

July 2022

Pandemics and Power: An Applied Analysis of American Inequality

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Recommended Citation

Engle, Megan A. (2022) "Pandemics and Power: An Applied Analysis of American Inequality," *Pursuit - The Journal of Undergraduate Research at The University of Tennessee*: Vol. 11 : Iss. 1 , Article 3.

<https://doi.org/10.7290/pur11cfwi>

Available at: <https://trace.tennessee.edu/pursuit/vol11/iss1/3>

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Pandemics and Power: An Applied Analysis of American Inequality

Several notable struggles have long defined the human experience. We fight against one another, the world, and our own limitations. From a humanitarian perspective, disease represents a struggle against human vulnerability and our interconnectedness. Contagion threatens established order, strains public systems, and spurs change. Disease has the potential to destroy individuals, populations, and societies. The conflict between humans and disease is so intrinsic to our existence, that pandemics at their core are not “simply... a medical phenomenon which threatens human culture and society, but rather a phenomenon which in many unpredictable ways, already is human culture and society” (Bjorkdahl and Carlsen 5). The coronavirus pandemic can be seen as a novel, modern iteration of this destructive process and pattern.

While public health crises bring about new issues, they also have a unique ability to reveal pre-existing problems within our society and perpetuate social processes. Understanding historical patterns related to public health crises provides greater insight on the ongoing pandemic and American policy needs. Research reveals that, both historically and presently, systemic social injustices and economic inequalities are inflamed by such public health crises. As a result, pandemics disproportionately affect minority groups in several interconnected ways. In examining public health theory, past pandemics, and the present moment, the effects of both power disparities and increased pressure on an already divided society become painfully apparent. The United States has reported the highest infection rates and death toll of any country (Elflein). By examining public health crises as social phenomena, a greater understanding of underlying issues and patterns contributing to this disastrous situation in the United States can be realized.

General Epidemiological Information

In order to examine both historical public health crises and the current pandemic, a proper foundation must first be laid. As such, it is first important to analyze what some common epidemiological terms denote. An outbreak is a notable, localized, and confined increase of the cases of a disease (Wilder-Smith and Freedman 1). An epidemic is a regionalized increase in cases, and a pandemic is a significant increase in cases across countries or continents (Wilder-Smith and Freedman 2). While these terms offer some description of the different levels of public health crises, these definitions are still rather ambiguous. Notably, these terms offer no real assessment of a disease's severity. As such, one pandemic may have a rather low mortality rate, and another could be disastrous. This variation is often unappreciated by or not properly conveyed to the public. Moreover, these terms are often borrowed outside of the medical field. Often these terms are employed to describe social issues with an air of urgency and gravity (i.e. a crime epidemic) (Rosenberg 1). Such application contributes to the politicization of epidemics and pandemics. As these terms have gained deeply troubled connotations, the labeling, addressing, and marketing of public health crises has become a complex, muddled affair. Judicious and clear employment of these terms can be helpful; lackadaisical, non-germane usage can contribute to a general desensitization to public health crises.

Whereas relatively minor pandemics and epidemics periodically occur, covid-19 is a once-in-a-lifetime public health crisis. On December 31, 2019, the discovery of this novel coronavirus was reported to the World Health Organization (Caleb). It was first recorded in Wuhan, China, and it quickly spread throughout and beyond the country (Caleb). After SARS-CoV and MERS-CoV, covid-19 is the third recorded zoonotic coronavirus ever (Caleb). While its predecessors only culminated in outbreaks and epidemics, on March 11, 2020, the World Health Organization officially declared covid-19 a pandemic (WHO). At this point, there were

approximately 118,000 reported cases in 114 countries and 4,291 deaths (WHO). Ten years prior, the H1N1 pandemic in 2009 stands as the closest reference point; however, the H1N1 pandemic's relatively low fatality rate, duration, and social impact demonstrate the ambiguity of relevant epidemiological terms. Ultimately, there is not a good modern reference point for the current pandemic. This pandemic has challenged us to collectively rethink public health responses and social processes.

