COVID-19 and the Working Class: Harm, Resistance, and Solidarity in the United States

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ABSTRACT

Compared to many other wealthy nations, the United States lacks a strong social safety net, has weak legal protections for workers, has suffered long-term declines in unionization, and has eroded the gains in prosperity achieved by the working class in the post-WWII era. Consequently, despite advancements in science and medicine, the U.S. working class has suffered great harms during the COVID-19 pandemic, from the direct effects of illness and mortality and from indirect familial, social, and economic impacts. The failure of the federal government to protect blue collar, service, and retail sales workers with strong mandatory worksite infection control regulations has further endangered working class communities. The dearth of federal leadership has been countered by solidarity and a diversified set of pandemic monitoring and mitigation efforts on the part of worker organizations (primarily labor unions), social service NGOs, Indigenous nations, and communities of color. Defeating the COVID-19 syndemic will require continued working class solidarity, an ethical framework for envisioning a future which prioritizes social and racial justice, and structural economic and sociopolitical transformations.

Population, Political Economy, and the Roots of the COVID-19 Pandemic

For thousands of years, human infectious diseases have disproportionately afflicted the poor.¹⁻³ Early regional shifts in subsistence strategies from foraging to agriculture led to explosive human population growth.⁴ The subsequent development of larger, more complex societies required labor specialization and environmental adaptation for food production and animal husbandry. The detrimental health effects of these subsistence and demographic transitions included malnutrition, reduced body stature, and increases in infectious disease, dental caries, and sedentism.⁴⁻⁶ These conditions set the stage for subsequent patterns of human disease. Although the Industrial Revolution brought technological innovations, increased material wealth for emerging middle classes, and advancements in science and medicine, the benefits of modernization were not enjoyed equally.⁷

A key tenet of classic epidemiologic transition theory⁸ posits that improvements in population health in modern times are dependent on a shift from a predominance of infectious to non-infectious diseases through linear stages of socioeconomic progress. However, the political, economic, and ecosocial realities of the past 50 years have belied this tidy narrative,⁹ as evidenced by the re-emergence of infectious disease pandemics¹⁰⁻¹² and syndemics.¹³⁻¹⁵ Despite the great wealth of the former colonial powers, declines in regular employment¹⁶ coupled with increasing precarity of blue collar and service work,^{17,18} the housing crisis,^{19,20} aging urban infrastructure,²¹ influx of refugees,²² exploitation of immigrants to meet workforce demands,^{23,24} and climate crisis-abetted agricultural and environmental destabilization²⁵ have all contributed to widening economic inequalities²⁶ and increases in class conflict.²⁷ The resulting degradations of local social environments²⁸ create the material conditions for zoonotic spillovers and proliferation of novel pathogens.^{10,25,29,30} The United States, despite its advancements in science and medicine, is particularly vulnerable compared with most other wealthy nations,³¹ because of its absence of a strong social safety net,³² weak legal protections for

workers,³³ long-term declines in unionization,²⁷ erosion of the gains in prosperity achieved by the working class in the post-WWII era,²⁶ and for-profit healthcare system.^{34,35}

The COVID-19 Syndemic: Airborne SARS-CoV-2 / Hazardous Labor / Structural Racism

"It's a vicious cycle. You're not living, you're surviving. Domestic work is not when you choose to do it, but when they need your services. We're completely invisible. We're visible when it comes to ensuring everything is clean, but we're invisible when it comes to our rights."

"Before the pandemic, I was living with my sister and her husband. In the apartment [there were 15 people]. The pantry in an apartment in one of those 'nice' zip codes – where they probably have no idea that COVID-19 exists – that's a [separate] living space for us, the newly arrived. [During the pandemic], I found a closet within someone else's home for me and my two children. It was 72 by 32 inches and rent was \$1,100 a month, with bills included."

