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Systemic Racism, the Government's Pandemic Response, and Racial Inequities in COVID-19

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SYSTEMIC RACISM, THE GOVERNMENT'S PANDEMIC RESPONSE, AND RACIAL INEQUITIES IN COVID-19

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ABSTRACT

During the COVID-19 pandemic, federal and state governments have disregarded racial and ethnic minorities' unequal access to employment and health care, which has resulted in racial inequities in infections and deaths. In addition, they have enacted laws that further exacerbate these inequities. Consequently, many racial and ethnic minorities are employed in low-wage essential jobs that lack paid sick leave and health insurance. This lack of benefits causes them to go to work even when they are sick and prevents them from receiving appropriate medical treatment. As a result, racial and ethnic minorities have disproportionately been infected and died from COVID-19. Although these actions seem race "neutral," they exemplify systemic racism, wherein racial and ethnic minorities are deemed inferior to white people, and thus do not receive the same access to resources, such as employment and health care. This Essay illustrates how systemic racism has resulted in racial inequities in COVID-19 infections and deaths through case studies in employment and health care. Using the health justice framework, it concludes with suggestions to eradicate systemic racism, redress harm, and engage communities in implementing an equitable pandemic response.

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INTRODUCTION

In June 2020, agricultural workers at a pistachio farm in Wasco, California, many of whom were racial and ethnic minorities, learned about a COVID-19 outbreak from other workers and the media. By that time, 150 workers and 65 family members tested positive.[1] After the announcement, the farm started to make masks available free of cost, whereas before they were charging workers $8 per mask.[2] In California, a COVID-19 outbreak at the Farmer John pork processing plant began in 2020 and has continued for nearly a year, "with more than 300 cases reported in January (2021) alone."[3] A nurse asked Latinos for additional identification, made them wait for appointments and test results, and called the police saying undocumented immigrants were seeking testing at the Elkhart County, Indiana, health care site.[4] In North Carolina, it is alleged that hospitals were sending away some Latinos even though their COVID-19 symptoms were serious enough to be admitted to the hospital.[5] Rana Zoe Mungin, a Black teacher, was twice denied a COVID-19 test and her symptoms were dismissed by an EMT as a panic attack.[6] She later passed away from COVID-19 at Brooklyn, New York's Brookdale Hospital. Deborah Gatewood, a Black, sixty-three-year-old Detroit health care worker, was turned away four times with COVID-19 symptoms from Beaumont Hospital, where she had

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[1] *See* Associated Press, *Farmworkers at Central California Pistachio Farm Strike After Dozens Test Positive for the Coronavirus*, L.A. TIMES (June 25, 2020, 5:29 PM), https://www.latimes.com/california/story/2020-06-25/farmworkers-at-central-california-pistachio-strike-after-dozens-test-positive-for-the-coronavirus; Jacqueline Garcia, *Dozens of Pistachio Plant Workers Infected with COVID-19*, KQED (July 6, 2020), https://www.kqed.org/news/11827498/dozens-of-pistachio-plant-workers-infected-with-covid-19; Dale Yurong, *Protest Held After Dozens of Farmworkers Test Positive for COVID-19 at Wasco Packing House*, ABC30 FRESNO (July 16, 2020), https://abc30.com/wasco-coronavirus-covid-packing-house-primex-farms/6321004/.

[2] Associated Press, *supra* note 1.

[3] Leah Douglas & Georgia Gee, *A COVID Outbreak at a California Meatpacking Plant Started a Year Ago—and Never Went Away*, MOTHER JONES (Mar. 16, 2021), https://www.motherjones.com/food/2021/03/a-covid-outbreak-at-a-california-meatpacking-plant-started-a-year-ago-and-never-went-away/.

[4] Shelia Selman, *Company Apologizes for Discrimination Against Latinos at Goshen COVID-19 Testing Site*, GOSHEN NEWS (July 3, 2020), https://www.goshennews.com/news/company-apologizes-for-discrimination-against-latinos-at-goshen-covid-19-testing-site/article_10ff0bf2-bc8a-11ea-b0c6-eb3aed4bb58c.html.

[5] Lynn Bonner, *State Adviser: Some NC Latinos Sick with COVID-19 Are Sent Home from Hospitals*, NEWS & OBSERVER (July 16, 2020, 5:32 PM), https://www.newsobserver.com/news/coronavirus/article244272717.html.

[6] Arielle Mitropoulos & Mariya Moseley, *Beloved Brooklyn Teacher, 30, Dies of Coronavirus After She Was Twice Denied a COVID-19 Test*, ABC NEWS (Apr. 28, 2020, 7:39 PM), https://abcnews.go.com/Health/beloved-brooklyn-teacher-30-dies-coronavirus-denied-covid/story?id=70376445; Shamar Walters & David K. Li, *New York City Teacher Dies from Covid-19 After She Was Denied Tests, Family Says*, NBC NEWS (Apr. 29, 2020, 4:42 PM), https://www.nbcnews.com/news/us-news/new-york-city-teacher-dies-covid-19-after-she-was-n1195516.

worked for thirty-one years.[7] These racial inequalities in employment and health care are associated with racial inequities in COVID-19 infections and deaths.

Historically, the federal and state government's legal and policy response to pandemics has ignored these racial inequalities in employment and health care, which are linked to racial inequities in infection and death.[8] During the COVID-19 pandemic, the federal and state governments have not only continued to disregard these inequalities in employment and health care, but they have also enacted laws and implemented policies that further exacerbate these inequalities, harming racial and ethnic minorities.[9] For example, prior to May 2020, Iowa's policy was to publicly confirm COVID-19 cases at businesses. However, when major COVID-19 outbreaks at meat and poultry processing plants occurred in May 2020—which were predominantly staffed by racial and ethnic minorities and undocumented immigrants—officials would only confirm outbreaks at businesses if 10% of a company's employees tested positive *and* reporters asked about the outbreaks.[10] This hampered reporting of cases and local officials' efforts to control infections, as the state even limited information given to local officials, including Perry city officials, where it was later learned that 58% of employees tested positive at a Tyson plant in Perry.[11] The failure to report cases left workers vulnerable to the workplace exposure of COVID-19. Although these laws and policies seem race "neutral," they disproportionately harm racial and ethnic minorities, and are a result of systemic racism.

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[7] John Eligon & Audra D.S. Burch, *Questions of Bias in Covid-19 Treatment Add to Mourning for Black Families*, N.Y. TIMES (May 20, 2020), https://www.nytimes.com/2020/05/10/us/coronavirus-african-americans-bias.html; Janelle Griffith, *Detroit Health Care Worker Dies After Being Denied Coronavirus Test 4 Times, Daughter Says*, NBC NEWS (Apr. 27, 2020, 8:33 PM), https://www.nbcnews.com/news/us-news/detroit-health-care-worker-dies-after-being-denied-coronavirus-test-n1192076.

[8] Ruqaiijah Yearby, *Structural Racism and Health Disparities: Reconfiguring the Social Determinants of Health Framework to Include the Root Cause*, 48 J.L., MED. & ETHICS 518, 520 (2020); Ruqaiijah Yearby & Seema Mohapatra, *Law, Structural Racism, and the COVID-19 Pandemic*, 7 OXFORD J.L. & BIOSCIENCES 1, 4 (2020); Philip Blumenshine, Arthur Reingold, Susan Egerter, Robin Mockenhaupt, Paula Braveman & James Marks, *Pandemic Influenza Planning in the United States from a Health Disparities Perspective*, 14 EMERGING INFECTIOUS DISEASES 709, 709–10 (2008); Supriya Kumar, Sandra Crouse Quinn, Kevin H. Kim, Laura H. Daniel & Vicki S. Freimuth, *The Impact of Workplace Policies and Other Social Factors on Self-Reported Influenza-Like Illness Incidence During the 2009 H1N1 Pandemic*, 102 AM. J. PUB. HEALTH 132, 134, 135–39 (2012); Monica Schoch-Spana, Nidhi Bouri, Kunal J. Rambhia & Ann Norwood, *Stigma, Health Disparities, and the 2009 H1N1 Influenza Pandemic: How to Protect Latino Farmworkers in Future Health Emergencies*, 8 BIOSECURITY & BIOTERRORISM: BIODEFENSE STRATEGY, PRAC. & SCI. 243, 253 (2010). In this Essay, the term "racial inequities" includes inequities experienced by ethnic minorities and undocumented immigrants.

[9] Yearby & Mohapatra, *supra* note 8, at 2–4.

[10] Brianne Pfannenstiel, *Iowa Officials Won't Disclose Coronavirus Outbreaks at Meatpacking Plants Unless Media Asks*, DES MOINES REG. (May 28, 2020), https://www.desmoinesregister.com/story/news/politics/2020/05/27/iowa-wont-disclose-covid-19-outbreaks-businesses-unless-media-asks-kim-reynolds/5267413002/.

[11] *Id.*

Systemic racism is a social system wherein the racial group in power creates a racial hierarchy that deems other racial groups to be inferior and grants those "inferior races" fewer resources and opportunities.[12] In the United States, this racial hierarchy[13] has become embedded in the government's pandemic response, often limiting racial and ethnic minorities' equal access to key resources such as employment benefits and protections, as well as COVID-19 testing, health care treatment, and vaccines. As a result, racial and ethnic minorities face increased risk of workplace exposure to COVID-19 because they work in low-wage, essential jobs that do not provide the option to work from home, and they cannot afford to miss work even when they are sick.[14] In fact, research shows that only 16.2% of Latinos and 19.7% of Blacks have jobs that they perform from home.[15] This means that only 1 in 6 Latinos and 1 in 5 Black workers can telework.[16] Furthermore, the jobs often do not provide health insurance, and thus, racial and ethnic minorities lack access to appropriate testing and treatment during the COVID-19 pandemic.[17] "Blacks remained 1.5 times more likely to be uninsured than whites from 2010 to 2018," and Latinos have an uninsured rate over 2.5 times higher than the rate for whites.[18] Due to increased workplace exposure and lack of access to treatment, racial and ethnic minorities have disproportionately been infected and died from COVID-19.[19]

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[12] David R. Williams, Jourdyn A. Lawrence & Brigette A. Davis, *Racism and Health: Evidence and Needed Research*, 40 ANN. REV. PUB. HEALTH 105, 107 (2019); SEAN ELIAS & JOE R. FEAGIN, RACIAL THEORIES IN SOCIAL SCIENCE: A SYSTEMIC RACISM CRITIQUE 267 (2016). In this Essay, we define racism broadly to include the problems experienced by ethnic minorities. We do this because courts have not always been clear about how they treat these ethnic minorities differently than racial minorities. *See* Khiara M. Bridges, *The Dangerous Law of Biological Race*, 82 FORDHAM L. REV. 21, 69–75 (2013).

[13] *See* Eduardo Bonilla-Silva, *Rethinking Racism: Toward a Structural Interpretation*, 62 AM. SOCIO. REV. 465 (1997).

[14] Yearby & Mohapatra, *supra* note 8, at 6.

[15] Elise Gould & Heidi Shierholz, *Not Everybody Can Work from Home: Black and Hispanic Workers Are Much Less Likely to Be Able to Telework*, ECON. POL'Y INST: WORKING ECON. BLOG (Mar. 19, 2020, 1:15 PM), https://www.epi.org/blog/black-and-hispanic-workers-are-much-less-likely-to-be-able-to-work-from-home/.

[16] *Id.* Research also shows how COVID-19 workplace exposure varies by race and ethnicity, with racial and ethnic minorities disproportionately exposed to COVID-19 in the workplace. *Id.*; LISA DUBAY, JOSHUA AARONS, K. STEVEN BROWN & GENEVIEVE M. KENNEY, URB. INST., HOW RISK OF EXPOSURE TO THE CORONAVIRUS AT WORK VARIES BY RACE AND ETHNICITY AND HOW TO PROTECT THE HEALTH AND WELL-BEING OF WORKERS AND THEIR FAMILIES 2 (2020), https://www.urban.org/sites/default/files/publication/103278/how-risk-of-exposure-to-the-coronavirus-at-work-varies.pdf.

[17] Yearby, *supra* note 8, at 4.

[18] Samantha Artiga, Kendal Orgera & Anthony Damico, *Changes in Health Coverage by Race and Ethnicity Since the ACA, 2010-2018*, KAISER FAM. FOUND. (Mar. 5, 2020), https://www.kff.org/racial-equity-and-health-policy/issue-brief/changes-in-health-coverage-by-race-and-ethnicity-since-the-aca-2010-2018.

[19] Yearby & Mohapatra, *supra* note 8, at 4–7, 10–16.

To put an end to racial inequities in COVID-19 infections and deaths, the government should adopt the health justice framework, which provides a community-informed agenda for transforming the government's emergency preparedness responses to eradicate systemic racism and achieve health equity. Based in part on principles from the reproductive justice, environmental justice, food justice, and civil rights movements, the health justice framework offers three principles to improve the government's emergency preparedness response: (1) structural remediation, (2) financial supports and accommodations, and (3) community engagement and empowerment. *First*, emergency preparedness laws and policies must address systemic racism by structurally changing the systems that cause racial inequalities in access to key resources.[20] *Second*, these emergency preparedness laws and policies must be accompanied by financial supports and protections, so that racial and ethnic minorities can stay home when they are sick.[21] *Third,* racial and ethnic minorities must be engaged and empowered as leaders in the development and implementation of emergency preparedness laws and policies to ensure that the laws address their needs.[22] By adopting these three steps, the government can improve their emergency preparedness response by not only protecting racial and ethnic minorities from harm, but also by providing material and institutional support to address racial inequities in COVID-19 infections and deaths.[23]

Many vulnerable communities,[24] including those that are low-income, disabled, and elderly, have experienced inequities in COVID-19 infections and deaths. In this Essay, we use racial and ethnic minorities as an illustrative

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[20] Angela P. Harris & Aysha Pamukcu, *The Civil Rights of Health: A New Approach to Challenging Structural Inequality*, 67 UCLA L. REV. 758, 806 (2020) ("[H]ealth justice . . . places subordination at the center of the problem of health disparities."); Lindsay F. Wiley, *Health Law as Social Justice*, 24 CORNELL J.L. & PUB. POL'Y 47, 87 (2014) ("Health justice naturally expands the focus beyond access to health care to address the community conditions that play such an important role in determining health disparities."); *id.* at 85 ("[Achieving health justice] will take organizing from the ground up; social change that transforms the current systems of neglect, bias, and privilege into systems—policies, practices, institutions—that truly support health[y] communities for all." (quoting a now-inactive website developed by The Praxis Project)).

[21] Wiley, *supra* note 20, at 95–96 ("[I]nterventions [grounded in health justice] reflect collective responsibility for health rather than individualistic interventions aimed at urging people to change their behaviors without necessarily making it easier for them to do so.").

[22] Harris & Pamukcu, *supra* note 20, at 765 (describing "the emergent 'health justice' movement [as] a framework that places the empowerment of marginalized populations at the center of action"); Wiley, *supra* note 20, at 101 ("[T]he health justice framework [should] root ongoing efforts to ensure access to health care and healthy living conditions more firmly in community engagement and participatory parity.").

[23] *See* Emily A. Benfer, *Health Justice: A Framework (and Call to Action) for the Elimination of Health Inequity and Social Justice*, 65 AM. U. L. REV. 275, 336–38 (2015).

[24] We use the term "vulnerable communities" as a way to standardize the discussion about these communities, particularly as the term pertains to the vaccine distribution, which uses the Social Vulnerability Index (SVI) and the COVID-19 Community Vulnerability Index (CCVI).

example of how the federal and state government's legal and policy response to pandemics has failed to address, and sometimes even exacerbated, inequities for many vulnerable communities.[25] Building on the work of public health researchers, sociologists, legal scholars, and our prior work,[26] we examine how the interplay of systemic racism, the government's pandemic response, and unequal access to resources has resulted in racial inequities in COVID-19 infections and deaths. We argue that these problems can be fixed by integrating the health justice framework, an emerging concept, into the federal and state governments' pandemic response.[27]

This Essay proceeds as follows. Part I discusses two forms of systemic racism (structural and interpersonal), how they negatively influence the federal and state governments' pandemic response, and the principles of the health justice framework that should be used to eradicate systemic racism in the government's pandemic response. Using meat and poultry processing workers as an example, Part II demonstrates how systemic racism in the government's pandemic response has caused and exacerbated employment inequalities. It concludes with suggestions for integrating the health justice framework into the government's pandemic response, such as requiring employee safety boards in all essential businesses. Part III explores examples of systemic racism in health care and how they have manifested themselves in this pandemic. After providing an overview of the challenges in health care that were laid bare in this pandemic, we suggest changes in income supplementation, universal health care coverage, medical educational incentives, and community involvement in decision-making.

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[25] Nina A. Kohn, *The Pandemic Exposed a Painful Truth: America Doesn't Care About Old People*, WASH. POST (May 8, 2020, 8:49 AM), https://www.washingtonpost.com/outlook/nursing-home-coronavirus-discrimination-elderly-deaths/2020/05/07/751fc464-8fb7-11ea-9e23-6914ee410a5f_story.html; T. Joanne Kene, Rachel Roubein & Susannah Luthi, *How Public Health Failed Nursing Homes*, POLITICO (Apr. 6, 2020, 4:30 AM), https://www.politico.com/news/2020/04/06/public-health-failed-nursing-homes-167372; Teresa Ghilarducci, *Covid-19 Makes Racial and Class Status Longevity Gaps Worse*, FORBES (Mar. 21, 2021, 7:43 PM), https://www.forbes.com/sites/teresaghilarducci/2021/03/21/covid-19-makes-racial-and-class-status-longevity-gaps-worse/?sh=207f2b21615d; The Marshall Project, *A State-by-State Look at Coronavirus in Prisons*, MARSHALL PROJECT (Mar. 26, 2021, 6:00 PM), https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons; Phillip Sloane, Ruqaiijah Yearby, R. Tamara Konetzka, Yue Li, Robert Espinoza, & Sheryl Zimmerman, *Addressing Systemic Racism in Nursing Homes: A Time for Action*, 22 J. AM. MED. DIRS. ASS'N 886–92 (2021).

[26] *See supra* note 8.

[27] Emily A. Benfer, Seema Mohapatra, Lindsay F. Wiley & Ruqaiijah Yearby, *Health Justice Strategies to Combat the Pandemic: Eliminating Discrimination, Poverty, and Health Inequities During and After COVID-19*, 19 YALE J. HEALTH POL'Y, L. & ETHICS 122, 136–41 (2020); Benfer, *supra* note 23, at 336–38; Wiley, *supra* note 20, at 47; Ruqaiijah Yearby & Seema Mohapatra, *Structural Discrimination in COVID-19 Workplace Protections*, HEALTH AFFS. BLOG (May 29, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200522.280105/full/.

