Original Research Article

Politics and Space

EPC: Politics and Space
2022, Vol. 0(0) 1–24

DOI: 10.1177/23996544211057677
journals.sagepub.com/home/epc
SAGE

COVID "death pits": US nursing homes, racial capitalism, and the urgency of antiracist eldercare

Shiloh Krupar
Culture and Politics Program and Geography, Walsh School of Foreign Service, Georgetown University, Washington, DC, USA

Amina Sadural
Culture and Politics Program, Walsh School of Foreign Service, Georgetown University, Washington, DC, USA

Abstract

Rampant COVID-19 outbreaks in US nursing homes have presented a massive biosecurity problem for the nation, bringing into stark relief the racialized stratification of eldercare administration and long-term care. This paper, by foregrounding the ways racial capitalism drives the chronic devaluation of nursing home residents and staff, provides an overview of how racism and ageism operate geographically through political ecologies of COVID in relation to the organization of the nursing home industry, medical scarcity, long-term care labor, and pandemic response to elderly populations. The inventory tracks some of the ways nursing homes condition race-based futures by arranging eldercare populations, workers, and spaces for extraction, abandonment, and blame for the pandemic. In doing so, it demonstrates the need for more equitable forms of aging and more just institutions of eldercare that put the social welfare of the aged, especially that of BIPOC elders and caregivers, above corporate compliance and financial performance that reproduce racial hierarchy and white supremacy in US healthcare. The article concludes by engaging with Black feminist data analytics and several policy efforts that challenge the structurally racist conditions of caregiving, pandemic response, and securitized segregation of the aged.

Keywords

Racial capitalism, labor, care, quarantine, pandemic, medicine, age, race

Introduction

Over one-third of all reported COVID-19-related deaths in the US have been nursing home residents or workers (Hochman, 2020). In some states the figure rises to fifty percent[1] (Quinton, 2020). Only

Corresponding author:
Shiloh Krupar, Culture and Politics Program and Geography, Walsh School of Foreign Service Georgetown University, 301 Intercultural Center, 37th and O Streets NW, Washington, DC 20057-0004, USA.
Email: srk34@georgetown.edu

less than half of one percent of Americans—an estimated 1.3 to 1.4 million people—live in these facilities. While the majority of deaths related to the coronavirus crisis have taken place within hospitals, the second most common setting is nursing homes and long-term care facilities. The high incidence of death in long-term care homes indicates the disproportionate impact of COVID-19 among the aging population, and the difficulty of these facilities to control the spread of COVID-19 among residents and staff.

Even as a flurry of reporting raises the issue of nursing homes as ground zero of the pandemic, general acceptance of nursing home infections and death—massively amplified by COVID-19—shows the lack of value placed on the elderly and their caregivers in the US. Ageist, ableist, and eugenics-oriented mindsets pervade consideration of nursing homes. In capitalist societies, eldercare is considered nonproductive, and thus is carried out by marginalized laborers, to serve "unproductive" elderly people (Federici, 2012). Failing eldercare is structural—a feature of the broader crisis of care evident across OECD nations (Armstrong and Armstrong, 2019; Williams, 2020). Critical scholarship has examined the neoliberalization of national health systems, such as that of Canada and the UK, and modes of privatization within publicly-subsidized long-term senior care (Armstrong et al., 2016; Baines and Armstrong, 2019). Neoliberal state retrenchment has intensified the exploitation of care workers who are drawn from feminized and racialized labor pools under deficit conditions (Molinari and Pratt, 2021: 13). Feminist political-economic scholars connect this reprivatization of social reproduction and devaluation of care labor across countries, scrutinizing the financial strategies of long-term care facilities. Assetization of social infrastructure and landed property serves as a primary way to lock in revenue streams throughout complex chains of care, while avoiding significant oversight of public funds used in highly leveraged acquisitions, subcontracting, and lease-back arrangements (Strauss, 2021; Williams, 2020; Horton, 2019; Bannerjee et al., 2012). Debates over substandard care in for-profit, nonprofit, and public long-term care facilities converge around the recognition of mounting zones of ageist and racist abandonment and outbreaks of infection.

This paper focuses on the specific manner in which racial capitalism and legislation works in the US to intensify and exploit this pattern of devaluation and extraction from eldercare. Situating the analysis within critical geographies of race and COVID-19, it shows how "death pits" of eldercare invert the capitalist family values extolled in American policies, to reveal the fundamentally "uncaring" authoritarian racial stratification at the center of American civics, institutions, and health care (Lopez and Neely, 2020; Sparke and Anguelov, 2020; Wallace et al., 2020; Cooper, 2017). The reluctance to speak about race in long-term care homes and policies around this industry further contributes to the lack of critical research on the way the pandemic is impacting elderly communities and caregivers. There is a bewildering and ever-expanding debate over which facilities have handled the coronavirus better, backed by a fusillade of variables and comparative assessments.[2] While all of these factors are worth examination, such studies remain unable to explain the *genocidal* effects of COVID-19 on elder BIPOC individuals due to the active incubating and spreading of the virus through racialized neoliberal pathways of disease-based bioinsecurity in places like nursing homes (Sparke and Anguelov, 2020). Population demographics of COVID-19 nursing home deaths show that while more white people reach old age in the US, the likelihood of elderly nonwhites to die from the coronavirus is much greater (Cunningham, 2017). Nursing homes with significant numbers of Black and Latinx residents have been twice as likely to be harmed by the coronavirus compared to those where the population is overwhelmingly white. Reportedly more than 60% of nursing homes where at least a quarter of residents are Black or Latinx have experienced at least one coronavirus case—double the rate of homes where Black and Latinx people make up less than five percent of the population (Gebeloff, 2020). Such comparisons reveal stark divisions and embodied inequities of health along racial lines. However, because such quantitative approaches "fix" race to bodies and use individual facilities as the unit of analysis, they are unable to explain how and why nursing

homes colossally fail to protect elder Black, Latinx, and other people of color. The mass lethality of the pandemic to BIPOC individuals, communities, and populations cannot be addressed or ameliorated through figures on racial demographics or social determinants of health but requires, instead, examination and dismantling of the operations of racism in the structure and at the basis of the US healthcare system. To explain and repair the devastation of the pandemic on nursing homes requires examination of how racialized financial geographies of the long-term care industry and its racially stratified work environments produce and perpetuate "deadly care" and "bioinequalities" that structure the capacity to age well (Ehlers and Krupar, 2019: 115–124; Fassin, 2009).

Aging is not only a biological process but also a process of embodying differential degrees of health rights disenfranchisement and political-economic subordination to the largely profit-driven organization of care for people in age-related decline. Before the pandemic, BIPOC elders had already been subjected to low levels of care and lack of resources in the nursing home sector (particularly nursing home chains that rely on public Medicare and Medicaid payments as part of their bottom line). This is on top of the embodied burden of racism's everyday and intergenerational attritional hazards that have negatively impacted BIPOC and other marginalized elders across their lifespans. The pandemic has grossly intensified the "premature death" of such individuals in age-related decline, compounding regressive racially-biased and age-based segregation and securitization. Ruth Wilson Gilmore explains racism as "the state-sanctioned and/or extra-legal production and exploitation of group-differentiated vulnerabilities to premature death, *in distinct yet densely connected political geographies*" (Gilmore, 2007: 28). This paper aims to situate the nursing home—and the deadly role of these institutions as prime COVID hot spots—within US political geographies that continue to value white lives and spaces and chronically devalue nonwhite health, labor, and spaces. While specific individual facilities and sometimes the industry more generally shoulder the blame for the spread of coronavirus infections and mass death in current popular accounting, this approach ultimately fails to intervene in the overtly racist organization of nursing homes and eldercare in the US. What is needed, by contrast, is critical geographical analysis of nursing homes as part of the racial capitalist organization of US healthcare and racialized segregation of the aged.

