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Interpersonal and Structural Violence in the Wake of COVID-19

Hospitals are struggling with recurrent surges of COVID-19 patients from low-income communities of color across the United States. Emergency departments face increasing rates of firearm violence patients despite overall decreases in emergency service volumes. In Los Angeles County, California, where we practice, intersecting COVID-19 and violence pandemics are devastating low-income inner-city neighborhoods historically subject to racism, public–private disinvestment, police brutality, and mass incarceration. This deadly pattern appears to be occurring in emergency rooms in poor, segregated neighborhoods across the country.

THE TOXICITY OF SOCIAL INEQUALITY

The social and economic damage unleashed by COVID-19, like cholera and hurricanes, is not random. Global warming and industrial agriculture have shaped the burden of COVID-19 mortalities; thus, COVID-19's mortal impact is defined as much by socioeconomic inequities as it is by viral biology.[1]

Disasters and contagions exacerbate social forces driving neighborhood-level structural vulnerabilities—often referred to by epidemiologists as individual-level "social determinants." These associate with poor health outcomes at the population level. Examples of structural vulnerability include housing insecurity, poverty, incarceration, racism in health care and criminal justice settings, and location within precarious legal labor markets (the box on page 1660 provides more detail).[2]

COVID-19 mortality rates are double in poor communities, which are often segregated by both race and class in the United States. In Los Angeles County, low-income zip codes have triple the COVID-19 mortality rates of wealthy ones. Nationwide, death rates are six times higher in predominantly Black versus White counties. Before the COVID-19 pandemic, firearm violence deaths were already 14 times higher for Black than for White men. Understanding the intersection of racism, poverty, and violence is core to understanding and remediating the cascade of toxic socioeconomic breakdown unleashed by COVID-19.[3]

By mid-September 2020, more than 60 million people had applied for unemployment in the United States since the beginning of the pandemic. A global economic recession is teetering into a Great Depression worse than that of the early 20th century. Skyrocketing unemployment rates propel precariously poor people to scramble for income by any means necessary. Even before the pandemic, almost 40% of the US population lived paycheck to paycheck and were unable to cover a $400 emergency expense. Historically racialized wealth inequality compounds the racist and classist consequences of these economic shocks. From 2001 to 2016, the wealth of upper-income–tier families increased 33%, and that of middle- and low-income families decreased 20% and 45%, respectively. This catapulted the upper income group to 7.4 and 75 times the wealth of the other groups, respectively. Meanwhile, corporations protect their bottom lines, and public health departments forecast austerity budgets that are already causing services to be slashed.[4]

VIOLENT LESSONS FROM US HISTORY

In Los Angeles County, as in most rust-belt cities from the end of the Korean War (1953) through the early 1990s, homicides rose against the backdrop of deindustrialization. Unions were busted and job insecurity and social inequality increased. The global narcotics industry filled the economic vacuum left by shuttered factories. Addiction markets became a desperate source of informal employment and generator of occupational injuries for poor urban youths. Expelled from the legal economy, they were shunted into entry-level workforces at the violent retail end points of the global narcotics chain.

The 1980s policy response of a zero tolerance "war on drugs," increasingly harsh and racist sentencing enhancements, massive investments in a carceral infrastructure, cutbacks to community and social programs, and lack of gun control created a predictable recipe for disaster. Domestic, interpersonal, criminal, and suicidal violence rose in the community. Battered and bullet-ridden youths flooded urban hospital trauma units.[5]

Health care systems responded by spawning a new high-tech, costly discipline of emergency trauma care at the expense of neighborhood public hospitals, preventative care, and public health. The American College of Surgeons published guidelines for optimal care of injured patients in 1976. Emergency

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SOCIAL FORCES DRIVING NEIGHBORHOOD-LEVEL STRUCTURAL VULNERABILITY TO VIOLENCE SINCE THE KOREAN WAR

Deindustrialization	Job loss, chronic unemployment, decimation of unions, plummeting legal labor force participation rates (especially among youths)
Rising levels of social inequality and wealth disparities	Poverty, social precarity, ethnic/racial/class segregation
Public–private sector services disinvestment	Real estate redlining, reduction in public subsidies to the poor and for education, expansion of urban/rural wastelands (abandoned property, toxic dumping, deserts of health care/food/public amenities)
Rise in underground economies	Narcotics markets, sex strolls, gang-based territorial control, white collar crime and other corporate/financial capital racketeering schemes
Historically unprecedented public investment in carceral infrastructure	War on Drugs: routinization of police brutality/corruption/racism, racial/class disparities in punitive sentencing
Gentrification	Race-/class-based population displacement, predatory corporate profiteering

medicine became a board-certified medical subspecialty in 1979.