As covid-19 is an ongoing public health crisis, relevant figures and statistics concerning the disease are constantly changing. This virus' astounding severity and rapid spread have illuminated systematic insufficiencies and troubling societal issues. That being said, reviewing previous epidemics and pandemics can still yield meaningful social information about our current moment. Examining public health crises as social processes and problems provides a unique view of how our society is structured and operates under pressures. In adopting historical and theoretical lenses, this research seeks to demonstrate how the covid-19 pandemic has adhered to and deviated from previous patterns.

Pandemic Processes

Scholars have identified a number of processes that underwrite typical social responses to public health crises and pandemics. While every epidemic and pandemic is largely distinct, studying previous incidents reveals notable underlying trends and issues. Understanding these commonalities allows for conscious and meaningful action in the present.

One relevant model related to the public and health crises is the social response pattern. This three-step process seeks to explain how the general population tends to react to public health risks and how that affects disease spread progression. During the first stage of this process, at the onset of a public health crisis, disease spread will occur faster than information

dissemination (Abraham 1307). This lag is due to an information deficit caused by the new, rapidly changing situation. It is also in part caused by a resistance to recognize the issue. Early on, the public tends to ignore the danger “until the acceleration of illness and deaths forces reluctant acknowledgment” (Jones 1681). The general societal tendency to resist acknowledging a pandemic or public health crisis stems from a distaste for the economic and social consequences of such events (Rosenberg 4). By nature, public health crises bring about major daily and long-term disruptions. Regardless of popular sentiments, recognition of the situation is necessary and inevitable.

In the second stage of this process, as hesitant realization spreads, the public demands information (Jones 1681). Typically at this point, governments and public health authorities will seek to control the dialogue, provide answers, and project certainty. This strategy is problematic in several ways. Notably, this approach fails because its goals are impossible. During the early stages of a public health crisis, there are rarely certainties or clear-cut answers. The situation and available information is always changing. In attempting project certainty in uncertain times, these bodies are merely delaying and amplifying confusion.

Additionally, research has shown that adopting a bilateral, dynamic information exchange model of communication is more effective in addressing public anxieties (Alyushina and Kucheruk 100). A bilateral process involves altering communication style and content to address the public’s specific needs (Alyushina and Kucheruk 100). That is to say that communication functions as a two-directional process between public health officials and the public. Effective communication must also be a dynamic process; as the situation and available information change, the message must change to reflect that. In doing this, the informing body can attain a higher level of civil rest and clarity. As such, some of the psychological and scarcity issues

associated with crises can be prevented or at least lessened. Seeking to control a singular, static narrative is apt to spur hostilities and confusion.

Finally, the pandemic will either be resolved through action or inaction; the disease will stop spreading when redress efforts advance, or when the malady has “exhausted the supply of susceptible victims” (Jones 1). Although through scientific advances humans have collectively become better suited to address public health crises, epidemics and pandemics remain trying times for both experts and laymen. The end of a public health crisis is often ill-defined; pandemics typically conclude “with a whimper, not a bang” (Rosenberg 8). From both a policy and popular standpoint, a pandemic is not a sprint; rather we are all running for our lives. The finish line is not clear, the course is unknown, and the danger is ever-changing. While these three pandemic phases can be used to interpret previous crises, it is often difficult to recognize them in real-time. These periods of avoidance, information, and resolution bleed into one another. Generally speaking, the effectiveness of early response efforts can influence the ultimate trajectory of the crisis (Rosenberg 8).

While the aforementioned three-step process offers a rather universal, and timeless assessment of pandemic social progression, there is another notable process associated with public health crises that speaks specifically to the contemporary era. In our modern age, with advances in science and increased access to information, there have undeniably been some changes to crisis redress. Examining modern public health crises, it is generally the case that as a public health crisis gains attention, there are aggressive governmental and organizational responses (Jones 1683). Typically, these measures are disproportionate to the actual danger at hand. Often, public fears and forecasts exceed actual outcomes; this is all to say that the perceived danger centers around a risk “that never [fully] materialize[s]” (Jones 1683). When

this discrepancy between expectations and reality becomes apparent to the public, panic begins to transform into distrust.