I. COVID-19, SYSTEMIC RACISM, AND HEALTH JUSTICE

Many low-income communities and low-wage workers—as well as racial and ethnic minorities—have been impacted disproportionately by COVID-19. In fact, there is some overlap between class and race in inequalities in employment and health care that are associated with inequities in COVID-19 infections and deaths, particularly among essential workers. However, the ways that racial and ethnic minorities have been treated and blamed for inequities in COVID-19 is different than how low-income communities and most low-wage workers have been treated. For example, some federal public health officials and state government officials have begun to blame minorities for racial inequities in COVID-19.[28]

After lifting mask mandates and other COVID-19 restrictions in March 2021, Texas Governor Greg Abbott blamed an increase in COVID-19 infections on undocumented immigrants from Mexico, without any supporting proof.[29] In June 2020, Ohio State Senator and physician, Stephen A. Huffman—who was charged with enacting laws to protect citizens from the spread of COVID-19 and treating COVID-19 patients—speculated "could it just be that African-Americans or the colored population do not wash their hands as well as other groups or wear a mask or do not socially distance themselves?"[30] In January 2021, he was appointed the chair of the Ohio Senate Health Committee by his cousin, Senate President Matt Huffman.[31] When asked about the inequities in COVID-19 infections and deaths during a White House COVID-19 briefing, then-Surgeon General Jerome Adams, a Black physician, noted that the inequities were not biological or genetic, but stated that people of color, particularly Blacks and Latinos, should "avoid alcohol, tobacco and drugs" to

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[28] *See* Carmen Sesin, *Latino Leaders Demand Florida Governor Apologize for Linking 'Hispanic Farmworkers' to COVID-19 Rise*, NBCNEWS (June 22, 2020, 6:23 PM), https://www.nbcnews.com/news/latino/latino-leaders-demand-gov-desantis-apologize-linking-hispanic-farmworkers-covid-n1231785; Brett Murphy & Letitia Stein, *Feds Explore Whether Latino Immigrants to Blame for Coronavirus Flare-ups*, USA TODAY (Jan. 26, 2021, 6:05 PM), https://www.usatoday.com/story/news/investigations/2020/06/18/coronavirus-flare-ups-raise-task-force-questions-immigration/3210219001/; Trip Gabriel, *Ohio Lawmaker Asks Racist Question About Black People and Hand-Washing*, N.Y. TIMES (June 11, 2020), https://www.nytimes.com/2020/06/11/us/politics/steve-huffman-african-americans-coronavirus.html; Sarah Westwood & Sunlen Serfaty, *HHS Secretary Tells Lawmakers Lifestyles of Meat-Processing Plant Employees Worsened Covid-19 Outbreak*, CNN (May 7, 2020, 4:58 PM), https://www.cnn.com/2020/05/07/politics/alex-azar-meat-processing-plants/index.html. Where relevant we have included a discussion of low-income communities.

[29] Noah Higgins-Dunn, *Texas Gov. Abbott Blames Covid Spread on Immigrants, Criticizes Biden's 'Neanderthal' Comment*, CNBC (Mar. 4, 2021, 11:42 AM), https://www.cnbc.com/2021/03/04/texas-gov-abbott-blames-covid-spread-on-immigrants-criticizes-bidens-neanderthal-comment-.html.

[30] Gabriel, *supra* note 28.

[31] Farnoush Amiri, *Legislator Who Questioned Black Hygiene to Lead Health Panel*, AP NEWS (Jan. 22, 2021), https://apnews.com/article/health-ohio-coronavirus-pandemic-0dd121777081707b4c061ed8e4649df6.

prevent the spread of COVID-19; "we need you to understand, especially in communities of color. We need you to step up and stop the spread so that we can protect those who are most vulnerable."[32] By blaming Black and Latino people for inequities in COVID-19 infections and deaths, these government officials reinforced the notion that Black and Latino people are "inferior" and behave in unhealthy ways, making them responsible not only for their own COVID-19 infections, but also for the infections of others. Additionally, these officials ignored past research that illustrated how racial inequalities in employment and health care—not behaviors—were associated with racial inequities during pandemics.

Over ten years ago, Blumenshine and coauthors hypothesized that there were racial inequities in infections and deaths during pandemics because racial and ethnic minorities have increased workplace exposure to viruses as a result of their employment in low-wage essential jobs that do not provide paid sick leave or the option to work from home, which are compounded by lack of access to a regular source of health care and appropriate treatment during pandemics.[33] A group of researchers using health and survey data showed that Blumenshine's factors were associated with racial and ethnic minorities' increased infection, hospitalization, and death from H1N1.[34] Specifically, racial and ethnic minorities were unable to stay at home and lacked access to health care for treatment, all of which increased their H1N1 infection and death rates.[35]

Although the federal government acknowledged the association of these factors and racial inequities in infections and diseases during pandemics in a 2012 report regarding health equity and pandemics,[36] federal and state

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[32] Curtis Bunn, *Black Health Experts Say Surgeon General's Comments Reflect Lack of Awareness of Black Community*, NBC NEWS (Apr. 15, 2020, 10:41 AM), https://www.nbcnews.com/news/nbcblk/black-health-experts-say-surgeon-general-s-comments-reflect-lack-n1183711.

[33] Blumenshine et al., *supra* note 8, at 709–10; *see* Robert J. Blendon, Lisa M. Koonin, John M. Benson, Martin S. Cetron, William E. Pollard, Elizabeth W. Mitchell, Kathleen J. Weldon & Melissa J. Herrmann, *Public Response to Community Mitigation Measures for Pandemic Influenza*, 14 EMERGING INFECTIOUS DISEASES 778, 778–86 (2008); Sandra Crouse Quinn, Supriya Kumar, Vicki S. Freimuth, Donald Musa, Nestor Casteneda-Angarita & Kelley Kidwell, *Racial Disparities in Exposure, Susceptibility, and Access to Health Care in the US H1N1 Influenza Pandemic*, 101 AM. J. PUB. HEALTH 285, 285–93 (2011).

[34] Quinn et al., *supra* note 33, at 286, 289–90.

[35] *Id.* They also found that racial and ethnic minorities suffered from health conditions that were risk factors for H1N1. *Id.* at 285.

[36] DENNIS ANDRULIS, NADIA J. SIDDIQUI, JONATHAN PURTLE & MARIA R. COOPER, H1N1 INFLUENZA PANDEMIC AND RACIALLY AND ETHNICALLY DIVERSE COMMUNITIES IN THE UNITED STATES: ASSESSING THE EVIDENCE AND CHARTING OPPORTUNITIES FOR ADVANCING HEALTH EQUITY 13 (2012), https://www.researchgate.net/publication/340390150_H1N1_Influenza_Pandemic_and_Racially_and_Ethnically_Diverse_Communities_in_the_United_States_Assessing_the_Evidence_and_Charting_Opportunities_for_Advancing_Health_Equity.

governments have disregarded these racial inequalities in employment and health care during the COVID-19 pandemic. Instead, the government's pandemic response includes "stay at home" orders and social distancing recommendations that do not address racial inequalities in employment and health care.[37] Although these actions seem race "neutral," they exemplify systemic racism, wherein racial and ethnic minorities do not receive the same access to resources as whites, increasing their exposure to COVID-19 and preventing their access to treatment. The harmful impact of systemic racism has become even clearer during the COVID-19 pandemic.

As of July 16, 2021, when compared to whites, Native Americans and Alaska Natives have two times the rate of COVID-19 cases, three times the rate of hospitalizations, and two times the deaths.[38] Blacks have three times the rate of hospitalization and two times the deaths, while Latinos have three times the hospitalization and two times the deaths.[39] These inequities will not go away unless the government improves its pandemic response by trying to achieve health equity through addressing systemic racism, providing financial supports, and engaging community members in the development and implementation of pandemic response laws and policies.

A. Systemic Racism and Racial Inequities in COVID-19

Systemic racism refers to a complex array of social structures, interpersonal interactions, and beliefs by which a dominant group categorizes people into "races" and uses its dominance to create a racial hierarchy in which other groups are disempowered, devalued, and have unequal access to resources.[40] Systemic racism includes many forms, but for this Essay, we focus exclusively on structural and interpersonal racism.[41] Structural racism refers to the way laws are used to provide advantages to whites, while disadvantaging racial and ethnic minorities by limiting their equal access to key resources (employment and

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[37] Ruqaiijah Yearby, *Structural Racism and Health Disparities: Reconfiguring the Social Determinants of Health Framework to Include the Root Cause*, 48 J.L., MED. & ETHICS 518, 520 (2020).

[38] *COVID-19: Risk for COVID-19 Infection, Hospitalization, and Death by Race/Ethnicity*, CDC (July 16, 2021), https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html.

[39] *Id.* Asian Americans have a lower rate of COVID-19 cases than whites and the same hospitalization and death rates as whites. *Id.*

[40] Williams et al., *supra* note 12, at 107; ELIAS & FEAGIN, *supra* note 12, at 267.

[41] Williams et al., *supra* note 12, at 107; *see also* Kira Hudson Banks & Jadah Stephens, *Reframing Internalized Racial Oppression and Charting a Way Forward*, 12 SOC. ISSUES & POL'Y REV. 91, 93 (2018); Courtney D. Cogburn, *Culture, Race, and Health: Implications for Racial Inequities and Population Health*, 97 MILBANK Q. 736, 740, 750 (2019).

health care), thus reinforcing the racial hierarchy.[42] It also includes the ways that trade associations and institutions work together to influence the government's pandemic response, which has established separate and independent barriers for racial and ethnic minorities' equal access to key resources.[43] Interpersonal racism operates through individual interactions, where an individual's conscious (explicit) and/or unconscious (implicit) racial prejudice limits equal access to resources in spite of antidiscrimination laws.[44]

Systemic racism negatively influences the government's pandemic response, often resulting in unequal access to key resources, such as employment and health care. For example, the food and agriculture industry, which includes the meat and poultry processing industry, has the second highest percentage (21%) of essential workers in the US.[45] The meat and poultry processing industry employs an estimated 525,000 workers in 3,500 facilities nationwide.[46] Meat and poultry plants have been hotspots for COVID-19 infections and deaths. In fact, research shows that 6% to 8% of all the COVID-19 cases and 3% to 4% of all COVID-19 deaths in the United States are tied to meat and poultry processing plants.[47] Racial and ethnic minorities account for a majority of these COVID-19 cases.[48] These racial inequities in infections and deaths are a result of systemic racism in the government's pandemic response.[49] The government has failed to enforce health and safety laws and permitted plants with COVID-19 outbreaks to remain open, prioritizing the needs of meat and poultry processing companies above those of racial and ethnic minority workers, which has resulted in worker deaths and record profits.

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[42] Yearby, *supra* note 8, at 520.

[43] Ren. . . Bowser, *Racial Profiling in Health Care: An Institutional Analysis of Medical Treatment Disparities*, 7 MICH. J. RACE & L. 79, 90–91, 97–98 (2001) ("The disparities in medical treatment between Blacks and whites have been estimated to result in at least 60,000 excess deaths in the Black population annually.").

[44] *See* Leith Mullings & Amy J. Schulz, *Intersectionality and Health: An Introduction*, *in* GENDER, RACE, CLASS, AND HEALTH: INTERSECTIONAL APPROACHES 3, 12 (Leith Mullings & Amy J. Schulz eds., 2006).

[45] Celine McNicholas & Margaret Poydock, *Who Are Essential Workers? A Comprehensive Look at Their Wages, Demographics, and Unionization Rates*, ECON. POL'Y INST.: WORKING ECON. BLOG (May 19, 2020, 11:25 AM), https://www.epi.org/blog/who-are-essential-workers-a-comprehensive-look-at-their-wages-demographics-and-unionization-rates.

[46] Michelle A. Waltenburg, et al., *Update: COVID-19 Among Workers in Meat and Poultry Processing Facilities — United States, April–May 2020*, 69 MORBIDITY & MORTALITY WKLY. REP. 887, 888 (2020).

[47] Charles A. Taylor, Christopher Boulos & Douglas Almond, *Livestock Plants and COVID-19 Transmission*, 117 PROC. NAT'L ACAD. SCI. U.S.A. 31706, 31706 (2020), https://www.pnas.org/content/early/2020/11/25/2010115117.long.

[48] Waltenburg et al., *supra* note 46, at 887–88; Shawn Fremstad, Hye Jin Rho & Hayley Brown, *Meatpacking Workers Are a Diverse Group Who Need Better Protections*, CTR. ECON. & POL'Y RSCH. (Apr. 29, 2020), https://cepr.net/meatpacking-workers-are-a-diverse-group-who-need-better-protections.

[49] Yearby, *supra* note 8.

Furthermore, in health care, the federal government under Trump largely left coordination and planning of COVID-19 testing to states.[50] The federal government did not intervene to ensure equitable access to testing in the first few months of the pandemic. In fact, studies showed that there were fewer testing sites serving minority communities in larger cities resulting in longer lines and sites running out of tests.[51] Thus, racial and ethnic minorities lacked equal access to testing. Additionally, minority communities lack access to quality hospital care, which has been the primary source of COVID-19 treatment and vaccine distribution, resulting in racial inequities in COVID-19 deaths.[52] Due to the government's decision to take a laissez-faire approach to testing and to make hospitals integral in the delivery of care during the pandemic, racial and ethnic minorities lack access to testing, treatment, and vaccines, which has caused racial inequities in COVID-19 infections and deaths.

The connection between systemic racism, the government's pandemic response, access to resources, and racial inequities in COVID-19 is shown in Figure 1.

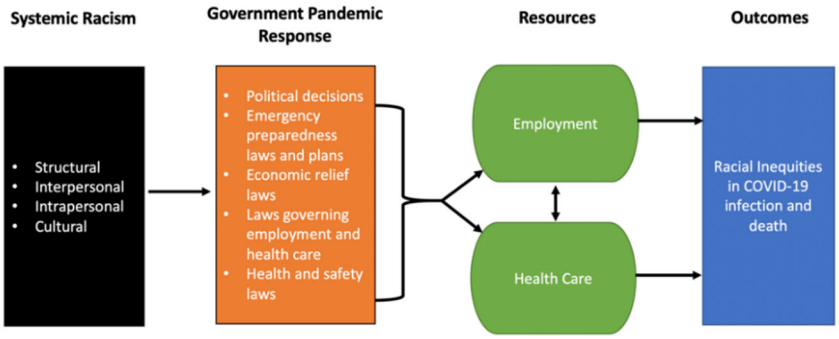

Figure 1. Systemic Racism, Government Pandemic Response, and Racial Inequities Model[53]

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[50] Soo Rin Kim, Matthew Vann, Laura Bronner & Grace Manthey, *Which Cities Have the Biggest Racial Gaps in COVID-19 Testing Access?*, FIVETHIRTYEIGHT (July 22, 2020), https://fivethirtyeight.com/features/white-neighborhoods-have-more-access-to-covid-19-testing-sites/; Michael D. Shear, Noah Weiland, Eric Lipton, Maggie Haberman & David E. Sanger, *Inside Trump's Failure: The Rush to Abandon Leadership Role on the Virus*, N.Y. TIMES (Sept. 15, 2020), https://www.nytimes.com/2020/07/18/us/politics/trump-coronavirus-response-failure-leadership.html.

[51] *Id.*

[52] Yearby & Mohapatra, *supra* note 8, at 1.

[53] Ruqaiijah Yearby & Seema Mohapatra, *Systemic Racism, Systems, and Health Inequities Model* (2020), adapted from Yearby, *supra* note 37, at 518–26; *see also* Aaron J. Siegler, Kelli Komro & Alexander C. Wagenaar, *Law Everywhere: A Causal Framework for Law and Infectious Disease*, 135 PUB. HEALTH REPS. 25S, 27S fig.1 (2020). Figure 1 provides a causal framework of the impact of law on prevention and treatment

To address these inequities, the government should adopt the health justice framework to eradicate the effects of long-standing systemic racism.

B. Health Justice Framework

The health justice framework provides a mechanism for systems-level change that goes beyond traditional legal notions of negative and positive rights to eradicate racial inequities to achieve health equity, in which everyone "has the opportunity to attain . . . full health potential and no one is disadvantaged from achieving this potential because of social position or any other socially defined circumstance."[54] It requires protection from harm and affirmative actions to provide material and institutional support to address racial inequities in health outcomes.[55] There are three broad principles within the framework: (1) structural remediation; (2) financial supports and accommodations; and (3) community engagement and empowerment.[56]

First, legal and policy responses must address systemic racism and, in particular, the impacts of it on the government's pandemic response, which includes political decisions, incomplete economic relief bills, and the enforcement of laws governing employment and health care that further exacerbate these inequalities. "Because emergencies typically exacerbate long-standing and interconnected"[57] inequalities in employment and health care, "legal and policy response[s] must address [these] root problems" by providing racial and ethnic minorities with the same benefits and protections as whites, such as paid sick leave.[58]

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continua for infectious disease. *Id.*

[54] CDC Nat'l Ctr. for Chronic Disease Prevention & Health Promotion, *Health Equity*, CDC, https://www.cdc.gov/chronicdisease/healthequity/index.htm (last visited Apr. 12, 2021) (quotation marks omitted).

[55] *See* Benfer, *supra* note 23, at 337–38.

[56] Benfer et al., *supra* note 27, at 137–41.

[57] *Id.* at 138.

[58] *Id.* at 146. Although the Supreme Court has not yet addressed government use of racial preferences to ameliorate systemic health disparities, in other contexts, like affirmative action, the Supreme Court has held that government actions classifying based on race must be subject to strict scrutiny, the most stringent level of judicial review under the Equal Protection Clause. *See* Parents Involved in Cmty. Schs. v. Seattle Sch. Dist. No. 1, 551 U.S. 701 (2007). Under the strict scrutiny test, even if the government has a compelling interest in using racial classifications, the use must be narrowly tailored to achieve the government's purpose, and there must be proof that attempts to use race-neutral means have failed to achieve the state's compelling goals. *Id.* at 702–03. In the public health context, state governments have a compelling interest in controlling the pandemic by contending with racial disparities in infection rates, serious illness, and death caused by COVID-19. Effectively controlling the pandemic by ensuring that racial and ethnic minorities are able to access COVID-19 vaccines, treatment, and support (such as sick leave to stay at home when they are sick) is clearly a compelling government interest, considering the way that COVID-19 has disproportionately impacted Black, Latino, and indigenous populations

Second, emergency preparedness laws and policies "mandating healthy behaviors . . . must be accompanied" with financial supports and accommodations to enable racial and ethnic minorities' compliance while minimizing harms.[59] Governments must provide racial and ethnic minority workers with financial supports, such as hazard pay and health insurance.[60] Specifically, the government can use these principles to further refine its current pandemic response plans and economic relief bills to intentionally focus on improving support to racial and ethnic minorities, one of the groups most impacted by the COVID-19 pandemic.

Third, racial and ethnic minorities must be engaged and empowered to take the lead in developing interventions to achieve health equity, which would help to ensure that the design and implementation of interventions intended to benefit them are actually tailored to their needs.[61]

Figure 2 illustrates how each prong of the health justice framework addresses each part of the systemic racism model in Figure 1.