This paper offers an initial inventory of the racialized stratification of eldercare administration and long-term care, brought into stark relief by COVID-19. It focuses on the ways racial capitalism drives the chronic devaluation of nursing home residents and staff, while fostering lucrative financialization of medicalized "care" for the aged. It is not a condemnation of the many dedicated staff of nursing homes but a critical overview of how racism and ageism operate geographically and intimately through the organization of the nursing home industry, long-term care labor, COVID quarantining and pandemic response to elderly populations. The paper tracks some of the ways nursing homes condition race-based futures, geographically arranging and intimately marking certain populations, individuals, and spaces for extraction, abandonment, and blame for the pandemic. It contributes to longstanding feminist engagement with the ethics of care under capitalist systems by foregrounding how an intersectional approach to care ethics is necessary—to address racist forms of control and abandonment, *and* the way any consideration of such ethics is always stratified by class inequality and structural violence. While the account here is but a sketch, it directs attention to what investigations *should* be foregrounding: Determining ways to create, foster, and affirm more equitable forms of aging *and* caregiving. This requires establishing more just institutions of eldercare that put the social welfare of the aged, especially that of BIPOC elders, and of marginalized essential care workers above corporate welfare and financial performance that reproduce racial hierarchy and white supremacy as the basis of US national healthcare.

This is crucial as pandemic responses ratchet up the stakes: Numerous states have been debating what to do with COVID-positive nursing home residents, and as a safety measure some facilities have refused to readmit residents who have tested positive, while others have evicted residents in

order to admit new COVID-positive patients who bring in additional government payments. Some of the very facilities that have seen rampant COVID-19 infections and deaths have been enlisted as quarantine facilities for coronavirus-stricken patients, to ease the burden on overwhelmed hospitals and in many cases to bolster financial performance. The same geographies and operations that have led nursing homes to be major coronavirus infection sites and routes now resurface as a carceral network of COVID-only eldercare facilities that territorially stigmatize and essentially blame one of the most vulnerable parts of the US population—the age-segregated, pervasively race-segregated, and infection-compromised nursing home resident—for the failure of the US to protect these people and the population from the virus. Such COVID holding camps, temporary hotels, and detention facilities further entrench US systemic geographical organization of medical scarcity (Aumoithe, 2020). The impulse of this paper is to direct attention to a different horizon of eldercare and US healthcare, by considering the nursing home resident *and* care worker as interconnected sites of premature death for BIPOC individuals and communities—and thus a crucial position from which to advocate for explicitly anti-racist reorganization of US healthcare and pandemic response.

The racialized financialization of the nursing home industry: Segregated care, medical scarcity, and captured markets

Harrowing accounts from doctors, nurses, and various medical staff throughout the onslaught of the coronavirus in 2020 show how surges of the virus have led to badly stretched resources, staffing, and room in US hospitals. The lack of ICU beds has necessitated tapping nursing homes to serve as an overflow for hospitals. This form of "triage" allows hospitals to release stabilized COVID patients to nursing facilities for convalescence, in order to free up beds and admit more COVID patients requiring emergency care.[3] It is important to contextualize the US's organization of pandemic response—especially widespread reported shortages of PPE, ICU beds, etc. and nursing home overflow—within a longstanding pattern of segregated healthcare. In other words, "medical scarcity" experienced during the pandemic should be situated within an historical political geography of federal support for segregated hospitals and for-profit healthcare, undergirded by cost-containment and efficiency measures that have especially targeted public city hospitals and drained medical facilities in lower-income inner-city communities (Aumoithe, 2020). Reviewing this political geography reveals the perilous creation and expansion of nursing home systems that have had a deadly impact on BIPOC populations during and long before the COVID-19 pandemic.

Political geography of US nursing homes

Federal and state policies dating back to the post-WWII era backed the construction of hospitals and nursing homes within conditions that permitted racial segregation. The Hill-Burton Act of 1946 allowed for segregation by facility and inside each facility, leading to what some critics have aptly labeled "American apartheid in healthcare" (Washington, 2006). Inequality of healthcare and health took geographical expression, within racialized arrangements of people and regions. The federal government provided construction funds for the massive expansion of hospitals in white suburbs, while barring funds to Black hospitals that lacked modern technologies (due to antiBlack austerity measures). Public hospital budgets, bed capacity, and supplies were then slashed in cities, as their occupancy rates fell due to the diversion of public funds to support white flight. When the Fair Housing Act (which mandated desegregation) was passed in 1968, racist redlining practices and subsidized construction of whites-only residential subdivisions had already produced an extensive national geography of segregated neighborhoods and exclusionary financial assistance.[4] The building of this American landscape essentially robbed Black people and other people of color from decades of government support. Further spending cuts and new accounting measures sought to

control costs and cut "unused" supplies, such as masks, gloves, medicine, and more, and kept equipment and staffing low in order for hospitals to increase their profitability. The rollout of these changes exacerbated the racist regional organization of American life and mounted grave conditions of medical scarcity for low-income urban communities and their elderly constituents in particular. The technocratic, market-neutral banner of "hospital cost containment" has served to justify policies that continue to prioritize white lives and devalue nonwhite lives, further entrenching the racist spatial organization of for-profit healthcare and laying the groundwork for scarcity and organized abandonment in these areas.

The same policies that led to the buildout of segregated healthcare in the US invited the expansion of nursing homes as speculative real estate developments *and* medicalized, financialized forms of care for the aged. The Hill-Burton Act provided support for nursing homes in addition to hospitals, and eventually buttressed an industry of medicalized aging care. This took place within a relational geography of disparity: On the one hand, the rise of suburban gated communities and retirement communities of predominantly whites who had received decades of support through the building of home equity and retirement funds; on the other hand, the creation of federally subsidized nursing homes and increased "warehousing" of middle-class to lower-income and minority elders underwritten by Congress's 1965 establishing of Medicare and Medicaid. In addition to round-the-clock medical attention and assistance with general daily activities, nursing homes can provide short-term care following hospitalization and/or long-term care for the "infirm elderly" who are no longer able to return to or remain in their homes (Ettlinger, 2017: 110). This "end of life" care is publicly funded for individuals who cannot privately cover their costs, with Medicare providing higher-paying reimbursements for short-term stays and Medicaid funding for longer-term care. Contrary to their seeming welfare orientation, nursing homes were the first major institution to capitalize on an aging society, and remain a forerunner in the ever-escalating privatization of US healthcare and its de facto racial geography and financialization. Corporatized healthcare and the huge expansion of the for-profit sector in the US biomedical sphere, where the provision of health services has come to be viewed as a business, have restructured the care of older individuals. There now exists a spectrum of eldercare driven by market logics—from luxury retirement communities to assisted living facilities and "memory care villages" to underfunded nursing homes—all of which have fomented age segregation in America. The US population is currently becoming older and more segregated by age, and the geography of age segregation in the US is embedded within spatial divisions that perpetuate racial segregation (Gebeloff, 2020). In other words, the sequestering of the aged in the US reflects and contributes to racial segregation (one usually goes to a nursing home in the zip code where one has lived) (Lowenstein, 2014). The nursing home industry in particular shows how racial segregation in healthcare and American life has deepened as the US has emerged as one of most age-segregated nations in the world (Freedman and Stamp, 2018). Moreover, the rise of for-profit nursing home chains has advanced "white accumulation" and white health through normalizing aging care built on a color line that relegates nonwhites and the urban poor to policy-produced conditions of medical scarcity (Harris, 1993).

