The Coronavirus has exposed for both society and policy the inequities in the social worlds we have constructed. While COVID-19 runs rampant in our grossly unequal societies, the world-wide anti-racism movement, catalyzed with the killing of George Floyd in Minneapolis in May 2020, the acceleration of the Black Lives Matter movement and growth in hate crimes against Asians, Jews and Muslims, have brought the hard lessons of ongoing racial inequities sharply home. Social hierarchies and beliefs have been disturbed as the collective realization dawns that it is not highly paid hedge fund managers, real estate developers, or corporate CEOs who keep societies going, but health care workers, teachers and day care workers, paramedics, factory and grocery store workers, truck and transit drivers, fast-food service crews, and garbage collectors. Most crucial to our societies continuing are the lowest paid of all in essential services, e.g. cleaners in hospitals, long-term care workers, and meat packing plant workers. What was previously mainly unquestioned is now sharply under interrogation.

The veil pulled back by the pandemic has also revealed the extent to which vulnerabilities to COVID-19, both bodily and financial, are structured by societal schisms across hierarchies of gender, race, and class and divisions of paid, unpaid and ‘gig’ labour. Declared a ‘she-cession,’ (coined by Armine Yalnizyan—see Global News, 2020), women have been disproportionately impacted financially by job loss, reduced work hours, intensification of the double/triple day of work (working from home for pay plus adding involuntary home schooling to domestic work), and kinkeeping or caregiving outside of their households. Those living in poorer neighbourhoods/communities, in crowded housing, in Indigenous communities and working in the ‘gig economy’ have succumbed to the virus at a much higher rate, with racialized populations most affected (Government of Canada, 2020). And it is the physically frail, particularly those older adults living in
congregate housing, who have had a sharply increased risk of death due to COVID-19. Sassen’s term, a ‘savage sorting,’ seems an apt descriptor (2014, p. 4).

The very different experiences of Canada and the U.S. within the first year and a half of the pandemic are of interest, as comparisons tend to be revelatory. This, in conjunction with the COVID-exposed inequities as they specifically shape social reproduction and life courses, is the focus of this commentary. We contemplate ways in which the social ground in Canada and the United States (U.S.) was differently tilled years in advance of the arrival of COVID-19, creating a fertile environment for the pandemic and responses to it, both in civil society and in policy, to play out. We couch our analytical reflections in our comparative, multi-method research of mid-life Canadians and Americans in two socio-economic groups managing in and after the Great Recession of 2008 (McDaniel et al., 2013, 2016). Such an approach permits us to examine contemporary realities of the COVID-19 pandemic in each country in terms of aspects of social reproduction and life course we discovered in that study. As well, the social ground tilled by the Great Recession and its aftermath informs our sociological reflections about what post-COVID life, especially social reproductive relations, may hold for each country.

**Framing**

Our reflections are framed by social reproduction theory and by the life course perspective. Social reproduction as a concept and theory, has a long history in sociology (see Bakker, 2007; Bakker & Gill, 2003; Luxton, 2006, among others). For our purposes, social reproduction has two dimensions: 1) the passing on through time and generations society’s structures and processes; and 2) the linking of micro and macro social structures and processes with the daily and generational renewal of human life/labour essential to the economic system’s endurance. In particular, feminist social reproduction theory holds that both inequalities and the capitalist economic system are buttressed by social reproduction systems (Bezanson & Luxton, 2006; Bhattacharya, 2017; Federici, 2013; Laslett & Brenner, 1989). Recent theorizing on intersectionality reveals how not only gender but also race, coloniality, sexuality, immigration status and more play into social reproduction and its pivotal role in capitalism (Bhattacharya, 2017; Collins, 2019). Historical specificities matter to the dynamics of the relations of social reproduction and economic systems.