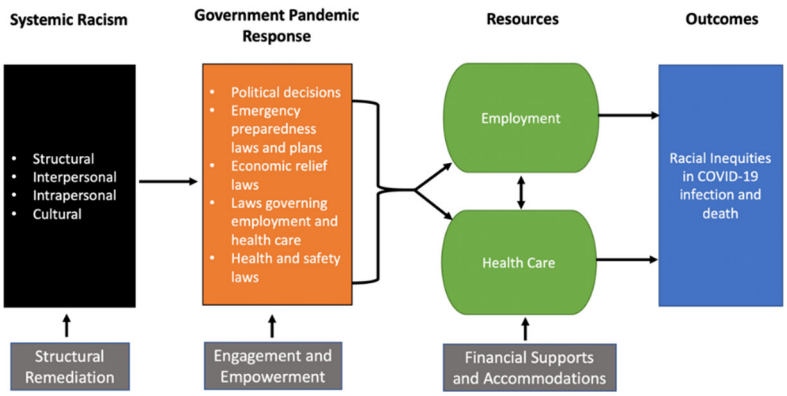

Figure 2. The Health Justice Framework and Systemic Racism Model[62]

in the United States.

[59] Benfer et al., *supra* note 27, at 138; Wiley, *supra* note 20, at 95–96 ("[I]nterventions [grounded in health justice] reflect collective responsibility for health rather than individualistic interventions aimed at urging people to change their behaviors without necessarily making it easier for them to do so.").

[60] *See* Siegler et al., *supra* note 53, at 26S.

[61] Benfer et al., *supra* note 27, at 137–41.

[62] Ruqaiijah Yearby & Seema Mohapatra, *The Health Justice Framework and Systemic Racism Model* (2020) (applying the Health Justice Framework from Benfer et al., *supra* note 27, at 137–41; Wiley, *supra* note 20, at 47; Benfer, *supra* note 23, at 337–38; Yearby & Mohapatra, *supra* note 53; Siegler et al., *supra* note 53, 26S fig.1).

By adopting these three principles, the federal and state government can improve their emergency preparedness response by not only protecting racial and ethnic minorities from harm, but also by providing material and institutional support to address racial inequities in COVID-19 infections and deaths.[63] Using the meat and poultry processing industry, the next Part discusses how systemic racism, particularly structural racism, in the government's pandemic response has resulted in employment inequalities and racial inequities in COVID-19 infections and deaths, concluding with suggestions for integrating the health justice framework into the government's pandemic response.

II. SYSTEMIC RACISM IN EMPLOYMENT

As of August 6, 2021, more than 58,913 meat and poultry processing workers have tested positive for COVID-19, and 297 have died.[64] Racial and ethnic minorities account for 87% of COVID-19 cases among meat and poultry processing workers,[65] even though they only account for 50% of meat and poultry processing workers.[66] Meat and poultry processing plants have been the site of many of the largest COVID-19 outbreaks in the United States.[67] However, the federal and state governments' pandemic response has not protected meat and poultry processing workers. In fact, structural racism illustrated by these political decisions influenced by meat and poultry trade associations, the failure to enforce health and safety standards, and the government's ineffective pandemic response have led to racial inequalities in employment.[68] These inequalities, such as lack of paid sick leave and punitive attendance policies, increase workplace exposure to COVID-19, which has resulted in racial inequities in COVID-19 infections and deaths. To rectify these problems, the

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[63] Benfer et al., *supra* note 27, at 138.

[64] Leah Douglas, *Mapping Covid-19 Outbreaks in the Food System*, FOOD & ENV'T REPORTING NETWORK (Apr. 22, 2020), https://thefern.org/2020/04/mapping-covid-19-in-meat-and-food-processing-plants (updated every weekday).

[65] Waltenburg et al., *supra* note 46.

[66] Fremstad et al., *supra* note 48.

[67] *See, e.g.*, Clark Kauffman, *Lawsuit: Tyson Managers Bet Money on How Many Workers Would Contract COVID-19*, IOWA CAP. DISPATCH (Nov. 18, 2020), https://iowacapitaldispatch.com/2020/11/18/lawsuit-tyson-managers-bet-money-on-how-many-workers-would-contract-covid-19/ (explaining that "more than 24,000 coronavirus cases had been tied to meatpacking plants nationwide" as of mid-June 2020); Mia Jankowicz, *The South Dakota Slaughterhouse Linked to More Than Half the State's Coronavirus Cases Had Offered Employees a $500 'Responsibility Bonus' to Come to Work in April*, BUS. INSIDER (Apr. 16, 2020, 6:47 AM), https://www.businessinsider.com/south-dakota-slaughterhouse-coronavirus-responsibility-bonus-2020-4.

[68] Heather Schlitz & Midwest Ctr. for Investigative Reporting, *Meatpacking Workers Say Attendance Policy Forces Them to Work with Potential Covid-19 Symptoms*, (Oct. 20, 2020), MIDWEST CTR., https://investigatemidwest.org/2020/10/20/meatpacking-workers-say-attendance-policy-forces-them-to-work-with-potential-covid-19-symptoms/.

government needs to provide workers with paid sick leave, enforce health and safety laws, and empower workers to revise the current emergency preparedness laws and policies.

A. Systemic Racism, Political Decisions, and Racial Inequities in COVID-19

By mid-March, the COVID-19 virus had reached the United States, and meat trade associations, like the National Turkey Federation and the North American Meat Institute (NAMI), were already urging the U.S. Department of Agriculture (USDA) Secretary to include meat and poultry processing workers in the Department of Homeland Security (DHS) Essential Critical Infrastructure list.[69] As a result of these lobbying efforts, the DHS list included these workers,[70] yet the DHS list was only supposed to be advisory.[71] Nevertheless, some meat and poultry trade associations asked the USDA and White House to intervene on their behalf to get states to adopt the DHS list.[72] In response, the USDA told the trade associations to have their members tell state officials to contact DHS to clarify who was an essential worker.[73] Thus, these trade associations were able to influence who was considered an essential worker, even though this decision was supposed to be left up to the states, which retain the primary power to make decisions during a public health emergency.[74] Yet, these same trade associations did not use their influence to ensure that these workers—whom they had designated as essential—received the employment benefits provided by COVID-19 economic relief bills, which would have limited their workplace exposure to COVID-19.

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[69] USDA OFF. SEC'Y, SECOND INTERIM ITEM REDACTED 36–38 (2020), https://www.citizen.org/wp-content/uploads/2020-OSEC-04055-F_2nd-Interim_Item-1_Redacted.pdf [hereinafter USDA PUBLIC CITIZEN FOIA] (e-mail from Julie Anna Potts, President & CEO, NAMI, to Mindy Brashears, Deputy Under Sec'y of Agric. for Food Safety & Inspection Serv., & Shawna Newsome, Chief of Staff, Food Safety & Inspection Serv.); *id.* at 127–30 (e-mail from Nathan Fretz, NAMI, to John Martin, Mindy Brashears, Under Sec'y of Agric. for Food Safety, Mary Dee Beal, Shawna Newsome, USDA, and Julie Anna Potts, President & CEO, NAMI); *id.* at 163–64 (e-mail from Shannon Herzfeld, VP of Glob. Gov't Rels., ADM, to Joby Young, Chief of Staff, USDA, Randy Russell, Chuck Conner, Michael Dykes, Cargill).

[70] Memorandum from Christopher C. Krebs, Dir. of the Cybersecurity and Infrastructure Sec. Agency, Guidance on the Essential Critical Infrastructure Workforce: Ensuring Community and National Resilience in Covid-19 Response (Mar. 19, 2020) (available at https://www.cisa.gov/sites/default/files/publications/CISA-Guidance-on-Essential-Critical-Infrastructure-Workers-1-20-508c.pdf).

[71] *Id.*

[72] *E.g.*, USDA PUBLIC CITIZEN FOIA, *supra* note 69, at 304–05 (e-mail from Lisa Wallenda Picard, Nat'l Turkey Fed'n, to Shawna Newson, Chief of Staff, Food Safety & Inspection Serv., Mindy Brashears, Under Sec'y of Agric. for Food Safety & Inspection Serv., Philip Bronstein, & Paul Kiecker, USDA Food Safety & Inspection Serv.); USDA OFF. SEC'Y, *supra* note 69 (e-mail from Herzfeld).

[73] USDA PUBLIC CITIZEN FOIA, *supra* note 69 (e-mail from Herzfeld).

[74] Jacobson v. Massachusetts, 197 U.S. 11, 19 (1905).

For example, the government enacted the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), which gave workers health coverage for COVID-19, increased unemployment benefits, and paid sick leave.[75] However, the CARES Act left out meat and poultry processing workers because it only applied to businesses with fewer than 500 workers, and most meat and poultry producers employ more than 500 workers.[76] In fact, JBS, a meat processing company, employs 3,000 workers at one plant, but has not provided its workers with paid sick leave or covered payments for COVID-19 testing.[77] Additionally, roughly 52% of meat and poultry workers are undocumented immigrants,[78] so the CARES Act does not cover them.[79] The failure to ensure that these workers were covered by the CARES Act, while lobbying to have them designated as essential workers, is an example of structural racism.[80] By working together to have their workers added to the essential list, but not supporting the distribution of employment benefits to these workers, the companies ensured that the workers would have to continue to go to work even if they were sick.[81] Thus, laws advantaged the companies while disadvantaging racial and ethnic minorities.[82] This further exacerbated the inequalities in employment, such as lack of paid sick leave and punitive attendance polices, for these workers.[83]

Many laws that expanded collective bargaining rights either explicitly excluded racial and ethnic minorities or allowed unions to discriminate against racial and ethnic minorities.[84] These employment laws benefited whites by providing them with access to unions that bargained for paid sick leave. However, "it left racial and ethnic minority workers without union representation and paid sick leave."[85] Without paid sick leave, working people "are 1.5 times more likely to go to work with a contagious disease and three

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[75] Erica Werner, Mike DeBonis & Paul Kane, *Senate Approves $2.2 Trillion Coronavirus Bill Aimed at Slowing Economic Free Fall*, WASH. POST (Mar. 25, 2020, 11:48 PM), https://www.washingtonpost.com/business/2020/03/25/trump-senate-coronavirus-economic-stimulus-2-trillion/.

[76] *See, e.g.*, H. Claire Brown, *Whistleblower Says JBS Asked Employees to Pay $100 for Covid-19 Test. Shocker: Few Participated*, COUNTER (Oct. 27, 2020, 11:29 AM), https://thecounter.org/covid-19-testing-jbs-greeley-colorado-meatpacking/.

[77] *Id.*; Schlitz et al., *supra* note 68.

[78] Taylor et al., *supra* note 47, at 31707.

[79] *See* Yearby & Mohapatra, *supra* note 8, at 7.

[80] *Id.*

[81] *Id.*

[82] *Id.*

[83] *Id.* at 5.

[84] Danyelle Solomon, Connor Maxwell & Abril Castro, *Systematic Inequality and Economic Opportunity*, CTR. AM. PROGRESS (Aug. 7, 2019, 7:00 AM), https://www.americanprogress.org/issues/race/reports/2019/08/07/472910/systematic-inequality-economic-opportunity/.

[85] Yearby & Mohapatra, *supra* note 8, at 5.

times more likely to go without medical care compared to those with paid sick days."[86] This continues today, as many racial and ethnic minority workers, especially those employed by meat and poultry processing plants, do not have paid sick leave,[87] "forcing them to go to work even when they were sick and increasing inequalities in their exposure to pandemic viruses, like COVID-19."[88]

Additionally, before the COVID-19 pandemic, meat and poultry processing companies' standard attendance policies were punitive. Points were issued for those who missed work, which was used as a reason for firing workers.[89] These policies have persisted throughout the COVID-19 pandemic as some of the biggest meat and poultry processing companies (JBS and Tyson) actively penalize workers for taking time off, even if it is for illness.[90] In fact, meat and poultry processing workers at Tyson and JBS note that they are required to go to work even if they are experiencing symptoms of COVID-19.[91] These companies also require workers to continue to work as they are awaiting test results.[92] One Tyson plant does not approve prearranged absences for things such as testing, unless it does not affect the production needs of the plant.[93] It is alleged that workers at JBS were threatened with loss of pay if they went home after medical checks showed that they suffered from COVID-19 symptoms.[94]

Excused absences for COVID-19 are only given if a worker has physician documentation of a positive COVID-19 test; otherwise, the worker is assessed

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[86] Emily A. Benfer & Lindsay F. Wiley, *Health Justice Strategies to Combat COVID-19: Protecting Vulnerable Communities During a Pandemic*, HEALTH AFFS. (Mar. 19, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200319.757883/full/.

[87] *Id.*

[88] Yearby & Mohapatra, *supra* note 8, at 5.

[89] *E.g.*, Schlitz et al., *supra* note 68; Anonymous Smithfield Worker, *I Work at Smithfield Foods. I'm Suing Them over Putting Our Lives at Risk for Your Dinner: Meat Processing Plants Can Do More to Protect Us from the Coronavirus*, WASH. POST (Apr. 24, 2020, 9:15 PM), https://www.washingtonpost.com/outlook/2020/04/24/smithfield-foods-lawsuit-coronavirus/; Jessica Lussenhop, *Coronavirus at Smithfield Pork Plant: The Untold Story of America's Biggest Outbreak*, BBC NEWS (Apr. 17, 2020), https://www.bbc.com/news/world-us-canada-52311877; Makenzie Huber, *'I Lost Him Because of That Horrible Place': Smithfield Worker Dies from COVID-19*, ARGUS LEADER (Apr. 16, 2020, 1:23 PM), https://www.argusleader.com/story/news/crime/2020/04/15/smithfield-foods-sioux-falls-sd-worker-dies-coronavirus-hot-spot/2994502001/.

[90] Schlitz et al., *supra* note 68. Smithfield initially used the point system as well, but halted the system once COVID-19 cases swelled. *Id.*

[91] *Id.*

[92] *Id.*

[93] *Id.*

[94] Brown, *supra* note 76; Tony Kovaleski, *Whistleblower Says COVID-19 Screening Process at JBS Plant Places Employees in Danger: "I Want the Governor to Know. I Want Everyone to Know"*, DENVER CHANNEL (Oct. 11, 2020, 6:20 PM), https://www.thedenverchannel.com/news/investigations/whistleblower-says-covid-19-screening-process-at-jbs-plant-places-employees-in-danger.

points, which can be used to fire them.[95] This was confirmed by JBS Spokesperson Nikki Richardson, who noted that "at no point during the pandemic have we assessed attendance points against team members for absences due to *documented* illness."[96] This attendance policy is associated with increased rates of infection because many workers cannot access testing due to cost, wait times, and fear of immigration enforcement, and thus, they continue to go to work since they cannot obtain physician documentation of a COVID-19 infection.[97]

For instance, at the JBS plant in Greeley, Colorado, where 6 workers died and 290 were infected with COVID-19[98] (nearly two-thirds of all Colorado COVID-19 cases at meat processing plants),[99] the attendance policy allowed for 6 points for absences before being fired, which was fewer than the 7.5 points allowed before the pandemic.[100] Workers could only recoup points by getting physician documentation of a positive COVID-19 test and calling an English-only attendance hotline, which is a separate and independent barrier for these workers because many workers do not speak English or have a physician to write the note.[101] To address this problem, JBS promised to provide workers with free COVID-19 tests after COVID-19 outbreaks at the plant.[102] However, JBS instead offered the low-wage and uninsured workers COVID-19 tests at its plant if they paid $100, which workers declined.[103]

Thus, meat and poultry processing workers were forced to continue to go to work even if they were sick, increasing their exposure to COVID-19 and causing racial inequities in COVID-19 infections and deaths. This is an example of structural racism because meat and poultry processing companies used the law to ensure their workers were deemed essential but did not provide them with paid sick leave that might disrupt production. Additionally, meat and poultry processing companies have enforced policies that penalize these workers for

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95 *See* Schlitz et al., *supra* note 68.

96 *Id.* (emphasis added).

97 *Id.*

98 Patty Nieberg, *Colorado Workers Protest COVID-19 Fine Issued to Meat Plant*, AP NEWS (Sept. 16, 2020), https://apnews.com/article/virus-outbreak-greeley-colorado-denver-f46d59db7b8d45898e975510cdd0ae0a.

99 Shelly Bradbury, *How Coronavirus Spread Through JBS's Greeley Beef Plant*, DENVER POST (July 12, 2020, 6:00 AM), https://www.denverpost.com/2020/07/12/jbs-greeley-coronavirus-investigation.

100 Schlitz et al., *supra* note 68.

101 *Id.*

102 Michael Roberts, *COVID-19:Rachel Maddow Crushes Greeley's JBS Plant After 7th Death*, WESTWORD (May 7, 2020, 7:33 AM), https://www.westword.com/news/covid-19-rachel-maddow-crushes-colorados-jbs-meat-plant-11706727.

103 Brown, *supra* note 76.

missing work even when they are sick. This inequality in employment benefits has advantaged companies by allowing them to continue to stay open, while disadvantaging workers by increasing their exposure to COVID-19, resulting in racial inequities in COVID-19. These problems were further aggravated by the government's failure to enforce worker health and safety protections.[104]

B. Systemic Racism, Failure to Enforce Health and Safety Laws, and Racial Inequities in COVID-19

The purpose of worker health and safety laws is to protect workers from being killed or otherwise harmed at work. During the COVID-19 pandemic, state health departments and the Occupational Safety and Health Administration (OSHA) have been in charge of regulating the health and safety of workers.[105] State health departments retain the primary public health power to enact laws to protect the health and safety of their citizens,[106] while the Occupational Safety and Health Act of 1970 (OSH Act) provides authority to OSHA and twenty-two states with OSHA-approved plans to regulate the health and safety of *most* workers.[107]

Under the OSHA regulations, employers must provide employees with personal protective equipment (PPE) and develop a respiratory protection standard to prevent occupational disease.[108] Moreover, under the OSH Act's general duty clause, employers must provide their employees with a place of employment free from recognized hazards that are causing or likely to cause death or serious harm.[109] Despite their powers, some states with OSHA-approved plans and OSHA itself have failed to enforce these laws to protect worker health and safety as illustrated by the COVID-19 infections and deaths of meat and poultry processing workers.

In Tennessee, a state with an OSHA-approved plan, the state's OSHA said that "[t]he only standard sanitation requirement Tennessee OSHA can govern is that employers provide soap and water for employees" because "[b]y TOSHA standards, face masks are not considered personal protective equipment, and the

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104 Yearby, *supra* note 8, at 520.

105 *See generally* 29 U.S.C. §§ 651–78 (detailing the occupational safety and health laws); Jacobson v. Massachusetts, 197 U.S. 11, 38 (1905).

106 *Jacobson*, 197 U.S. at 38.

107 29 U.S.C. §§ 651–78; U.S. Dep't of Lab., OSHA, *State Plans*, OSHA, https://www.osha.gov/stateplans (last visited Mar. 19, 2020).

108 29 C.F.R. §§ 1910.134(a)(2) (2020); 29 C.F.R. § 1910.132(a) (2020).

