

DYING FOR THE ECONOMY: DISPOSABLE PEOPLE AND ECONOMIES OF DEATH IN THE GLOBAL NORTH¹

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Abstract: This essay explores the idea of dying for the economy that has been a proposition supported by President Trump and the Republican Party in discussions about how to reopen the economy in light of the COVID-19 pandemic and massive lockdowns. While to most of us this seems like crazy talk, I argue that the loss of some peoples' lives in order to sustain a buoyant economy is a rationale acceptable to many in the corporate sector as well as their pro-business political partners. I first explore theoretical discussions about biopolitics, necropolitics, and the long historical relationship between capitalism and death. I then point to an emerging literature on "economies of death" and apply that to the opioid epidemic in the United States as an illustrative case of a "necroeconomy". I reflect upon parallels between the opioid epidemic and the COVID-19 pandemic, turning to current debate in the United States about reopening the economy versus the associated public health risks of further lives being lost. The rhetoric of these debates reflects widespread economic values that prioritize some lives over others, making explicit who is ultimately "killable" in the quest to return to a flourishing and efficient economy.

Keywords: necropolitics; necroeconomy; neoliberalism; racial violence; pandemic

Introduction

As the COVID-19 pandemic rolls on, taking its toll on people, families, and livelihoods the world has become fixated on the proximity of death. The United States has been hit very hard with more deaths than any other country in the world. Like other wealthy industrialized nations, the US is fighting the disease in big cities and rural populations as it continues to deal with horrific scenes of exhausted medical staff, overcrowded hospitals, stacked bodies in mass graves, lack of proper equipment, and the disproportionate suffering experienced by the marginalized, people of colour, and Indigenous communities. Amid the horror, certain moments stand out. One of these was when Texas Lieutenant Governor Dan Patrick went on Fox News to tell media host Tucker Carlson that older people (who are more susceptible to the virus) should be prepared to die rather than have the economy suffer.

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A surprised Carlson sought clarification, asking the lieutenant governor if he thought a failing economy was scarier than dying, and the response was “yeah” (Beckett 2020). A month later, the lieutenant governor stubbornly repeated on Fox News that “there are more important things than living” (Brown 2020).

The statement that the economy is worth dying for caught many off-guard and created a media storm. But coming from the mouth of a conservative politician loyal to the Trump administration, the valuing of economic efficiency over life should not have come as a surprise. Trump had talked a few days earlier about the need to weigh loss of life against the longer-term benefits of a return to work and an upswing in the economy. Notably Trump had not gone so far as UK’s Prime Minister Boris Johnson, who initially advocated the idea of “herd immunity” and allowing the virus to run its course, despite projections of massive loss of life. Nonetheless, Trump’s cavalier dismissal of the virus as a “hoax”, ongoing refusal to listen to medical expertise, withdrawal from the World Health Organization, and promotion of untested drugs in his effort to spin a narrative of an imminent return to economic normalcy rattled the entire population and many around the world. Not insignificantly, Trump’s actions and attitude reflect many other pro-business radical right leaders such as President Jair Bolsonaro of Brazil, Prime Minister Narendra Modi of India, President Vladimir Putin of Russia, President Alexander Lukashenko of Belarus, and Prime Minister Boris Johnson of Britain. These leaders refused, like Trump, to act quickly ahead of the World Health Organization’s warnings of an imminent health crisis. And like Trump, they acted with incredible callousness toward the most vulnerable in society, many of who are unable to “shelter-in-place”. As one analyst has noted, “[a] clear lesson we can draw already is that the nationalist right is terrible at dealing with pandemics . . . the myth that the nationalist right cares about ‘the people’ has been shattered” (Friedman 2020).

In this essay I explore the idea of dying for the economy. While to most of us this seems like crazy talk, I argue that the loss of some peoples’ lives in order to sustain a buoyant economy is a rationale acceptable to many in the corporate sector as well as their pro-business political partners. After all, “profit over people” is a rationale that has undergirded the global political economy for centuries and insidiously pervaded all elements of social life through neoliberal ideology over the past 50 years (Hickel 2018; Chayes 2020). However, today we are facing a new form of economic logic that goes beyond considering certain populations (i.e. migrant labourers, young women, black youth, Indigenous tribes) as particularly exploitable and disposable. I argue—as have others—that the logics of capitalism have shifted in recent years to view certain populations not only as disposable, but in fact only valuable when dead. Death, in short, has become a commodity around which monetary value and late capitalist activities flourish.