Disproportionate responses to public health crises cause long-term issues. When epidemics and pandemics frequently play out as less severe than expected, government and public health authorities gradually lose popular credibility. During the H1N1 Swine Flu Pandemic in 2009, growing public mistrust caused many to question the competency of the government and public health authorities (Abraham 1307). This doubt and skepticism cause some to even reject vaccination (Abraham 1307). When the public largely does not trust policymakers and experts, meaningful action is dramatically slowed. Poor communication and ineffectual practices decrease political and institutional efficacy, thus placing the public at increased risk of contagion; if vaccines and issued medical advice are not trusted by the general public, the risk of disease increases. As such, over time, disproportionate responses create a negative feedback loop; the original, real danger is less than projections, which causes a decrease in public trust and compliance, which in turn increases the danger.

Essentially, the public is apt to become desensitized to public health crises which can exacerbate the problem. Although pandemics and epidemics often fail to meet expectations, sometimes they surpass them. This presents a serious problem, as the public grows accustomed to over-preparation and mild crises. Therefore, when more severe epidemics and pandemics occur, the public is apt to approach them with skepticism. Like in the parable of the boy who cried wolf, when the public feels repeatedly misled about danger, they are not likely to respond properly to a legitimately severe crisis. While it is difficult to accurately communicate in a dynamic situation, misrepresentations, such as disproportionate response, can lead to serious

long-term issues. The mistrust and hesitancy of many to accept the reality of the coronavirus pandemic demonstrate the danger of this pattern.

Pandemic Problems

In analyzing epidemics and pandemics, another unfortunate social tendency emerges related to public health crises; the abnormal pressures placed on society by these crises tend to intensify underlying issues of inequality and discrimination (Jones 1682). Minority and marginalized groups are often both at a disproportionately high risk of contagion and likely to face increased persecution during public health crises. Understanding the social issues associated with pandemics allows for more impactful policy and action. Moreover, studying these issues with a historical lens offers context to the social unrest and injustices we have seen throughout the coronavirus pandemic.

Stigmatization and Systemic Inequalities

Up until about the sixteenth century, malady and epidemics were generally viewed in a moralistic and religious lens rather than a scientific one (Rosenberg 5). As such, those who succumbed to illness were often blamed for their plight. Gradually, scientific and secular explanations of disease have emerged. Since that period, with varying margins, these two views of disease have coexisted (Rosenberg 5). While today the field of epidemiology explains the spread of disease, there are still popular holdover beliefs and notions about disease predisposition that hold some troubling implications. Laymen tend to seek reassurance of their personal safety by attributing higher risk to those of compromised character or lower socioeconomic status; two things which are often conflated in the public's mind (Rosenberg 6, 8). In other words, the general public tends to believe the impoverished, minority populations, and the so-called immoral are more likely to become sick. This belief is problematic because it is a faulty

interpretation of a legitimate tendency. This moral-centric, self-serving view does not capture the true cause of this disparity. Economically disadvantaged populations, marginalized groups (including prison populations), and racial minorities typically see increased rates of disease during public health crises (Solis et al. 1). These individuals have a higher risk of contagion not because of some lack of morality, but rather because of their systemic vulnerabilities.

These groups historically have had less access to healthcare services and increased exposure to contagion (Rosenberg 8). Generally speaking, these subsets of the population have and do both live and work in crowded, poorly ventilated, and improper quarters (Rosenberg 6). Consequently, this segment of the population tends to see increased rates of disease. Although housing conditions within the industrialized world have largely improved over time, the working class remains largely in substandard housing, with little healthcare access, and increased risk of exposure via their metiers as compared to the middle and upper classes (Rosenberg 6). Society's general tendency to misattribute the cause of marginalized groups' increased risk of disease can inhibit effective redress. When marginalized segments of the population do not have access to the policy process and are blamed for sickness, there is no meaningful pressure to advocate their interests within the formal political process. These groups are arbitrarily, systemically devalued by those in sociopolitical power, and their disproportionate suffering can be used to create a comforting, false narrative for others.