The Federal Housing Administration—that had implemented redlining and heavily subsidized white suburbanization—offered mortgages that paid ninety-percent of nursing home project costs, resulting in a building boom in nursing home construction (Ehlers and Krupar, 2019: 118). An early booster for the corporatization of nursing homes, these federal loan guarantees became standard financing for private nursing homes (nonprofit and for-profit), spurred the massive growth of the nursing home industry, and incentivized the business of sequestering old people in the US. The introduction of Medicare and Medicaid funding for short-term and long-term nursing care also bolstered the growing corporatization of the industry by covering the initial mortgage interest for nursing home facilities, thus enabling firms to use their money to finance the purchase of other properties (Ehlers and Krupar, 2019: 118–119). With the benefits of these subsidies and the federal

government's absorption of risks, privatization and chain management of nursing homes further catalyzed the growth of the for-profit nursing home industry. For-profit organizations leveraged the equity of one property to purchase multiple and/or larger properties through the sale of stock and consolidation of large corporate pyramid schemes. Because the building investment and cost of financing real estate lie at the center of the financial success of most nursing homes, chains of these facilities became a source of capital for the parent company. Moreover, although nursing homes have low profit margins, sophisticated accounting techniques associated with chain management have allowed companies to maneuver high ratios of debt to total assets in order to ensure the cash flow from nursing homes to the parent company. Mergers, acquisitions, and takeovers have consolidated nearly 70% of US nursing home beds within for-profit facilities that are increasingly owned by large corporate providers (CDC, 2021; Strauss, 2021).

Financialization of long-term care

Nursing home chains are complex corporate bodies with multiple layers of corporate ownership—sometimes five or more—that implement various strategies to increase corporate profits and gain market control of related long-term care service. They essentially channel money through the nursing home to other parts of the corporate body, to avoid taxation and to receive ongoing federal subsidies that increase their profit margins while limiting their liability and obscuring responsibility for care. This routing of revenue around the network enables owners to claim that an individual nursing facility operated at a loss and thus requires additional government subsidies, even as owners and CEOs rake in profits.[5] Many nursing home companies have developed or are branches of separate real estate investment trusts (REITs), a scenario that allows for the nursing home's rent to be paid "in-house" to the separate management company in order to save on corporate taxes. Such arrangements can also involve tax exemptions from corporate income taxes on top of profit-sharing agreements between the nursing home and other parts of the corporate umbrella. The complex strategies of real estate financing operate as a kind of "value-generating obscurantism" for the larger corporate body that has emerged around the nursing home: Ownership data and chain affiliation are not adequately known or compiled (Krupar, 2013: 198). Their complicated corporate structures shield for-profit owners from liability determinations in lawsuits that might arise due to violations of legally imposed requirements for nursing home operations and care delivery (Ehlers and Krupar, 2019: 118).

The rise of these investor-owned companies of "care systems" prioritizes profit maximization for shareholders over care delivery, a scenario that affects services aimed at the elderly and especially Medicaid-supported long-term care (Ehlers and Krupar, 2019: 117). Studies have shown that for-profit models of long-term care delivery have granted Medicaid recipients greater access to care—but to care that is inferior to what public and nonprofit-owned organizations provide (Amirkhanyan et al., 2008). Nursing homes have long had a financial incentive to refuse or evict Medicaid patients in favor of those who pay through Medicare and private insurance, which reimburse nursing homes at much higher rates than Medicaid.[6] Medicaid covers longer-term stays for people who need extensive care for chronic issues and who are poorer and require more government assistance. Private nursing homes often avoid Medicaid's lower reimbursement of end-of-life care, opting instead for Medicare-supported residents with short-term therapy needs that can lead to additional payments. As we discuss further below, this logic continues today in the pandemic: Reportedly some facilities have pursued evictions and resident "swapping" to boost their financial position under the cover of pandemic-related visitation bans and suspended government oversight. By contrast—but with further devastating implications—many large for-profit facilities and chains have welcomed Medicaid-supported residents per a different economic calculus: They scale up the number of Medicaid payments by raising their acceptance of Medicaid-beneficiary residents, while

minimizing the operational costs of the facility. This leads to inflating the number of lower-paid nurse practitioners and aides, decreasing the number of on-site registered nurses, and often having no doctors on staff.[7] The inevitable decline in quality of care of these for-profit "Medicaid Mills" has prompted some facilities to simply account for regulatory sanctions and government fines as part of the normal cost of business—a grave trend that, as we suggest below, rationalizes the contracting of these facilities to serve as COVID-only holding centers (Gupte, 1976). Even so, such nursing homes widely complain about and blame Medicaid's low payments as the reason for their care deficiencies, as they simultaneously capitalize on Medicaid's longstanding structural racism and turn a profit through economies of scale and the financial strategies described above (Eljay, LLC, 2015).[8]

Captured markets of eldercare

The elderly infirm essentially serve as vehicles of financial extraction for corporate welfare over social welfare—either to support exclusive nonprofit services and facilities or to fortify the for-profit nursing care industry that seeks to get the most lucrative aggregate of residents with minimal staff. Per the conditions outlined here, for-profit nursing home chains operate as captured markets that capitalize on existing conditions of segregation and socially constructed medical scarcity. That is, nursing homes *organize racist captured markets of eldercare* that intensify the risks and dangers to communities of color. Their financial bottom line relies on the US's ongoing racist organization of aging and health disparities that disproportionately place elderly BIPOC individuals in these increasingly corporatized for-profit nursing home chains.

Well before the pandemic, the financial structural organization of the nursing home industry has disproportionately harmed BIPOC elders and women of color nursing home residents. Elderly Black individuals are more likely to end up in nursing homes, where Medicaid is the primary payer, compared to their White counterparts, and dual-eligible patients for Medicare and Medicaid are more likely to be discharged from hospitals to for-profit nursing homes (Jenkins Morales and Robert, 2020). Many nursing home residents that are dual-eligible beneficiaries of Medicare and Medicaid are women of color, who face extensive health complications because of social disparities and lives spent caring for others. The cumulative effects of racism take the form of years of less access to healthcare and healthy food; difficult work; economic hardship and poverty; retirement insecurity; higher rates of diabetes, asthma, and other conditions that lead to chronic illness and the need for long-term care. Throughout the program's history, Medicaid policies have failed to provide comprehensive healthcare to low-income individuals nor resolved racial health disparities and widespread de facto racial segregation of hospitals and nursing homes (Rosenbaum and Westmoreland, 2012). Moreover, states have been allowed to curtail care for vulnerable populations by excluding them from access to Medicaid, deepening the racialized geography of care and health disparities, particularly harming Black communities in Southern states (KFF, 2021).

Initial distributions from the $175 billion made available by the Coronavirus Aid, Relief and Economic Security (CARES) Act continued this racist policy trend: Hospitals serving the greater proportion of wealthier, privately insured patients were given double the relief funds received by those focused on low-income patients on Medicaid or with no coverage at all (Schwartz and Damico, 2020). Numerous Medicaid providers had to wait weeks before being eligible for economic relief. At the moment when people need Medicaid more than ever due to the pandemic, the US has lacked robust funding to pay for the care of vulnerable low-income populations (Cunningham, 2020). This neglectful racist policy has exacerbated the conditions in the "Medicaid Mills" and for-profit facilities that rely on public assistance as part of their revenue model. Medicaid-supported nursing homes have been less resourced with sufficient personal protective equipment (PPE), cleaning materials, and appropriate staff levels, worsening gaps in care and hygiene in situations where there is already minimal client interaction with skilled staff (McClure et al., 2020). On top of

the regressive tax of poor health, compounded by the structural racism of Medicaid low reimbursements, BIPOC individuals and populations—who bear the double burden of being more prone to serious illness and less likely to receive intensive care—have been subjected to disproportionate suffering caused by US pandemic policy that has exacerbated the racist organization of eldercare and healthcare.