In this essay, I hope to bring the theoretical interventions around “economies of death” into view for people to comprehend in an immediate and tangible way. I discuss the theoretical concepts and framework informing “economies of death” that blur the line between “letting die” and “making die”. I then explore how this framework may help us better understand the opioid epidemic in the United States as an illustrative case of a “necroeconomy”. I then return to the global COVID-19 pandemic and reflect upon debates in the United States about how quickly to reopen the economy versus the associated public health risks of further lives being lost. These debates are occurring in some form or other in almost every country in the world. The rhetoric of these debates and how they are being conducted reflect widespread economic values that prioritize some lives over others, making explicit who is ultimately “killable” in the quest to return to a flourishing and efficient economy.

Death and Capitalism

For the past 20 years there has been lively debate among Foucauldian scholars around the concept of biopolitics and biopower, which under late capitalist seem to have ever greater theoretical application.² Very briefly, biopolitics refers to a political rationale that takes the management of populations as its objective.³ In Michel Foucault’s view, this rationale began developing throughout the 17th and 18th centuries and was fully unleashed in the 19th century in conjunction with modern forms of nationalism and capitalism. Biopower enabled an expansive capitalist system, allowing for “the controlled insertion of bodies into the machinery of production and the adjustment of the phenomena of population to economic processes” (Foucault 1978: 140–141). Biopower also helped constitute the modern state as the defender of society, and on that basis justified mass slaughter in wars against other populations and countries.⁴

Building upon Foucault’s insights, scholars such as Giorgio Agamben (1998), Achille Mbembe (2003, 2019), Roberto Esposito (2008), and Timothy Campbell (2011) have furthered theoretical conversations on biopower and the right of the sovereign state to inflict death in its management of certain populations. For instance, Mbembe draws upon the colony and slave plantations as early sites of capitalism where “necropolitics” was practiced. By necropolitics, he refers to the conditions in which people lived at the mercy of the colonizer/slaveowner in an existence in-between life and death. According to Mbembe:

the ultimate expression of sovereignty resides, to a large degree, in the power and the capacity to dictate who may live and who must die. Hence, to kill or to allow to live constitute the limits of sovereignty, its fundamental attributes. To exercise

sovereignty is to exercise control over mortality and to define life as the deployment and manifestation of power (2003: 11–12).

It is important to remember that capitalism and death have always been intimately linked. From its earliest iterations in the 17th and 18th centuries, modern state capitalism is associated with an acceptable loss of human life in the business of making money. Capitalist ventures endorsed by the state, such as the slave trade and gold mining in the New World, are intertwined with horrific histories of brutality and genocide of Africans and Indigenous populations. Today, in the rhetoric of late capitalism, death is often expressed as “collateral damage” or “acceptable risk”. This rationale informs tragic events typically associated with developing nations, such as the Rana Plaza factory collapse in Bangladesh that killed well over 1,000 young girls and women (due to poor building regulations). But similar “disasters” occur in wealthy industrialized nations as well such as the Grenfell 24-story tower fire in London that killed 72 people in June 2017 (due to cheap combustible external cladding), and the Boeing 737 airplane crashes in October 2018, and March 2019, killing 189 and 157 people respectively (due to inadequately tested software) (Bulley et al. 2019; Hodkinson 2020). Whether occurring in the global south or global north, these events reflect executive decision-making that accounted for a certain level of potential death (and punitive fines) as part of a strategy maximizing profit. According to Peter Baker, a government:

makes money-versus-lives trade-offs all the time. When a regulatory agency weighs in a new safety rule, it measures the cost to industry or consumers against the gain by assigning a dollar value to each life that might be saved. If a new rule costs billions of dollars but would only prevent a few dozen deaths, it is likely it would not be adopted—even though someone would die as a result (2020).

Economies of Death

Drawing upon the long histories of exploitative capitalism that include pre-calculated collateral loss of life, there is emerging a theoretical intervention that speaks to the particular economic conditions of the 21st century. An increasing number of social theorists and philosophers are talking about “economies of death” or “neco-economies” (Lopez and Gillespie 2015). These theories differ from earlier discussions of biopolitics and necropolitics in that in the new neco-economy death itself has become the goal and driver of business. For instance, the sociologist Fatmir Haskaj argues:

Death as a source of value marks a new space in capital that exceeds the former limits identified under modernity . . . in which living labor is the primary source of value . . . this is a direct product of neoliberalism's tendency to marketize all aspects of human activity and I maintain that this is a new space of capital that profits in killing and death, not to produce commodities, but as the commodity itself—a *necroeconomy* (2018: 1149).

