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Fundamentally uncaring: The differential multi-scalar impacts of COVID-19 in the U.S

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ABSTRACT

2020 in the United States was marked by two converging crises—the COVID-19 pandemic and the large-scale uprisings in support of Black lives. These crises were met with both a counterproductive and inadequate response from the federal government. We examine these converging crises at the individual, social, and political scales. The biological realities of COVID-19 impact different populations in widely varied ways—the poor, the elderly, Black, Indigenous, and people of color, and those living with comorbidities get sick and die at the highest rates. Social distancing guidelines shifted millions of people to work-from-home and millions more lost their jobs, even as care laborers, preponderantly women, Black, Indigenous, and people of color, were asked to put their and their loved ones' lives on the line for the continuation of all of our lives. These biological, social, and economic crises have been punctuated by civil unrest, as millions took to the streets for racial justice, noting the unequal impacts of the pandemic. These converging crises have laid bare decades of neoliberal and neoconservative policies and ideologies, undergirded as they have been by racial capitalism, for their fundamental uncaringness. In this paper, we argue that this pandemic not only made a wider population more acutely aware of the necessity and importance of the need to care and for caring labors, but also that we stand at the precipice of potentiality–of producing a more caring society. To frame our argument, we draw on Nancy Scheper-Hughes and Margaret Lock's (1987) framework of three bodies—individual, social, and political—to unpack the multi-scalar entanglements in the differential impacts of COVID-19, questions of care, and their articulation in the current political-economic context.

1. Introduction

Around the world and in the United States in particular, 2020 has been marked by converging crises: the COVID-19 pandemic, a reckoning with structural racism and a mass uprising, and the failure of the federal government to respond to either. Together, decades of neoliberal and neoconservative policies, undergirded by racial capitalism and coupled with a growing distrust of science, government agents, and experts, have created the conditions that promote COVID-19's "extraordinarily capable and efficient" transmission and its "considerable degree of morbidity and mortality" (Fauci, 2020). And as journalists, public health experts, and scholars have made clear, the impacts of this pernicious disease are not evenly distributed. Black, Indigenous and People of Color (BIPOC) communities suffer disproportionately from both the disease and from the economic recession it has catalyzed. At the same time, thanks to the large-scale rebellion for Black lives that took off across the U.S. and around the world in the spring and summer, there has been an increase in attention to systemic and structural racism and its impact on everything from police brutality to economic opportunity to the uneven burden of disease and unequal access to health care. Indeed, across the country, state and local leaders declared racism a public health crisis, many of them following the publication on June 1 of an open letter in support of the protests signed by over 1200 public health experts (APHA, 2020).

In this moment of multiple crises, alternative forms of solidarity and care have emerged through mutual aid, volunteering, and protesting (Chenoweth et al., 2020). These community configurations often take on the responsibilities of (and make demands on) the state to care and provide for the most vulnerable. These groups make up what, drawing on the work of Nancy Scheper-Hughes and Margaret Lock (1987), we call the "social body," which has stepped in to help protect and care for individual bodies in the face of the failure of government or the "body politic." Building on Scheper-Hughes and Lock's (1987) work, we argue that the converging crises of government failure, racial capitalism, and

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COVID-19 bring entrenched entanglements of the individual body, social body, and body politic to the foreground of public discourse and understanding, enabling a reimagining of care ethics as a political project of redistribution emerging from the social body in order to heal and maintain individual bodies and to challenge the body politic. We posit that the politics of care that the consequences of COVID-19 and the ongoing movement for Black lives have solidified reveals the multi-scalar nature of care ethics and holds the possibility for healthier and more caring futures. To make this argument, we first explain the methods we use. Then, we explain the framework laid out by Scheper-Hughes and Lock (1987) and offer a grounding in the literature of care labors and care ethics. After that, we offer background and context through which to better understand the events of 2020. From there we turn to the events of 2020, analyzing them at the scales of the individual body, social body, and body politic. We finish with an exploration of the entanglement of those scales to argue for a reorientation of politics around relationships, reciprocity, and care to heal the body politic through the social and individual bodies.