Cindia Martinez, 34, housekeeper in San Francisco, quote excerpted from:³⁶

The COVID-19 pandemic has been shaped by complex interactions of ecological, biological, demographic, social, economic, and political factors. Understanding the complexity of these interactions requires a theoretical framework that integrates biosocial processes with the forces that generate inequalities in exposure risk, infections, illness severity, and mortality. Numerous studies have illustrated the central role of social contexts over individual biologies in the production of health disparities.³⁷⁻³⁹ A social environmental frame⁴⁰ to the problem of SARS-CoV-2 transmission must consider the multiple spatial scales at which airborne infection risk is structured and reinforced by social class and racial/ethnic inequalities.^{41,42} These nested and overlapping spatial scales include the individual body, the household, the school, the worksite, the neighborhood, the city, the region, the state, the nation, and the globe.

The syndemic theoretical framework^{13,43,44} has been proposed to make sense of the COVID-19 pandemic in specific global contexts.^{14,15,45-47} Syndemics are defined as public health threats which arise

from the interaction and synergy of two or more separate disease processes or risk conditions that are exacerbated by social environmental factors.⁴⁴ The recognition of synergistic relationships between biological, social, economic, and political factors that influence disease patterns more clearly elucidates complex biosocial pathways than conventional biomedical or individual behavioral causal models.

A recent report on the joint impacts of social class, race/ethnicity, and gender on COVID-19 mortality,⁴⁸ found that among working age adults, COVID-19 mortality in 2020 was five times higher among the working class (those with no college education) than among college graduates. Within each social class, male gender and non-white race/ethnicity resulted in much higher COVID-19 death rates. Working class jobs (blue collar, service, and retail sales) are “never remote” occupations that require onsite labor, and offer workers little control over their time or environment. The American Time Use Survey of 6,600 adults found that working at a workplace (not home) during May – December 2020 was most frequent for transportation workers (91%), service workers (88%), workers with no high school diploma (89%), and high school graduates with no college (87%).⁴⁹ A major U.K. study on socioeconomic inequalities and COVID-19⁵⁰ found that percent working from home during the study period and the “proximity to others” rating of individual occupations were both associated with COVID-19 mortality.⁵¹

The study of social class disparities in COVID-19 mortality,⁴⁸ the UK report,⁵⁰ important theoretical development,⁴² worksite COVID-19 outbreak investigations⁵²⁻⁵⁸ and other empirical studies,^{17,59-63} reveal a tripartite syndemic – comprised of airborne SARS-CoV-2, hazardous labor, and structural racism – as a primary driver of the COVID-19 pandemic. Ecological correlation studies of county-level socioeconomic indicators and crude (non-age-adjusted) death rates have found higher COVID-19 mortality in counties with higher economic adversity,⁶⁴⁻⁷² poorer housing quality,^{65,73} greater household crowding,^{64,74} higher levels of air pollution,^{75,76} higher social vulnerability as measured by the

CDC index,^{46,77-80} higher percent Black and/or other racial minority population,^{64,65,67,70-72,75,76,79,81-84} and greater neighborhood racial segregation.^{69,70,76,85,86} Two ecological studies which analyzed age-adjusted COVID-19 mortality in small areas found similar results to the county studies.^{87,88}

Importantly, a syndemic paradigm also readily discredits racist bioessentialist claims that masquerade as empirical explanations for disease disparities. Operational assumptions of homogeneity within racial/ethnic groups can reinforce a bioessentialist paradigm⁸⁹⁻⁹¹ that situates and explains observed racial/ethnic disparities in health outcomes as an inevitable consequence of the frailties of human bodily constitutions,⁹² rather than as the embodiment of outcomes of adversarial social relations such as racism, class exploitation, and gender violence.^{44,93-95} In the context of the COVID-19 pandemic, the hegemonic biomedical focus on bodily frailty (variously attributed to “genetic susceptibility,” “unhealthy lifestyles,” or “cultural behavior patterns”) moralizes otherness and has readily translated into decontextualized pervasive rhetoric in public discourse on “pre-existing conditions,” “comorbidities,” and “vaccine hesitancy” as key explanations for racial/ethnic disparities in COVID-19 incidence and outcomes.⁹⁶