The United States drew on military logistics and technologies developed in its Korean and Vietnamese invasions and covert campaigns. Modern trauma systems excel at street corner triage with rapid patient transport to designated trauma centers and protocolized resource-intensive treatments. Posttrauma survival improved, but neighborhood-based social determinants of health were left unaddressed.[6]

Social inequality, racism, and militarism are patently bad for public health. When vulnerable individuals are denied access to meaningful employment and deprived of socioeconomic supports, as is occurring during the COVID-19 pandemic, the result is disastrous. When state interventions generate suffering and personal stress, they manifest as individual-level violence to self, kin, friends, and acquaintances. These rising levels of ostensibly interpersonal (but structurally driven) violence undermine social support systems frayed by scarce economic resources. Survival exigencies throw unemployed youths into informal economies, increasing their exposure to violent crime and neighborhood insecurity.

Opportunistic politicians, populist media, and careerist policymakers instrumentalized the rise in public insecurity during the 1980s. They advocated and implemented racist profiling and militarized policing. A massive prison infrastructure was built to contain the rising economic dislocation, suffering, and protest generated by deindustrialization and community disinvestment. Predictably, the systemic routinization of increasingly harsh, racist policing tactics, enhanced sentencing in courts, mass incarceration, and service cutbacks devastated the primarily urban communities of color they targeted in former industrial factory zones. More subtly, social support systems (family, face-to-face community solidarities, collective cultural rituals) that contain youth violence in all societies were weakened. Social supports require publicly funded resources to be sustainable among vulnerable populations in large, depersonalized urban centers. Cycles of economic precarity, shifting narcotics epidemics, and the generalized scramble for scarce resources foments individualistic victim blaming, racism, xenophobia, and generalized distrust and cynicism. Given the disproportionately destructive impact of COVID-19, it is predictable that these structural vulnerabilities will worsen as they are met by ongoing police violence, silence, and withdrawal of existing programs.

WHAT IS TO BE DONE?

Austerity social service budget cuts contradict a rising nationwide recognition that "Black Lives Matter" and call for shifting tax dollars into agencies with supportive rather than repressive priorities. The unprecedented COVID-19 global pandemic offers health care providers unique opportunities for public advocacy, policy reform, and community-centered interventions that must be recognized as essential for effective personalized quality medical care.

The US model of concentrating high-tech, expensive hospital trauma care for violently injured patients in centralized locations far from low-income communities has obviously failed to engage with the structural forces that fuel unacceptable rates of injury and reinjury, unaddressed post-traumatic stress disorder, and other toxic social sequelae. Alternatively, hospital-based violence intervention programs offer a practical community-centered vision of sociostructurally essential trauma care in moments of crisis. These programs decrease reinjury rates, justice involvement, and health care costs by offering longitudinal accompaniment and wraparound services to violently injured patients and their families. They reduce rehospitalization by augmenting quality of life. This strengthens solidarity links in stressed communities.

The incorporation of peer-based accompaniment is especially crucial for moving beyond reactive crisis responses. Hospital-based violence intervention programs create preventative health links with injured patients, families, neighbors, and social service providers and educational and vocational resources. Most importantly, it can expand the purview of health systems and providers to include advocacy and policy reforms that could mitigate upstream social forces and structural determinants of health, including vulnerabilities to violence.[7]

COVID-19 and violence is a disastrous syndemic of structural

violence changing our world and survival chances. In solidarity with vulnerable patients, we need to engage with communities to deliver sustained upstream structural interventions that will outlast humanitarian crisis moments. Economic injustice and racism disproportionately kill or incapacitate our most structurally vulnerable patients, whether from COVID-19–generated respiratory failure or from a spray of bullets. By diagnosing the immediate pathology of patients and by engaging with underlying structural violence in society, health care providers and researchers can help the United States avoid reliving failed history and stem the intertwined pandemics of COVID-19 and violence devastating urban communities of color. AJPH

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

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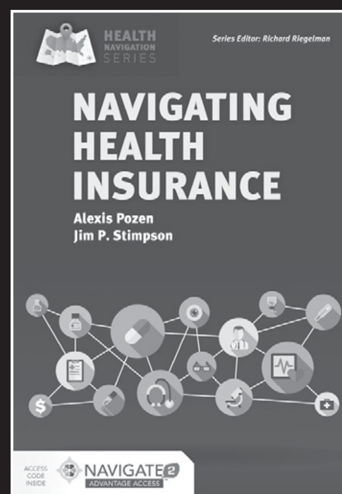
A Practical, Balanced Guide to Understanding Health Insurance



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