2. Methodological note

This study offers a qualitative analysis of how neoliberal and neoconservative policies affect caring relationships at multiple scales in the unfolding coronavirus pandemic. Scheper-Hughes and Lock (1987, p. 8) write, "[t]he 'three bodies' represent … not only three separate and overlapping units of analysis [what we think of as scales], but also three different theoretical approaches and epistemologies." Using data gathered largely through Coronavirus Taskforce Press Briefings, newspaper articles, published studies, social media, and our own experiences, this paper examines each of these bodies to understand this moment of converging crises. Following Becky Mansfield (2008), our analysis is iterative as we move between theoretical questions taken from health geography, medical anthropology, and care ethics, and open coding, placing theoretical concerns about the current racialized political-economic arrangements and care ethics in conversation with the details of caring labors through the unfolding pandemic. Based in a grounded theory approach—"an inductive, recursive research method that involves successive iterations of data collection, analysis, and verification in order to reveal categories and their properties" (Knigge, 2017, p. 3232)—our method is driven by a qualitative approach to documentary analysis. This includes systematic, daily surveys of a wide range of media through "theoretical sampling," or, "the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges" (Glaser and Strauss, 2017, p. 45). We begin with news from international sources like *The Guardian*, national sources like *The New York Times*, *The Washington Post*, and National Public Radio, as well as local sources like *The Seattle Times* and *The Valley News*. We also receive a daily newsletter from the University of Washington MetaCenter for Pandemic Preparedness and Global Health Security which provides summaries of and links to the latest scientific literature about the pandemic. Every day, we spend between one and two hours reading the latest news and taking notes on stories related to the pandemic and governmental and non-governmental (e.g. mutual aid societies, activist collectives, and individuals) responses to the epidemic. We have found Twitter and community listservs particularly valuable for gathering local data on mutual aid-type activities. Likewise, our lived experiences in this pandemic contribute to the grounded theory we offer and inform both our claims and how we interpret the other data we are collecting. In addition, we watched the daily Coronavirus Taskforce Press Briefings, occasional Press Briefings with the White House Press Secretary, and Trump's rallies and interviews, conducting in-time fact checking to better grasp the narrative put forward by the White House. From news stories and briefings, we gathered relevant related documents, such as CDC, media, and non-governmental organization data and reports, legislative bills, and reports. Our broad approach is designed to not only gather data about what is happening at the scales of the individual, social, and political, but also to encompass competing perspectives, which are important for grasping the nuances of ethical issues related to care. For example, when the Capitol Hill Organized Protest (CHOP—previously known as Capitol Hill Autonomous Zone, or CHAZ) took root across six blocks and Cal Anderson Park in Seattle, WA, it was variously celebrated and denounced across social media, news outlets, and in interviews. Conservative social media personality Andy Ngô regularly shared clips of defensive strikes by protestors against the police, claiming the protestors were "Antifa militants" who had violently taken over an entire neighborhood. President Trump (2020) tweeted, "Domestic Terrorists have taken over Seattle, run by Radical Left Democrats, of course. LAW & ORDER!" Mayor Jenny Durkan responded to his tweet (Cuomo, 2020), in a CNN interview, "We have four blocks in Seattle that is more like a block party atmosphere." The Rolling Stone Magazine (Royale, 2020) called it "a peaceful realm where people build nearly everything on the fly, as they strive to create a world where the notion that Black lives matter shifts from being a slogan to an ever-present reality." Based on the same facts, these different claims reveal deep political tensions across writers and speakers (McHugh, 2015) that produce different interpretations. These different interpretations promise to teach us much about the importance and reconfiguration of care during this pandemic.

2.1. *From care labor to care ethics*

"Mankind has been so programmed/That they don't care about nothin'/That has to do with care/C-A-R-E" - Nina Simone "Isn't it a Pity".

In their 1987 field-defining piece, "The Mindful Body," Nancy Scheper-Hughes and Margaret Lock charted a course for medical anthropology that recognizes the interconnections between the biological body, which is so often the object of biomedicine (the individual body), the social systems that healthy and ill people are a part of (the social body), and the political-economic structures and systems through which people get sick and get well and medicine is practiced (the body politic). Their contention is that while these three bodies require different theoretical and methodological approaches, they are interconnected. Further, health and illness must be understood through these interconnections, as should society as a whole. This approach focuses on relationships among bodies, between society and biology, and among scales. They write, "Sickness is not just an isolated event, not an unfortunate brush with nature. It is a form of communication – the language of the organs – through which nature, society, and culture speak simultaneously. The individual body should be seen as the most immediate, the proximate terrain where social truths and social contradictions are played out, as well as a locus of personal and social resistance, creativity, and struggle" (1987, p. 31). The focus on relationships across scales is particularly valuable for understanding the converging crises of COVID-19, racial (in)justice, and governmental failure in 2020.

In 2020, as public attention has turned to the impact of structural racism on society, the disproportionate impact of COVID-19 on particular populations, and the failure of the federal government's response, the concept of racial capitalism is particularly important for understanding care across the three bodies (Bailey and Moon, 2020). Racial capitalism refers to the ways in which capitalism and racism are and always have been intertwined, as capitalist accumulation for the racially dominant (whites) comes at the expense of racial subordinates, especially Black people (Robinson and Kelley, 2000; Pulido, 2016). At root, racial capitalism is "a technology of *antirelationality* (a technology for reducing collective life to the relations that sustain neoliberal democratic capitalism)" (Melamed, 2015, p. 78, emphasis in the original). This, as scholars of racial capitalism and activists in the streets and on Twitter detail, is particularly untenable in a pandemic that depends on our relationships with one another both to propagate and to survive. As

scholars of neoliberalism and neoconservatism have demonstrated, and as the pandemic makes clear, policies and ideologies across the three scales of the body have asserted a calculative technology of competitive individualism that disregards a sensibility of societal responsibilization, engendering what Kim England (2010) calls a deepening 'care crisis.' This care crisis has become a central point of solidarity building during the pandemic.