Discrimination, Persecution, and Scapegoating

Another issue that emerges for marginalized and minority groups during public health crises is increased persecution and targeting. In line with aforementioned popular views of contagion, minority groups, who often experience disease at higher rates due to their systemic vulnerabilities, have often been stigmatized or blamed in conjunction with epidemics and

pandemics (Rosenburg 6). Believing that these segments of the population are either responsible for or carry the disease, the larger public tends to ostracise or persecute them. This desire to find an outgroup scapegoat has long stood as a means to discount danger for the ingroup. In associating the threat with another group and actively targeting them, the rest of the population is diverting their attention away from the real issue and creating a sense of protection for themselves. This tendency can be seen at many historical and contemporary points throughout the world.

Notably, during the Bubonic Plague (1347–1352), Jewish communities were targeted and persecuted at increased rates (Jones 1682). During this period, based on the relevant available records, it is estimated 47% of Jewish communities in Europe experienced observable forms of persecution (Jedwab et al. 356). Around this time, there were 53 recorded pogroms and 13 expulsions of Jewish communities (Jedwab et al. 356). Many Jewish individuals were also targeted and tortured into false confessions about poisoned wells or other presumed causes of the disease (Jedwab et al. 347). These actions indicate a direct association between the Jewish population and the disease in the minds of the general public. By arbitrarily casting their fears and frustration concerning the public health crisis onto the Jewish population, the majority group was attempting to create a sense of safety for themselves; they tried to identify and eliminate the cause of the disease. However, this course of action only perpetuates suffering.

Researchers found that Jewish communities with a higher economic impact on their regions tended to see lower rates of persecution (Jedwab et al. 345). As such, it can again be stated that public health crises inflame issues of inequality and intensify societal value systems. Economically influential groups were largely protected from persecution because their services and capital outweighed the general public's bias against them. This trend also demonstrated the

scope of economic concerns and fears associated with public health crises. By not targeting economically influential groups, society is demonstrating a desire to maintain some semblance of normalcy and stability within their quickly changing world. This trend also points to implicit value hierarchies. In this situation, economic safety and perceived health risks were pitted against one another. The outgroup here valued preserving what they could of economic stability over the facade of personal safety they attempted to gain through persecution. This preoccupation with economics in public health crises can also be seen in our response to covid-19 as well.

Additionally, periodically throughout the nineteenth century across America, immigrant populations were being targeted as the cause of disease outbreaks, notably cholera. In New York City in 1892, there were calls to stop the immigration of “ignorant Russian Jews and Hungarians” as they were seen as “a positive menace to the health of this country” (Markel 422). The *New York Times* asserted that “their mode of life... makes them always a source of danger” (Markel 422). Around the same time in Boston, the public was proclaiming “not a single immigrant should have been allowed to enter our ports... [and] some steamships that bring immigrants to the United States are guilty... [and] they ought to be made to suffer for their acts” (*Boston Investigator*). Ultimately, the popular and flawed belief during this time was that “[c]holera... originates in the homes of this human riff-raff” (Markel 422).

This sentiment speaks to an underlying nationalistic, anti-immigration ideology. As aforementioned, public health crises strain societies and shed light on pre-existing values, issues, and conflicts. Although immigrant populations in this era tended to exhibit a higher rate of disease, this rhetoric attempts to associate them, their character, and their habits with malady rather than the subpar living and working conditions they faced. As such, these stances inhibit

actual meaningful action, and they only call for arbitrary and harmful policies. Isolating vulnerable groups creates more social strife than public safety. Moreover, the former is an issue that greatly outlasts the theoretical latter benefit. This example also demonstrates the potential to use public health crises as a platform to advance political goals.

Asian communities have also historically faced significant persecution and discrimination in association with public health crises. In 1876, White residents of Antioch, California expelled the city's Chinese population and then burned its Chinatown down (Pfaelzar 147). This expulsion was spurred by a fear of sexually transmitted infections spreading from Chinese sex workers to White men and subsequently their wives (Pfaelzar 148). Analyzing existing records, it appears that the majority group was not upset with the White men who were frequenting the brothels or prostitutes, but rather their anger was solely placed on the Asian sex workers (Pfaelzar 148). Although both groups played an active role in creating this public health crisis, popular sentiment valued the former group over the latter on account of both their race and occupation. This framework disassociates people's actions from consequences, and as a result, it creates a culture without accountability for socially privileged individuals.