Discussions of biopolitics, and the capacity of the sovereign state to decide who can live or die within social and legal frameworks, are not the same as talking about an economic system based on the “monetization of death and killing” (Haskaj 2018: 1151). “[A] necroeconomy is unlike biopower since it is invested not in life but rather in death directly and it is this dying and death that becomes commodified” (Haskaj 2018: 1163). It is this late capitalist formation of a new kind of economy and emerging marketization of death that I wish to focus on. It differs from illicit trafficking of such things as kidneys, corneas, and other human tissue because these new necroeconomies are implicitly/explicitly condoned by the state (Scheper-Hughes and Wacquant 2003). A necroeconomy can be thought of as an extension of the neoliberal free-market economy, and as such enjoys the nation-state's legal and political infrastructure and protections to support it.

Fatmir Haskaj helps us better understand the rise of “death economies” in so-called “failed states” of the global south (Grimm et al. 2016; Woodward 2017). Through an examination of mass slaughter in the Rwandan genocide (1994) and in the Yugoslav Wars (1991–2001), he argues that these countries' inability to create legitimate and stable societies helped set the conditions in which death camps and genocide were seen as the only option (Haskaj 2008). In such desperate conditions, “surplus populations and the unemployed and unemployable” are transformed into “death-subjects” (Haskaj 2018: 1155). He goes on, a necroeconomy is the “last hope to extract ‘a quantum of value’” from populations no longer deemed to have any living labour value (Haskaj 2018: 1164). Economic activities flourish in these new death economies based on war, destruction, and displacement—people are compensated for murdering, people are hired to dig graves, people are mobilized to loot and plunder, people are employed to bring in water and food, people are rewarded for promoting peace. Haskaj argues:

Ethnic cleansing, genocide, environmental “disasters” and generalized poverty have become productive industries that release the accumulated stored value of life, as death, into circulation . . . Murder and displacement releases this value, but, even more importantly for neoliberalism, brings in foreign investment in the form of NGOs, the United Nations, foreign personnel and their material

belongings, services to support these institutions and belongings and finally grants and loans to stabilize the country and encourage its reincorporation into the mainstream flows of neoliberalism (2018: 1165).

But necroeconomies do not just exist in the “failed states” of the global south. Feminist and political geographers Patrica Lopez and Kathryn Gillespie widen the discussion in their edited volume *Economies of Death* to include examples from various regions and countries of the world including the United States. Their innovative analysis explores direct (making die) and indirect (letting die) forms of killing in the context of late capitalism, arguing that these practices are intimately tied to political, social, and economic precarity and racialized hierarchies of human value (Butler 2004). They argue:

Under capitalist logics, a differential hierarchy operates in which some bodies and lives must die so that others may live and flourish. The “economies of death” as a framework draws attention to the destructive nature of capitalism, the breaking down of living bodies for labor, commodity extraction, and the accumulation of capital (Lopez and Gillespie 2015:179)

One of Lopez and Gillespie’s central concerns is the lack of ethics in late capitalist societies where a “hierarchy of killability” has become mundane and acceptable. Their point is that all of us, individually and collectively, are implicated in the practices of capitalism that dehumanize some people and then allow them to die for the benefit of certain others. As they state, “it is not the impact that the deaths of Others will have on our own liveliness that is our concern, so much as the absolute disinterest in the liveliness of Others—human, non-human animals, and environment” (Lopez and Gillespie 2015: 182).

The Opioid Epidemic

For many people living in the global north, discussions about capitalizing on death make little sense. Such publics have been relatively buffered from the ravages of neoliberalism as it has played out in developing economies through structural adjustment loans and austerity policies imposed by the World Bank and International Monetary Fund. Northern populations have generally not experienced the “slow violence” of neocolonialism and the racialized exploitation of people and natural resources that has ravaged populations across Africa, Central and South America, and Asia (Harvey 2005; Nixon 2013; Robinson 2014; Brown 2015). For many in the global north, the argument that today’s capitalist system is in part sustained through the commodification of death—that people are more

valued dead than alive—is dismissed as the rantings of scholars out of touch with reality. This is evidenced in the widespread public shock over the matter-of-fact statements by Boris Johnson regarding “herd immunity” and Lieutenant Governor Patrick saying people should die for the economy.