Racial-capitalist organization of long-term care work and deadly impact of COVID-19 on nursing home residents and staff

The gross numbers of COVID-19 deaths in long-term care homes have made visible not only the warehousing and substandard care of the elderly in American society but also the neglect of essential care workers, many of whom are women of color and immigrants. Public discourse rallies support for "frontline workers," marshalling war and sacrifice metaphors in the service of one's country in a battle against the global coronavirus pandemic. Former President Trump stoked this heroic narrative of the US medical workforce with descriptions of frontline workers as "warriors" and "soldiers running into bullets" (Johnson, 2020). There is sick irony to how much funding the US directs to Defense and the military-industrial complex compared to the domestic "homefront" of the pandemic. Moreover, this rhetoric heinously normalizes, through reverent speech, the deaths and suffering of the medical workforce, and forestalls critical reflections on the shortcomings of the US response to the pandemic. The heroicizing narrative of the "frontline" focuses attention on people and not structures: It distracts from the structural inadequacies of US healthcare and the chronic devaluation of significant portions of the workforce. The phrase "heroic healthcare workers" usually refers to doctors, nurses, and hospital settings—not the expansive and diverse outlay of facilities and forms of care, such as long-term care and home care, or the many low-paying jobs swept under the category of "essential worker": Nursing assistants, home health aides, domestic care providers, custodial staff, and so forth. Much of this work is dismissed as low-skilled domestic care and reimbursed at rock-bottom rates by state Medicaid programs. Moreover, profit-making privately owned and operated care centers rely on a racialized and gendered division of labor to fill the ranks of these low-paying positions.

Organization of long-term care labor

Long-term non-hospital care for the aged is performed predominantly by women who are disproportionately women of color, with a high percentage of immigrants and migrants, who are assumed to be both cheap and disposable. 91% of frontline health workers are women; 37% of nursing assistants are Black women; 20% of nursing assistants are foreign-born individuals (PHI, 2019: 3; Smiley et al., 2018). The treatment of their labor is predicated on racist societal assumptions about their inferior quality of labor, deficient skills, and lack of better employment options (Das Gupta, 2020). Nursing assistants comprise over 30% of nursing home staffing and over 16% of continuing care and assisted living facilities (U.S. Bureau of Labor Statistics, 2020). Despite the "essential" work they perform day in and day out, before and during the pandemic, their bodies and labor are chronically devalued by the structuring of the US healthcare system. Even though they are considered "essential" workers, they earn low wages and are vulnerable to potential workplace violence in a sector with little stability or workers' rights—insecurities that are compounded by the way citizen status stratifies caretaking of the aged. In short, "expendability becomes synonymous with long-term care workers" (Das Gupta, 2020).

The chronic devaluation of long-term care workers means that nursing homes present deadly conditions not only for residents *but also for workers*. Nursing homes are part of the overall racist organization of labor and work environments in the US and the "work or else" imperative, heightened during the pandemic in order to "save the economy." Such care workers are usually not

unionized and thus offered little to no workplace protection, no federal assistance, and no hazard pay, paid sick leave, or overtime pay. The precarity and low pay prompt workers to juggle multiple jobs at different facilities, at even higher risk to themselves and to residents (Fortiér, 2020). In 2019 the median hourly wage for nursing assistants was $14.26 (US Bureau of Labor Statistics, 2020).[9] Nursing assistants face workplace injuries 3.5 times more often than the average US worker, and in 2019 11% of nursing assistants had no health insurance (PHI, 2019: 7). The long-term care sector overall sees unprecedented levels of job disruption due to lack of childcare, complicated by the onslaught of the virus and concerns about exposing their families to COVID (Emanuel, 2020). The CARES Act mandated that employers with fewer than five-hundred employees must grant ten days of sick leave, but *exempted* emergency and healthcare workers from this benefit. A New York federal district judge subsequently ruled against this exemption, directing that healthcare workers are entitled to this benefit. The Health and Economic Recovery Omnibus Emergency Solutions Act (HEROES Act) also would have undone these exemptions and included $200 billion for hazard pay for essential workers in addition to expanded family and medical leave, paid sick days, unemployment compensation, nutrition and food assistance programs, housing assistance, among other provisions (House Committee on Appropriations, 2020). It passed the House on 15 May 2020, but stalled in the Senate; ultimately the paid leave requirement was allowed to expire in December 2020 (Liu, 2020).

The vicissitudes of COVID relief in the US has especially harmed immigrant care workers who face significantly less access to paid sick days—reportedly only 53% of immigrant women compared to 61% of US-born women (Institute for Women's Policy Research, 2016). This compounds the precarity of their citizenship status/opportunity in the context of racist immigration policies and migrant surveillance and detention (Martin and Mitchelson, 2009). Exacerbating the hardships within the nursing home and care work sector, the Trump administration expanded the "public charge" rule to make it more difficult for the immigrant population of this workforce to renew their visas or obtain a green card if they access the government assistance to which they are legally entitled (e.g. Medicaid, CHIP, SNAP) (Ruskin and Sadural, 2019). In this case, care sector workers are disqualified even from regressive and punitive "workfare" because they are cut off from pathways to citizenship in order to survive. The policy boils down to a catch-22 that structurally "captures" and degrades this labor pool within the predatory captured market of the nursing home industry.

Working conditions under COVID-19

Nursing homes have reported that they have been much lower in priority than hospitals for federal and state PPE supplies, and within the aged care industry, Medicare and Medicaid-supported nursing homes are less resourced with sufficient PPE, cleaning materials, and appropriate staffing levels (Kinder, 2020).[10] *The New York Times* reported that at Forest Haven Nursing and Rehabilitation Center in Baltimore County, where many residents are Black, workers had been given rain ponchos and nylon hair bonnets in April 2020 after the state of Maryland required all nursing homes to supply their staff with protective equipment. The paper has since reported that workers later received proper supplies, including gowns, masks, and face shields; however, at least ninety-seven people, including twenty-seven workers, had contracted the virus and eight residents had died (Gebeloff, 2020). On the other side of the country in East Los Angeles, at the five-star facility of Buena Ventura Post Acute Care Center where many residents are Latinx, a certified nursing assistant indicated that workers were not given masks until well into the outbreak; administrators provided plastic swimming goggles to care workers in lieu of medical-grade eye protection (Gebeloff, 2020). Nursing home employees describe retaliation and job loss when they have complained about the lack of PPE and inappropriate work conditions during the pandemic (Khimm, 2020).