Popularly circulating claims at the time asserted that over 90% of Chinese prostitutes were infected (Pfaelzar 148). The region's White population looked at Chinese and Asian immigrants as "a disgrace that must be wiped out" and a "contaminating influence" (*Milwaukee Daily Sentinel*). While reports from the time claim "no violence was used, nor did any unbecoming conduct detract from the dignity and propriety of the whole proceeding," the act of expulsion is intrinsically discriminatory, divisive, and violent (*Milwaukee Daily Sentinel*). This event demonstrates the illogical nature of popular responses to crises, suggests that existing

social cleavages can easily be inflamed to a boiling point, and shows that ingroups have immense control over communal narratives.

There are numerous other incidents of Asian persecution and discrimination related to public health crises in American history. In 1900 in San Francisco during a bubonic plague epidemic, the city's Chinatown was forcibly roped off and placed under quarantine (Jones 1682). This type of isolationist and targeted response demonstrates the far-reaching effects of social division and unjust power structures. More recently, a 2019 survey study found that 1 in 7 Asian American adults reported experiencing discrimination in a medical setting (McMurtry et al. 1426). This population also self-reported a much higher rate of avoidance of medical services due to a fear of racial discrimination (McMurtry et al. 1426). With both decreased quality of care and likelihood to seek care, this group is at an increased risk of contagion during public health crises. Both the long history of persecution related to public health crises and the pattern of interpersonal discrimination related to healthcare speak to underlying hostilities the White majority group maintains towards Asians. These aforementioned events also speak to society's propensity to violence, extremism, and division in face of the alarming, unpredictable changes that often accompany public health crises.

These incidents of persecution are only a sample of a terrible pattern. Together, they show how public health crises can intensify social divides, highlight social values systems, and spur widespread social movements. Added strain on societal systems simply fuels existing problems. Groups with political, economic, and social influence are apt to target those without it. Historically, those who faced these injustices were constrained in their ability to affect change through traditional channels. Given their relatively lesser socioeconomic and political status, these outgroups were largely excluded from decision-making processes. In all of these outlined

cases, those with the power to affect meaningful change were those perpetuating and benefitting from the injustice. Furthermore, lacking mass communication and other modern technologies, mobilization and organized resistance were more difficult for these aforementioned outgroups.

Modern Application

In many senses, the coronavirus pandemic has unfortunately been a modern iteration of these social problems and processes. Examining the United States' experience of this public health crisis, it becomes apparent that preexisting divides, inequalities, and biases were grossly inflamed under the pressure of the novel coronavirus. Throughout this pandemic, minority groups have seen increased persecution, infection rates, and mortality. Their disproportionate experience of the coronavirus pandemic represents the escalation of social tensions and amplification of economic divides. However, as the public health crises continue to occur in the modern era, a plethora of new factors have been introduced to this social equation. Namely, the rise of mass media and digital communication has changed how different social groups interact with one another, and they have reshaped how our collective narrative is formed. As a result, issues of inequality and injustice have gained increased popular and political attention over the past few months. Understanding how the aforementioned patterns and problems are manifesting and changing now will allow for meaningful redress.

Health Disparities

Long before the pandemic, there have been serious health-related divides in America. Our country's long history of racism and wealth inequality disadvantage segments of the population in extreme and often unseen ways. Minority populations are at a generally higher risk of poor health due to their disproportionately high poverty rates and limited access to healthcare resources (Galea and Abdalla 2). A Princeton study concluded that the socioeconomic divides

between different racial groups in America directly impact their life expectancy and quality (Carlson). The life expectancy for an African American individual is 3.5 years shorter than that of their White counterpart (Galea and Abdalla 2). The life expectancy for an Indigenous individual is 4.06 years shorter than their White counterpart (Carlson). These statistics speak to the serious and far-reaching effects of racial injustices and divides in America on the lived experience, and they show the dire nature of healthcare disparities. The added pressure of the pandemic has greatly inflamed these divides.