The life course perspective, also well known in sociology (McDaniel & Bernard, 2011; Riley, 1979; Settersten, 2020; Shanahan et al., 2016), sees individual experiences as part of contextual processes, as lives intersect with societal changes and with history. Key to this commentary is that life course is simultaneously individual and social, so that not only are individual lives affected by social structures and processes, but emergent life course patterns create social change. There exists a dynamic dialectic between individuals and others in their lives, a linking of lives, and linkages between individuals and social structures too. Further, life course perspectives involve path dependency, gravity and shocks (McDaniel & Bernard, 2011). Path dependency is a function of the timing of life course events so that early negative life events tend to accumulate over lives. Gravity pulls those born to disadvantage down, although escaping the pull of gravity is possible. And shocks are sudden collective events that affect populations but not all equally. COVID-19 is an example of a collective unequal shock, as was the Great Recession of 2008+. 
Comparing the U.S. and Canada in the great recession and after

Canada and the U.S. despite being close neighbours, are very different (Lipset, 1991). Esping-Andersen (1990) categorized them together, but that is true only in broad brush strokes. The two countries have very different histories, governance structures and diverge in neo-liberal politics and political polarization (see Bélanger & Wadden, 2011; Brown, 2006). Their respective welfare states have both undergone restructuring (Gazso & McDaniel, 2010) but there are more universal social programs and a greater commitment to redistribution in Canada than the U.S. (Bélanger & Wadden, 2011). Canada has universal public health insurance for medically necessary doctors’ visits and hospitalization, while the U.S. has private health insurance largely provided by employers. Importantly, Canadians have greater faith in public institutions than Americans and are less politically polarized (Canadian Press, 2021; Leonhardt & Sertez, 2020; Pew Research, 2014). These differences have been apparent in the experiences of the Great Recession and have bearing on COVID times.

Our multi-method Canada/U.S. study began in Fall 2007/Spring 2008 as the financial crisis was emerging. The two countries dramatically differed in how governments and citizens weathered the Recession as it emerged (see Table 1).

In our study, we conducted a first set of in-depth interviews in Fall 2007/Spring 2008 and again in 2013 with different samples of midlife respondents (age 45 to 64) in two socioeconomic classes (working and middle class) in comparable anonymous cities in each country. Respondents were asked a range of questions on how they were doing and how they anticipated doing, as well as how they saw prospects for their younger relatives as they navigated their life courses (McDaniel et al., 2016). Four themes emerged in this study that we see as relevant to shaping life courses and social reproductive relations during the contemporary pandemic: trust in the state, the American Dream, health care worries, and gendered generational relations.

In 2013, 5 years after the Great Recession, working and middle-class Americans in midlife shared their deep distrust of government as well as their profound anxieties about health care and social security. When probed about their perceptions of the economic and social climate their offspring or younger relatives might experience in the future, mid-life Americans expressed open

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1 We paralleled the qualitative research with comparative quantitative national data analysis for each country over the duration of our study.
Table 2  COVID-19 confirmed cases and deaths: Canada and U.S. as of 23 August 2021

|          | Confirmed cases | Deaths | % fully vaccinated |
|----------|----------------|--------|-------------------|
|          | #s per capita  | #s per capita |                  |
| US       | 37,861,263    | .116   | 529,154 .0019     | 52.04            |
| Canada   | 1,475,537     | .039   | 26,758  .0007     | 65.89            |

Source: Johns Hopkins Coronavirus Resource Center. COVID-19 Dashboard, 23 August 2021. coronavirus.jhu.edu/map.html

hostility toward government. Canadians, in contrast, were less apprehensive about weathering the economic recession and expressed confidence in the availability of universal health care and other government/community support programs (McDaniel et al., 2013). Canadians were inclined to trust the state to provide support in risky or challenging times.

American mid-life respondents, in anticipating their later years and the futures of their children or younger relatives, expressed frustration about not having government supports yet still remained optimistic about their children’s economic prospects. Canadians did not share this same blind faith. The difference echoes the cultural trope of the “American Dream,” a second major theme of our findings. Regardless of class, Americans solidly conformed to a defining collective imaginary, that a life characterized by adversity or disadvantage can be overcome by individual efforts and lead to social mobility, particularly intergenerational mobility. Canadians, with the exception of new immigrants, thought their children’s lives would be more of a struggle. This was particularly expressed by working class people (McDaniel et al., 2016).

The theme of health worries captured how not one American in the 2013 phase of our research failed to mention their deep worries about health care if they should fall ill or lose their jobs. This was not surprisingly a looming concern among working class respondents, many of whom worked in precarious jobs. Canadian respondents often replied that even if they faced physical or mental health challenges in the wake of the Great Recession, at least they could count on having health care when needed without cost to them. American and Canadian respondents spoke animatedly about their experiences of, and concern about, gendered generational relations. Americans and Canadians alike anticipated that their older relatives would require more hands-on support and that this would involve gendered generational relations: women would provide care no matter what economic privilege they enjoyed (McDaniel et al., 2016). This would exacerbate a gendered social reproduction, life course script.