The unreliable to nonexistent protection available in these work environments during the pandemic has prompted high turnover of staff in an already largely understaffed industry. Because the business model of many large for-profit nursing home facilities seeks to minimize care costs while maximizing occupancy rates, care is predominantly provided by nursing assistants (over 30%). The median hourly wage for a registered nurse (RN) is $35.17; the 90th percentile of the hourly wage for a nursing assistant is $19.53 (the median again is $14.26) (USBLS, 2020). There is no standard federal ratio of staff to residents: Nursing homes are required merely to have one RN on duty 8 hours per day, 7 days a week, and a licensed nurse overnight, with no guidelines on the recommended mix or diversity of staff. Many state regulations also emphasize staffing numbers rather than the mix of staff training/expertise, leaving little incentive for homes to hire more skilled and expensive personnel. "While federal rules issued in 2016 would have strengthened staffing requirements, including one that required homes to have an infection specialist on staff, they have yet to take effect," and the Trump administration weakened them (Amirkhanyan et al., 2020). Furthermore, instead of employing one nursing assistant for every seven residents—the minimum required by experts—some facilities employ only one nursing assistant for every ten or even 15 residents, and according to federal data prior to the pandemic, the average nursing home provided a mere 3.9 h a day of nursing care per patient (Quinton, 2020).

As renowned sociologist of long-term care Patricia Armstrong and her collaborators have repeatedly emphasized, the "conditions of work are the conditions of care" (Armstrong et al., 2020; Armstrong and Armstrong, 2019; Baines and Armstrong, 2019; Bannerjee et al., 2011, 2012; Hickam et al., 2003). Due to the grave working conditions of long-term care in the US, the nursing home industry consistently failed at controlling infections well before the pandemic. The Congressional Government Accountability Office released a report in May 2020 on systemic issues of deficient care that found more than 80% of nursing homes were cited for infection control lapses and about half had persistent problems from 2013 to 2017 (Shogren, 2020). Over *half* of the facilities in the states of Delaware, Mississippi, Missouri, Illinois, Michigan, and California reported at least one deficiency related to infection control in 2017 (Chidambaram, 2020). The CDC has reported that around 380,000 people died each year from infection at long-term facilities prior to the pandemic (Stockman et al., 2020). Generally, government inspection of for-profit homes found nine violations in an average regulatory inspection cycle, compared to 6.4 at nonprofit homes and 6.8 at government/public homes, and these trends have remained constant over the past two decades (Amirkhanyan et al., 2020). A June 2020 report that linked COVID-19 cases in nursing homes with federal data on regulatory violations observed more COVID-19 cases per capita in for-profit than nonprofit or public homes (per state data from Illinois, Nevada, Colorado, South Carolina, Oklahoma, and Oregon) (Amirkhanyan et al., 2020). Another study of eight states, including California, Connecticut, Florida, Illinois, Maryland, Maine, New Jersey, and Pennsylvania, associated nursing homes that have nurse staffing shortages—a common feature of for-profit long-term care facilities—with susceptibility to the spread of COVID and with higher COVID deaths (Figueroa et al., 2020).

Much of the nursing home industry rejects this research linking low staffing and for-profit ownership to worse COVID outcomes. Spokespersons instead point to an earlier May 2020 study that finds low correlation of COVID cases with prior infection violations, Medicaid dependency, and ownership, and emphasizes instead factors including facility size, urban location, and "greater percentage of African American residents" (Abrams et al., 2020). The latter research avers race-neutral quantitative comparative assessment of COVID correlations to essentially uphold the status quo: It directs attention to racial and spatial determinants of health as the explanation for infection rather than the outcome of the structural racism of health, the nursing home industry, and its financial operations. It also offers no reflection on the ways that deregulation and lax enforcement of infection control violations by the Centers for Medicare and Medicaid Services (CMS)—both before and during the pandemic—may have contributed to the spread of the virus.

A Congressional investigation into CMS and the five largest for-profit eldercare/long-term care organizations observes that while CMS has issued guidelines for nursing homes in response to the pandemic, this guidance has often been unclear, and CMS failed to take adequate steps to ensure nursing homes comply with its recommendations (Select Subcommittee on the Coronavirus Crisis, 2020a, 2020b). COVID testing equipment and guidelines illustrate the lack of effective federal guidance and enforcement in response to an unprecedented pandemic: In July 2020 CMS sent 600 rapid testing kits to nursing homes as a short-term measure, promising 15,000 over the next few months and requiring (rather than recommending) that nursing homes with more than 5% COVID positivity rate test all residents and staff every week. However, "state health departments report that they have yet to receive any guidance from CMS about the new testing requirement and what their role would be in enforcing it" (Englund, 2020). To mitigate the spread of infection of COVID-19 in the absence of adequate policy and protection, some long-term care workers elected to move into their long-term care work sites, as a stop-gap measure to limit exposure routes and protect their own families (Stockman et al., 2020). Many others left their jobs and took unemployment to keep their families safe. IntelyCare, a nurse staffing company, reported that thirty percent of its certified nursing assistants "chose" unemployment and the $600 CARES Act check over subjecting themselves to work environments that critics of the nursing home industry have called COVID "death pits" (Emanuel, 2020; Stockman et al., 2020). The impact of the coronavirus on nursing home residents and staff—largely women of color staff and disproportionate numbers of BIPOC elderly—reveals how chronic devaluation of long-term care labor and of the aged population, particularly those that rely on public benefits, leads to the premature death of vulnerable parts of US society.

COVID Detention Centers? The Confluence of Deadly Care and Biosecuritization of the Aged

The onslaught of COVID-19 in nursing homes makes clear that a deadly system of care was happening before the pandemic and is ongoing. In 13 states, long-term care facility residents and staff comprised more than half of COVID-related deaths (Quinton, 2020). New Hampshire saw 80% of its deaths occur among nursing home staff and residents; 58% of deaths in New York state happened in nursing homes in New York City alone (Shapiro et al., 2020; Taylor et al., 2020). The convergence of deadly conditions for workers and residents alike in nursing homes shows how neoliberal economic rationalities, financial performance imperatives, and proceduralized forms of caretaking and regulation delimit caring for those in age-related decline. The pandemic has amplified the detrimental effects of the highly racialized revenue-raising and cost-cutting imperatives of for-profit nursing homes to such a degree that the banal operations of chronic devaluation in this industry fuel extreme vulnerability, disease incubation, and infectious spread, stoked by systemically substandard care across the country's age-segregated facilities.

Proceduralized substandard care

Hospitals, seeking to keep costs down, push doctors to treat patients for less and discharge more vulnerable patients "quicker and sicker" to the growing industry of nursing homes; hospital accounting systems also focus on the disease category rather than the patient, restructuring the patient's experience of care to fall in line with the economic dimensions of treatment rather than the human dimension of care (Ehlers and Krupar, 2019: 115–117; Preston, 1992: 95). The increased proceduralization of care delivery addresses the biological body rather than a person with complex needs. Long-term care patients become a series of biological events that need to be monitored and accounted for under the medicalized gaze. "Nursing home care primarily focuses on physical limitations and addressing incapacities rather than attending to the needs of the whole person, due in

part to the medicalization of care but also to the documentation required of nursing homes by the government for them to continue to receive any funding" (Ehlers and Krupar, 2019: 120). Exacerbating the gap between clinical quality measures and the patient/family experience of nursing homes, a "maze of regulations" that nurses and nurses' aides must continually navigate results in a regime of continually filling out forms—an endless bureaucracy of documentation that in turn leads to decreased care (Ettlinger, 2017: 124). The emphasis on efficiency and compliance sacrifices conversation and the minutiae of slow careful assistance and attention in this context, because it does not count toward government reimbursement: "In this light, abuse derives from actually following the rules" (Ehlers and Krupar, 2019: 121).