Examining coronavirus infection, death, and vaccination rates by race, the serious implications of socioeconomic inequalities and injustices become even more painfully visible. Adjusted for age, Pacific Islanders and Latinx individuals are 2.5 times more likely to die from the coronavirus than their White counterparts (“Color Of Coronavirus”). Additionally, African Americans and Indigenous individuals are respectively 2.3 and 2.2 times more likely to die from the coronavirus than their White counterparts (“Color Of Coronavirus”). Representing only 0.8% of the population and 1.3% of coronavirus deaths in the United States, Indigenous individuals exhibit the highest actual mortality rate (“Color Of Coronavirus”).

These staggering disparities in outcomes reflect the effects of unequal access to healthcare and the legacy of racially-based medical bias (Galea and Abdalla 2). While it would be logical to vaccinate populations that have been disproportionately affected by the pandemic at higher rates, that is not happening. As of mid 2021, the vaccination rate of White individuals is 1.5 times higher than that of Latinx individuals and African American individuals (Ndugga et al.). Near the end of April, the overall rate of vaccination increased by approximately 1%, but racial inequalities in vaccination rates remained constant (Ndugga et al.).

Inequality in vaccination is in large part due to the systemic vulnerabilities, resource limitations, and cultural hesitancies facing minority groups. Statistically undervaccinated populations tend to live farther from vaccination locations, have less access to transportation infrastructure, and are less likely to have broadband internet (Lewis). With these serious disadvantages, vaccination is harder for communities of color. Moreover, with a long history of medical bias and unethical treatment of minorities in the American healthcare system, many in these groups express decreased institutional efficacy (Khubchandani et al. 276). This pattern of mistreatment has contributed to increased vaccine hesitancy in communities of color. All of this is to say, groups that have been disproportionately affected by the pandemic are being undertreated and undervaccinated leaving them at a higher risk.

The apparent divides between social majority and minority groups' experiences of the pandemic reflect the arbitrary devaluation of certain communities. As these groups have historically been excluded from the American policy process, their interests have long been underrepresented in the formal political process. This exclusion from the public sector and decision-making has perpetuated and augmented resource inequality and healthcare disparities seen in America. As division and exclusion allow for resource concentration with the powerful in-group, our social structures have been built to maintain these outlined social, economic, and political cleavages.

Social Unrest

The divides and tensions associated with healthcare inequality have been further compounded by general social unrest. Throughout and before the pandemic, the American public has been becoming more divided and discontented. This represents a continuation of the aforementioned social response patterns; increased pressure fractures societal systems and

intensifies existing issues. The coronavirus pandemic is deviating from typical iterations of social response patterns in that historically marginalized interests have gained much more domestic and international attention. This mass mobilization is a promising sign for policy change and redress, but resistance to change still remains large.

From a partisan standpoint, political division has been escalating and defining civic life in America for years. Public health policy responses to the pandemic further fueled the conflict between conservatives and progressives (Brennan). Throughout the pandemic, conservatives' focus on personal liberties and autonomy has been at odds with progressives' focus on the communal good (Brennan). This tension has manifested in interpersonal conflicts, policy debates, and disjointed public policy (Brennan). The question central to this conflict is that of our obligation to the community. Should our policy reflect an individualist or collectivist worldview? This question is also central to racial and economic debates in America. Answering this question requires us to consider the ideal relationship between freedom and equality in American society. There has been an observable and continually growing push to expand economic and social equality, but it has been constantly met with strong resistance.

The United States, a liberal political system, has historically prioritized freedom over equality (Ball et al.). The American cultural narrative has long been that of individual triumph and success; rags to riches, the boot-strap narrative, etc. In practice, this cultural and political ideology has allowed for the rise of great inequality. While historically the public discourse has focused on the overly-simplistic narrative of the top 1% versus the general population, we are now forced to realize the much more complex reality of socioeconomic stratification in America (Galea and Abdalla 1). The divide between the top 20% of Americans and the bottom 80% is continually growing (Galea and Abdalla 1). Over the years, this increasing economic divide has

contributed to growing social division (Galea and Abdalla 1). The lower socioeconomic segment of society has historically been underrepresented and marginalized in the public arena. This segment of the population is disproportionately composed of racial minorities (Galea and Abdalla 1).