Yet people in the United States have been living within a necroeconomy for decades without acknowledging it or thinking about it in such terms. This is the ongoing opioid epidemic that rocked the United States beginning in the mid-1990s. Some commentators argue that this epidemic could only happen in the US given its particularly poor health care system. However, I suggest that while the epidemic is extreme in terms of scale, it should not be considered an anomaly with respect to what it says about the global pharmaceutical industry’s casual disregard for human life, and more disturbingly, its aggressive exploitation of human death. Moreover, the pharmaceutical industry is one facet of a global political economy and shares with other sectors a set of neoliberal market logics that carry across into agribusiness, oil, mining, infrastructure development, and the prison-industrial complex. The building of mega dams that flood villages, the dumping of pesticides in rivers, the blowing off of mountain tops for easier mineral extraction, the wholesale imprisoning of black youth—all of these industries are engaged to some degree in a late capitalist system that ranks some people’s lives and livelihoods less valuable than others. Stating this in a more palatable way, all these industries choose economic efficiency over human well-being. While not necessarily engaged in “economies of death”, they reinforce a sensibility that some human lives are worth more than others. Collectively, these industries foster the political and social conditions in which a new type of economy based on the “monetization of death” may seem even reasonable and practical. My argument is that there are only degrees of culpability separating “letting die” and “making die”, and in the current political landscape of the United States these fine-grained distinctions are becoming blurred and at times hard to differentiate.

How does discussion of “death economies” help us better understand the U.S. opioid epidemic that has devastated primarily working-class communities for the past two decades? There has been an outpouring of analyses and commentary from the medical community detailing the extent of the epidemic (see Lewis et al. 2015; Jones et al. 2018). Beyond the medical profession, some excellent books have been published on the opioid epidemic, many by leading investigative journalists frustrated that the issue was not receiving adequate media attention. These books include Barry Meier’s *Pain Killer* (2003), Sam Quinones’ *Dreamland* (2015), Beth Macy’s *Dopesick* (2018), Chris McGreal’s *American Overdose* (2018), and most recently Eric Eyre’s *Death in Mud Lick* (2020). None of the literature uses the term “necroeconomy” or “economy of death” but the facts of the epidemic suggest it could be easily so labelled.

Very briefly, the epidemic began in 1996 when the medicine OxyContin began to be prescribed by doctors as a form of pain management. OxyContin had been approved the year before by the U.S. Food and Drug Administration and was produced by Purdue Pharmaceuticals, a multinational company that had grown exponentially since the 1970s, when its owners—three brothers from the Sackler family—started acquiring drug companies around the world (Posner 2020). They made huge profits on the end-of-life drug MS-Contin, but as its patent was about to expire the company sought a new lucrative drug to take its place. OxyContin seemed to fit what they were looking for, expanding their market beyond the hospice and end-of-life sector to a general public looking for a new pain relief solution (Macy 2018: 20). Importantly, OxyContin was a crushable morphine-based medicine that made it medically more acceptable and accessible to a wider patient base.

From the start, the Purdue sales team promoted OxyContin as having a very low rate of potential addiction, as low as 1 percent among users. Dr J. David Haddox, the pain specialist employed by Purdue, constantly touted this statistic to the “new army” of sales reps as they

fanned out to evangelize to doctors and dentists in all fifty states with this message: Prescribing OxyContin for pain was the moral, responsible, and compassionate thing to do—and not just for dying people with stage-four cancer but also for folks with moderate back injuries, wisdom-tooth surgery, bronchitis, and temporomandibular joint disorder, or TMJ (Macy 2018: 27).

OxyContin was readily prescribed by doctors, many of them understaffed and unable to spend adequate time with their patients. According to testimonials, many of these doctors thought of the drug as a quick fix. They also knew the drug would be covered by insurance companies more readily than a regime of more expensive alternatives such as physical therapy or acupuncture.

Purdue took its marketing strategies extremely seriously. The company targeted doctors known to prescribe a lot of pain medicine and deliberately sought out family doctors who would prescribe medication for a wide range of ailments, including school sports injuries, work-related injuries, osteoporosis, and depression. The advertising statistics are staggering—in just three years between 1996 and 1998, Purdue’s direct marketing to doctors jumped from \$360 million to \$1.3 billion. Company reps were expected to make over a million calls a year to doctors working in hospitals and family-based practices. For their efforts, reps were richly rewarded with big bonuses up to \$20,000 and fancy holidays. They enticed prescribing doctors with a variety of gifts and perks, including expensive dinners, tickets, turkeys at Christmas, pedicures, and so on (Macy 2018: 31–32). These perks grew ever more lavish, with Purdue holding:

more than forty national pain management and speaker-training conferences, luring doctors to resorts from Boca Raton, Florida, to Scottsdale, Arizona. The trips were free including beach hats with the royal-blue OxyContin logo. More than five thousand doctors, nurses, and pharmacists attended the conferences during the drug's first five years—all expenses paid (Macy 2018: 47).