A number of checks on the decline of care in nursing homes have been put into place to avoid harm being done to residents. The 1987 Nursing Home Reform Act at its inception vested the Secretary of Health and Human Services with broad oversight powers to enforce various standards of care, safety, health, and welfare related to nursing homes and their residents; this included care quality criteria, facility inspections, and the enforcement of new sanctions and fines for repeated violations. The Obama administration sought even further regulation of the US healthcare system, which directly impacted nursing home care. However, enforcement has remained uneven at best and the Trump administration rolled back many of these efforts. Currently there are Congressional investigations of nursing home facility performance during the pandemic: This is an important but inadequate race-blind regulatory approach that tracks the application of COVID relief money. Thus far it has resulted in the return of $109 million in taxpayer dollars by a major nursing home chain that had not used the funds for its legally intended purpose of supporting direct patient care (Select Subcommittee on the Coronavirus Crisis, 2020a, 2020b). But oversight like this is the exception. Chronic, systemic staffing challenges have been so dire that site inspections and reporting have temporarily ceased or been scaled back in order to allow staff to focus on the everyday survival of residents and the maintenance of long-term care facilities (Centers for Medicare and Medicaid Services, 2020a).

The grave circumstances of the pandemic bring the confluence of "social death" and "premature death" of the elderly infirm into stark relief. The US generally treats old age in ways that attempt to forestall aging, contain and socially distance infirm elderly, and secure against widespread "wasting of productive life" (Cooper, 2006: 2). The country has continually pursued policies and made social choices that relegate the ill elderly outside of the boundaries of community and subject to the historical-geographical disparities of racially segregated residences and medical resources. Nursing homes often serve to physically sequester the ill and dying out of sight from the general populace. They can be socially alienating to residents, who are excluded from the lives they once had; and they tend to negate the subjectivity of individuals in their care, in that the needs of the elderly are often subsumed in the process and proceduralization of delivering care (Ehlers and Krupar, 2019: 166–117). As we have noted, this form of "social death" for those in age-related decline in the final years of their lives in the US intersects with the racial-capitalist structuring of the healthcare system and society more generally, which cause foreshortened lives of BIPOC individuals and communities through financially extractive, stratified care.

Pandemic bioinsecurity of the aged

Ongoing debates regarding the placement of stable COVID-positive elderly people show the dystopian possibility of "COVID detention facilities" and the urgent need for anti-ageist and anti-racist eldercare research and action. As previously mentioned, hospitals, hospital leaders, and hospital workers have been desperate to find ways to relieve their facilities and supplies in the face of multiple surges of COVID patients. A federal call to action exhorted state and local officials to work with nursing homes to designate certain sites for recuperating COVID-positive and/or COVID-negative discharged patients in order to avoid further transmissions (Centers for Medicare and

Medicaid Services, 2020b). Some states declared that nursing homes could not refuse to readmit medically stable residents discharged from the hospital on the sole basis of their having had COVID, even if they have not yet tested negative (Barker and Harris, 2020). Facilities also could not demand a negative COVID test prior to readmission. Importantly, nursing homes that declared themselves unable to follow CDC guidelines to care for these residents and protect others from infection were exempted.[11]

Critics have emphasized their legitimate fear of further infections and death in nursing homes. They point to the unpreparedness of nursing homes to prevent the spread of the virus and to keep residents and staff safe, and argue that nursing homes are simply not equipped to act as hospitals and should not be used as "depositories" of infected individuals (Barker and Harris, 2020). In areas where a requirement for COVID testing has been implemented, it has led to calls for all residents who test positive for COVID to be separated and transferred to designated COVID-only facilities. A growing number of these COVID-only sites now exist within specific nursing homes or in alternative locations such as hotels, stadiums, unused facilities, field hospitals, or other newly built care sites. Hospitals and other advocates conversely argue that waiting for a COVID test lengthens stays in already overrun hospitals, and organizing a separate COVID wing or floor of an existing facility—creating cohorts of COVID-positive residents and their caregivers—is sufficient if CDC guidelines and safety measures are followed.[12] Outside of the debate, there continue to be accounts of infirm elders passing away while waiting in limbo as nursing homes refuse to accept them without a negative COVID test.[13] At the same time, many nursing homes are financially incentivized to evict long-term nursing home residents in favor of COVID patients, in order to swap out any low-paying Medicaid residents for significantly higher-paying Medicare patients. On top of this, nursing homes can be reimbursed even more for COVID patients than for Medicare-covered residents with relatively milder health issues. When states restricted hospitals from performing nonessential services, the sector lost money from the dwindling of lucrative post-surgery rehabilitation needs; treating COVID patients became a way to fill the financial void (Silver-Greenberg and Harris, 2020).

It is not known how many long-term care residents have been moved and how safe these discharges have proceeded in different states, because site visits were suspended, thus leaving such actions behind closed doors. At least 12 states permitted the involuntary transfer of non-COVID residents to set up COVID-only facilities, and only three mandated tracking the numbers of transfers (Jaffe, 2020a, 2020b). By June 2020, at least 6400 involuntary transfers had occurred during the pandemic, many to homeless shelters (Silver-Greenberg and Harris, 2020). In Texas, one woman had been moved out "temporarily" from a nursing home for repairs, but then was told she could not move back because it had become a COVID-only site (Jaffe, 2020a, 2020b). Massachusetts's policy implementation of COVID-only sites for nursing home residents further demonstrates the harm of reshuffling residents for these purposes: The state mandated a "readmit as long as you can safely" policy but sanctioned involuntary transfers of nursing home residents. Essentially between March-April 2020, state-chosen facilities were emptied of non-COVID residents to be set aside as COVID-only sites; the transfers were involuntary and "sudden," with little to no notice given.[14] One woman reportedly found out about the transfer of her mother through Facebook (Ma, 2020). The state abandoned this plan once people in transfer started testing positive for COVID. In addition to the threat of COVID, transfer trauma—the negative mental, emotional, and physiological consequences of being moved to a new home—is a serious potential harm to nursing home residents with dementia, especially in the case of sudden and involuntary transfers (Jaffe, 2020a, 2020b).

Political ecologies of COVID detention

In another prominent case, Governor Whitmer and Michigan's state legislature were at odds over whether to allow nursing home residents with the novel coronavirus to remain in or return to their nursing homes after hospitalization.[15] The Governor vehemently criticized the state legislature's

efforts to create what her office characterized as COVID "detention centers" with no clear staffing, financing, or measures to support frail residents through a potentially traumatic transfer (Lawler, 2020). Current policy requires that nursing homes create COVID isolation centers within their facilities or in a separate building; if they don't have this capacity, then they are to send residents to a "care and recovery center" (CRC) (Mauger, 2020a, 2020b). This allows hospitals to discharge stable COVID patients to the nursing home from which they came, or to such an alternative care facility. Qualification for CRC designation reportedly factors in the "death-to-case ratio" performance of nursing homes during the pandemic and a facility's federal staffing ratings. In contrast, Florida's implementation of the COVID-only facilities policy Governor Whitmer's opponents have championed led to selecting facilities with some of the highest rates of COVID deaths, and that do not meet minimum state standards at inspections, to serve as state-designated COVID isolation centers (Zaragovia, 2020). As the state contracted nursing homes with high death rates to serve as official COVID-segregated facilities, reporting data on the number of infections or the location of COVID cases slowed or ceased entirely, particularly around the time of the 2020 Presidential election. Arizona officials have similarly declined to share publicly the names and locations of COVID hot spot nursing homes under the rationale that "they don't want to lose the trust of the facilities," and 2021 has seen a steady stream of reporting on the deliberate suppression of COVID-19 data (Biscobing, 2020).[16]

COVID hot spots in nursing homes present a massive biosecurity problem for the nation. However, efforts to quarantine COVID-positive elderly infirm repurpose the same geographies of age- and race-based segregation, racially stratified medical scarcity, and financially extractive eldercare to create a carceral network of COVID-only facilities. This risks territorially stigmatizing and blaming, through banishment, one of the most vulnerable parts of the US population—infection-compromised nursing home residents—for the failure of the country to protect them from the virus. It puts caretakers at further risk by potentially forcing them to move around more and/or be deployed to COVID-only facilities, on top of the already precarious work status, coercive mobility, and exposure such workers experience due to holding multiple jobs. The lockdown of nursing homes because they are COVID hot spots exacerbates their exploitative and oppressive functions. COVID detention and quarantining actively incubate and spread the disease, creating "death pits" that are necro-ecological rather than merely metaphorical. The emergence of COVID-only facilities also further compounds the racialized geographies of property values and placement of care facilities according to segregationist rationales rather than epidemiological needs.