Geographers have long highlighted the scales and spatialities of care labor and its crises (Dyck, 2005; McEwan and Goodman, 2010). Caringscapes, no longer relegated to the home and private spheres, have emerged in scholarship of the social, and therefore, political realms over the past two decades (Milligan and Wiles 2010; Popke 2006). Thinking through scales of a politics of care, scholars have examined the global impacts of colonialism on care chains (Raghuram et al., 2009) down to the paid and unpaid care labors in the home (Milligan, 2003), to include the shift of care from institutional settings into the home driven by austerity (Brown, 2004; Power and Hall, 2018). Other scholars have taken up the ways in which care extends from clinics through social networks as social relationships undergird successful global health programs (McKay, 2018). Further, the deepening commodification of care in institutional settings such as long term care homes, hospices, community care centers, and hospitals (Bowlby, 2011; Conradson, 2003; Parr, 2003) has exacerbated uneven distributions of care receiving as well as care-giving, felt unevenly along race, class, gender, ability, and other axes. It also reveals their limitations: forty-one percent of all deaths due to COVID-19 in the U.S. and eighty percent in Canada are linked to nursing homes, retirement communities, and long-term care facilities (Brown, 2020; Faghanipour et al., 2020; New York Times, 2020). More recently, these shifts in care labor have prompted calls to center race and intersectionality in care scholarship (Hankivsky, 2014; Raghuram, 2019). In many ways, the pandemic underscores the urgency to take up this charge.

To understand the limits and possibilities of care during this pandemic, we turn to scholarship on care ethics, which takes as its starting point a social ontology of relationality, in which attentiveness, respect, mutuality, and trust are fundamental to building a caring society at multiple and entangled scales (Bartos, 2012; Tronto, 1993). The lens of care ethics highlights the uneven power structures traversing gender, sexuality, race and ethnicity, class, migration status, and disability (Bourgault and Robinson, 2020), not merely to offer critique and deconstruction, but to also invite and enact a mode of affirmative change (Beasley and Bacchi, 2005; Lawson, 2007). Standing in stark contrast to utilitarian- and Kantian-based ethics, care ethics paves the way for thinking beyond power structures as they currently exist across multiple scales in order to think toward a political being that is inclusive (rather than exclusive), addressing the expressed needs of the disenfranchised, as they articulate them (Held, 2018; Lloyd et al., 2012). In this way, care ethics is "a transformative ethos rather than a normative ethics," a mode of doing rather than a set of rules of morality (Puig de la Bellacasa, 2017, p. 67). It pushes back against tendencies under neoliberalism and neoconservatism to pit individuals and societies against one another and takes seriously the violence of racial capitalism, asserting, instead, the importance of "caring with"—of building solidarities toward a less violent (both structural and kinetic) world (Tronto, 2013). As Scheper-Hughes and Lock (1987, p. 29) remind us, "It is sometimes during the experience of sickness … that mind and body, self and other become one." That this pandemic is felt across and through scalar distinctions opens the way for an ethic of care that attends to the multi-scalar articulations of the body.

This pandemic makes obvious how racial capitalism has fostered neither a caring nor care-full world. As the need for care became evident in its universalism, the need for an ethic of care that attends to the unequal experience of the pandemic broadly, and the impacts of racial capitalism, particularly, become more evident. Using a framework of care ethics, we examine how an attention to racial capitalism across the entangled scales of the body offers insights into the possibilities for reconfiguring the body politic to be more caring and anti-racist, drawing inspiration from new configurations of care in the social body, and ultimately engendering health in individual bodies.