109 29 U.S.C. § 654(a)(1).

standard does not require an employer provide them."[110] The failure to require face masks is in direct contravention of OSHA regulations that require employers to provide PPE, including respirators at no cost to the employee,[111] to address respiratory issues, which cannot be addressed simply by washing one's hands.[112] Evidencing structural racism, the failure to enforce these laws has left many essential workers, who are predominantly racial and ethnic minorities, without access to health and safety protections to limit workplace exposure to COVID-19. Thus, it is not surprising that during this time, the COVID-19 infections went from 163 on May 1, 2020, to 566 on May 23, 2020, as a result of infections among essential workers.[113]

OSHA has also failed to protect meat and poultry processing workers, an example of structural racism, which has advantaged meat and poultry processing companies and disadvantaged racial and ethnic minorities. Since 2010, OSHA has been working on an airborne infectious disease rule that would require employers to conduct a worksite hazard assessment to determine how an airborne infectious disease can spread within the worksite or adopt specific measures to limit the spread of the airborne infectious disease in the worksite.[114] Although the rule was shelved in 2017,[115] OSHA still has the power to issue an emergency temporary standard (ETS) to address COVID-19, which would take immediate effect if it determines:

> (A) that employees are exposed to grave danger from exposure to substances or agents determined to be toxic or physically harmful or from new hazards, and (B) that such emergency standard is necessary to protect employees from such danger.[116]

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[110] Wyatt Massey, *Chattanooga's Essential Workers Fear Risks as COVID-19 Numbers Rise*, CHATTANOOGA TIMES FREE PRESS (May 25, 2020), https://www.timesfreepress.com/news/local/story/2020/may/25/chattanoogas-essential-workers-fear-risks-cov/523778/?bcsubid=4b3ec861-3e0e-48ac-96b4-a3d2b655fdf7&pbdialog=reg-wall-login-created-tfp (quoting Chris Cannon, assistant administrator with Tennessee OSHA).

[111] 29 C.F.R. § 1910.134(c)(4) (2020).

[112] OSHA OFF. OF TRAINING & EDUC., MAJOR REQUIREMENTS OF OSHA'S RESPIRATORY PROTECTION STANDARD 29 C.F.R. § 1910.134, at 4 (2006), https://www.osha.gov/sites/default/files/training-library_major_requirements.pdf.

[113] Massey, *supra* note 110.

[114] U.S. Dep't of Lab., OSHA, *Infectious Diseases Rulemaking*, OSHA, https://www.osha.gov/dsg/id (last visited Mar. 3, 2021); Summary of Stakeholder Meetings on Occupational Exposure to Infectious Disease, July 29, 2011 (OSHA-2010-003-0236), https://www.regulations.gov/document/; U.S. Department of Labor, Infectious Diseases SER Background Document (OSHA-2010-0003-0239) (on file with authors).

[115] *Id.*

[116] 29 U.S.C. § 655(c)(1). Recently, former Department of Labor officials under Trump stated that a draft ETS was reviewed by Loren Sweatt, Principal Deputy Assistant Secretary of OSHA, Patrick Pizzella, Deputy Labor Secretary, and Eugene Scalia, Labor Secretary, in April 2020, but they rejected it because it "would have

In May 2020, Members of Congress[117] and numerous organizations[118] representing essential workers employed in the health care, food, and agricultural industries petitioned OSHA to issue an ETS. When OSHA denied the petition, the unions filed a petition with the Court of Appeals for the D.C. Circuit to force OSHA to issue an ETS.[119] Yet, in June 2020, that court ruled against the unions, stating that OSHA reasonably determined that an ETS was not necessary because of the regulatory tools that OSHA had to ensure that employers were maintaining hazard-free work environments.[120]

Instead of publishing an ETS, OSHA partnered with the Centers for Disease Control and Prevention (CDC) to issue nonbinding worker health and safety guidance for meat and poultry processing workers, which employers *may* follow.[121] The guidance recommends the creation of a COVID-19 assessment and control plan, which includes providing PPE and implementing social distancing measures.[122] The guidance also explicitly states that employers should "work with the appropriate state and local public health officials and occupational safety and health professionals" to develop plans for operating and addressing COVID-19 outbreaks.[123] There are several problems with the guidance and OSHA's actions.

First, the guidance is not mandatory.[124] Thus, some OSHA officials have referred complaints regarding the failure to implement health and safety protections noted in the guidance to local health departments or stated that all

been ineffective and cumbersome for businesses." Ian Kullgren & Bruce Rolfsen, *Virus Worker Safety Rule Tests Biden After Trump DOL Nixed Draft*, BLOOMBERG L. (Mar 23, 2021, 3:27 PM), https://news.bloomberglaw.com/daily-labor-report/virus-worker-safety-rule-tests-biden-after-trump-dol-nixed-draft. Although OSHA never issued the draft ETS during the nine months after it was presented or through the end of the Trump Administration, these officials issued statements about the draft ETS as a way to critique the speed of the issuance of an ETS by Biden's OSHA, which has been in place for 2 months. *Id.*

117 Alex Gangitano, *Democrats Press OSHA Official on Issuing an Emergency Temporary Standard*, HILL (May 28, 2020, 1:12 PM), https://thehill.com/homenews/house/499943-democrats-press-osha-official-on-issuing-an-emergency-temporary-standard.

118 Richard L. Trumka & Various Organizations, *A Petition to Secretary Scalia for an OSHA Emergency Temporary Standard for Infectious Disease*, AFL-CIO (Mar. 6, 2020), https://aflcio.org/statements/petition-secretary-scalia-osha-emergency-temporary-standard-infectious-disease.

119 *See* Emergency Petition for a Writ of Mandamus, and Request for Expedited Briefing and Disposition 32, *In re* Am. Fed'n of Lab. & Cong. of Indus. Orgs., No. 20-1158, 2020 WL 3125324 (D.C. Cir. June 11, 2020), *rehearing en banc denied* (July 28, 2020), https://www.eenews.net/assets/2020/05/21/document_ew_05.pdf.

120 *Id.* at *1.

121 *Meat and Poultry Processing Workers and Employers: Interim Guidance from the Occupational Safety and Health Administration*, CDC (July 9, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/meat-poultry-processing-workers-employers.html.

122 *Id.*

123 *Id.*

124 *Id.*

they can do is "contact an employer and send an advisory letter outlining the recommended protective measures."[125] Second, the guidance fails to recommend testing for all workers after identification of an infected worker, which is necessary to track all worker infections as well as to prevent the spread of COVID-19. Compounding this issue, OSHA is not enforcing the reporting requirements for COVID-19 infections, hospitalizations, and deaths.[126] Third, the guidance was issued long after severe industry outbreaks occurred.[127] By March 30, 2020, the federal government was aware that the Canadian meat processing plant Olymel had had to shut down because of COVID-19 infections, yet the CDC and OSHA guidance for meat and poultry processing workers was not issued until April 26, 2020.[128] Finally, OSHA has relied on employers to make a "good faith" effort to comply with the mandatory requirements of the respiratory requirement, the general duty clause, and its advisory worker health and safety guidance rather than conduct in-person inspections.[129] The failures to enforce the respiratory requirement and general duty clause, finalize the airborne infectious disease rule, issue an ETS, and publish mandatory guidance are examples of structural racism because they have led to racial inequalities in employment health and safety protections. These inequalities have harmed racial and ethnic minority workers—while benefiting companies—leading to racial inequities in COVID-19. This is illustrated by the COVID-19 outbreak in Waterloo, Iowa.

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125 Maria Perez, *Workers Are Getting Sick and Dying, but OSHA Won't Crack Down on Businesses That Fail to Follow COVID-19 Guidelines*, MILWAUKEE J. SENTINEL (Apr. 15, 2020, 6:00 AM), https://www.jsonline.com/story/news/2020/04/15/osha-wont-crack-down-businesses-dont-meet-covid-19-guidance/2987618001.

126 29 C.F.R. §§ 1904.2(a)(1), 1904.7(a), 1904.39(a)(2) (2020); David Michaels, *OSHA's 'Absurd Reinterpretation' of a Regulation Regarding Workers and Covid-19*, STAT NEWS (Nov. 24, 2020), https://www.statnews.com/2020/11/24/osha-absurd-reinterpretation-regulation-workers-covid-19/.

127 Ruqaiijah Yearby, *Protecting Workers That Provide Essential Services*, *in* COVID-19 POLICY PLAYBOOK: LEGAL RECOMMENDATIONS FOR A SAFER, MORE EQUITABLE FUTURE, at 180–81 (Scott Burris, Sarah de Guia, Lance Gable, Donna E. Levin, Wendy E. Parmet & Nicholas P. Terry eds., 2021), https://static1.squarespace.com/static/5956e16e6b8f5b8c45f1c216/t/6064ad386b6e756cabb56f96/1617210684660/COVIDPolicyPlaybook-March2021.pdf; Memorandum from Michael Grant, Ctrs. for Disease Control Nat'l Inst. for Occupational Safety & Health, et al., to Joshua Clayton, S.D. Dep't of Health, Strategies to Reduce COVID-19 Transmission at the Smithfield Foods Sioux Foods Falls Pork Plant 15 (Apr. 22, 2020), (https://covid.sd.gov/docs/smithfield_recs.pdf).

128 USDA PUBLIC CITIZEN FOIA, *supra* note 69 (e-mail from Potts).

129 Press Release, U.S. Dep't of Lab., Statement of Enforcement Policy by Solicitor of Labor Kate O'Scannlain and Principal Deputy Assistant Secretary for OSHA Loren Sweatt Regarding Meat and Poultry Processing Facilities (Apr. 28, 2020) (https://www.dol.gov/newsroom/releases/osha/osha20200428-1); Press Release, U.S. Dep't of Lab., OSHA, U.S. Department of Labor's OSHA and CDC Issue Interim Guidance to Protect Workers in Meatpacking and Processing Industries (Apr. 26, 2020), (https://www.osha.gov/news/newsreleases/national/04262020).

In mid-April 2020, 18.2% of Iowa meat processing plant workers were infected with COVID-19, the highest percentage of these workers infected by COVID-19 nationwide.[130] In fact, at one point in April, not only were 90% of all COVID-19 cases in Waterloo, Black Hawk County, Iowa, tied to the Tyson meat processing plant where managers and supervisors had a betting pool on which workers would test positive for COVID-19,[131] but also Black Hawk County had the most COVID-19 cases in Iowa.[132] Wrongful death lawsuits have been filed against Tyson in response to this outbreak, alleging that Tyson required workers to work long hours in cramped conditions,[133] including those transferred from other facilities that were shut down for COVID-19 outbreaks; failed to provide appropriate PPEs, sufficient social distancing, or safety measures; and ignored letters from county officials asking Tyson to close the facility "to ensure the safety and well-being of Tyson's valuable employees and our community."[134] To date, OSHA has not fined Tyson for its failure to protect workers, which resulted in the COVID-19 outbreak.

Furthermore, Iowa, a state with an OSHA-approved plan, twice declined assistance from the CDC to address these COVID-19 outbreaks.[135] By mid-May 2020, Iowa still had the highest percentage of COVID-infected meat and poultry processing workers nationwide, with 1,784 meat processing plant workers infected.[136] The state cited Iowa Premium Beef Plant $957 for a record keeping violation, where 338 out of 850 workers tested positive for the virus, making it the first hotspot for COVID-19 in Iowa.[137] Yet, neither the state nor OSHA has cited any of these Iowa facilities for violations of the general duty standard.[138] In fact, Iowa passed a business liability law that protects businesses, including

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[130] Jonathan W. Dyal et al., *COVID-19 Among Workers in Meat and Poultry Processing Facilities — 19 States*, *April 2020*, 69 MORBIDITY & MORTALITY WKLY. REP. 557, 558 (2020), https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6918e3-H.pdf.

[131] Kauffman, *supra* note 67.

[132] Donnelle Eller & Barbara Rodriguez, *Donald Trump's Keep-Open Order Creates Anxiety in Iowa City with a Meatpacking Plant, Relief for Farmers*, DES MOINES REG. (Apr. 29, 2020, 7:37 PM), https://www.desmoinesregister.com/story/money/agriculture/2020/04/29/trump-order-reopen-meat-packing-plants-create-anxiety-waterloo-farmers-who-face-destroying-pigs/3047760001.

[133] Fernandez v. Tyson Foods, Inc., Case No. 6:20-cv-02079-LRR-KEM (N.D. Iowa Nov. 11, 2020), https://htv-prod-media.s3.amazonaws.com/files/amended-complaint-tyson-1605748137.pdf.

[134] *Id.* at 1, 9–10.

[135] Kauffman, *supra* note 67.

[136] *Id.*

[137] Ryan J. Foley, *Iowa Fines Beef Plant $957 After Huge Coronavirus Outbreak*, AP NEWS (Sept. 24, 2020), https://apnews.com/article/virus-outbreak-health-iowa-archive-iowa-city-b11ef8d6b6c97b2ddc38c9b81a2eb971.

[138] *See, e.g.*, Ryan J. Foley, *Iowa Finds No Violations at Tyson Plant with Deadly Outbreak*, ABC NEWS (June 23, 2020, 9:28 PM), https://abcnews.go.com/Business/wireStory/iowa-finds-violations-tyson-plant-deadly-outbreak-71419502.

meat and poultry processing companies from being sued for COVID-19 infections.[139] This is structural racism.

OSHA and states' failure to enforce the laws and require employers to provide a workplace free from COVID-19 exposure has harmed meat and poultry processing workers and increased their risk for COVID-19 infection, hospitalization, and death, while benefiting companies, which do not have to spend money on safety protections or decrease production. The harm is disproportionately experienced by racial and ethnic minorities, who make up a majority of these workers. This harm has been made worse by the government's emergency preparedness laws, policies, and interventions that prioritize profit over safety.

C. Systemic Racism, Emergency Preparedness Response, and Racial Inequities in COVID-19

By April 2020, the CDC documented that there were 4,913 COVID-19 cases and 20 deaths among meat and poultry processing workers based on data reported from 19 states, showing that meat and poultry processing workers were particularly susceptible to COVID-19 infection in the workplace.[140] Instead of addressing these health and safety problems by following their own guidance and implementing preventative measures such as requiring workers to stay at least six feet apart and installing Plexiglass barriers, meat and poultry trade associations sent a letter dated April 17, 2020, to the President asking for assistance in keeping plants open.[141] On April 20, 2020, NAMI sent a draft executive order to the President to use to keep food processing, production, and supply companies open.[142] Nine days later, Trump issued Executive Order 13917 ("Order"), which included language from the draft executive order, such as a focus on the risk of meat shortages and the need to keep open meat and poultry processing facilities.[143] Alluding to the powers granted by the Defense

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[139] *Id.*; *see also* IA S. File 2338, 88th Gen. Assemb., Reg. Sess. (Iowa 2020). The law limits recovery for workplace COVID-19 exposure to acts that were intended to cause harm or constitute actual malice, but provides a safe harbor if the business complied with either a federal or state statute, regulation, order, or public health guidance related to COVID-19. *Id.*

[140] Dyal et al., *supra* note 130, at 558.

[141] USDA PUBLIC CITIZEN FOIA, *supra* note 69, at 122 (e-mail from Dale Moore, Exec. Vice President, Am. Farm Bureau Fed'n, to Joby Young, Chief of Staff, USDA); USDA PUBLIC CITIZEN FOIA, *supra* note 69, at 359–61 (e-mail from Julie Anna Potts, President & CEO, NAMI, to Stephen Censky, Deputy Sec'y of Agric., USDA).

[142] USDA PUBLIC CITIZEN FOIA, *supra* note 69, at 354 (e-mail from Julie Anna Potts, President & CEO, NAMI, to Stephen Censky, Deputy Sec'y of Agric., USDA).

[143] *Id.*; Exec. Order No. 13917, 85 Fed. Reg. 26,313 (May 1, 2020).

Production Act of 1950, the President delegated authority to the USDA to regulate and ensure that meat and poultry processing plants stayed open or reopened during the COVID-19 pandemic to guarantee that there were no meat shortages, even as these plants were becoming COVID-19 hotspots.[144]

The issuance of the Order and the actions of the USDA have provided advantages to companies allowing them to stay open and continue production,[145] while disadvantaging racial and ethnic minority workers by limiting protection from workplace exposure.[146] For example, although the Order argued that meat and poultry protein would be "scarce" and "essential to the national defense," it did not stop meat exports.[147] In mid-June, the USDA noted "that total pork exports to mainland China in April reached their highest monthly total since the agency began keeping track 20 years ago,"[148] and as of July 2, 2020, beef (5%) and pork (14%) production were up compared to a year ago.[149] For example, even as worker infections and deaths continued to rise, Tyson increased production of meat, pork, chicken, and prepared foods.[150] As a result, Tyson announced a net income of $692 million for the fourth quarter of 2020, up from $369 million for the same period in 2019,[151] and expected a revenue of $42 billion for 2020. These profits were made even as workers were being infected and dying from COVID-19. As of March 8, 2021, over 12,523 Tyson workers have been infected with COVID-19, in addition to the major COVID-19 outbreak in Iowa.[152] Rather than using the money to compensate or protect

144 Exec. Order No. 13917, 85 Fed. Reg. 26,313 (May 1, 2020).

145 Tim Stelloh, *Meat Processing Plant Ordered to Shut Down After Covid-19 Outbreak; Company Sues New Mexico: Officials in the State Ordered the Stampede Meat Plant to Close After Six Employees Tested Positive in Four Days*, NBC NEWS (Nov. 9, 2020, 6:19 PM), https://www.nbcnews.com/news/us-news/meat-processing-plant-ordered-shut-down-after-covid-outbreak-company-n1247189.

146 Yearby, *supra* note 8, at 520.; Yearby & Mohapatra, *supra* note 8, at 4–5.

147 Exec. Order No. 13917, 85 Fed. Reg. 26,313 (May 1, 2020); Defense Production Act, 41 U.S.C. § 4511(b).

148 Michael Corkery & David Yaffe-Bellany, *As Meat Plants Stayed Open to Feed Americans, Exports to China Surged*, N.Y. TIMES (June 23, 2020), https://www.nytimes.com/2020/06/16/business/meat-industry-china-pork.html (stating that the "[meat] industry publicly lobbied the Trump administration to intervene with state and local officials or risk major meat shortages across American grocery stores").

149 Jacob Bunge, *Coronavirus Surge Tests Safeguards for Meatpacking Workers*, WALL ST. J. (July 2, 2020, 3:52 PM), https://www.wsj.com/articles/coronavirus-surge-tests-safeguards-for-meatpacking-workers-11593719573.

150 *Id.*

151 Tonya Garcia, *Tyson Foods Shares Rise After Earnings Beat, 2021 Dividend Announced*, MARKETWATCH (Nov. 16, 2020, 8:10 AM), https://www.newsbreak.com/news/2103353545279/tyson-foods-shares-rise-after-earnings-beat-2021-dividend-announced.

152 Douglas, *supra* note 64.

workers, Tyson has used the Order to challenge worker and family requests for compensation and safety protections.[153] Nevertheless, Tyson is not alone.

