social determinants of health in the pandemic's response and continuing a misguided focus on individual responsibility, the virus easily exploited preexisting inequalities and created new ones. This leaves these same communities at risk once again in the future.

Despite basic recognition of the importance of structural factors in health outcomes by public health institutions and the overwhelming data to demonstrate it,[115] the response to COVID-19 mirrors the neoliberal approach of earlier public health crises: privileging the trope of personal responsibility, rational risk mitigation, and individual behavioral change

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coronavirus-immigrants.html (on file with the *Columbia Law Review*) (last updated May 12, 2020).

113. Paige Nong, Minakshi Raj, Melissa Creary, Sharon L.R. Kardia & Jodyn E. Platt, Patient-Reported Experiences of Discrimination in the US Health Care System, 3 JAMA Network Open, Dec. 2020, at 1, 7–9; David R. Williams & Toni D. Rucker, Understanding and Addressing Racial Disparities in Health Care, 21 Health Care Fin. Rev. 75, 79, 87–88 (2000).

114. Lani Guinier & Gerald Torres, The Miner's Canary: Enlisting Race, Resisting Power, Transforming Democracy 11–12 (2003). They later clarify that you could use any marginalized group as a test. See id. at 166 ("We have chosen in this book to focus on race; yet our analysis need not be limited to race. We encourage others to explore the ways in which gender and race intersect to produce synergies of social change.").

115. See CDC, Social Determinants of Health, supra note 20 ("Resources that enhance quality of life can have a significant influence on population health outcomes. Examples of these resources include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins."); see also Social Determinants of Health, WHO, https://www.who.int/health-topics/social-determinants-of-health [https://perma.cc/V2TW-P4BV] (last visited Jan. 8, 2021) ("Research shows that the social determinants [of health] can be more important than health care or lifestyle choices in influencing health.").

over social determinants of health and structural drivers of risk as the centerpiece of the response.[116]

The current data paint a dire picture. SARS-CoV-2 exposure mitigation is severely restricted by living and work conditions, and the risk of contracting the disease and developing life-threatening conditions is exacerbated by the presence of underlying health conditions that in turn are the result of structural conditions outside of an individual's control.[117] The experience of racial minorities in the COVID-19 crisis continues to illustrate how our public health responses have been skewed toward the ideology of personal responsibility for mitigating risk in the context of pandemics. Instead, the analysis in this Piece argues for a reorientation away from personal responsibility and toward the social determinants of health and structural sources of risk that lie beyond individual control.

116. See supra Parts I, III.

117. Mayor Walsh Declares Racism a Public Health Crisis, Bos. Pub. Health Comm'n (June 12, 2020), https://www.bphc.org/onlinenewsroom/Blog/Lists/Posts/Post.aspx?ID=1302 [https://perma.cc/W9CE-5VUY] (noting Boston's declaration of racism as a public health crisis and the "impact that racism has on the lives of residents and their overall health").