Social class mortality disparities are just the tip of the syndemic inequality iceberg. For every working age adult COVID-19 decedent, there are dozens to hundreds of survivors. The socioeconomic and familial consequences of COVID-19 diagnosis and illness can be devastating even for those who fully recover their health. Loss of income, job loss, large medical and hospital bills not covered by insurance, and social stigmatization are just a few of the consequences which impact the working class disproportionately. Moreover, the long term health sequelae of SARS-CoV-2 infection are severe in some survivors, leading to crippling fatigue, work-related disability, and inability to perform caretaking tasks for children, elders, and dependent adults.^{97,98} All of these negative consequences can lead to familial and household instability, in some cases culminating in increases in household crowding,

evictions from rental housing, and homelessness. Even among working class adults who have never tested positive for COVID-19, the pandemic has been shown to cause job lay-offs,⁴⁷ food insecurity,⁴⁷ sleep disturbances,⁹⁹ and psychosocial stress.⁹⁹

Working Class and Minority Community Mobilizations Against COVID-19

"I'd really like for people to value the work of those who take care of elderly people and children, because they can't fend for themselves. And it's not valued."

Leticia López, 30, housekeeper in Houston, quote excerpted from:³⁶

"In the pandemic, employers asked us to use toxic products that were more harmful to our health and worsened my condition. [...] As housekeepers, we don't have health or safety protections. How is it possible that our work, which makes other work possible, is something that isn't properly valued? We're human beings and we deserve protections."

Evelin Alfaro, 40, housekeeper in San Francisco, quote excerpted from:³⁶

The Occupational Health and Safety Act of 1971 requires employers to provide *"a place of employment which [is] free from recognized hazards that are causing or are likely to cause death or serious physical harm."*¹⁰⁰ The U.S. Occupational Health and Safety Administration (OSHA) is a regulatory and enforcement agency which has the power to issue mandatory safety standards, inspect worksites, issue citations, and levy monetary fines against employers found in violation of safe workplace standards.¹⁰¹ Unfortunately, years of extremely insufficient funding by congress and erosion of authority by anti-labor presidential administrations have crippled OSHA's ability to protect American workers.^{101,102} During 2020-2021, OSHA has received thousands of worker complaints about COVID-19 and unsafe working conditions, but has investigated only a small fraction of those complaints. As of May 2021, only 346 employers had been cited for violations and the average fine was less than \$4,000.¹⁰²

After promises from the new presidential administration in January 2020, labor unions and the public health community had expected OSHA to issue an Emergency Temporary Standard (ETS), covering all worksites in the U.S., with enhanced and enforceable requirements for workplace safety from airborne infectious disease.¹⁰¹ This ETS was expected to conform to the NIOSH hierarchy of controls (Figure 1), and place the burden of ensuring workplace safety on employers and not on worker behaviors.¹⁰³ Instead, the administration was overly optimistic in the face of declining daily COVID-19 case counts in the spring of 2021 in the U.S., and downplayed the Delta variant surge in Asia. In June 2021, OSHA issued an ETS which only covered healthcare workplaces such as hospitals and nursing homes,¹⁰⁴ leaving the vast majority of workplaces covered only by voluntary safety guidelines.

Figure 1.
National Institute of Occupational Safety and Health (NIOSH)
Diagram of Hierarchy of Controls of Occupational Hazards to Workers.

Source: <https://www.cdc.gov/niosh/topics/hierarchy/default.html>

The dearth of federal agency leadership and initiative to protect U.S. workers from COVID-19 has been met by solidarity and a diversified set of pandemic monitoring and mitigation efforts on the part of worker organizations (primarily labor unions), social service NGOs, and communities of color. There is no national surveillance system for tracking COVID-19 testing, cases, hospitalizations, or deaths by occupation, industry, or any other measure of social class.^{102,105} Only a few state health departments require reporting of worksite outbreaks by employers. The only federal agency to require reporting of worksite COVID-19 infections is the Center for Medicare and Medicaid Services, for nursing home workers only. As of September 26, 2021, over 650,000 cases and over 2,000 deaths among nursing home staff had been reported.¹⁰⁶