2.2. *Setting the stage for a pandemic and a mass uprising*

For all their contestations and varied expressions, we live in an era defined by the marriage between neoliberalism and neoconservatism, and undergirded by white supremacy (Brown, 2019; Cooper 2017). Arising separately in the early-twentieth century, by mid-century, the two schools of thought found synergism in their devolution of social relations in the name of freedom—freedom of choice, individual freedom, and freedom from the coercion of collectivism—secured economically and morally through white, heteronormative familial obligation (Meyer, 1960; Whyte, 2019). Permeating across scales, policies from global political economic relations down to the very fabric of our social and individual bodies have led to an upward redistribution of capital and resources and downward pressures on families and individuals, especially women, increasing social, political, and economic inequality and precarity (Duggan, 2014). Structured along lines of cost-effectiveness and cost-benefit analyses, neoliberal policies follow a pro-business model, enforcing free market economics, unfettered capital flows, and market competition supported by, for instance, economic deregulation of trade, investment, and finances (Hickel, 2016). This rollback regime of neoliberalism has, for decades, undermined local and global health and social service provisions which have been met with intensified rollout regimes of targeted investments and market conforming governance (Sparke, 2020) that "are more properly understood as dialectically intertwined moments of ongoing regulatory transformation" (Peck and Theodore, 2019, p. 258). The disciplinary welfarism of both neoliberal and neoconservative policies relies on surveillance of the poor, in particular BIPOC and immigrants, to impart 'appropriate' behaviors in the undertaking of self-making practices such as self-responsibilization and individualism (Schram et al., 2009). Within this framework, the failure to thrive is understood as personal moral failure, not the outcome of the structural inequalities and racism wrought by the policies and philosophy of the past 400 years (Mitchell, 2016). That the multiple crises (biomedical, economic, social, and political) of the pandemic have been felt most acutely by BIPOC communities is neither an accident nor outcome of individualized failure; rather, these are the outcomes of racial capitalism (Rahman, 2020).

Well before the novel coronavirus emerged, the US government under President Trump worked to dismantle the already-fractured public health and emergency response infrastructure. Despite the dire outcomes of a pandemic simulation in 2017, the administration disbanded the Global Health Security and Biodefense unit in the National Security Council, downgrading pandemic preparedness as a national security concern and further widening the gaping hole in leadership and coordination (Ayotte et al., 2019). Meanwhile, more than 700 positions were left unfilled at the CDC, and the administration cut the U.S. Field Epidemiology Training Program expert, an early warning position in China (Goodsell, 2019; Mayer, 2020). Domestically, Trump's budget proposals attempted to reorganize and slash the budgets of government agencies such as the EPA, CDC and the National Institutes of Health and gut a wide range of social service programs, including the Affordable Care Act (ACA), food stamps (SNAP), and Disability Insurance and Supplemental Security Income (social security). While Congress rarely enacted the budget cuts to their fullest, the proposals reflect a concerted set of rollbacks in the name of small-government, and a pointed anti-poor, anti-science, "America First" philosophy of the administration. Although the intertwined crises of 2020 are the result of more than the Trump administration, the administration's policies and rhetoric intensified forty years of expanding uncaring tendencies, exposing the long-simmering anxieties of white, heteronormative, patriarchal working- and middle-class Americans and highlighting a longer history of racial capitalism and anti-democratic sentiments in the US and across

the West (Brown, 2019). As a result of these efforts and longer-standing policies, the country was ill-equipped to take seriously the pandemic as a biological agent and a social force.

Given this broader context, the question of who bears the weight of protecting and caring for individuals and social bodies—and how—reveals the gendered and raced reality of care labors in the U.S. Roughly 91 percent of nurses, who spend the most time interacting with patients, are women, and 19.2 percent of registered nurses and 29 percent of licensed practical nurses identify as racial or ethnic minorities. Further, foreign born nurses make up between 15 and 22 percent of the workforce, depending on the sector, even as foreign born people make up only 13 percent of the U.S. population (Hohn et al., 2016; Smiley et al., 2018). Racial disparities are also clear in the shift to work-from-home, with only 20 percent of African American and 16 percent of Latinx workers able to work-from-home, compared to 30 percent of their white and 37 percent of their Asian counterparts (Gould and Shierholz, 2020). As these numbers make clear, the ability to enact public health measures to protect one's individual body and those of the rest of the community are racialized as the social body is shaped by racial capitalism just like individual bodies are. At home, unpaid care labors expanded unprecedentedly. With 50.7 million pre-K through 12 students, 30 million of whom rely on reduced or free lunches, schooling from home put exponential pressure on parents and care givers, especially women (Miller, 2020). This means that well-meaning sentiments like, "For many of us, we have been given the gift of time with our families that is uncommon in our modern age," which one of us received from the superintendent of schools, ignore the reality many households face. Informal and unpaid caring labor, not seen as productive, offloads costs to those who do this work (Milligan, 2000; Pittman, 2018) and is often sidelined in conversations about labor (McDowell, 2015) despite permeating across the entangled scales of everyday life, especially in the pandemic. It is these multi-scalar crises that permeate individual and social bodies and is rooted in decades of neoliberal and neoconservative policies in the body politic that we turn to now, beginning with the individual body.