After the Order was issued, JBS reported $581.2 million in net profits in the third quarter of 2020 beating analyst's forecasts.[154] The JBS plant in Greeley, Colorado, where 6 workers died and 290 were infected with COVID-19[155] (nearly two-thirds of all Colorado COVID-19 cases and all of Colorado meat plant infections at that time),[156] was fined $15,615 for worker infections and deaths.[157] This is 0.00003% of last year's profits, which were $51.7 billion, and infinitesimal compared to the $280 million it was fined for foreign bribery in 2020.[158] The fine is also miniscule compared to the approximately $21.4 million fine OSHA levied against BP after an explosion killed fifteen workers and the $81 million OSHA fine for failing to abate those hazards.[159] Nevertheless, JBS has used the Order to challenge the fine,[160] arguing that they complied with the OSHA and CDC guidance, even as they enforced attendance policies that penalized workers for staying at home when they were sick, required workers to continue to work as they were awaiting test results, and only allowed absences for COVID-19 if workers had physician documentation of a positive COVID-19 test.[161] Thus, the Order is an example of structural racism.

Meat and poultry trade associations and companies worked together to influence the government's pandemic response, leading to the issuance of an

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153 Jon Steingart, *Tyson Worker's Family Vows to Press 'Stronger' COVID Suit*, LAW360 (Aug. 10, 2020, 4:03 PM), https://www.law360.com/articles/1299875/tyson-worker-s-family-vows-to-press-stronger-covid-suit. However, Judge Linda Reade ruled that the Order did not negate Tyson's responsibility, since it was signed two days after one of the workers had died and well after the worker contracted COVID-19. William Morris, *Tyson Suit Returned to State Court by Judge*, DES MOINES REG. 2021 WLNR 199977 (Jan. 4, 2021).

154 *Brazil's JBS Turns $581.2 Mln Net Profit in Q3, Beating Analyst Forecasts*, YAHOO!FINANCE (Nov. 11, 2020), https://finance.yahoo.com/news/brazils-jbs-turns-581-2-015514838.html.

155 Nieberg, *supra* note 98.

156 Bradbury, *supra* note 99.

157 Nieberg, *supra* note 98.

158 Kimberly Kindy, *More Than 200 Meat Plant Workers in the U.S. Have Died of Covid-19. Federal Regulators Just Issued Two Modest Fines*, WASH. POST (Sept. 13, 2020, 9:49 AM), https://www.washingtonpost.com/national/osha-covid-meat-plant-fines/2020/09/13/1dca3e14-f395-11ea-bc45-e5d48ab44b9f_story.html; Sylvan Lane, *Owners of Meatpacker JBS to Pay $280M Fine over Foreign Bribery Charges*, HILL (Oct. 14, 2020, 4:26 PM), https://thehill.com/policy/finance/521070-owners-of-meatpacker-jbs-to-pay-280m-fine-over-foreign-bribery-charges.

159 David Michaels & Gregory R. Wagner, *Halting Workplace COVID-19 Transmission: An Urgent Proposal to Protect American Workers*, CENTURY FOUND. (Oct. 15, 2020), https://tcf.org/content/report/halting-workplace-covid-19-transmission-urgent-proposal-protect-american-workers/.

160 *Id.*; *see also* Matthew Santoni, *Pa. Meat Plant Says OSHA Should Handle Virus Death Claims*, LAW360 (June 17, 2020, 5:45 PM), https://www.law360.com/articles/1283845/pa-meat-plant-says-osha-should-handle-virus-death-claims.

161 Schlitz et al., *supra* note 68.

Order that allowed them to keep producing meat, while increasing racial and ethnic minorities' workplace exposure to COVID-19. Moreover, since the Order, the USDA has used its power to override states' public health authority, keep open or reopen many meat and poultry processing plants, and issue line speed waivers, which has been associated with high rates of COVID-19 infections and deaths of meat and poultry plant workers.[162] This is demonstrated by the COVID-19 outbreak at the Smithfield plant in Sioux Falls, South Dakota.

On April 16, 2020, it was announced that there were 735 COVID-19 infections at the Smithfield meat processing plant in Sioux Falls, making it the largest COVID-19 hotspot at that point.[163] Yet, the first case of COVID-19 detected in the plant was on March 24, 2020, twenty-three days before the announcement.[164] The plant did not totally halt production until April 14, and by that time it had become the COVID-19 hotspot for the entire state.[165] The South Dakota Department of Health and the CDC completed an inspection of the facility[166] on April 16 and 17 because, at the time, the outbreak was one of the largest in the United States.[167] The CDC report provided recommendations for the plant to protect workers, which were allegedly changed to be merely suggestions that could be adopted "whenever possible" and, "if feasible," at the request of the USDA.[168] After the report was issued, Smithfield continuously emailed the USDA using the CDC's findings as support for reopening the plant even as employee test results were still pending, an OSHA investigation was

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[162] USDA PUBLIC CITIZEN FOIA, *supra* note 69, at 214 (e-mail from Ashley Peterson, Nat'l Chicken Council, Senior Vice President, to Mindy M. Brashears, Under Sec'y for Food Safety, USDA); USDA PUBLIC CITIZEN FOIA, *supra* note 69, at 256 (e-mail from Keira Lombardo, Exec. Vice President, Corp. Affs. & Compliance, Smithfield Foods, to Mindy Brashears, Under Sec'y for Food Safety, USDA); USDA PUBLIC CITIZEN FOIA, *supra* note 69, at 179–80 (e-mail from Ashley Peterson, Nat'l Chicken Council, Senior Vice President, to Mindy Brashears, Under Sec'y for Food Safety, USDA); USDA PUBLIC CITIZEN FOIA, *supra* note 69, at 271 (e-mail from Julie Anna Potts, President & CEO, NAMI, to Mindy Brashears, Under Sec'y of Agric., USDA); USDA PUBLIC CITIZEN FOIA, *supra* note 69, at 306 (e-mail from Mindy Brashears, Under Sec'y for Food Safety, USDA, to Michael P. Skahill, Vice President, Gov't Affs., Smithfield Foods).

[163] Alexandra Sternlicht, *Smithfield Foods Becomes Largest Coronavirus Hotbed in United States, South Dakota Governor Yet to Mandate Stay Home Order*, FORBES (Apr. 16, 2020, 6:07 PM), https://www.forbes.com/sites/alexandrasternlicht/2020/04/16/smithfield-foods-becomes-largest-coronavirus-hotbed-in-united-states-south-dakota-governor-yet-to-mandate-stay-home-order/?sh=4901428c2143; Caitlin Dickerson & Miriam Jordan, *South Dakota Meat Plant Is Now Country's Biggest Coronavirus Hot Spot*, N.Y. TIMES (May 4, 2020), https://www.nytimes.com/2020/04/15/us/coronavirus-south-dakota-meat-plant-refugees.html.

[164] Memorandum from Michael Grant et al., *supra* note 127, at 1.

[165] *Id.* at 1–2.

[166] *Id.* at 1.

[167] Eli Rosenberg, *The CDC Softened a Report on Meatpacking Safety During the Pandemic. Democrats Say They Want to Know Why*, WASH. POST (Sept. 30, 2020, 9:53 PM), https://www.washingtonpost.com/business/2020/09/30/cdc-meatpacking-smithfield/.

[168] *Id.*

being conducted, and the South Dakota Governor was trying to get Smithfield to comply with state health and safety laws.[169] In response to these emails from Smithfield, the USDA issued a letter dated May 6, 2020, stating that the facility should be reopened.[170] The facility reopened on May 7.[171] In September, OSHA issued a citation and fine of $13,494 for the Smithfield plant after 1,294 employees tested positive, 43 were hospitalized, and 4 died of COVID-19.[172] The OSHA "citation and notification of penalty" letter for the plant shows that COVID-19 infections continued to spread throughout the plant well into June.[173]

Additionally, meat and poultry trade associations and companies have worked together to override local and state government's implementation of public health measures, which has been associated with racial inequities in COVID-19 infections and deaths. On March 26, 2020, the USDA sent an email to a meat and poultry association stating that they were working with the Food and Drug Administration to develop guidelines for social distancing in food plants, which the USDA was asking state and local health departments to follow.[174] However, the USDA *emphasized* that:

> [T]he jurisdiction of health issues will be *left* to the local health departments. The requirements might change in areas of increased illness and/or if there is a confirmed illness in the processing facility.

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169 USDA PUBLIC CITIZEN FOIA, *supra* note 69, at 257 (e-mail from Michael P. Skahill, Vice President, Gov't Affs., Smithfield Foods, to Mindy Brashears, Under Sec'y for Food Safety, USDA); USDA PUBLIC CITIZEN FOIA, *supra* note 69, at 323 (e-mail from Michael P. Skahill, Vice President, Gov't Affs., Smithfield Foods, to Mindy Brashears, Under Sec'y for Food Safety, USDA); USDA PUBLIC CITIZEN FOIA, *supra* note 69, at 272 (e-mail from Keira Lombardo, Exec. Vice President, Corp. Affs. and Compliance, Smithfield Foods, to Joby Young, Chief of Staff, USDA).

170 USDA PUBLIC CITIZEN FOIA, *supra* note 69, at 10–11 (e-mail from Mindy Brashears, Under Sec'y for Food Safety, USDA, to Ken Sullivan, CEO, Smithfield Foods); USDA PUBLIC CITIZEN FOIA, *supra* note 69, at 306 (e-mail from Michael P. Skahill, Vice President, Gov't Affs., Smithfield Foods, to Mindy Brashears, Under Sec'y for Food Safety, USDA).

171 *Smithfield Foods to Reopen Sioux Falls, South Dakota Facility After CDC Conducts Thorough Site Inspection and Affirms Company Meets or Exceeds All Employee Health and Safety Guidance*, SMITHFIELD FOODS (May 6, 2020), https://www.smithfieldfoods.com/press-room/company-news/smithfield-foods-to-reopen-sioux-falls-south-dakota-facility-after-cdc-conducts-thorough-site-inspection-and-affirms-company-meets-or-exceeds-all-employee-health-and-safety-guidance.

172 U.S. Dep't of Lab., OSHA, *U.S. Department of Labor Cites Smithfield Packaged Meats Corp. for Failing to Protect Employees from Coronavirus*, OSHA (Sept. 10, 2020), https://www.osha.gov/news/newsreleases/region8/09102020 [hereinafter *OSHA Smithfield Citation*]; Kindy, *supra* note 158; Stephen Groves, *Smithfield Foods Pork Plant Faces OSHA Fine from Outbreak*, AP NEWS (Sept. 10, 2020), https://apnews.com/article/health-sioux-falls-virus-outbreak-b22c3423c44a16ca02e0423d9a45198c.

173 *OSHA Smithfield Citation*, *supra* note 172; Mike Dorning & Michael Hirtzer, *Smithfield Fine in Deadly Covid Outbreak Labeled 'Paltry'*, BLOOMBERG (Sept. 10, 2020, 9:33 PM), https://www.bloomberg.com/news/articles/2020-09-10/smithfield-fine-in-deadly-covid-outbreak-draws-jeers-as-paltry.

174 USDA PUBLIC CITIZEN FOIA, *supra* note 69, at 252–54 (e-mail from Mindy Brashears, Under Sec'y for Food Safety, USDA, to Julie Anna Potts, President & CEO, NAMI).

> If there are illnesses they may require more stringent social distancing recommendations and/or quarantines. *We will rely on* [*health departments*] *to make the best decisions based on public health.*[175]

After the Order, the USDA's stance changed as it worked to support the needs of meat and processing plants, assisting them to stay open and reopen meat and poultry processing plants with COVID-19 outbreaks, even if state and local health departments were trying to use their public health powers to close facilities in order to slow the spread of COVID-19.[176] In fact, after the Order, the USDA never again deferred to the states' health departments requirements.

By May 5, 2020, citing the powers granted under the Order, the USDA Secretary issued a letter requesting a clear timetable for the resumption of operations for any meat or poultry processing plant closed since May 1, which included written documentation of their operations and health and safety protocols based on the OSHA and CDC guidance.[177] In the letter, the USDA disregarded its prior statements that it would rely on health departments to make the best decisions based on public health. After the letter, the USDA received emails from meat and poultry trade associations requesting assistance with state and local health departments wanting to close facilities due to COVID-19 outbreaks, requiring all employees be tested, and implementing a six-foot physical distancing requirement. In response to one of the emails, the USDA intervened in a state's decision to reopen a meat processing plant. Specifically, the USDA pressured Illinois into reopening the Smithfield Kane County, Illinois, meat processing plant that had closed due to a COVID-19 outbreak.[178] Since the Order, the USDA's letter, and the USDA's interventions, COVID-19 infections and deaths in meat and poultry processing facilities have skyrocketed.

The CDC issued an updated meat and poultry processing plant report showing that in the one month after the Order was issued the number of COVID-19 infections more than tripled and the number of deaths quadrupled.[179]

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175 *Id.* (emphasis added).

176 USDA PUBLIC CITIZEN FOIA, *supra* note 69, at 256 (e-mail from Mindy Brashears, Under Sec'y for Food Safety, USDA, to Keira Lombardo, Exec. Vice President, Corp. Affs. & Compliance, Smithfield Foods).

177 USDA PUBLIC CITIZEN FOIA, *supra* note 69, at 348–50 (e-mail from Michael Cole, Senior Advisor to the CEO, Smithfield Foods, to Mindy Brashears, Under Sec'y for Food Safety, USDA).

178 USDA PUBLIC CITIZEN FOIA, *supra* note 69, at 119 (e-mail from Michael P. Skahill, Vice President, Gov't Affs., Smithfield Foods, to Shawna Newsome, USDA).

179 Waltenburg et al., *supra* note 46, at 888; Matthew R. Groenwold, Sherry L. Burrer, Faruque Ahmed, Amra Uzicanin, Hannah Free & Sara E. Luckhaupt, *Increases in Health-Related Workplace Absenteeism Among Workers in Essential Critical Infrastructure Occupations During the COVID-19 Pandemic — United States, March–April 2020*, 69 MORBIDITY & MORTALITY WKLY REP. 853, 856–57 (2020), https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6927-H.pdf.

Specifically, there were 16,233 confirmed cases of COVID-19 infections for meat and poultry processing workers and 86 COVD-19 related deaths in 239 plants.[180] Of the 9,919 (61%) cases with racial and ethnic data, 56% occurred in Latinos, 19% occurred in non-Latino Black, 13% in non-Latino whites, and 12% in Asians.[181] Yet, even the CDC acknowledged that the actual numbers of infections and deaths for meat and poultry processing workers were *probably higher* because only twenty-three states submitted data and "only facilities with at least one laboratory-confirmed case of COVID-19 among workers were included."[182] Furthermore, policies to keep open meat and poultry processing plants with outbreaks have not only harmed workers, but they have also harmed children and people in the greater community.

Recent data has associated Latino and Black children's higher risk of COVID-19-related hospitalizations with social factors, such as the employment conditions of their parents (e.g. serving as an essential worker).[183] Research further shows that having a meat or poultry processing plant in the county is associated with a 51% to 75% increase in cases and 37% to 50% increase in deaths of all people in the county, not just those who worked at the plant.[184] Plant closures decreased county-wide infections and deaths.[185] In the first week, closures resulted in lower county COVID-19 rates, and by week two, the rates for counties with plants that had been closed were roughly the same as counties without plants.[186] If the plants remained closed for three to four weeks, the counties with these closed plants had lower COVID-19 rates than counties without plants.[187] Consequently, research shows that the government's pandemic response, which has allowed meat and poultry plants to remain open, has benefited meat and poultry processing companies, while increasing workers, children, and entire communities' infections and deaths. A majority of these infections and deaths have been experienced in racial and ethnic minorities, leading to racial inequities.[188]

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180 Waltenburg et al., *supra* note 46, at 887.

181 *Id.* at 887–88

182 *Id.* at 889.

183 Chelsea Janes, *Hispanic, Black Children at Higher Risk of Coronavirus-Related Hospitalization, CDC Finds*, WASH. POST (Aug. 8, 2020), https://www.washingtonpost.com/health/2020/08/07/hispanic-black-children-higher-risk-coronavirus-related-hospitalization-cdc-finds/.

184 Taylor et al., *supra* note 47, at 31706.

185 *Id.*

186 *Id.* at 31709.

187 *Id.*

188 Complaint Under Title VI of the Civil Rights Act of 1964, 42 U.S.C. §§ 2000d-2000d-7; 7 C.F.R. §§ 15.1–15.12, at 16, Benjamin v. JBS S.A., No. 2:20-cv-02594 (E.D. Pa. July 8, 2020), https://food.publicjustice.net/wp-content/uploads/sites/3/2020/07/2020.07.08-Food-Chain-Workers-v.-Tyson-Foods-Title-VI-complaint-FINAL-1.pdf.

In addition to usurping the authority of OSHA and the states to keep open plants, the USDA granted line speed waivers that increase the risk of COVID-19 infection for poultry workers.[189] During 2020, line speed waivers were given to plants that had a history of OSHA violations, reports of severe injuries, or were the site of an outbreak.[190] The line speed waivers conflict with the 2014 Modernization of Poultry Slaughter Inspection rule that set a maximum speed and did not allow for waivers.[191] The issuance of line speed waivers is evidence of structural racism. The USDA issued waivers that advantaged meat and poultry companies allowing them to increase production, while preventing workers from standing six feet apart, one of the safety recommendations for preventing infections.[192] Research shows that these waivers are associated with increased rates of infection. Taylor, Boulos, and Almond showed that waivers were associated with a doubling of COVID-19 cases in counties with a meat and poultry plant compared to counties with nonwaiver plants.[193] For plants that were issued waivers in 2020, the rate of cases in counties with a meat and poultry plant was quadruple that of counties with non-waiver plants.[194]

Since the Order, the USDA's letter, interventions in plant closures, and granting of line speed waivers, COVID-19 infections and deaths in meat and poultry processing facilities have skyrocketed. These actions are examples of structural racism because meat and poultry trade associations and companies worked together to influence the President and the USDA, which resulted in the reopening of facilities where racial and ethnic minorities were unnecessarily infected with COVID-19 and died. To stop racial inequities in infections and deaths, which are the result of political decisions influenced by meat and poultry trade associations, the failure to enforce health and safety standards, and the government's ineffective pandemic response that has led to racial inequalities in employment, the federal and state government should use the health justice framework.

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189 Shayla Thompson & Deborah Berkowitz, *USDA Allows Poultry Plants to Raise Line Speeds, Exacerbating Risk of COVID-19 Outbreaks and Injury*, NAT'L EMP. L. PROJECT 1 (June 17, 2020), https://www.nelp.org/publication/usda-allows-poultry-plants-raise-line-speeds-exacerbating-risk-covid-19-outbreaks-injury/.

190 *Id.* at 3.

191 *Id.* at 4.

192 *Id.* at 3.

193 Taylor et al., *supra* note 47, at 31708.

194 CHARLES A. TAYLOR, CHRISTOPHER BOULOS & DOUGLAS ALMOND, SUPPLEMENTARY INFORMATION FOR LIVESTOCK PLANTS AND COVID-19 TRANSMISSION 19 (2020), https://www.pnas.org/content/pnas/suppl/2020/11/19/2010115117.DCSupplemental/pnas.2010115117.sapp.pdf.