Several worker-led grassroots efforts have attempted to compensate for the lack of federal government leadership in tracking worksite transmissions of SARS-CoV-2. The Food and Environment Reporting Network tracked COVID-19 outbreaks in the food processing industry for 500 days, gathering data from local and state health agencies, unions, local news reporting, and employers.^{107,108} On the last day of their unfunded volunteer surveillance project (September 2, 2021) a cumulative total of 91,717 workers at 1,466 meatpacking and food processing plants had been reported as confirmed cases of COVID-19.¹⁰⁷ Similarly, several national labor unions implemented their own COVID-19 tracking systems, including surveys of workers about worksite conditions and employer compliance with current mitigation recommendations from the CDC and OSHA.¹⁰²

Labor unions have provided important protections to workers impacted by COVID-19, through political and legislative advocacy^{102,109} and contract negotiations for specific infection prevention and control concessions.¹¹⁰ Furthermore, unionized worksites experienced greater compliance with public health recommended mitigation strategies¹¹¹ and lower COVID-19 mortality rates¹¹² compared with similar non-unionized worksites.

In a recent study of social class and COVID-19 mortality, it was shown that among the working class and those with some college, Indigenous men and women suffered the highest rates of COVID-19 mortality compared with all other racial/ethnic groups.⁴⁸ Indigenous people have proactively advocated for their most vulnerable community members. In Minnesota, tribal leaders meet regularly with the Lieutenant Governor and officials of the Department of Health to share concerns and provide advice on mitigation strategies.¹¹³ On the Navajo Nation, over 100 Diné community health representatives (CHRs) have taken on extensive new responsibilities to serve rural tribal members during the pandemic. In addition their pre-pandemic duties as lay health educators, the CHRs conduct crisis management, logistics planning, food and water distributions, contact tracing, social work referrals, and mental health counseling.¹¹⁴

Native Hawaiians and Pacific Islanders, who prior to the COVID-19 pandemic suffered high rates of low-wage employment, poverty, homelessness, and incarceration, have responded to the pandemic's devastating impacts with grassroots community solidarity initiatives. In Hawaii and the western U.S., local groups have organized elder care services, and cultural and social events to combat the stress and isolation of the pandemic.¹¹⁵

The Navajo Nation CHR program, with its emphasis on self-determination and care that is both community-directed and community-centered, is a model for workers and local communities across the U.S.¹¹⁴ Similarly, in California and other states, new local coalitions of Hispanic farmworkers, public health workers, community medical clinic staff, and some growers and employers have formed to provide services, education, viral testing, quarantine and isolation housing, and vaccinations to migrant farmworkers and their families.¹¹⁶

CONCLUSION

"For six years, I nannied two children seven days a week. [...] The children's parents are doctors. [...] They didn't raise my salary in six years. I didn't mind all that work because I loved the children so much. In December 2020 I didn't go to work because my husband tested positive for COVID-19. [...] They told me to stay home and take care of myself. When I recovered, I sent them a negative test, and they fired me. Just like that, without saying anything. They didn't let me say goodbye to the kids. That hurts a lot."

Leticia López, 30, housekeeper in Houston, quote excerpted³⁶

"By dissolving social class divisions into occupational categories, educational attainment, and income, the socioeconomic status concept glosses over the structural nature of one class exploiting others. ... [It could] lead one to [falsely] conclude that racial and ethnic inequities in health can be eliminated without structural changes in economic relations."

Oliver and Muntaner¹¹⁷

The human history, thousands of years long, of social stratification and consequent extreme disparities in the burden of infectious diseases is daunting but does not preclude the possibility for transformational social change. A *moral reckoning*,¹¹⁸ an *ethos of care*,⁴¹ and a *moral fusion coalition*,¹¹⁹ have been advanced as ethical frameworks for envisioning and advocating for a future in which social and racial justice and public health for all are valued above unlimited economic growth and concentration of wealth and power in the hands of a few. Defeating the COVID-19 syndemic will require working class solidarity and structural economic and sociopolitical transformations.

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