Drug overdose is the leading cause of accidental deaths in the United States and driving the overdose figures is opioid addiction. The prescribing rates for prescription opioids among adolescents and young adults nearly doubled between 1994 and 2007. By 2012, 259 million prescriptions were written for opioids, which is more than enough to give every American adult their own bottle of pills (ASAM 2016). This in turn led to widespread addiction to opium, leaving people searching for doctors to write new prescriptions or turning to heroin or fentanyl on the black market. One commentator writes:

In 2016 11 million Americans mis-used prescription opioids, and 2.1 million adults reported that they were addicted. In the year to September 2018 opioid overdoses killed 48,000 people. That took the total death toll since 2000 to 400,000, greater than the number of American combat deaths in the second world war, the Korean war and the Vietnam war combined (Economist 2019).

Another writes:

The clues to the scale of the catastrophe were in the details long before the death statistics were taken seriously. The firefighters called out more often for overdoses than fires. The teachers buying food for the growing numbers of students neglected by parents spending their time and money on drugs. The pharmacies popping up in small towns where other shops were in retreat for lack of business. The surge in babies born with withdrawal symptoms and cared for by grandparents. The firms unable to find enough workers to pass a drug test (McGreal 2018: xii).

A third commentator adds:

The rate of casualties is so unprecedented that it's almost impossible to look at the total number dead—and at the doctors and mothers and teachers and foster parents who survive them—and not wonder why the nation's response has been so slow in coming and so impotently executed when it finally did (Macy 2018: 5).

However, it was not until 2016 that the Centers for Disease Control and Prevention (CDC) announced prescribing guidelines to doctors that strongly recommended

limiting the use of opioid drugs to manage pain. This was not an enforceable set of guidelines and left totally up to doctors to change prescribing methods that had prevailed for decades. From all accounts, many patients still taking OxyContin remain on doses that exceed the CDC's recommendation. In rural America, "overdose rates are still 50 percent higher than in urban areas" (Macy 2018: 274).

Disposable People

It is important to note that the patients first targeted by Purdue were largely poor and white, living in the former mill and mining towns of central Appalachia. These towns of "the unemployed and unemployable" had been hit hard by the shift to sustainable energy, leaving behind communities facing extreme poverty, depression, and plagued by what the economists Anne Case and Angus Deaton later called "diseases of despair" (Case and Deaton 2020). In theoretical terms, these communities were no longer exploitable as living labour in low-paying and high-risk jobs. But Purdue saw an opportunity to create a new market of exploitation based on addiction and death. In this context we should remember the words of Fatmir Haskaj who argued that a necroeconomy is the "last hope to extract 'a quantum of value'" from populations no longer deemed to have any living labour value (Haskaj 2018: 1164; see also Petras and Eastman-Abaya 2018).

Moreover, the Appalachian towns and other rural communities in which the epidemic quickly spread are the forgotten fly-over populations that hold little consequence to politicians and formal avenues of accountability. Isolated, often uneducated, with limited resources to seek help or make a fuss, these rural populations were ostensibly "disposable" people. According to Beth Macy:

When a new drug sweeps the country, it historically starts in the big cities and gradually spreads to the hinterlands, as in the cases of cocaine and crack. But the opioid epidemic began in exactly the opposite manner, grabbing a toehold in isolated Appalachia, Midwestern rust belt counties, and rural Maine. Working-class families who were traditionally depending on jobs in high-risk industries to pay their bills—coal mining in Southwest Virginia, steel milling in western Pennsylvania, logging in Maine—weren't just the first to experience the epidemic of drug overdose; they also happened to live in politically unimportant places, hollows and towns and fishing villages where the treatment options were likely to be hours from home (Macy 2018: 7–8).

Into these rural communities of the unemployed, Purdue's marketeers brought hope in the form of prescription opioids. Not only did pain prescriptions dull the emotional toll of joblessness, depression, and long-term mining injuries, but it also

became a commodity that could be sold on the black market for significant sums that could put food on the table and pay bills. From Purdue's perspective it was entirely predictable—and in fact banked upon—that pain pills would become the “new coal” (Macy 2018: 18; Zee 2009).