D. Health Justice: Eradicating Systemic Racism in Employment

To address systemic racism in employment, the government must change its pandemic response using the three principles of the health justice framework: (1) structural remediation; (2) financial supports and accommodations; and (3) engagement and empowerment. These solutions build on our prior work and the work of David Michaels and Gregory Wagner, both former senior OSHA officials.[195]

First, the emergency pandemic legal and policy response must eradicate systemic racism by providing paid sick leave to all workers, even if they are undocumented immigrants, "because [it] reduces costly spending on emergency health care, reduces the rate of influenza contagion, and saves the U.S. economy $214 billion annually in increased productivity and reduced turnover."[196] Cities, such as Oakland, California, are already requiring that employers provide paid sick leave to essential workers during the pandemic.[197] However, comprehensive paid sick leave should be required and supported at the federal level. This can be accomplished with the enactment of a national paid sick leave law, not limited by worker status or employer size, and with retaliation protection.

The government must also enforce the health and safety laws to ensure that all essential workers, especially racial and ethnic minorities, are not exposed to COVID-19 in the workplace. Federal and state agencies should use their legal authority to prohibit punitive attendance policies that require workers to go to work sick. Section 5 of the OSH Act includes a general duty standard that requires employers to provide employees with a place of employment free from recognized hazards that are causing or likely to cause death or serious harm.[198] Although this is a new use of the "general duty" standard, it should be used to prohibit punitive attendance policies that require sick workers to come to work because this is a recognized hazard that is likely to cause death or serious harm.

Additionally, OSHA and states must adopt an ETS based on the 2010 proposed airborne infectious disease rule to protect workers.[199] This should be

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195 Benfer et al., *supra* note 27; Yearby & Mohapatra, *supra* note 8; Yearby & Mohapatra, *supra* note 27; Michaels & Wagner, *supra* note 159.

196 Benfer & Wiley, *supra* note 86.

197 Bay City News, *Oakland City Leaders OK Paid Sick Leave for Essential Workers*, NBC BAY AREA (May 13, 2020, 7:57 AM), https://www.nbcbayarea.com/news/local/oakland-city-leaders-ok-paid-sick-leave-for-essential-workers/2289529/.

198 29 U.S.C. § 654(a)(1).

199 U.S. Dep't of Lab., OSHA, *Infectious Disease Rulemaking: Introduction*, OSHA (2020), https://www.osha.gov/dsg/id.

followed immediately with the publication of a final rule based on the 2010 proposed airborne infectious disease rule with increased fines, including a penalty for those who are serial violators. On January 21, 2021, President Biden issued an Executive Order on Protecting Worker Health and Safety and a COVID-19 plan with recommendations to address these issues, but the recommendations were not mandatory and did not revoke Trump's previous Order.[200] Some states are already leading the way. Virginia was the first state to enact a workplace COVID-19 safety standard,[201] while California, Michigan, and Oregon have also enacted workplace laws, strengthened recording and reporting requirements, and issued larger fines than OSHA.[202] These laws should be used as a model for changes in the federal response. Moreover, as proposed by Michaels and Wagner, federal and state governments must also expedite workplace COVID-19 case reporting and responses to COVID-19 outbreaks, improve the health and safety inspection process by hiring enough inspectors to conduct in-person inspections and issue citations promptly,

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[200] Exec. Order No. 13999, 86 Fed. Reg. 7,211 (Jan. 21, 2021); OFF. OF THE PRESIDENT, NATIONAL STRATEGY FOR THE COVID-19 RESPONSE AND PANDEMIC PREPAREDNESS (2021), https://www.whitehouse.gov/wp-content/uploads/2021/01/National-Strategy-for-the-COVID-19-Response-and-Pandemic-Preparedness.pdf. However, as the Inspector General of the U.S. Department of Labor noted, "Guidance in and of itself cannot operate in lieu of an ETS as an enforcement tool." U.S. DEP'T OF LAB., OFF. OF INSPECTOR GEN., COVID-19: INCREASED WORKSITE COMPLAINTS AND REDUCED OSHA INSPECTIONS LEAVE U.S. WORKERS' SAFETY AT INCREASED RISK 10 (Feb. 25, 2021), https://www.oig.dol.gov/public/reports/oa/2021/19-21-003-10-105.pdf.

[201] VA. DEP'T OF LAB. AND INDUS., VA. OCCUPATIONAL SAFETY & HEALTH PROGRAM, §16VAC25-220, EMERGENCY TEMPORARY STANDARD INFECTIOUS DISEASE PREVENTION: SARS-COV-2 VIRUS THAT CAUSES COVID-19 (July 15, 2020), https://www.doli.virginia.gov/wp-content/uploads/2020/07/COVID-19-Emergency-Temporary-Standard-FOR-PUBLIC-DISTRIBUTION-FINAL-7.17.2020.pdf; Eli Rosenberg, *Virginia Poised to Create First Pandemic Workplace Safety Mandates in Nation, as Trump Labor Agency Sits on Sidelines*, WASH. POST (June 24, 2020, 5:15 PM), https://www.washingtonpost.com/business/2020/06/24/virginia-safety-rules-covid/; Lulu Garcia-Navarro & Christianna Silva, *Virginia Poultry Workers See Victory in New COVID-19 Protection Rules*, NPR (July 19, 2020, 7:58 AM), https://www.npr.org/2020/07/19/892757768/virginia-workers-see-victory-in-covid-19-protection-rules; 13NewsNow Staff, *Newport News Businesses React to Newly Adopted Workplace Safety Rules*, 13 NEWSNOW (July 16, 2020, 7:56 PM), https://www.13newsnow.com/article/news/health/coronavirus/gov-northam-tweets-that-virginia-will-be-first-state-to-enforce-coronavirus-workplace-safety-standards/291-dd5443fd-a3c6-442e-b4df-15b7a6dc7ffa.

[202] Cara Ball, *Whitmer Signs New Order Outlining Safety Guidelines for Workers at Meat Packing Plants*, WXYZ DETROIT (July 9, 2020, 5:43 PM), https://www.wxyz.com/news/coronavirus/whitmer-signs-new-order-outlining-safety-guidelines-for-workers-at-meat-packing-plants; Chuck Abbott, *Some States Tougher Than OSHA on Coronavirus Workplace Outbreaks*, SUCCESSFUL FARMING (Nov. 6, 2020), https://www.agriculture.com/news/business/some-states-tougher-than-osha-on-coronavirus-workplace-outbreaks; Sophie Quinton, *Some States Aren't Waiting for the Feds to Create COVID-19 Worker Safety Rules*, SEATTLE TIMES (Aug. 23, 2020, 3:38 PM), https://www.seattletimes.com/business/some-states-arent-waiting-for-the-feds-to-create-covid-19-worker-safety-rules/; Fox 2 Detroit, *State Hands Out $33,400 in Fines to Businesses Violating COVID-19 Safety Rules*, FOX 2 DETROIT (Aug. 21, 2020), https://www.fox2detroit.com/news/state-hands-out-33400-in-fines-to-businesses-violating-covid-19-safety-rules.

amplify inspection results by using press releases and social media, and support free workplace testing.[203]

Finally, information from inspections and testing should be disaggregated by race, ethnicity, job duty, and occupation, and it should be made publicly available. This data should be readily accessible to the workers, state and local officials, and the media. It is essential that the government require employers to publicly report COVID-19 infections and death data among their workers to promote contact tracing and the mitigation of outbreaks in workplaces. All these policies to eradicate systemic racism should universally apply to all states and employers that employ one or more workers. This will ensure that low-wage workers, who are predominantly racial and ethnic minorities, finally receive some of the same employment benefits as other workers.

Second, the government must provide financial support and accommodations to address the harms caused by the government's pandemic response and racial inequalities in employment. Specifically, the government should provide essential workers with financial supports until the end of the COVID-19 pandemic, such as hazard pay, savings accounts, and survivorship benefits for their families. Also, based on suggestions from a coalition of South Dakota meat plant workers, the state and federal government should use federal COVID-19 economic relief funds to invest directly in "the communities of color severely and disproportionately impacted by the deadly virus. Invest this money into culturally appropriate and multilingual mental health services for those tested positive and their family members and friends who are directly impacted by this trauma."[204] This can be accomplished through the implementation of a guaranteed basic income until the end of the pandemic.[205]

A guaranteed basic minimum income and health insurance for workers from these communities would minimize the economic harms of not going to work, enabling them to comply with social distancing measures.[206] The idea of a guaranteed basic minimum income is not new. In 1976, Alaska implemented a guaranteed basic income called the Alaska Permanent Fund and has been sending dividends to every Alaskan resident since 1982.[207] Thus, for almost 20

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[203] Michaels & Wagner, *supra* note 159.

[204] Makenzie Huber, *Letter Asks Noem to Meet with Meatpacking Workers Before Smithfield Plant Reopens*, ARGUS LEADER (Apr. 30, 2020, 2:46 PM), https://www.argusleader.com/story/news/2020/04/30/letter-asks-noem-meet-meatpacking-workers-before-smithfield-plant-reopens/3058042001/.

[205] Kimberly Amadeo & Thomas J. Brock, *What Is Universal Basic Income? Pros and Cons of a Guaranteed Income*, BALANCE (Aug. 19, 2020), https://www.thebalance.com/universal-basic-income-4160668.

[206] *Id.*

[207] Michael J. Coren, *When You Give Alaskans a Universal Basic Income, They Still Keep Working*,

years, Alaska has provided guaranteed support for residents, helping to address poverty, with no change in full-time employment. The mayors of Mount Vernon, New York, and St. Paul, Minnesota, have used part of their CARES Act money to provide a guaranteed income program for some residents.[208] This financial relief must be provided to all essential workers regardless of immigration or worker status.

Moreover, the federal and state governments should require employers to provide essential workers, who have been infected with COVID-19, with workers' compensation. This is important because although California, Michigan, and Kentucky have passed laws making it easier for all employees to prove workplace COVID-19 exposure so they can receive workers' compensation, in other states it is unclear whether state workers' compensation laws provide coverage for workplace infectious disease outbreaks.[209] Virginia's law specifically notes that an infectious or contagious disease is covered under workers' compensation, yet many states have not provided such clarification.[210] Even though many states, like Missouri and Washington, have expanded workers' compensation to cover COVID-19 infection, some of these laws are limited to first responders or health care personnel. Finally, all laws and regulations enacted to shield businesses from workplace liability for infections and deaths must include financial supports and accommodations including, but not limited to, hazard pay, death benefits, workers' compensation for infections, mandatory infectious disease protections, and significant increased funding and authority for enforcement of worker health and safety laws.

Third, many emergency preparedness laws and policies have been ill-informed and ineffective in stopping the workplace spread of COVID-19. Thus, the federal and state governments must engage and empower racial and ethnic minorities in the development, implementation, and evaluation of emergency

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QUARTZ (Feb. 13, 2018), https://qz.com/1205591/a-universal-basic-income-experiment-in-alaska-shows-employment-didnt-drop/.

[208] Sarah Holder, *2021 Will Be the Year of Guaranteed Income Experiments*, BLOOMBERG (Jan. 4, 2021, 7:00 AM), https://www.bloomberg.com/news/articles/2021-01-04/guaranteed-income-gains-popularity-after-covid-19; Emma Nelson, *St. Paul Will Use CARES Act Money for Guaranteed Income Experiment*, STAR TRIB. (Sept. 16, 2020), https://www.startribune.com/st-paul-will-use-cares-act-money-for-guaranteed-income-experiment/572435192/. Many opponents of guaranteed basic income believe that it will lead to higher rates of employment because people will not continue to work if the receive a guaranteed basic income. *Id.* However, since 1976, Alaska has provided every Alaskan resident with a guaranteed basic income to address poverty, with no change in full-time employment. Coren, *supra* note 207.

[209] NCII Insights, *COVID-19 and Workers Compensation: What You Need to Know: Frequently Asked Questions: Update*, NAT'L COUNCIL COMP. INS. (Oct. 8, 2020), https://www.ncci.com/Articles/Pages/Insights-Coronavirus-FAQs.aspx#.

[210] VA. CODE ANN. § 65.2-401 (1997).

preparedness laws and policies. Racial and ethnic minorities, along with other essential workers, should take the lead in crafting and revising emergency preparedness laws and policies that not only address racial inequalities in employment, but also provide financial supports and accommodations. For example, the Los Angeles County supervisors unanimously approved a program "in which workers from certain sectors will form public health councils to help ensure that employers follow coronavirus safety guideline."[211] The councils will be used in the food and apparel manufacturing, warehousing and storage, and restaurant industries.[212] Third-party organizations, such as nonprofits and unions, will support the councils by educating the council members about health orders and helping them report violations.[213] These employee councils should be instituted nationally and given the power to identify and report health and safety violations.

Additionally, it is important that the structures of the regulating bodies change. As proposed by Michaels and Wagner, the White House should have a worker protection coordinator, who is based at the White House and develops and implements a worker protection policy and research agenda.[214] The federal government should also develop a national COVID-19 worker protection plan that requires all employers to develop and implement infection control plans and provides better protection for workers raising safety concerns.[215] Racial and ethnic minorities and other essential workers must be a part of these changes. Thus, there should be an employee safety board that consults the White House worker protection coordinator and assists in the development and implementation of a worker protection policy and research agenda. There should also be employee safety boards that advise Congress, OSHA, and the USDA in the creation, implementation, tracking, and evaluation of a national COVID-19 worker protection plan. These boards would give workers the same power meat and poultry processing companies have to influence Congress, OSHA, the USDA, ensuring that the lives of workers are protected.

These are just a few suggestions for eradicating systemic racism in the government's pandemic response. However, addressing systemic racism in employment alone will not eliminate racial inequities in COVID-19 infections

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211 Leila Miller, *L.A. County Approves Program for Workers to Form Public Health Councils to Curb Coronavirus Spread*, L.A. TIMES (Nov. 10, 2020, 3:45 PM), https://www.latimes.com/california/story/2020-11-10/la-me-la-county-public-health-councils.

212 *Id.*

213 *Id.*

214 Michaels & Wagner, *supra* note 159.

215 *Id.*

and deaths. As discussed in the next Part, the government must also address systemic racism in health care, which results in racial inequities in COVID-19 infections and deaths.

III. SYSTEMIC RACISM IN HEALTH CARE

Equal access to quality health care is also limited by systemic racism, particularly structural and interpersonal racism, which has harmed racial and ethnic minorities before and during the pandemic.[216] Unfortunately, there is reason to fear that these harms will continue after the pandemic ends. Building on our prior work that discusses how structural racism in health care has limited racial and ethnic minorities' access to health care, this Part provides an analysis of how racial inequities in COVID-19 have played out in the health care arena.[217] It also describes how systemic racism like structural and interpersonal racism have affected health care access in the United States for racial and ethnic minorities by limiting access to hospital care, through inequitable vaccine allocation decisions, and physician bias. The lack of an adequate governmental pandemic response, including lack of testing, treatment, and financial support, has led to racial and ethnic minorities faring worse during the pandemic.[218] There was even a lack of data collection to properly and fully document the racial inequities in COVID-19 infections and deaths.[219] Sadly, this is nothing new.

The reality is that many people of color have unequal access to health care, which has led to inequalities in access to treatment, infections, and deaths during the COVID-19 pandemic.[220] As of March 2021, there are significant racial inequalities in vaccination allocation and uptake. Before the vaccines were even authorized in the United States, there were concerns that Black and Latino people were less likely to trust the vaccines due to discrimination and medical mistreatment in these communities.[221] As a result of these barriers, racial and

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216 Erin K. Stokes, Laura D. Zambrano, Kayla N. Anderson, Ellyn P. Marder, Kala M. Raz, Suad El Burai Felix, Yunfeng Tie & Kathleen E. Fullerton, *Coronavirus Disease 2019 Case Surveillance*, 69 MORBIDITY & MORTALITY WKLY. REP. 759 (2019), https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6924e2-H.pdf.

217 Benfer et al., *supra* note 27; Yearby & Mohapatra, *supra* note 8; Yearby & Mohapatra, *supra* note 27.

218 Clarence C. Gravlee, *Systemic Racism, Chronic Health Inequities, and Covid-19: Syndemic in the Making?*, AM. J. HUM. BIOLOGY (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7441277/pdf/AJHB-9999-e23482.pdf.

219 *Id.*

220 *Id.*

221 William Wan, *Coronavirus Vaccines Face Trust Gap in Black and Latino Communities, Study Finds*, WASH. POST (Nov. 23, 2020, 7:55 PM), https://www.washingtonpost.com/health/2020/11/23/covid-vaccine-hesitancy/.

ethnic minorities will not be able to access vaccines and any COVID-19 treatments, which can be addressed by adopting the health justice framework.[222]

A. Systemic Racism, Hospital Care, and Racial Inequities in COVID-19

Different forms of racism limit racial and ethnic minorities' access to quality health care.[223] Structural racism has led to segregated living conditions where access to health care facilities and high-quality health care providers is limited.[224] Research shows that health care institutions have closed hospitals in low-income communities and communities of color to relocate in more affluent communities as a result of "neutral" policies that disproportionately harm low-income communities and communities of color.[225] Hospitals and physicians' offices in many racially segregated communities have closed, resulting in a lack of access to health care services.[226] The remaining hospitals in these areas are thus overburdened, which results in poorer care than in other areas.[227] "Neutral" decisions to close hospitals in low-income communities and communities of color often fail to consider the need for the equal distribution of health care facilities among all communities, leaving these vulnerable communities without access to health care and provider services.[228] The governments' decision to use

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[222] *Id.*

[223] Ruqaiijah Yearby, *Breaking the Cycle of "Unequal Treatment" with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias*, 44 CONN. L. REV. 1281, 1284–87 (2012).

[224] *Id.* at 1291.

[225] ALAN SAGER & DEBORAH SOCOLAR, CLOSING HOSPITALS IN NEW YORK STATE WON'T SAVE MONEY BUT WILL HARM ACCESS TO CARE 27–28 (2006) (on file with authors); Michelle Ko, Jack Needleman, Kathryn Pitkin Derose, Miriam J. Laugesen & Ninez A. Ponce, *Residential Segregation and the Survival of U.S. Urban Public Hospitals*, 71 MED. CARE RSCH. & REV. 243, 245 (2014); Renee Y. Hsia, Tanja Srebotnjak, Hemal K. Kanzaria, Charles McCulloch & Andrew D. Auerbach, *System Level Health Disparities in California Emergency Departments: Minorities and Medicaid Patients Are at Higher Risk of Losing Their Emergency Departments*, 59 ANNALS EMERGENCY MED. 359 (2012); Renee Hsia & Yu-Chu Shen, *Rising Closures of Hospital Trauma Centers Disproportionately Burden Vulnerable Populations*, 30 HEALTH AFFS. 1912 (2011); Yu-Chu Shen, Renee Y. Hsia & Kristen Kuzma, *Understanding the Risk Factors of Trauma Center Closures: Do Financial Pressure and Community Characteristics Matter?*, 47 MED. CARE 968 (2009).