2.3. The individual body

To begin their analysis, Scheper-Hughes and Lock (1987) argue that individual bodies have been framed through biomedicine as biological entities separate from the societies in which they live and further that this framing is incomplete for understanding health. COVID-19 offers a devastating illustration of this point. The data show that the bodily experiences of COVID-19 vary widely from asymptomatic to severe respiratory distress and organ failure. While it's not clear why bodies respond so differently, some of this variation is rooted in the social structures that racial capitalism and neoliberalism-neoconservatism have engendered. As a number of scholars, doctors, and policy experts have argued, health inequalities, although often individualized as the consequence of personal choices and moral failure, are an outcome of "a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics" (CSDH, 2008, p. 1). In the U.S., these structural inequalities are compounded by the legacies of settler colonialism, slavery, and ongoing racial discrimination which are embodied by people of color, particularly Black, Indigenous, and Latinx people, who suffer disproportionately from the preexisting conditions that make them vulnerable to adverse outcomes from COVID-19: diabetes, obesity, heart disease, and asthma (Hatch, 2016; Laster Pirtle, 2020). The prevalence of these comorbidities among BIPOC are the outcome of weathering (Geronimus, 1996), or the cumulative effects of inequality and racism on the health of individuals not simply as biomedical materiality, but as a "dimension of human distress (i.e., the social relations of sickness)" (Scheper-Hughes and Lock, 1987, p. 10). Indeed, COVID-19 has made clear racial capitalism's weathering impacts (Crews and Purnell, 2020). Additionally, well-documented disparities in access to, quality of, and satisfaction with health care for BIPOC further exacerbate this public health crisis as they are less likely to have health insurance, take longer to seek medical attention, and when they do, are less likely to be administered a COVID-19 test or have their complaints taken seriously (Nelson, 2011; Poteat et al., 2020; Roberts, 2011).

At the outset of the pandemic, racial and ethnic data about morbidity and mortality were hard to come by. With data available for only 44 percent of positive tests and 94.1 percent of deaths six months into the pandemic, Black people accounted for 21.9 percent of deaths, although they represent only 13.4 percent of the total population in the country. Data is even harder to come by for American Indian and Alaska Native (AI/AN) people who are often miscategorized racially (most often as white) or noted in the "other" (uncounted) category (Nagle, 2020). In a study of 23 states with 70 percent completion of ethnicity data, AI/AN people, who account for 0.7 percent of the population, represented 1.3 percent of COVID-19 cases (Hatcher, 2020). This is all the more striking for populations with higher exposure rates, particularly healthcare workers and incarcerated people.

With no federal database for healthcare worker morbidity and mortality, *The Guardian* found, six months into the pandemic, that over 1000 healthcare workers had died of COVID-19. Among those for whom racial and ethnic data was available, 62.1 percent identified as "Black, Latinx, Asian/Pacific Islander, or Native American" and 30.5 percent were born outside the U.S. (Renwick and Dubnow, 2020). Similarly, there is no unified federal reporting system for COVID-19 among the 2.1 million people incarcerated in prisons, jails, and detention centers. But mass testing at 16 jails and prisons across the U.S. revealed prevalence rates ranging from 0 to 86.8 percent—the median infection rate across all 16 was 29.3 percent, representing 12 times the national rate in jails and prisons (Hagan, 2020). Likewise, in the same time period, ICE reported a cumulative total of 4444 confirmed cases out of approximately 22,000 people detained in its facilities, or 20.2 percent (ICE, 2020). As these data show, the most vulnerable populations in the U.S.—healthcare workers, incarcerated people, undocumented migrants, all of whom are disproportionately BIPOC—are at particularly high risk of contracting this deadly virus. This is weathering and racial capitalism in action.

The failure to collect data, particularly about front-line healthcare workers, prisoners, and undocumented migrants, reflects an erasure of the lived experiences and struggles of vulnerable individuals in the pandemic. Without fine-grained detail about who is getting sick and dying, public health agencies lack the ability to direct money and resources to the populations most in need, exacerbating already-existing health inequalities and potentially leading to adverse long-term social and economic outcomes (Krieger et al., 2020). Willful not knowing is to aggressively not care. To care ethically calls for attentiveness, responsibility, responsiveness, and competence contextualized across difference rather than flattened to the white norms that underwrite the unevenness in data collection (Raghuram, 2019). As the punitive and uncaring policies of the Trump administration made clear, care "is needed more than ever" (Hirschmann, 2018, 5). And the care that is needed is a politicized and collectivized care that recognizes the social dimensions of individual illness (Scheper-Hughes and Lock, 1987).

2.4. The social body

The best methods we have for preventing COVID-19—the best way to preserve a person's ability to breathe—rely on the social body. Staying home, keeping distance, wearing masks; these are the best tools we have to slow the spread of disease, but they work only if enough people participate. By now, the battle over these measures in the United States is common knowledge as politicians weigh social distancing against the economy. This logic of the economy over life has placed increased pressure on individuals and families to protect themselves and others "by a society that has made the premature death of some essential" for the continuation of its economy (Tyner and Rice, 2020). Meanwhile,

so-called anti-maskers take pride in exercising their American right to freedom by not wearing a mask even as masks protect other people. These two features of the American response—the economy over people and the right to not protect others—fails to comprehend that we are all connected in this pandemic and that everyone's individual health is entangled with that of the people who inhabit the social body.