Domestic “Killing Fields”

For its calculated irresponsibility, Purdue was fined \$634 million in 2007 by the Food and Drug Administration for claiming OxyContin was less addictive than other pain medications.⁵ But even after this public offence, the prescription drugs kept flowing into communities as other pharmaceutical and drug distribution companies such as CardinalHealth and Mallinckrodt stepped in to fill the extraordinary demand for oxycodone and hydrocodone pills. Data released in 2019 from the federal Drug Enforcement Administration show that drug companies targeted towns and rural regions that had long histories of abuse that Purdue had earlier primed. According to AP reporters Geoff Mulvihill and Matthew Perrone:

West Virginia, Kentucky, Tennessee and Nevada all received more than 50 pills for every man, woman and child each year. Several areas in the Appalachian region were shipped an average of well over 100 pills per person per year. “It’s like being on the front lines of a war every day,” said Joe Engle, sheriff of Perry County, Kentucky, which received 175 pills per person per year. “Our people here in eastern Kentucky have been taken advantage of by these pharmaceutical companies. It’s one of the worst things you can do to a society, to a people. And we’re suffering” (Mulvihill and Perrone 2019).

Adds Wendy Welch, an Appalachian health care provider, “[w]e’re not victims here, except for when it comes to Purdue Pharma” (cited in Macy 2018: 275). This notion of populations being victims returns us to Fatmir Haskaj’s earlier theoretical discussion when he writes:

In a necroeconomy, an economy of death, the accumulation of capital occurs from below, directly, not through surplus value (cheap labor) but rather through surplus populations that are (re)produced as death-subjects, as people whose role in the economy is to be victims (Haskaj 2018: 1163).

Perhaps most disturbing about the decades-long opioid epidemic is the complicity of the federal government in these grossly unethical and entirely predictable death-causing activities. As the prize-winning journalist Chris McGreal writes in his book *American Overdose* (2018), one of the main reasons for the pharmaceutical

industry's success was its coopting the Food and Drug Administration (FDA) and members of Congress. Specifically, the FDA refused to incorporate a public health dimension into its drug approval process that would determine if a drug was effective for its intended usage as well as a wider assessment of its actual usage in communities. The FDA, or at least certain units within the FDA, was fearful of being attacked by big pharmaceutical companies for going beyond a very narrow remit of drug approval, and as a result was susceptible to pressure from powerful pharmaceutical lobby groups (McGreal 2018: chapter 17). The FDA did introduce some regulatory hurdles that required pharmaceutical companies submit risk-management plans and conduct market surveillance, but these hurdles were largely ineffective. McGreal comments:

A former head of the Food and Drug Administration has called America's opioid epidemic "one of the greatest mistakes of modern medicine". It is neither a mistake nor the kind of catastrophe born of some ghastly accident. It is a tragedy forged by the capture of medical policy by corporations and the failure of institutions in their duty to protect Americans. Even as the alarm was first sounded, some of the United State's most powerful medical bodies forced open the doors to the mass prescribing of opioids (McGreal 2018: xiv).

Parallels Between the Opioid Epidemic and COVID-19 Pandemic

Donald Trump came into office in 2016 with a campaign promise to stop the opioid epidemic. But apart from calling it a public health emergency, his record of combatting the issue is poor according to a Government Accountability Office report (2018). And while deaths from drug overdose fell from 70,000 deaths in 2017 (the highest annual figures on record) to 67,000 deaths in 2018, this modest drop was in large part due to efforts begun much earlier under the Obama administration. As some commentators note, the decline in death figures occurred in spite of Trump's efforts that included his attack on Obamacare and cutting Medicaid and other avenues to local medical access (Lopez 2020). Not helping the president's record has been his installing pro-industry commissioners, such as his first appointee Scott Gottlieb, who over two years decreased the FDA's regulatory and enforcement oversight (Pillar 2019).

Yet despite the inadequate response to quelling the opioid epidemic, it has not seemed to have hurt Trump's popularity among his core base of cynical capitalists and disaffected poor white rural communities plagued by "deaths of despair". The plain facts are that the Trump administration knew (1) the opioid epidemic would continue largely unabated, (2) that it would kill approximately 50,000–70,000 people a year, and (3) economically cost the federal government little, with state

and local agencies picking up \$10.5 million per person in related medical, police, and welfare costs (Macy 2018: 29). In short, the ongoing epidemic has not seemed to hurt Trump politically with his core Republican constituencies, and despite his campaign pledge to take down “Big Pharma” has not altered his cozy relationship with the pharmaceutical industry (as evidenced by many of his senior staff leaving the White House landing extremely lucrative jobs with major drug companies) (Herrig 2020).