[226] Yearby & Mohapatra, *supra* note 8. Numerous public hospitals have recently closed in major urban areas—hospitals which had served predominantly poor and predominantly Black neighborhoods—including Philadelphia, Milwaukee, metropolitan Chicago, the San Francisco Bay area, and Washington, D.C.. Joseph P. Williams, *Code Red: The Grim State of Urban Hospitals*, U.S. NEWS & WORLD REP. (July 19, 2019, 11:23 AM), https://www.usnews.com/news/healthiest-communities/articles/2019-07-10/poor-minorities-bear-the-brunt-as-urban-hospitals-close. As hospitals closed in predominantly Black neighborhoods, physicians connected to the hospitals left the area and the remaining hospitals' resources were strained, causing the care provided to gradually deteriorate. Brietta R. Clark, *Hospital Flight from Minority Communities: How Our Existing Civil Rights Framework Fosters Racial Inequality in Healthcare*, 9 DEPAUL J. HEALTH CARE L. 1023, 1035 (2005) ("Hospital closures set into motion a chain of events that threaten minority communities' immediate and long term access to primary care, emergency and nonemergency hospital care.").

[227] Clark, *supra* note 227, at 1034.

[228] Many of these "neutral" decisions were tied more to the race of the community residents than economic

hospitals as COVID-19 testing and treatment sites, while closing clinics and other community based health care facilities was seemingly race "neutral."[229] Nevertheless, the closed health care facilities were disproportionately located in predominantly Black, Latino, and Native American neighborhoods, limiting racial and ethnic minorities' access to coronavirus testing and treatment during the pandemic.[230]

For example, a majority of "[B]lack counties have three times the infection rate and nearly six times the mortality of majority white counties," yet these counties lack access to COVID-19 testing and treatment sites.[231] More specifically, the "predominantly Black north St. Louis got its first testing site April 2, three weeks after the first sites went up in the suburbs," and the "information campaign targeting Black residents did not start until a week after that"; by that time all of the COVID-19 deaths were Black people.[232] According to Dr. Will Ross, the chairman of the St. Louis health advisory board making decisions about the area's COVID-19 response, Black lives were unnecessarily lost because "race neutral" decisions by the government regarding the placement of testing sites ignored the fact that Black communities most impacted by COVID-19 lacked access to testing sites.[233] This was exacerbated by the national shortage of testing supplies. Yet, hospitals serving predominantly white and wealthy areas were able to secure ventilators and testing materials, as well as stockpile protective equipment in St. Louis, Missouri; Merrillville, Indiana; and Nashville, Tennessee.[234]

These inequities are in part due to structural racism, where neutral polices used to identify testing and treatment sites reinforce the racial hierarchy in which whites are able to access health care, while Black, Latino and Native Americans are prevented from accessing health care.[235] Additionally, many facilities and

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reasons. *See* Yearby, *supra* note 224, at 1301–05.

229 *Id.*

230 *Id.*

231 Emily Cleveland Manchanda, Cheri Couillard & Karthik Sivashanker, *Inequity in Crisis Standards of Care*, 383 NEW ENG. J. MED. e16 (2020), https://www.nejm.org/doi/full/10.1056/NEJMp2011359.

232 Robert Samuels, Aaron Williams, Tracy Jan & Jose A. Del Real, *This Is What Happens to Us: How U.S. Cities Lost Precious Time to Protect Black Residents from the Coronavirus*, WASH. POST (June 3, 2020), https://www.washingtonpost.com/graphics/2020/politics/coronavirus-race-african-americans/.

233 *Id.*

234 *Id.*; Blake Farmer, *Long-Standing Racial and Income Disparities Seen Creeping Into COVID-19 Care*, KAISER HEALTH NETWORK (Apr. 16, 2020), https://khn.org/news/covid-19-treatment-racial-income-health-disparities/.

235 Christian Weller, *Systemic Racism Makes Covid-19 Much More Deadly for African-Americans*, FORBES (June 8, 2020, 5:00 AM), https://www.forbes.com/sites/christianweller/2020/06/18/systemic-racism-makes-covid-19-much-more-deadly-for-african-americans/?sh=65fa658f7feb.

doctors' offices that provide non-COVID-19-related care closed temporarily due to state and local COVID-19 restrictions.[236] This is also a race neutral decision that harms minorities. Moreover, due to systemic inequities in housing, education, health care, and employment, Black, Latino, and Native American communities suffer from a higher proportion of chronic illnesses and preexisting conditions than white people, which are often risk factors for infections and deaths.[237] Thus, these populations were not able to access care, and they are also in groups more likely to have transportation barriers in finding care outside their areas.[238]

B. Systemic Racism, Vaccination Decisions, and Racial Inequities in COVID-19

During this pandemic, there is a scarcity problem in terms of personal protective equipment, testing, ICU beds, vaccines, and even treatments.[239] These allocation decisions about who should get what resources are familiar in the health care system. The United States allocates all sorts of health care access depending on insurance status and ability to pay.[240]

1. Insurance and Race

Access to health care in the United States is also driven by health insurance, whether it is public insurance, such as Medicare or Medicaid, or private insurance, often provided as a perk of employment.[241] Insurance coverage differs greatly by race with Black, Latino, and Native Americans often uninsured or underinsured.[242] In fact, some researchers have deemed the lack of health insurance an epidemic much like COVID-19.[243] 91% of disproportionately

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[236] *Id.*

[237] *Id.*

[238] Abigail L. Cochran, *Impacts of COVID-19 on Access to Transportation for People with Disabilities*, 8 TRANSP. RSCH. INTERDISCIPLINARY PERSPS. (2020), https://reader.elsevier.com/reader/sd/pii/S2590198220301743?token=33C68549A2C6147F007F139DFF19BA6562FFF3DB9D927EEBBD66191E6D8A48362DF8ADEA6E3F1F44991116778E3363F2.

[239] NETWORK FOR PUB. HEALTH L., COVID-19: RACIAL DISPARITIES AND CRISIS STANDARDS OF CARE (2020), https://www.networkforphl.org/wp-content/uploads/2020/05/COVID-19-Racial-Disparities-and-Crisis-Standards-of-Care.pdf.

[240] *Id.*

[241] Gaby Galvin, *For Many, Health Insurance Another Likely Casualty of COVID-19*, U.S. NEWS & WORLD REP. (June 4, 2020, 12:10 PM), https://www.usnews.com/news/healthiest-communities/articles/2020-06-04/coronavirus-threatens-to-widen-racial-ethnic-health-insurance-gaps.

[242] *See* Heeju Sohn, *Racial and Ethnic Disparities in Health Insurance Coverage: Dynamics of Gaining and Losing Coverage over the Life-Course*, 36 POPULATION RSCH. POL'Y REV. 181 (2017).

[243] *See* Steffie Woolhandler & David U. Himmelstein, *Intersecting U.S. Epidemics: COVID-19 and Lack of Health Insurance*, ANNALS INTERNAL MED. (Apr. 7, 2020), https://doi.org/10.7326/M20-1491.

Black counties are in the South, where many states have not expanded Medicaid under the Affordable Care Act (ACA), leaving many Black adults without health insurance.[244] These racially segregated counties have much higher rates of COVID-19 infection and deaths than majority white counties.[245] Additionally, many people of color work in jobs that do not provide employer-sponsored health care, and the ACA plans are often unaffordable to many.[246] Many racial and ethnic minorities living in states that did not expand Medicaid under the ACA are stuck with no insurance and are struggling to meet their financial needs, making health care a luxury item.[247] These inequities are in part due to structural racism, because the "neutral" decision to not expand Medicaid for budgetary reasons has reinforced the belief that Black, Latino, and Native Americans do not deserve access to health care.[248] During COVID-19, the lack of Medicaid expansion has limited Black, Latino, and Native Americans access to health care.[249] Additionally, alarming numbers of people lost their jobs during the pandemic and as a result lost access to employer sponsored insurance.[250] Purchasing COBRA or other insurance depends on financial resources, which are much lower in Black and Latino populations than white populations.[251]

2. Differential Protection Within Health Care Providers

In terms of the allocation of PPE during the COVID-19 pandemic, some groups were protected—such as physicians in private hospitals—and some groups were not—like health care and custodial workers in public hospitals, workers in nursing homes, and home health care workers.[252] Within the health care system, there was a hierarchy in terms of who gets N95 and surgical masks

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[244] Gregorio A. Millett et al., *Assessing Differential Impacts of COVID-19 on Black Communities*, 47 ANNALS EPIDEMIOLOGY 37, 39–40 (2020).

[245] Erin Schumaker, *Majority White Counties Have Significantly Fewer COVID-19 Cases: Study: It's Not About Luck or Genetics, Experts Said. It's Structural Racism.*, ABC NEWS (Aug. 12, 2020, 5:07 PM), https://abcnews.go.com/Health/majority-white-counties-significantly-fewer-covid-19-cases/story?id=72328054.

[246] Colleen Grogan & Sunggeun Ethan Park, *The Racial Divide in State Medicaid Expansions*, 43 J. HEALTH POL., POL'Y & L. 539, 540 (2017).

[247] *Id.*

[248] *Id.* at 539–45, 551–61.

[249] *See* Rachel R. Hardeman, Eduardo M. Medina & Rhea W. Boyd, *Stolen Breaths*, 383 NEW ENG. J. MED. 197, 198 (2020).

[250] *Id.*

[251] Farmer, *supra* note 235.

[252] Adia Wingfield, *The Disproportionate Impact of COVID-19 on Black Health Care Workers*, HARV. BUS. REV. (May 14, 2020), https://hbr.org/2020/05/the-disproportionate-impact-of-covid-19-on-black-health-care-workers-in-the-u-s; Yearby & Mohapatra, *supra* note 27.

and who must supply their own PPE.[253] Due to structural inequities in education and income, often those at the top of the health care food chain—physicians—are white and from more privileged backgrounds.[254] Medical assistants, nurses, and other allied health staff are more often people of color and from low-income backgrounds.[255] So within a hospital setting, it was not unusual to have some health care providers, such as physicians, with adequate PPE, while medical assistants, nurses, and other allied health staff were left with makeshift protection.[256] One stark statistic revealed that Filipino-Americans, who make up 4% of U.S. nurses, accounted for 31.5% of COVID-related nurse deaths.[257] The reasons why need to be explored, but there is speculation that the inequities are in part due to a colonial and cultural history that prevents Filipino-American nurses from complaining, even if they were sick, given inadequate PPE, or given more dangerous jobs than other nurses.[258] This is an example of how work and health care intersect as well as how certain people of color face barriers to protect themselves due to their lack of power that results in racial inequities in COVID-19 deaths.

3. Vaccine Access: A Case Study in Missed Opportunities

As discussed above, nationwide, there are vast racial inequities in COVID-19 infections, hospitalizations, and deaths.[259] Although preventable, similar inequities have occurred with vaccinations, with Black and Latino individuals being vaccinated at much lower rates than white people.[260] In the St. Louis

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253 Artiga et al., *supra* note 18.

254 *Id.*

255 *Id.*

256 *Id.*

257 Allana Akhtar, *Filipinos Make Up 4% of Nurses in the US, But 31.5% of Nurse Deaths from COVID-19*, BUS. INSIDER (Sept. 29, 2020, 9:53 AM), https://www.businessinsider.com/filipinos-make-up-disproportionate-covid-19-nurse-deaths-2020-9; *see also* Usha Lee McFarling, *Nursing Ranks Are Filled with Filipino Americans. The Pandemic Is Taking an Outsized Toll on Them*, STAT NEWS (Apr. 28, 2020), https://www.statnews.com/2020/04/28/coronavirus-taking-outsized-toll-on-filipino-american-nurses/.

258 *Id.*

259 *See* Samantha Artiga, Bradley Corallo & Olivia Pham, *Racial Disparities in COVID-19: Key Findings from Available Data and Analysis*, KAISER FAM. FOUND. (Aug. 17, 2020), https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-covid-19-key-findings-available-data-analysis/; Lily Rubin-Miller, Christopher Alban, Samantha Artiga & Sean Sullivan, *COVID-19 Racial Disparities in Testing, Infection, Hospitalization, and Death: Analysis of Epic Patient Data*, KAISER FAM. FOUND. (Sept. 16, 2020), https://www.kff.org/report-section/covid-19-racial-disparities-in-testing-infection-hospitalization-and-death-analysis-of-epic-patient-data-issue-brief/.

260 Nambi Ndugga, Samantha Artiga & Olivia Pham, *How Are States Addressing Racial Equity in COVID-19 Vaccine Efforts?*, KAISER FAM. FOUND. (Mar. 10, 2021), https://www.kff.org/racial-equity-and-health-policy/issue-brief/how-are-states-addressing-racial-equity-in-covid-19-vaccine-efforts/.

region, where the first person to die from COVID-19 was a Black nurse,[261] data shows that, as of February 12, 2021,71% of those vaccinated are white people, while only 8% of Black people are vaccinated.[262] This is also true in Chicago, where Black people make up 30% of the population, 60% of all COVID-19 cases, but only 19% of those that have been vaccinated.[263] Such a result could have been prevented had there been a government response that proactively worked to address these inequities.

Since the early months of the pandemic, national organizations such as the National Academies of Sciences, Engineering, and Medicine (NASEM); Johns Hopkins Bloomberg School of Public Health;[264] and the World Health Organization Strategic Advisory Group of Experts (WHO SAGE) were trying to avoid these inequities by studying ways that vaccines could be allocated to prioritize people most likely to contract, get sick, or die from COVID-19. For example, WHO SAGE considered the need to "ensure equity in vaccine access and benefit within countries for groups experiencing greater burdens from the COVID-19 pandemic."[265] The NASEM Preliminary Framework for Equitable Allocation of COVID-19 Vaccine noted that mitigating health inequities was one of its foundational principles.[266] NASEM recommended phases of prioritization based on age, occupation, and comorbidities and that vaccine access within each phase be "prioritized for geographic areas identified as vulnerable through CDC's Social Vulnerability Index (SVI)."[267] The SVI

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[261] Rebecca Rivas, *Nurse Judy Wilson-Griffin Is the First COVID-19 Death in St. Louis Region*, ST. LOUIS AM. (Mar. 21, 2020), http://www.stlamerican.com/news/local_news/nurse-judy-wilson-griffin-is-first-covid-19-death-in-st-louis-region/article_1d422bea-6b06-11ea-83e1-17bbd703c8fb.html.

[262] KMOV.com Staff, *White Population Makes Up Vast Majority of Those Vaccinated in the St. Louis Area, Causing Alarm*, KMOV4 (Feb. 12, 2021), https://www.kmov.com/news/white-population-makes-up-vast-majority-of-those-vaccinated-in-st-louis-area-causing-alarm/article_8fdc9f8c-6d7b-11eb-9838-1f05d6020493.html.

[263] Gloria Oladipo, *How Chicago's Vaccine Rollout Is Inhibited by Longstanding Inequality*, GUARDIAN (Feb. 5, 2021, 6:00 AM), https://www.theguardian.com/us-news/2021/feb/05/chicago-blacks-latinos-vaccine-distribution.

[264] ERIC TONER ET AL., INTERIM FRAMEWORK FOR COVID-19 VACCINE ALLOCATION AND DISTRIBUTION IN THE UNITED STATES (2020), https://www.centerforhealthsecurity.org/our-work/publications/interim-framework-for-covid-19-vaccine-allocation-and-distribution-in-the-us.

[265] WHO, WHO SAGE VALUES FRAMEWORK FOR THE ALLOCATION AND PRIORITIZATION OF COVID-19 VACCINATION (2020), https://apps.who.int/iris/bitstream/handle/10665/334299/WHO-2019-nCoV-SAGE_Framework-Allocation_and_prioritization-2020.1-eng.pdf.

[266] COMM. ON EQUITABLE ALLOCATION OF VACCINE FOR THE NOVEL CORONAVIRUS, DISCUSSION DRAFT OF THE PRELIMINARY FRAMEWORK FOR EQUITABLE ALLOCATION OF COVID-19 VACCINE (2020), https://www.nap.edu/resource/25917/25914.pdf.

[267] *Id.*; *see also* Harald Schmidt, *Disadvantage Indices Can Help Achieve Equitable Vaccine Allocation*, STAT NEWS (Feb. 1, 2021), https://www.statnews.com/2021/02/01/disadvantage-indices-can-help-achieve-equitable-vaccine-allocation/; *see also* Seema Mohapatra & Maya Manian, *COVID Vaccine Prioritization and the Perils of Colorblind Constitutional Jurisprudence*, ACS EXPERT F. (Apr. 21, 2021), https://www.acslaw.org/

designates a numerical score between zero and one for county or tract level geographic regions, with a score closer to one being more vulnerable.[268] This score considers the following social factors: percentages of people below poverty, unemployed, income, with no high school diploma, aged sixty-five or older, aged seventeen or younger, older than age five with a disability, single-parent households, minority status, how many speak English "less than well," and housing factors such as multi-unit structures, mobile homes, crowding, vehicle ownership, and group quartering. Although race is considered in the SVI, it is one of over fifteen factors considered in the score. NASEM recommended that 10% of each state's vaccinations should be reserved for the worst SVI quartiles in states and that vaccine delivery to these areas be expedited. NASEM's plan also prioritized workers in essential industries, such as meat processing plants, as well as those with co-morbid conditions, both of which include a greater percentage of racial and ethnic minorities.[269]

The CDC's Advisory Committee on Immunization Practices (ACIP) considered each of these frameworks when developing its own vaccine allocation plan for the federal government.[270] ACIP did not include consideration of SVI in its prioritization. Instead, ACIP's phases prioritized high-risk health care workers and residents and staff of nursing homes first in Phase 1A.[271] The next phase, 1B, prioritized those aged seventy-five and older and essential frontline workers who work in meat processing plants, food and agricultural jobs, grocery stores, prisons, transit and transport, manufacturing, education, postal, police, fire, and EMS workers. The next phase, 1C, includes those ages sixty-five to seventy-four, workers in other essential fields including those in media, construction, and food service, and those people ages sixteen to sixty-four who have high risk factors for serious infection. Although none of these phases specifies race, in its advice to states, the CDC advised states said they should consider people at increased risk of acquiring or transmitting COVID-19 including people from racial and ethnic minority groups and people from tribal communities.[272] The CDC framework is not legally binding,

expertforum/covid-vaccine-prioritization-and-the-perils-of-colorblind-constitutional-jurisprudence/.

[268] Harald Schmidt, *Covid-19: How to Prioritize Worse-Off Populations in Allocating Safe and Effective Vaccines*, BMJ (Oct. 5, 2020), https://www.bmj.com/content/371/bmj.m3795.

[269] *Id.*

[270] SARA OLIVER, OVERVIEW OF VACCINE EQUITY AND PRIORITIZATION FRAMEWORKS (2020), https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2020-09/COVID-06-Oliver-508.pdf (comparing vaccine allocation frameworks proposed by national and international organizations).

[271] KATHLEEN DOOLING, PHASED ALLOCATION OF COVID-19 VACCINES (2020), https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2020-12/slides-12-20/02-COVID-Dooling-508.pdf (describing how high-risk health care workers and residents and nursing home staff are in Phase 1A).