The pressing question is not *why* some refuse to wear the mask, but rather, *what* the underlying moral philosophy is that rejects an individual's responsibility to 'the social.' For some in the US in 2020, to be asked to be concerned for the welfare of others is to suffer under "radical left politics". Likewise, the primacy of the economy over lives reflects a logic that resembles neoliberalism-neoconservatism, and yet moves beyond these ideologies as an "antipolitical yet libertarian *and* authoritarian … a popular right-wing reaction" that explicitly attacks the social (Brown, 2018, p. 11). In this logic, the health of the economy is divorced from the health of its workers and consumers.

Scheper-Hughes and Lock's (1987) "symbolic equations" between healthy body and healthy society, diseased body and malfunctioning society, is an apt framework for understanding COVID-19 in the US. The implications of the failure to foster health and to recognize the social body of the pandemic are obvious in the United States where the summer of 2020 saw dramatic increases in cases in the very states where stay-at-home orders were lifted early and where partisan-based resistance to social distancing and wearing masks was highest (Lipsitz and Pop-Eleches, 2020). The results were as predictable as they were devastating: BIPOC got sick and died at much higher rates, children and young adults, who were thought to be less susceptible to the disease, fell ill and died at increasing rates, and Arizona and other places implemented crisis of care standards.

But this was not the only result. As the mass uprising revealed, the twinned pandemic and protest movement opened up space for new possibilities. Indeed, the value of care labors came under reconsideration: homeschooling led to a Twitter explosion of parents lauding teachers as heroes (Perry, 2020); the plight of nursing home and home healthcare aids workers became a national conversation (Jamison, 2020); and calls for hazard pay for essential workers rose sharply (Repko and Palmer, 2020). It is in these and other acts that we see the emergence of a more-widely acknowledged sensibility about the need for care and care labors not just individually, but also socially. To be able *to* care requires a recognition of the need *for* care (Lawson, 2007). Further, the protests that began under the banner of Black Lives Matter and shifted toward broader calls to "defund the police" forced a national reckoning with structural racism. As the summer unfolded, polls indicated changing attitudes about racism, policing (everything from reform to abolition), and the removal of Confederate monuments. Police reform legislation appeared across the country, at city, state, and federal levels. Although most were anemic and many failed, they signaled a willingness to hear the protestors and a political will to *be responsive* and acknowledge the need for care, and to care for BIPOC communities in particular.

More to the point, in protest encampments and in communities across the US, new forms of solidarity emerged as the social body stepped in to the void left by the government to care for individuals. From the autonomous zones of protests in West Coast cities like Seattle and Portland to rural communities in Northern New England, formal and informal mutual aid organizations emerged to ensure individuals had food, housing, and the income they needed to implement social distancing measures, often connecting individuals to the state. These meal trains, pop-up clinics, and socially distanced support systems represent a call for a politics of care, and to care ethically. To care ethically, in the midst of the pandemic and in the wake of the protests is to first acknowledge and then address the historical legacies of settler colonialism, slavery, and Jim Crow, and the ongoing structural and kinetic racism in the U.S. that continues to bear down on the bodies of BIPOC. These ongoing processes of disenfranchisement have fostered a political economic terrain in which BIPOC are disproportionately represented in the ranks of essential workers *and* the unemployed; weathering has led to the very co-morbidities that make BIPOC more susceptible to and more likely to die from the disease; and, carceral and policing apparatuses imprison and murder BIPOC at alarmingly unequal rates to whites. At the same time, there has been a broader recognition and reevaluation of care labors and their absolute need for society to function. The social body developed a new understanding for the need for care and for what is at stake: the health of individual bodies and the social body are entangled, and to care for one is to care for the other.

2.5. The body politic

A social body oriented to care ethics foregrounds the needs of the disempowered and offers new possibilities for understanding the body politic. As Scheper-Hughes and Lock (1987) demonstrate and as the pandemic makes clear, the relationship between the social body and individual bodies isn't simply a set of metaphors; these relationships are about power and control and are shaped by larger political processes. In the United States, perhaps the most remarkable aspect of the pandemic has been the chaotic non-response from the federal government, in which the government has abdicated federal responsibility while also making it more difficult for states and municipalities to care for their populations. In short, the pandemic response in the US has been marked by an evacuation of the body politic. In its place, the social body stepped in.