King County, Washington—the epicenter of COVID-19 in the state and major early hotspot nationally—sought to mitigate the spread of the virus through emergency measures, such as removing people from homeless shelters to hotel rooms, using modular units and purchasing empty hotels to house people showing signs of the virus. The purchase of an Econo Lodge in Kent as temporary COVID-19 quarantine housing revealed that City of Kent officials were not consulted, fomenting concerns over undemocratic decision-making, unclear safety requirements and subcontracting arrangements for COVID-designated facilities (Sun, 2020). Establishing this COVID-designated hotel and modular units in the Top Hat neighborhood of White Center prompted criticism for ostensibly targeting historically marginalized BIPOC neighborhoods, intensifying risks to residents through proximity to state-administered COVID hot spots and stigmatizing the area as a COVID containment zone. The county responded that decisions were largely based on where properties were publicly owned and available, while residents and local officials questioned the underlying motive of locating the facilities in non-white areas and along historic disinvestment patterns, when other county land was available free of dense housing and without large numbers of elderly.

Regardless of the intentions behind plans for COVID-designated quarantine hotels and COVID-only care centers, this approach risks marginalizing the provision of long-term care through closed

doors, public bans, data blocks, and social death; it abdicates corporate and government responsibility to provide safe environments, adequate PPE, paid sick leave, COVID testing, and more, and places the burden of inadequate planning and lack of preparedness onto the elderly and their care providers. That nursing home residents and staff are especially vulnerable to the virus is not simply due to old age but to the chronic devaluation of nursing home residents and staff. The racist tactic of blaming innate susceptibility and individual behaviors lurks within calls to help fragile patients, while a eugenics-laden discourse emboldens actions to expand facilities that are wholly inadequate to provide safety and protection during the pandemic. The COVID-19 decimation of long-term care recipients and care providers in the US reveals the way the US treats the elderly infirm as a liability and devalues their caregivers. It exposes the disparities of citizenship and rights across the elder bodies of poor seniors, elderly women, BIPOC and immigrant seniors, LGBTQ+ seniors, as well as the predominantly Black immigrant female workforce that provides their care under precarious conditions. These populations are stratified, insecure, and exist in a kind of "biological subcitizenship," subjected to the captured market and labor pool of eldercare, and to the punitive necro-ecological effects of COVID-only emergency quarantine measures (Sparke, 2017).

Conclusion: Antiracist eldercare research, policy, and geographies

In response to COVID-19, "governments have introduced crisis management interventions that include border closures, quarantines, strict social distancing, marshalling of essential workers and enforced homeworking" (Branicki 2020: 872). Such strategies have created a range of enhanced vulnerabilities and negative effects for already marginalized people, including elevated risks for workers in low-paid, precarious and care-based employment, over-burdened case numbers and fatalities among BIPOC communities, gendered barriers to work, and adverse health owing to reduced resources, more unpaid work, and increased exposure to gender-based violence (Branicki 2020: 872, 874). In response, this paper has explored ways that *racism is the pandemic* from the perspective of eldercare. The approach refuses colorblind ideologies of the pandemic as biomedical rather than social; it attributes the disproportionate deaths of Black and brown people to racism—and to pandemic responses that remake and compound race as a marker and embodied experience of vulnerability and risk in the US.

This paper has sought to illuminate political geographies of racism and ageism that undergird the organization of eldercare and pandemic governance. It has focused on the racialized stratification of US eldercare as a site of premature death for residents and staff, specifically for BIPOC individuals and communities, as revealed and perpetrated by pandemic responses. This is a crucial position from which to advocate for the explicitly anti-racist reorganization of eldercare and healthcare. Such deaths remain undercounted and excused by American culture, while simultaneously spectacularized in ways that essentialize race, normalize harm, and ignore existing alternatives to dominant forms of organized care. According to New York Attorney General Letitia James' 2021 report on her office's investigations into nursing home responses to the COVID-19 pandemic, "A larger number of nursing home residents died from COVID-19 than the New York State Department of Health's (DOH) published nursing home data reflected and may have been undercounted by as much as 50 percent" (New York State Attorney General, 2021). At the same time as this undercounting has unfolded, "the regular drumbeat of COVID-19 mortality numbers through data dashboards, data trackers, and charts and graphs represent how inured we are to the datafication of death" (Gallon, 2021). Kim Gallon and the COVID Black project warn that COVID mortality data especially risks presenting Black deaths as tautology, further pathologizing Black life rather than restoring Black humanity (Gallon, 2020a, 2020b, 2020c, 2021). Critical race scholars and scholars of Black life critique the way pandemic data and counting the dead can relegate Black Americans' relatively high death rates of COVID-19 to comorbidities and personal responsibility (Benjamin, 2020; Farrow,

2020). Black doctors bear the double load of "battling a disease that's disproportionately harmed their community while dealing with entrenched racism" and educating others about the ways that pre-existing conditions and other risk factors are actually manifestations of longstanding anti-Black racism in the US (Williams, 2021; Gallon, 2020b).[17] Chronicling lives lost and data that identifies disparities in health may insensitively disregard the actual trauma of data on COVID-19 deaths, and deny the devastation of what is happening by compressing "black humanity into quantitative containers" (Gallon, 2020c).

Black feminist data scholars advise remaining skeptical of all data, including counterdata, and recognize an ethic of risk related to data because its care "equally holds the possibility of liberation *and* oppression at once" (Gallon, 2020b). Black feminist data ethics exhorts transforming the datafication of death into recovery of humanity and social change. We are reminded that among the COVID-19 death counts are our family members, loved ones, neighbors, colleagues, and people we share spaces with. While the virus makes us painfully aware of the vulnerability of all humans, this should not cover over or absolve the racial capitalist organization of resources, residential life, and disparate but always relational geographies of who is resilient and valued versus vulnerable, disregarded, and/or spectacularly marked for death. Policy must look beyond the "social determinants of health" to map out and contest racial hierarchies that sustain and are at the basis of eldercare, healthcare, and other systems. Put differently, we should scrutinize the *making* of social determinants of health—the relational and highly political geographies of health disparities and premature death—*in order to pursue their unmaking through policy and practice*. The securitization of nursing homes is a key place to begin, where premature death and social banishment were normalized and obscured long before the pandemic. Instead of pursuing ways to protect these existing institutions, which perpetuates the delusion that we live in a post-racist world and that race-neutral policies are somehow possible, desirable, and not racist, the focus should be on why the US colossally fails to protect vulnerable elders and essential caregivers—and more generally the wide range of essential care workers that anchor the economy and everyday life—from racist policies and institutions (Sparke and Anguelov, 2020).