Thinking of the opioid epidemic as a necroeconomy—and there seems every reason to do so—helps us to better understand Trump and Republican responses more generally to the COVID-19 pandemic. Certainly, these events are not equivalent, but it is not unreasonable to think that lessons learnt by Trump regarding the first epidemic may have informed his decision-making about the second. Like the annual figures on the opioid crisis, in early March 2020 it was estimated that the first wave of the pandemic would kill approximately the same number of people (50,000–70,000 deaths). Like the opioid crisis, state and local agencies (and not the federal government) were held primarily responsible for the pandemic’s management and related economic expenses. And like the opioid crisis, deaths of certain populations were deemed acceptable in order to get an economy back on track. The major difference was that the white, rural poor, who suffered disproportionately in the opioid crisis, were replaced by precariat workers, many of colour, living in major urban cities.

As many commentators have noted, gross economic inequalities and economic vulnerabilities have been revealed and exacerbated with the pandemic. Marginalized minorities and people of colour are being disproportionately impacted as they maintain essential services and hustle to find the capacity to shelter-in-place. It is estimated that people of colour are up to three times as likely to die from COVID-19 than white people. This is because in the United States, African American, Latinx, and Indigenous communities are overrepresented in “essential” jobs that include health care providers, delivery drivers, grocery store clerks, first-responders, and so on. In many cases, these front-line workers are denied adequate testing and tracing of the virus, or even adequate protective clothing. President Trump explicitly stated that he would take no responsibility for coordinating a national strategy for providing this life-saving equipment, and left it up to the 52 state governors to compete among themselves for scarce resources.

Throughout 2020, chaos and irresponsibility infused the political backdrop to talks by Trump and governors trying to determine how best to reboot the economy. There were sincere and ethical calculations being made by some to slowly phase in a reopening. But others such as Brian Kemp, Republican governor of Georgia, forged ahead with swift proposals to reopen his state’s economy against the advice of most health experts. According to Rashad Robinson, president of the

racial justice advocacy group Color of Change, Georgia's governor "has targeted a whole set of businesses where black people both work and patronize". For those workers and customers, "it is an absolute death sentence" (Tankersley 2020). At the federal level, the sense of certain people being disposable or "more killable" than others was even greater. President Trump's executive order declaring meatpacking plants must remain open on 28 April 2020 marked a new phase of targeted oppression, given the meatpacking industry mostly employs immigrants and people of colour (Worrall 2015). The order overturned the decisions of labour unions and some meat companies and state governors who had closed plants because they were "hot spots" of contagion with thousands of employees becoming ill. "Using executive power to force people back on the job without proper protections is wrong and dangerous", tweeted Richard Trumka, president of the AFL-CIO.⁶ Stuart Appelbaum, president of the Retail, Wholesale and Department Store Union, added "[w]e only wish that this administration cared as much about the lives of working people as it does about meat, pork and poultry products" (cited in Swanson and Yaffe-Bellany 2020).

As the months dragged on into July 2020, contagion and deaths by COVID-19 in the United States continued to rise. The US reached the highest death toll of any other country, and given the lack of leadership, testing, and respect for medical expertise, will presumably hold this ranking into the foreseeable future. In addition to anger and debate about the racial discrepancies of who was dying from the disease, a central concern gripped the public regarding the reopening of schools. This reopening would force children and teachers to go back to campus despite warnings by public health officials and objections from teachers' unions. Trump aggressively attacked the "tough and expensive" guidelines issued by the federal Centers for Disease Control and Prevention on how to safely reopen schools, forcing the criteria for returning to be softened over the objections of health experts. And he threatened that if schools did not reopen he would cut their federal funding. But one of his most callous moves was to force 53 Native American schools across ten states that come under his federal jurisdiction to reopen by September. This ruling applies despite huge fears of rising numbers of infections being the result. Native American reservations—particularly the Navaho Reservation—have the highest hospitalization rate of any other minority group in the country. This is largely due to lack of running water, electricity, access to health care, underlying health conditions, and multigenerational families living in small confined spaces. Sue Parton, president of the union representing Bureau of Indian Education employees stated:

I am concerned about the infection and the spread of the virus through our staffing, to the teachers, to the employees . . . Then I look at it from the aspect of being a Native American community member myself, and I worry about the

spread throughout our Native community. I don't want to see that happen, and I just don't think that there has been enough scientific evidence to show that it is safe for staff and students to go back to school as normal (Green 2020).