In places like Europe, East Asia, and Canada, where the pandemic was more effectively contained, the central governments foregrounded public health concerns. At the same time, these countries have robust systems of universal healthcare as well as either relatively robust welfare states or systems in place to support people who are isolating or quarantining. This is not the case in the United States. Healthcare in the U.S. is not considered a public good—one which is afforded to everyone for the good of both the individual and social bodies. The ACA, signed into law under the Obama administration, was an attempt to address this, to redistribute care to all Americans through the expansion of government-run and private health insurance (Martinez et al., 2018). Upon taking office in 2016, together with the Republican-led Senate, Trump worked to gut the ACA and make it especially difficult for the poor and immigrants, largely BIPOC, to access insurance (Perreira et al., 2018). Rollback amendments, approved state-by-state, made it more difficult for people to access Medicaid and Medicare while simultaneously new forms of surveillance and control of the poor were rolled out (Alker and Pham, 2018). As a result, 2017 saw the first growth in uninsured people since the ACA was implemented. The pandemic compounded this, as 5.8 million adults lost their health insurance due to unemployment in the spring of 2020 (Dorn, 2020). In short, the US faced this pandemic with a healthcare system in the worst shape in ten years.

The Trump administration has had a similar impact on the public health system in the U.S., leaving key public health administration positions unfilled, slashing the budget of the Prevention and Public Health Fund, and failing to follow their own National Biodefense Strategy. Constitutionally, primary public health powers are held by individual states, territories, and tribes, while infectious disease pandemic prevention and mitigation powers are held at the federal level (Gostin and Hodge, 2017). This is further complicated by designated funding structures and streams, federal regulations, and individual states' governors' varied powers during a public health emergency. This disjointed structure has led to conflicting jurisdictional claims and "confusion about, or even denials of, ultimate responsibility in times of disaster" (Gostin and Wiley, 2016, p. 394).

During the pandemic's first wave, this fragmentation coupled with market-driven thinking created a 'wild west' market as states competed against each other and the federal government for PPE, ventilators, and more; prices for portable X-ray machines went up 20-fold and the price for PPE rose by more than 1000 percent (SHOPP). Under capitalism, the market was doing exactly as it should. To view this as a straightforward case of neoliberalism, however, misunderstands the way politics under

Trump operates. In his weekly press briefings and other media venues, he made clear his requirement that governors be "appreciative" of him, personally, for his handling of the multiple crises (Trump et al., 2020). Those who were not saw their states' shipments of tests, masks and personal protective equipment (PPE) intercepted by government officials, and diverted to other states and federal hospitals that had offered more favorable praise for Trump with little regard for need (McCarthy, 2020; Rasbach, 2020). Meanwhile, White House aides insisted that governors demonstrate they have made a concerted effort to assess their own supplies before accessing supplies from the Federal Emergency Management Agency (Cook and Diamond, 2020). Jared Kushner, son-in-law and advisor to the president, complained, "it's supposed to be our stockpile; it's not supposed to be state stockpiles that they then use" prompting an edit to the webpage devoted to the National Stockpile (Dale, 2020). In this statement, Kushner exposed the antipolitical and antisocial politics of an administration that refutes and refuses the importance of a cohesive federal response to the pandemic.

These Trumpian politics stem from the belief that the primary way that individual actors relate is through competition, driven by zero-sum 'winning' and 'losing.' By contrast, a care ethical approach starts from the premise that we are social beings, interdependent and dependent upon each other for our own existence—something that is more evident than ever due to the pandemic (Held, 2005). To allow for the marketization of much needed life-saving equipment, therapeutics, and health care to such an unprecedented extent is to pass off responsibility for care and the caring labors expected of the political body to the market, or what Joan Tronto (2013) calls the "production pass," wherein the primary concern is for the economy over the needs of the people. Under Trump's efforts, states, cities, and hospitals were treated as individualized subjects, relieving the federal government of its primary responsibilities during a health emergency, placing blame on governors and mayors for both the pandemic and the economy and further destabilizing trust in government.

As should be abundantly clear by now, the impacts of Trump's policies are uneven, depriving the most vulnerable of the PPE they need to stay safe in their front-line jobs and depriving others of life-saving medical equipment like ventilators. While community organizations, mutual aid societies, and activist groups have done tremendous work to care for the sick and vulnerable, their efforts have not been able to shape the body politic under President Trump. Scheper-Hughes and Lock (1987, p. 27) write that the body politic filters "more and more human unrest, dissatisfaction, longing, and protest into the idiom of sickness, which can then be safely managed by doctor-agents". But the multi-fold crises of the pandemic in the United States begs the question of what happens when those most affected do not have access to the doctor-agents who can manage the idiom of sickness? What happens in the face of the collapse of the body politic? In the U.S., this collapse has opened up new spaces for "the emergence of new locations for collective moral deliberation about questions concerning the distribution, assessment and quality of care" (Sevenhuijsen, 2003, p. 180). In these spaces, the social body took up residence to care for individual bodies.