Comparing the U.S. and Canada in the COVID-19 pandemic

The very old, those living in long-term care, and those with underlying health issues comprised the bulk of COVID-19 deaths in both countries during the early waves of the virus. At present, however, new variants are differentially affecting people under 50 and children. The difference overall between the two countries in terms of lives lost, however, is suggested by Table 2, as of 23 August 2021. The gap keeps widening as the overall toll of confirmed virus cases in the U.S. has skyrocketed once again with the Delta variant. More than 90,000 were in hospital in the U.S. as of 23 August 2021, “more than in any previous surge except last winter’s” reports The New York Times (2021). A greater proportion of Canadians are fully vaccinated despite the reality that Canada does not have a domestic vaccine supply like the U.S. The U.S. ranks number one in the world for COVID cases and deaths, a ranking unchanged for over a year (Johns Hopkins...
Meanwhile Canada’s cases and deaths per capita, have remained very much lower, when calculated per capita. Canada ranked 46 in the world for case numbers in August 2021, dropping from 22nd in February 2021.

The differences between the two nations before the pandemic have certainly meant differences in individuals’ life courses during the pandemic, especially in their access to health care and policy supports, and their relationship with social reproduction. In Canada, each province is responsible for its own health care system led by a public health officer. Provinces must, however, under the Canada Health Act, adhere to certain common principles such as equal access to treatment regardless of age, existing health conditions, and financial circumstances to be eligible for federal transfer funds. With COVID-19, provinces differ in their responses to “flatten the curve” of growth in numbers of cases, and in degrees of success of doing so, as well as in managing hospital access. In general, however, public health authorities and ministries across Canada planned in advance and continue to make contingency beds available if needed for COVID-19 patients, including by cancelling ‘elective’ surgeries or moving patients to less burdened health care regions in some provinces.

In the U.S., planning for emergency demands on hospitals is challenging since health care is more private and dispersed over jurisdictions. There has also been less of a coordinated policy response and more emphasis on individual responsibility. Patients without health insurance can be shuffled from one hospital to another, compromising urgent care and isolation if they do have the virus, which can be unsettling to familial networks. Those without insurance may resist going to doctors or hospitals unless very ill for fear of the cost, potentially placing greater responsibility on kin for their care. This reflects our study’s findings that Americans have grave concerns about their access to health care. Tests for COVID-19 are not readily available to all and costs for private tests can be prohibitive. As well, those in either precarious work or undocumented fear losing jobs or being deported if they seek health care. When cases become prevalent, it is easy for health care jurisdictions to become overwhelmed, which appears to have happened in several U.S. states (Tanne, 2021).

As well, for the most part, as our earlier research suggested, Canadians and Americans differ in their trust in the state, now with regard to taking the necessary precautions recommended by state authorities to reduce numbers of infections for themselves, their kin, and their communities. A Fall 2020 online survey by Leger and the Association for Canadian Studies found 21% of Canadians versus 43% of Americans believed that being required to wear a mask in public places violates their individual freedoms. The pandemic may be a perfect Foucauldian moment in which discourse moves quickly from the body to the polity. The political frontier becomes our lungs, our nasal passages, and our politics a cloth covering nose and mouth.

Social reproduction and life courses upending

“Epidemics are great laboratories of social innovation, the occasion for the large-scale reconfigurations of body procedures and technologies of power” (Preciado, 2020, 4).

Our Great Recession research found differences between mid-life Americans and Canadians as they weathered, or did not weather, the financial crisis. For many Americans, the Great Recession marked a deepening of already sharp inequalities on every front: race, immigration status, employment, education, housing. The financial crisis of 2008 may have so deeply ‘baked in’ inequality in U.S. society that it set the stage for lasting problems. It has manifested in what are called ‘Deaths of Despair’ whereby the social reproduction of long-standing inequalities eviscerate opportunities
and hope and lead to higher mortality among those under the heel of inequality (Case & Deaton, 2020). Indeed, the gap between minority and majority populations with underlying health issues has greatly widened since the Great Recession in the U.S. and life expectancy in the U.S. has dropped – this is not the case in Canada (Chodosh, 2018; Statistics Canada, 2019).