Bahozhoi Kinsel, who oversees Kaibeto Boarding School in Arizona, added “[t]his is the Bureau of Indian Education playing God. This is what they do” (Green 2020).

Many more examples can be given of the federal government and corporate sector's callous—if not explicit—disregard for putting some populations such as the elderly, homeless, immigrant, incarcerated, and people of colour at risk of death by COVID-19. The general public's anger at this indifference runs deep from communities and constituencies across the country and political spectrum. Patricia O'Neill (2020) argues that “the message to those of us who are classified as ‘old’ or ‘poor’ or ‘working class’ is that we are expendable”. More specifically, Eric Orts, a professor of business ethics, writes:

If the CEO of a large company received certain knowledge of toxic conditions in the workplace that put the lives of employees at serious risk and the CEO did nothing, and workers died as a result, then he or she would be liable for negligence or reckless homicide. President Trump has sovereign immunity. Nevertheless, his inaction for months after being informed of credible intelligence reports of the threat of Covid-19, his statements encouraging citizens to risk their lives by taking unproven drugs, his encouragement of large groups of protestors who risk exposure to the coronavirus and his continuing failure to adopt a coherent national plan of defense are at least the moral equivalent of negligent mass manslaughter (Orts 2020).

It seems that the logic whereby certain people are regarded disposable so that other people can flourish is becoming more pervasive. As noted by political theorist Tarik Kochi (in comments about Boris Johnson that could as easily apply to Trump), “[i]ncompetence and populist nationalism take place then in the context of a neoliberal world view which has turned a dangerous and deadly virus into systematic social violence”. The idea of any government being involved in “systemic social violence” returns us to the earlier discussion of the opioid epidemic that was deliberately and knowingly orchestrated by Purdue Pharmaceuticals. Purdue's success lay in building an entirely new economy flourishing on the production of death—a necroeconomy. And this economy was condoned, at times explicitly, by federal agencies who bended to pressure from corporate lobbyists. Just to be clear, creating a market of addiction and ultimately death by overdosing was the objective of Purdue Pharmaceuticals and subsequent drug companies who stepped in to offer generic options.

Concluding Comments

While President Trump’s explicit indifference to life in the context of COVID-19 does not amount to a carefully planned genocide equivalent to the opioid epidemic, the underlying rationale of there being a “hierarchy of killability” condoned by the nation-state cannot be denied (Lopez and Gillespie 2015: 182). This is what the pandemic has explicitly revealed in ways that the opioid epidemic—that was initially hidden from view in poor rural communities—could not. Moreover, the pandemic underscores that economies of death don’t just happen in the “failed states” of the global south but are emerging across the global north as well. The idea of certain people dying for the economy has now infiltrated political and corporate sectors and become for an increasing number of big businesses a rather mundane, even acceptable, proposition. No wonder the Republican Party is being called “The Party of Death” (Fraze 2020). Against such insidious logics of rationalized and racialized violence, we must always ask: whose grandma, whose young child, whose dad or daughter is being asked—if not forced—to risk their life for the well-being of select others?

Notes

1. I would like to thank the anonymous comments from reviewers, and Kathryn Gillespie for generously sending me a copy of her edited volume while I was in lockdown during the pandemic.
2. A lot has been written on biopolitics and it is not my intention to recount these discussions here (see Lemke et al. 2011; Campbell and Sitze 2013; Adams 2017).
3. Of note in Foucault’s analysis is that biopolitics work through state institutions such as prison, health and legal systems, regulating and managing people’s lives through a “closely meshed grid of material coercions” (Foucault 1997: 36). Foucault’s insights highlight the way power governs human and social bodies, managing through various technologies of power every facet of human life including people’s subjectivities.
4. “The conventional understanding is that biopower optimizes, fosters and intensifies life in order to ‘make live’ while being haunted by the specter of a vast geography of exclusion, annihilation and death” (Haskaj 2018: 1149).
5. This fine pales in comparison to gross profits made—it is estimated that Purdue’s profits amounted to \$35 billion by 2017.
6. The American Federation of Labor and Congress of Industrial Organizations (AFL-CIO) is the largest federation of unions in the United States made up of 52 national and international unions.

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