Emerging from this social body, especially those that came out of the national uprising for Black lives, has been a call for a recognition of care as fundamental to relationships. These movements are grounded in a redistribution-as-care model, representing a turn toward care ethics. As we note above, protests, and the autonomous zones they produced, became spaces of care as volunteers provided food, health care, mental health and spiritual support, masks, and hand sanitizer, all for free. Some had voter registration tables, as the social body and the body politic came together. In Seattle and other cities, these autonomous zones made space for encampments for the unhoused, allowing Health and Human Services to provide direct outreach and referrals. As a transient site of care, "the emergence and endurance of such spaces depend[ed] upon the willingness of some individuals to move towards others and, amongst those being engaged in this way, upon a receptivity to such initiatives" (Conradson, 2003, p. 508). And receptive they were. Perhaps the most compelling evidence of the caring nature of these spaces was the outsized militarized response that came first from police and then the president, himself, who could not fathom that caring spaces can exist without a narrow understanding of "law and order". In response, he mobilized the National Guard, Border Patrol, Homeland Security, and other federal securitization forces, as he sought to dismantle these networks of care rather than care for the body politic.

The more general recognition of the care crisis during the pandemic also led presidential candidate Joe Biden to make care the third of four economic rollouts of his campaign platform. His plan begins from the tripartite recognition that families are emotionally and financially strained by caregiviging, that caregivers are underpaid and undervalued, and there is an immense shortage of paid caregivers in the country (Biden, 2020). Activists, academics, and others have long argued for an attention to this multi-fold care crisis (Addati et al., 2018; Oxfam, 2014; Williams, 2012), but this pandemic brought each of these concerns—systemic racism, economic inequality, the need for more robust social safety—into public discourse. In exacerbating and highlighting the failures of the body politic to care, to take seriously the needs of the social and individual bodies, the pandemic fostered a caring response against the neoliberal-neoconservative imperatives to individualize care. In its place is a turn to the social body *as a body* that is learning to hear each other, to act together, to share in meaning-making, and to care *with* each other. It is this recognition of the interconnectedness of the social body that is pushing the body politic to directly address care, and in time, perhaps to be more caring. Brought together in solidarity by crisis, this politic of caring offers a moment of collective political will that refuses the devolution of social responsibility at the scale of the body politic, demanding, instead, new configurations of care-full policies that attend to the lived realities of everyday people.

2.6. Entanglements of care

If nothing else, the COVID-19 pandemic made plain the uncaring nature of the political-economic arrangements of the U.S. to a wider public. The historical legacies of racial capitalism that bear down on the bodies of BIPOC, the uneven valuation of lives worth saving both in the U.S. and abroad, the relentless extension of market-based competition to include the invisibilization and devaluation of both paid and unpaid caring labors, and the individualization of the responsibility to mitigate against the disease have all become clear in 2020. As Wendy Brown (2017, p. 149) argues, "[t]he project of the state is to facilitate economic growth and a strong investment climate, not the well-being of a particular sector or people, and the project of capital is to generate such growth". When examined at multiple scales through the framework of the three bodies, however, these processes take on different meanings. In this paper, we investigated three bodily scales: the individual, the social, and the political. While analytically useful, as Scheper-Hughes and Lock make clear, these divisions are artificial. Indeed, these scales are entangled, enmeshed, collapsed, expanded, and ultimately fused through this pandemic and through the structures of inequality it exposes and through which it is experienced. Taken together, these three bodies highlight how care is nested; they reveal that to speak of specific caring practices (nursing, food delivery, homeschooling) necessarily requires understanding those practices within larger frames of care (pandemic preparedness and response, the release of necessary medical equipment and supplies), and in a context of uneven social life and community efforts to address that unevenness. Perhaps, therefore, what COVID-19 has done most clearly is to highlight the very basis of care ethics: that we are deeply interdependent social creatures who will not and cannot thrive without care across multiple scales at once.

While it is tempting to wallow in the despair of this pandemic, its unequal impacts, and the failure of the US government, we have chosen to conclude with hope. From the autonomous zones of urban protests to the informal mutual aid societies of rural communities, a new vision of care has taken hold across the US. This ethic of care as redistribution

radiates out from the social body to push for a more caring body politic and to serve the needs of the most vulnerable individuals first. From these efforts in the social body, there has emerged a wider recognition of the need for a reconfiguration of the body politic. This is an important first step. After all, for a caring democracy, we need to think more expansively about what it means to enact democratic caring. Care ethics asks each of us to consider the stakes of what it means to live in an anti-racist, caring democracy together. This democracy moves beyond the "self" as a "separate, essential core", instead understanding a self that is always in relation to others (Hekman, 1995). This is the message that Scheper-Hughes and Lock offer as well. While care is often perceived as an intimate and personal affect, activity, and ethic, in fact, it informs the very foundation of what it means to live in a society together (Robinson, 2011; Tronto, 1993); it is what sustains the entangled individual, social, and political bodies. While the current configuration of the political economy asserts an anemic theory of care, foregrounding economic relations and competition as the basis of all relations, care ethics offers a transformative ethos for reimagining what is possible when we take care of each other. Imagine how different the US will look in 2021 if this is the case.

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Appendix A. Supplementary data

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