The COVID-19 crisis seems not different from the fallout of the Great Recession but is another tremor of deepening inequality that has dire consequences, many still unfolding, for the reproduction of societal structures and labour, and for generational relationships. The American Dream may still be held firm by Americans but surely is tempered by the shocking economic toll of COVID-19 in the U.S. as well as by upended life courses. COVID-19 infection among minority low wage workers is particularly acute in the U.S. (Gebeloff et al., 2020; Morrison, 2020) meaning racial inequality textures who bears greater responsibility for social reproduction, often deepened when jobs are lost. Canada too has inequalities but to a lesser extent than the U.S. and with a far less deep experience of the Great Recession, and with more risk insurance social structures. The recovery in Canada was quicker and more complete. That said, the COVID-19 pandemic took the veil off old inequalities and those that most Canadians either did not know existed or were in denial about. Perhaps some Canadians have been dreaming of economic and social mobility as they age like their American counterparts, but COVID-19 introduced acute economic struggles, particularly for younger workers and women in non-union service, hospitality and retail occupations subject to closure (Lemieux et al., 2020).

In both Canada and the U.S., the pandemic has exposed long-standing aspects of gendered, generational relations of social reproduction. It has long been known from socio-economic research that the gender ‘revolution’ was distinctly partial, with more women in the paid labour market but in lower paid gender-segmented work for the most part. On the homefront, the division of labour and responsibilities has been very much more like a mid-20th century model than a 21st one (Guppy et al., 2019), exacerbated and made more widely visible in the pandemic (Morse & Anderson, 2020). White collar workers are able to work from home but with day cares and schools closed, women workers who remain primary carers face constant interruptions. Women in academia, for example, particularly those with children, have had their productivity sharply compromised (Lanigin, 2021). And women in the gender segmented labour force, were more likely to be completely out of work with pandemic closures than men. The social reproduction link between the micro division of labour domestically and the macro-level workplace requirements that largely benefit men, jumped out for all to see.

Health worries among Americans we found in 2013 have deepened in the pandemic, whether they have paid work or not (Smith, 2021). Many Americans who lost jobs during the pandemic also lost their health insurance, paralleling what happened in the Great Recession. Canadians can still be content, as we found in our Great Recession study, that whatever happens with their jobs, they can count on health care without cost, including vaccines. Frontin and Woodbury (2020) find that 7.7 million American workers lost jobs with health care benefits because of the pandemic, with health care plans that included 6.9 million dependents, leaving 14.6 million people without health care coverage. Among Canadians, job loss in 2020 disproportionately affected workers earning below average wages (Bundale, 2020) who nonetheless still retain health care coverage, universal in Canada. With loss of wages together with health insurance, Americans find themselves working harder to care for and sustain themselves and their family members. An ongoing survey of lower and middle income Americans of colour (Robert Wood Johnson Foundation, 2021) finds that more than 70% of respondents in 2021 see the pandemic as a moment for positive change to ensure health care as a fundamental right and to reduce income inequality. That said, this survey found that respondents are becoming less concerned about health risks and more prioritizing
“freedom over their health.” And they still do not see systemic racism as a barrier to good health, despite the greater risks this group faces. As we noted, the issue of access to health care was a dominant concern among American respondents in our Great Recession study. And individual choices and rights, a big issue in the pandemic, also came up repeatedly among American respondents in mid-life, but not so with Canadians.

The pandemic has made clear that perhaps Canadians in mid-life should have had more health worries, specifically about long-term care, than they did in our 2008/2013 interviews. Inequality by age and frailty emerged as highly visible, more so than in the U.S. That could be, however, due to the very large numbers of COVID deaths in the US, of which long term care residents were a smaller proportion than in Canada. Canadians in long term care accounted for the majority of deaths due to COVID-19 in the early waves. Those in frail health are more susceptible to viruses, but these deaths were largely the result of structural conditions in facilities that had been known but ignored and not regulated for years: shared rooms, no place to isolate in case of infection, and part-time low paid care workers, often racialized women, who sometimes had to work in multiple facilities. Given these conditions, the situation is ripe for the virus to spread. Once blocked from entry to the facilities, family caregivers have now stepped up to provide stop-gap care for ailing relatives or those vulnerable to the virus. This is an example of the social reproduction of both ageism and structural workplace inequalities. The key life course concept of linked lives is made starkly clear: life opportunities of mid-life relatives, differentially women, are constrained by having no option but to care for older relatives, even when the elders are living in paid residential care.