This pattern of stratification and marginalization has created strong racial and social divides within American society. The historic and modern abuse of African American, Indigenous, Latinx, Asian, Pacific Islander, immigrant, and LGBTQ+ communities has deeply damaged our society. (Galea and Abdalla 1). These groups are socioeconomically and politically disadvantaged, and they have been traditionally excluded from our collective national narrative (Galea and Abdalla 1). This kind of exclusion augments inequality over time and perpetuates marginalization. When segments of the population are devalued, degraded, and disadvantaged, the collective does not benefit from the productivity, ingenuity, and potential of all its members. Inclusion and equality promote growth and process. These ongoing social injustices have been gaining popular attention, but addressing the complex, interconnected issues of sociocultural, economic, and political inequality would require an extensive restructuring of our nation's power structures and value systems. Due in part to the scope of this issue, redress is slow, nonlinear, and opposed.

These divides have been sustained and have intensified for years because a large segment of the population was benefiting from it. For decades the top 20% of the population has been enjoying personal economic growth and political influence (Galea and Abdalla 2). As such, it has remained in their interest to preserve the status quo and perpetuate existing social patterns (Galea and Abdalla 2). Expanding opportunities for the rest of the population would diffuse power more throughout the country. Those who have historically enjoyed relatively concentrated social,

economic, and political power would not directly benefit from an expansion of power and resources. In fact, they would be relatively hurt by such a change. With the concept of scarcity, addressing inequality requires the reduction of some groups' power and resources. As those who would benefit from the diffusion of power have been excluded or marginalized in the policy-making process, these issues have not received sufficient national attention or redress. Nonetheless, as divides continue to intensify, these issues have been gradually gaining popular interest (Brescia 3).

Traditionally, without a meaningful platform to advance their interests within the formal political process, minority groups have been pushing for change through protests and other social movements (Brennan). While this is a long-standing tendency, protests and activism have exponentially increased during the pandemic (Brennan). I contend that this is due to the inherently exasperating nature of public health crises on social systems and the spread of new media. Given the rise and integration of mass communication technologies into quotidian life, the general public now has a unique ability to voice their political and social opinions to a much larger audience much faster (Brescia 3). As a result in the modern era, historically marginalized groups have a new platform to air their grievances, demand redress, and mobilize support. While technological innovates and communication advancements do not inherently create social change, they facilitate the process (Brescia 4).

Specifically, the availability and prominence of news media and social media in our daily lives have provided minority groups with a much greater ability to mobilize their interests. Studies have reported that between 80% and 90% of people today consume media for a total of twenty-four hours per week (Hall and Li). Throughout the pandemic, stay-at-home orders and social distancing measures have contributed to a rise in media consumption (Hall and Li). With

the speed, availability, and prevalence of information about current events and issues all increasing, people are becoming more cognizant of what is happening in the world around them. Additionally, with more voices and interests being represented in our media, greater attention is being placed on historically under-acknowledged issues, thereby placing greater pressure on the state to address them.

For minority groups and their interests, social media has been an extremely powerful tool throughout the pandemic. In the Digital Age, everyone has the ability to participate in the dissemination and consumption of information. As a result, today's media landscape is extremely rich, dynamic, and interconnected. To an extent, social media acts as an equalizing force in our public discourse. It provides average individuals with unprecedented and relatively unmediated access to the public forum. Certainly, there remains a unique system of power dynamics that influences how information is circulated. Nonetheless, social media provides historically marginalized groups greater opportunity to advance their interests in the public sphere. Additionally, research has shown that people are more likely to post and interact with emotional content on social media during crises (Steinert). This pattern has been seen during the coronavirus pandemic (Steinert). With the increased prevalence of and receptiveness towards pathological content, cultural value shifting is likely to occur in periods of crisis (Steinert). Whereas minority groups now have increased access to the public and control over their narrative through social media, they are able to take advantage of this pattern. This all simply means that social media and the pandemic have allowed people to communicate and mobilize much more effectively and quickly.