More must be done than prioritizing nursing facility residents and staff for essential vaccines, testing, and equipment. Compliance is also not enough. The Trump administration's release of "strike teams" to nursing homes during the onslaught of the virus was essentially a band-aid for the systemic staffing problems of the industry (Centers for Medicare and Medicaid Services, 2020c). Additional training and certification requirements imposed on nursing home facilities do nothing to address systemic turnover of workers and constant staff and supply shortages, nor the devastating effects of COVID on the racially stratified population of elderly in nursing homes and long-term care environments. Rather than pandemic responses and crisis management rooted in the calculation and management of impacts in financial and legal terms, we should instead question whether financial performance and business productivity are all there is to aspire to in the organization and delivery of care: Are nursing home markets desirable or socially appropriate in any other sense but for predatory racial capitalist organization of care? How might we begin reorganizing the racialized geographies of age segregation that relegate elders and their caregivers to facilities in a system that hastens death for profits? What steps can be taken to eradicate racist arrangements of medical scarcity that underpin for-profit eldercare and Medicaid, in order to protect the most vulnerable against the virus and take social responsibility for the production of vulnerability to the virus? Most immediately, we should incentivize nursing homes to address existing health disparities in the care of minority patients through tax incentives and grant programs; mandate quality measures that factor in racial and ethnic disparities especially related to Medicaid; restructure leave and pay; and provide support and pathways to citizenship for immigrant caregivers. However, a broader Reconstruction of America is needed to go further to eradicate age- and race-based segregation through transformations of residential and public life.

There are already manifold everyday practices and policy-directed efforts—particularly those grouped broadly under "abolition"—that challenge the status quo and thus the structural conditions of caregiving, in order to heal social, political-economic, and epistemic rifts (Montenegro De Wit, 2020: 118). The conjuncture of systemic racism and COVID-19 has created an extraordinary moment wherein we see that racist institutions are vulnerable to reinvention. Intersectional, anti-racist ways of caring enact a different horizon of eldercare and healthcare in the US tied to an explicitly political framework of social justice. We see mutual aid networks and community groups performing critical care-work for vulnerable elderly. There are also activist networks that "build on the US civil rights movement by establishing multigenerational support for 'elder councils' and other institutions" that hold old age in esteem and that advocate for economic and health justice for people of all ages (Ehlers and Krupar, 2019: 127–8). Established in 1970 and named in admiration of the Black Panthers, the Gray Panthers coordinate intergenerational advocacy networks across the US that confront ageism and social justice issues, including the fair treatment of nursing homes, racism in the aging policy-making arena, and provocative demands to reorganize social institutions that perpetuate neglect and exploitation of the elderly and their caregivers. Targeting economic insecurity among older adults of color and LGBTQ elders, the Diverse Elders Coalition campaigns for policies and programs that improve aging for the diverse communities that compose the US population (Diverse Elders Coalition, 2021). This includes immigration system reforms that provide more for domestic care workers; increased support for family caregivers whose unpaid care labor enables family members, friends, and neighbors to age with health and dignity; a dependent care credit that individuals, who spend part of their working years caring for elderly family members, can apply toward their Social Security earnings; and culturally competent in-language resources to help meet daily needs, from groceries and transportation to care options for physical and mental health (Ehlers and Krupar, 2019: 128). How we handle the pandemic and its aftermath must prioritize a racially equitable social organization of institutions, healthy lives and livelihoods, and "good deaths" as a paramount intergenerational public works project.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

ORCID iD

Shiloh Krupar https://orcid.org/0000-0001-9402-9338

Notes

1. These figures may still be an undercount as new information continues to roll out, such as in the state of NY.
2. For example: Facility size and density; location; ownership and management structure; differences across states; the federal five-star rating system and prior infection violations; staffing/understaffing; deficiencies of care linked to whether an institution is for-profit, nonprofit, or public, and more.
3. This national emergency has been met with incredible commitment and resolve to save as many lives as possible, in situations where difficult forms of triage have had to be implemented and in conditions that have involved horrendous risks and sacrifices by medical workers. The critique developed here focuses on structural-institutional issues and conditions, not individuals, intentionality, or effort.
4. See Rothstein's (2017) *The Color of Law* for further information.

5. For example, the owners of Aperion Care have paid themselves hundreds of thousands to millions of dollars in annual rents for each building (Jaffe, 2020a, 2020b).
6. Medicare provides eighty-four percent more funding for these residents than Medicaid recipients.
7. In many states, regulations emphasize staffing levels and not mix, incentivizing the hiring of lower-paid personnel. Refer to the next section on long-term care labor.
8. For more detail, refer to "10 Things to Know About Medicaid" (Rudowitz et al.) and "A Report on Shortfalls in Medicaid Funding for Nursing Center Care" (Eljay, LLC, 2015).
9. The situation is even more precarious for home health workers whose sector is even more invisibilized: Less than 1 in 5 home care workers have access to paid leave, and many companies incorrectly list them as private contractors to exclude them from overtime payment (Famakinwa, 2019; Kinder, 2020). Two thirds of home health workers leave their jobs every year; in 2019 they made a median wage of $11.52 (Newman, 2019).
10. Home care workers are even less prioritized with a survey finding 75% of home care agencies facing shortages of masks and sanitizers.
11. For example, New Jersey implemented this policy (Fallon, 2020).
12. The state of Michigan references recent data showing the state had better COVID outcomes than could have been expected relative to the rest of the country, with the requirement in place for recovering COVID patients to be allowed back into their nursing homes (Erb and Oosting, 2020).
13. In one tragic account, a man was discharged from a hospital after improving with COVID, but his nursing home wouldn't accept him unless he tested negative. He had no place to go and was to be moved to another state. His daughter thereafter struggled to find him a new nursing home. Although eventually she did, her father passed away while enduring this process (Barker and Harris, 2020).
14. In the pandemic, CMS has waived the requirement for advance notice to be given *before* transfer (Centers for Medicare & Medicaid, 2021: 19).
15. Governor Whitmer vetoed the original bill saying residents cannot be readmitted without a negative test, after it passed the state House and Senate with bipartisan support. The policy that remained stated residents must be discharged to their original facility if it is able to cohort COVID and non-COVID residents, or to an alternative care location such as a "regional hub." These hubs have now evolved into the CRC policy.
16. There are concerns that the Health Insurance Portability and Accountability Act has been used to block access to and/or forestall release of the numbers and locations of COVID-19 outbreaks in states, such as Arizona.
17. In December 2020, Dr Susan Moore shared on social media her struggle with both COVID-19 itself and the anti-Black medical racism of those who were supposed to care for her. She ultimately passed (Nirappil, 2020).

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Author biographies

Shiloh Krupar is Provost's Distinguished Associate Professor in the School of Foreign Service at Georgetown University, where she teaches in the Culture and Politics Program. Her research examines the biopolitical administration of asymmetrical life, geographies of waste and vulnerability, neoliberal biomedicine, and queer approaches to bureaucracy and ecology. She is author of *Hot Spotter's Report: Military Fables of Toxic Waste* (University of Minnesota Press, 2013), co-author of *Deadly Biocultures: The Ethics of Life-making* (University of Minnesota Press, 2019), co-editor of *A People's Atlas of Nuclear Colorado* (2021, https://www.coloradonuclearatlas.org/), and co-author of *Exaction: Territories of Austerity, Bias, Dross* (SAGE forthcoming).

Amina Sadural is a Culture and Politics Program candidate in the School of Foreign Service at Georgetown University. Her research examines immigration with particular focus on the racial liberalism of migrant detention. She is co-author of "Beyond the Border: Fear and Family Separation," published on *Medium*.