Post-COVID Canada and U.S

Crises such as COVID-19 that affect everyday lives so inalterably are likely to leave lasting footprints. Contemplating a post-COVID period even through a sociological lens, however, is necessarily speculative in two ways. First, any consideration of the future of societies is perilous. Secondly, in this pandemic, the unknowns loom larger than ever before, so lessons from previous pandemics or even from the early stages of this pandemic, may not apply. The considerable new factor is social media and the rapidity through which myths and falsehoods can not only spread but also be the bases for rapid formation of virtual influence groups which have the power to contest and politicize biomedical and public health research and messaging. Dr. Anthony Fauci, a world renowned infectious disease expert and advisor to multiple U.S. Presidents, has had death threats for speaking and advising on medical science (Kuchler, 2020).

We take on the challenge of nonetheless offering speculations and by grounding ours in our previous research. First, related to the ‘she-cession,’ women’s options for work will continue to be substantially reduced as particularly middle class, indoor malls close or downsize, along with decreasing options for clerical work as more white collar people work distantly. If unpredictable and random closures of in-person day care and school persists, especially mothers’ paid work options in general will be hindered and their gendered generational relations exacerbated, given

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2 “The US has always valued individual rights, he [Fauci] says, but warns that this could make it hard to tackle the pandemic, even when we have a vaccine. “Our forefathers...had the guts to come by boat from Europe and wherever else. That's the general spirit: you don’t always trust authority,” he says. Now it has been taken to an “extreme”, with a movement against science and authority helping to form “the foundation for the anti-vaccine movement, that we don’t trust what the government is telling us. That is very, very problematic right now” (Kuchler, 2020)
continued primacy attached to men’s earning in both countries. There may be a sharper decline for U.S. women as a result of several factors including not only limited options for childcare but the higher birthrate and higher poverty levels. Second, if big box and discount stores become more common, the demand for cheap goods will increase, possibly affecting trade policies with China and countries of SE Asia. Third, higher education options, particularly in the U.S., may diminish as online options become more comfortable and extreme political polarization including cultural wars over what is truth increase. The implication may be even less social mobility options for immigrants and first-generation attendees who cannot accrue social capital through in-person attendance at post-secondary campuses, thus both widening inequalities further and dampening the American Dream. Life courses may be disrupted in both countries as education and job opportunities shift. Given the state of the situation post-Great Recession in the U.S., it would seem that the depth of the disruption to life courses may be greater there than in Canada. Finally, the political polarization of the pandemic and of sensible measures to contain it (e.g. mask-wearing, social distancing and closures/lockdowns) will likely persist in the U.S., making it much harder to gain control when cases are increasing exponentially. The post-COVID world in the U.S. may continue to see polarization centre on vaccines (Northwestern Now, 2020). In Canada, a small minority distrust expertise but most people took the advice of public health professionals resulting in smaller and more controlled outbreaks. Whether this difference between the two countries in trust in the state will continue post-COVID remains to be seen but seems likely based on differences expressed in our Great Recession study.

Turning our focus from speculation, we see broad policy-relevant lessons gleaned from our reflections. One giant shift in a post-COVID world in both Canada and the U.S. as well as for many other countries, is the stunning recognition that a key tenet of neo-liberalism, i.e. less government, is now in question. Markets cannot solve crises like pandemics just as they could not solve the multiple crises of the Great Recession. There is need for system wide public policy approaches including solid public health measures and universal access to health care. Viruses do not care about health insurance, and those infected with the virus who are without health insurance, and often interact widely in essential jobs, put everyone at risk. It should be remembered that the Affordable Health Act, a signature piece of U.S. policy over the past two decades, grew out of the Great Recession and what that financial crisis revealed. In Canada, the incompleteness of universal health insurance and of day care has been shown in sharp relief as the pandemic unfolded. Long term care is not covered by Canada’s public health insurance scheme and daycare, although now recognized as vital to the economy and women’s work, has not had the policy attention needed.

Will the pandemic crisis be seized as a policy innovation opportunity? The window of opportunity is pried open and time will tell if Canada and the U.S. seize the moment to weather the upending of social reproduction and life courses that the pandemic has created. That said, we end with one comment: there will likely be ongoing worldwide conflicts over expertise, power, global trade, ideologies and what countries are ‘deserving’ of the ‘best’ vaccines and drugs to help those with COVID-19. We may witness not just an upending of social reproduction and life courses in North America with COVID-19 but with vaccine access, we may see an implosion of social reproduction in the Global South.

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