From a social perspective, this change in communication processes is perhaps the most notable difference between the coronavirus pandemic and aforementioned public health crises.

There still remains an undeniable power disparity between those with and those without power in the formal political process, but we are seeing a transformation of social pressures from previously destructive to more constructive cycles. It is important to note that this communication change has not directly reduced the health, economic, and social inequalities faced by minority groups during public health crises. Rather, the democratization of public communication represents an early step towards addressing these issues. Acknowledging these issues is necessary for further action. While there remains much to do to address these issues, this shift remains a large break from traditional societal patterns.

It must also be acknowledged that this period has seen a rise in conservative protests and demonstrations (Brennan). These events can be interpreted as an attempt to push back against the diffusion of political and economic power. This group feels threatened by the mobilization of oppositional social movements. Addressing existing inequalities is likely to harm this group's interests. Conservative demonstrations during the pandemic also represent an attempt to cope with or challenge the feeling of loss associated with the 2020 presidential election (Brennan). The difference between this group's worldview and recent events has created a strong sense of cognitive dissonance. This kind of mental unease drives many to try to reshape their perceptions of reality (Manjoo 45). On a large scale, this process can lead to the spread of conspiracy theories and extreme social cleavages (Manjoo 45). That is exactly what has happened. Existing divides and far-right movements have gained popularity with this subgroup, as they offer an alternative narrative that reaffirms their perceptions. This development reflects historical patterns of intensifying social cleavages, but it also represents an attempt to counter novel developments in the public's social response. In essence, this behavior shows the historically powerful social group's attempt to double down on tradition in order to suppress change.

In examining both progressive and conservative behavior during this period, it is clear that division is intensifying. This type of escalating cleavages is consistent with historical social response patterns to public health crises, but the power dynamics behind this process are shifting. Just as the social response phases to pandemics are not clearly differentiated, the endpoint of this division is also incredibly unclear. Only time will tell where this will lead. The increasing domestic and international focus on issues of racial, gender, and economic inequalities remains a promising sign for further social change.

Conclusion

Historically, there have been several notable processes and problems associated with public health crises. General responses to public health crises are marked by hesitancy, uncertainty, and fear. Unfortunately, that fear often manifests in social conflict between majority and minority groups. Public health crises place extreme and sudden pressure on social systems. As a result, pandemics tend to reveal who the dominant culture values and who it does not. The gravity of these processes and issues cannot be overstated.

In many ways, these historical patterns define the current public health crisis, but we are also seeing promising changes. The rise of digital media and mass communication technology has contributed to a power and cultural shift. As historically marginalized voices are gaining more access to decision-making and the popular discourse, the injustices they face are becoming more difficult to ignore. Widespread pushback against the traditional social order and practices offers a promising sign for the future. That said, this process has also augmented and highlighted the country's pre-existing racial and economic cleavages. Examining historic public health crisis responses would suggest that this intensification of divisions is normative.

However, I contend that the escalation of these divides and their associated conflicts represents something more. Whereas historically increased division associated with public health crises has merely demonstrated the perpetuation of polarized power dynamics, now we are seeing a greater call and march towards meaningful redress. Social media and the digital environment have given traditionally suppressed actors comparatively more power within our society. The barriers to equality remain large, but the power structure underlying this conflict is now fundamentally changed. We are no longer operating in a system where injustice is completely ignored and unseen; there are now more mechanisms to force accountability or at least mobilize opposition. With the proliferation of socially progressive voices in our informal social discourse, we may be approaching critical mass for social change. Much more must still be done for the realization of true, lasting equality. One thing is clear. We cannot and will not ever return to the world before covid-19. As our world tries to restore some semblance of normalcy, we must work to consolidate and perpetuate constructive social change.

Acknowledgements

This research was made possible through an enrichment grant awarded by the University of Tennessee Honors and Scholars Department. I would also like to extend my greatest appreciation to Dr. Robin Gray Nicks (University of Tennessee Department of English) and Dr. Chana Solomon-Schwartz (University of Tennessee Department of Political Science) for their mentorship, supervision, and support.

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