[272] CDC, COVID-19 VACCINATION PROGRAM INTERIM PLAYBOOK FOR JURISDICTION OPERATIONS

however, and states have varied widely in how much they have followed ACIP's framework.[273] In fact, the Biden Administration's own national COVID-19 strategy seemed to conflict with CDC guidance.[274] The failure to explicitly tie vaccine allocation to the groups most impacted by COVID-19 infections and deaths in each state has left racial and ethnic minorities with the same limited access to vaccines that they had to testing and treatment.

For example, many states changed their plans multiple times based on public opinion or for political purposes, rather than ensuring that racial inequities in infections and deaths were addressed.[275] In the South, a majority of vaccine allocation sites were situated in predominantly white neighborhoods, and a study of counties in Pittsburgh found that Black residents would need to travel farther than white residents to get a vaccine.[276] Some states rallied against vaccinating undocumented immigrants, which is both unwise from a scientific and humanitarian point of view.[277] Florida's state response is illustrative of how the government's pandemic response has often harmed people of color. Florida Governor Ron DeSantis ignored the ACIP recommendations and instituted his own plan whereby those sixty-five and older could be vaccinated. He directed vaccine clinics to be set up in predominantly white, wealthy areas of Florida, allegedly to vaccinate campaign donors that lived there and improve his

(2020), https://www.cdc.gov/vaccines/imz-managers/downloads/COVID-19-Vaccination-Program-Interim_Playbook.pdf (including directions for state administrators of vaccine programs to consider people at increased risk of acquiring or transmitting COVID-19 including people from racial and ethnic minority groups and people from tribal communities).

[273] Jennifer Kates, Jennifer Tolbert & Josh Michaud, *The COVID-19 "Vaccination Line": An Update on State Prioritization Plans*, KAISER FAM. FOUND. (Jan. 11, 2021), https://www.kff.org/coronavirus-covid-19/issue-brief/the-covid-19-vaccination-line-an-update-on-state-prioritization-plans/.

[274] OFF. OF THE PRESIDENT, NATIONAL STRATEGY FOR THE COVID-19 RESPONSE AND PANDEMIC PREPAREDNESS (2021), https://www.whitehouse.gov/wp-content/uploads/2021/01/National-Strategy-for-the-COVID-19-Response-and-Pandemic-Preparedness.pdf; Schmidt, *supra* note 268; *Interim Considerations for Phased Implementation of COVID-19 Vaccination and Sub-Prioritization Among Recommended Populations*, CDC (Mar. 2, 2021), https://www.cdc.gov/vaccines/covid-19/phased-implementation.html.

[275] Jennifer Tolbert, Jennifer Kates & Josh Michaud, *The COVID-19 Vaccine Priority Line Continues to Change as States Make Further Updates*, KAISER FAM. FOUND. (Jan. 21, 2021), https://www.kff.org/policy-watch/the-covid-19-vaccine-priority-line-continues-to-change-as-states-make-further-updates/; Victoria Bekiempis, *Florida's Republican Governor Accused of 'Playing Politics' with Covid Vaccine*, YAHOO!NEWS (Feb. 19, 2021), https://news.yahoo.com/floridas-republican-governor-accused-playing-173935771.html.

[276] Sean McMinn, Shalina Chatlani, Ashley Lopez, Sam Whitehead, Ruth Talbot & Austin Fast, *Across the South COVID-19 Vaccine Sites Missing from Black and Hispanic Neighborhoods*, NPR (Feb. 5, 2021), https://www.npr.org/2021/02/05/962946721/across-the-south-covid-19-vaccine-sites-missing-from-black-and-hispanic-neighbor.

[277] *The GOP's Foolish Campaign Against Vaccinating Undocumented Immigrants*, SLATE (Mar. 9, 2021, 9:39 PM), https://slate.com/news-and-politics/2021/03/republicans-covid-vaccines-undocumented-immigrants-lies.html.

reelection chances.[278] Even without such egregious reports, vaccination prioritization based on age alone discriminates against people of color, who are more likely to be younger and have lower life expectancies.[279] Age-based approaches harm Black people, whose average age is younger than white people and who have a lower life expectancy than other races.[280] For example, in Alabama, the vaccine was initially allocated to those who were seventy-five years or older. However, at least 83% of Alabama's Black population did not meet this age requirement for a vaccine.[281] More specifically, "in 47 of the state's 67 counties, life expectancy among Black people is less than 75 years old."[282] Some states, like Maine and Connecticut, transitioned to purely age-based criteria, despite the criticism that it disadvantaged racial and ethnic minorities, who are younger, more likely to have comorbid conditions, and whose work or housing conditions may expose them to infection, regardless of age.[283] This is illustrated by Florida's prioritization of age in the initial phases of the vaccine rollout, resulting in the vaccination of mostly white people. Furthermore, racially neutral arguments that we must choose efficiency over equity create a false dichotomy. It was not efficient to give the limited amount of vaccine doses to people who are not at the most risk for infections because those who are at the most risk of being infected will continue to be infected, the virus will mutate, and those vaccines will not fully protect those who received it. Therefore, governments must target the most at-risk populations and protect them from infection, which would ensure that the impacts of this pandemic do not last for generations.[284]

Some states tried to address inequities in their initial prioritization plans. Eighteen states mention SVI, but only California, Indiana, Louisiana, Michigan,

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[278] Igor Derysh, *DeSantis Allies Discussed How Vaccine Sites in Wealthy Areas Could Boost His Re-election Hopes*, SALON (Mar. 10, 2021, 6:35 PM), https://www.salon.com/2021/03/10/desantis-allies-discussed-how-vaccine-sites-in-wealthy-areas-could-boost-his-re-election-hopes/; Bekiempis, *supra* note 276.

[279] Oni Blackstock & Uché Blackstock, *Opinion: Black Americans Should Face Lower Age Cutoffs to Qualify for a Vaccine*, WASH. POST (Feb. 19, 2021, 5:51 PM), https://www.washingtonpost.com/opinions/black-americans-should-face-lower-age-cutoffs-to-qualify-for-a-vaccine/2021/02/19/3029d5de-72ec-11eb-b8a9-b9467510f0fe_story.html.

[280] *Id.*; *see also* Govind Persad, Emily A. Largent & Ezekiel J. Emanual, *Opinion: Age-Based Vaccine Distribution Is Not Only Unethical. It's Also Bad Health Policy.*, WASH. POST (Mar. 9, 2021, 1:24 PM), https://www.washingtonpost.com/opinions/2021/03/09/age-based-covid-vaccine-distribution-unethical/.

[281] Naomi Thomas & Deidre McPhillips, *More than 90% of Alabama's Black Population Lived in a County Where Life Expectancy Didn't Meet Eligibility, CNN Analysis Shows*, CNN (Feb. 10, 2021, 11:34 PM), https://www.cnn.com/2021/02/10/health/alabamas-black-population-vaccine-eligibility/index.html.

[282] *Id.*

[283] Persad et al., *supra* note 281.

[284] Harald Schmidt, Lawrence O. Gostin & Michelle A. Williams, *Is It Lawful and Ethical to Prioritize Racial Minorities for COVID-19 Vaccines?*, 324 JAMA 2023 (2020).

North Dakota, Ohio, and Tennessee noted that they planned to prioritize those most vulnerable using SVI.[285] For example, Tennessee planned to reserve 10% of its allocation for high SVI areas. Some states that did not mention SVI still tried to identify vulnerable groups. Massachusetts allocated an additional 20% of vaccines "to communities that have experienced disproportionate COVID burden and high social vulnerability."[286] Similarly, New Hampshire planned to "allocate 10% of available vaccine doses for disproportionately impacted populations."[287] New Hampshire noted that it planned to use the COVID-19 Community Vulnerability Index (CCVI) to determine which populations to target.[288] Yet, some states, like Texas, discouraged efforts by some counties to focus on vulnerable ZIP codes. Texas Governor Abbott threatened pulling Dallas' vaccine allocation when county officials indicated they were planning to target areas of the county with high minority populations.[289] As a result, county officials reversed course from that plan. President Biden set up a federally sponsored vaccine site in those vulnerable areas in Dallas as a response to the political maneuvering by the governor. Unfortunately, as of March 2021, Texas was still trailing behind other states in terms of both vaccination rates and equity.[290]

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[285] HARALD SCHMIDT ET AL., EQUITABLE ALLOCATION OF COVID-19 VACCINES: AN ANALYSIS OF ALLOCATION PLANS OF CDC'S JURISDICTIONS WITH IMPLICATIONS FOR DISPARATE IMPACT MONITORING (2021), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3803582.

[286] *Id.* at 10, tbl.2.

[287] NH DIVISION OF PUBLIC HEALTH SERVICES, DIVISION OF PUBLIC HEALTH SERVICES, BUREAU OF INFECTIOUS DISEASE CONTROL, NH COVID-19 VACCINATION ALLOCATION GUIDELINES FOR PHASE 1B, 1 (2021), https://www.dhhs.nh.gov/dphs/cdcs/covid19/documents/phase-1b-technical-assistance.pdf. The CCVI considers thirty-four variables including those in the SVI (including race) and COVID-19 specific risk variables, such as population density, chronic conditions, and health care system spending and infrastructure. Vulnerability—How Well a Community Handles the Repercussions of a COVID-19 Outbreak—Matters, PRECISION FOR COVID, https://precisionforcovid.org/ccvi/ (last visited Mar. 28, 2021). In its initial plans, New Hampshire indicated that it would "initially provide vaccine[s] to NH's racial and/or ethnic minority community then include other vulnerable populations, such as those that are geographically isolated or those living in economic hardship" and "[r]eserve vaccine[s] for use in targeted response in these identified census tract areas if needed." BUREAU OF INFECTIOUS DISEASE CONTROL, *supra*.

[288] SURGO VENTURES, COVID-19 COMMUNITY VULNERABILITY INDEX (CCVI) METHODOLOGY (2020), https://covid-static-assets.s3.amazonaws.com/US-CCVI/COVID-19+Community+Vulnerability+Index+(CCVI)+Methodology.pdf.

[289] Ishena Robinson, *Dallas Wanted to Prioritize Vaccines for Hard Hit Black and Latino Neighborhoods, But Texas Officials Blocked That Plan*, ROOT (Jan. 22, 2021, 10:30 AM), https://www.theroot.com/dallas-wanted-to-prioritize-vaccines-for-hard-hit-black-1846109022.

[290] Renuka Rayasam, *A Big Challenge for Biden's Big Vax Promise*, POLITICO (Mar. 11, 2021, 7:30 PM), https://www.politico.com/newsletters/politico-nightly/2021/03/11/a-big-challenge-for-bidens-big-vax-promise-492078; Nicole Cobler, *Why Does Texas Rank Near Last in Percentage of Residents Vaccinated Against COVID-19?*, MIAMI HERALD (Mar. 15, 2021), https://www.miamiherald.com/news/nation-world/national/article249943673.html.

Due to centuries of mistreatment in the health care system, many Black and Latino people are rightfully distrustful of the vaccine, in larger percentages than white people.[291] However, the lack of access to vaccines is just another failure that breeds mistrust. The state and federal response to vaccine allocation has left these groups behind. Although Dr. Anthony Fauci, infectious disease expert and the famous government "face of science" during the pandemic, touted the fact that a Black physician—Dr. Kizzmekia Corbetta—helped develop the vaccine to try to sway public opinion.[292] Additionally, the first person who received the COVID-19 vaccine in the United States was Sandra Lindsay, a Black nurse in New York City,[293] who received the vaccine from a Black physician on camera.[294] The races of the women were not accidental, as there is a real concern that Black people have indicated they will not get vaccinated more than other racial and ethnic groups.[295] Yet, this type of messaging does not help if there is a lack of equitable access to vaccines. And, in fact, there remains a lack of access to vaccines in Black and Latino communities. Although there is a need for large scale public health campaigns tailored to Black and Latino populations to help gain the trust of these populations, the lack of access diminishes trust itself.[296] This conundrum is being worked through right now as of this writing, but it is important that members of the community be involved in creating policy related to vaccines and treatments. Trump and his associates like Rudy Giuliani received monoclonal antibody treatments, with Giuliani saying the quiet part out loud that he got "celebrity" treatment.[297] The reality is that there already was a two-tiered health care system in the United States prior to the pandemic, and there is a real concern that this is being replicated with COVID-19 care and prevention in

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[291] Nada Hassanein, *There's Skepticism in Black, Latino Communities About COVID-19 Vaccines, but Women of Color Can Help Swing the Momentum*, USA TODAY (Dec. 14, 2020, 11:18 AM), https://www.usatoday.com/story/news/health/2020/12/14/covid-19-vaccine-women-color-critical-minority-communities-black-latino/6509739002/.

[292] Anne Branigin, *Dr. Anthony Fauci Appeals to Black Community: 'The Vaccine That You're Going to Be Taking Was Developed by an African American Woman'*, YAHOO!NEWS (Dec. 10, 2020), https://www.yahoo.com/lifestyle/dr-anthony-fauci-appeals-black-010000250.html.

[293] Allana Akhtar, *Meet Sandra Lindsay, a Nurse in New York City Who Was the First Person in America to Get the COVID-19 Vaccine*, BUS. INSIDER (Dec. 14, 2020, 7:14 PM), https://www.businessinsider.com/meet-sandra-lindsay-first-us-person-get-covid-19-vaccine-2020-12.

[294] *Id.*

[295] *Id.*

[296] Erika D. Smith, *Column: 'Why Won't Black Folks Trust Us' on COVID-19? These Doctors and Nurses Have Answers*, L.A. TIMES (Nov. 29, 2020, 5:00 AM), https://www.latimes.com/california/story/2020-11-29/coronavirus-vaccine-covid-black-doctors-nurses-racism-healthcare.

[297] Ben Gittleson & Jordyn Phelps, *Rudy Giuliani Says He Got 'Celebrity' Coronavirus Treatment, Advice from President's Doctor*, YAHOO!NEWS (Dec. 10, 2020), https://www.yahoo.com/gma/rudy-giuliani-says-got-celebrity-184200016.html.

terms of how treatments and vaccines are being allocated, which may further lead to racial inequities in infections and deaths.

C. Systemic Racism, Physician Care, and Racial Inequities in COVID-19

Even prior to the pandemic, access to physician care has been worse for Black and Latino individuals, especially those who live in segregated areas. For example, a 2012 study found that segregated areas where Black and Latino individuals lived lacked adequate access to primary care physicians.[298] Prior to the ACA becoming law, Black people were twice as likely not to be able to access health insurance as white Americans.[299] Even though the ACA expanded insurance coverage to more Americans, the lack of providers near where people live and work to provide health care to them was an impediment to getting access to health care.[300]

Additionally, many Black people have reported feeling discriminated against in health care settings.[301] This racism has many causes. One is the lack of health care providers that are also Black. Another is the lack of culturally competent care and training that providers receive in medical school. Physicians often hold implicit and explicit biases that show up in a patient encounter, which is evidence of interpersonal racism. Black Americans are much less likely to encounter a physician who is also Black, than white or Asian Americans are to encounter physicians who look like them. One study showed that increasing the workforce of Black doctors could protect Black people from dying of heart-related ailments and reduce such death by 19%.[302] Lack of access to health care has a significant impact on poor health outcomes for low-income individuals of color and people of color, which has been exacerbated by the COVID-19 pandemic.

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[298] Darrell J. Gaskin, Gniesha Y. Dinwiddie, Kitty S. Chan & Rachael R. McCleary, *Residential Segregation and the Availability of Primary Care Physicians*, 47 HEALTH SERVS. RSCH. 2353, 2356, 2368–69 (2012).

[299] *See* Alana Biggers, *Racism in Healthcare: What You Need to Know*, MED. NEWS TODAY (Sept. 16, 2020), https://www.medicalnewstoday.com/articles/racism-in-healthcare#how-racism-impacts-health.

[300] *See generally* Darrell Hudson, Tina Sacks, Katie Irani & Antonia Asher, *The Price of the Ticket: Health Costs of Upward Mobility Among African Americans*, 17 INT'L J. ENV'T RSCH. & PUB. HEALTH 1179 (2020).

[301] James E. Wright II & Cullen C. Merritt, *Social Equity and COVID-19: The Case of African Americans*, 80 PUB. ADMIN. REV. 820 (2020).

[302] *How to Fill the Crucial Need for More Black Cardiologists*, AM. HEART ASS'N (OCT. 20, 2020), https://www.heart.org/en/news/2020/10/20/how-to-fill-the-crucial-need-for-more-black-cardiologists; *see also* Manchanda, et al., *supra* note 232; Kristen Pallok, Fernando De Maio & David A. Ansell, *Structural Racism – A 60-Year-Old Black Woman with Breast Cancer*, 380 NEW ENG. J. MED. 1489, 1491 (2019).

When medical care is an expensive proposition and medical encounters are tinged with racism, it is no surprise that Black people delay or avoid seeking health care until absolutely necessary.[303] We see that anecdotally even when Black people sought COVID-19 care, their symptoms were often dismissed.[304] The *New York Times* reported that "for many black families, mourning coronavirus deaths brings an added burden as they wonder whether racial bias may have played a role."[305] Indeed, Kaiser Health News reported that "doctors may be less likely to refer Black people for testing when they show up for care with signs of infection."[306]

D. Health Justice: Eradicating Systemic Racism in Health Care

The governmental pandemic response only made the inequalities in access to health care worse for racial and ethnic minorities. Instead of bolstering more support for these communities in terms of financial support, increased health care and testing access, and culturally competent care, it seemed that states and the federal government buried their head in the sand to ignore the problems. There is a saying that has been often repeated during this pandemic that is some version of "when the rest of America gets a cold, Black people get pneumonia." The essence of this statement is that populations that are already vulnerable due to systemic racism fare worse in any situation, whether the common cold, or as we are seeing now, a global pandemic. The government should have implemented and enforced laws to: (1) ensure that people get reduced or free health care coverage during the pandemic and increased access to Medicaid, (2) reduce the cost of COBRA or other continuation coverage, and (3) deploy an emergency reserve of public health officers and physicians to segregated and rural areas to provide these populations with equal access to testing and treatment. These things did not happen. However, it is not too late to right the wrongs of the last sixteen months, and there is still at least another year of pandemic response.

With a new administration, there is some hope that these populations will not be ignored, especially as President Biden has appointed people to manage the COVID-19 response who are interested in health equity.[307] However,

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[303] Janice A. Sabin, Brian A. Nosek, Anthony G. Greenwald & Frederick P. Rivera, *Physicians' Implicit and Explicit Attitudes About Race by MD Race, Ethnicity, and Gender*, 20 J. HEALTH CARE POOR & UNDERSERVED 896, 907 (2009).

[304] *Id.*

[305] Eligon & Burch, *supra* note 7.

[306] Farmer, *supra* note 235.

[307] Brita Belli, *Nunez-Smith to Lead Biden Health Equity Task Force*, YALE NEWS (Dec. 8, 2020),

President Biden may not be able to overhaul the system due to the close margins in the Senate. For example, the American Recovery Plan was passed with no Republican support, and Democratic Senator Joe Manchin from West Virginia was able to stop the $15 minimum wage provision President Biden wanted due to his opposition to the measure.[308] Thus, we propose the adoption of the health justice framework.

First, legal and policy responses must address systemic racism and, in particular, the impacts of it on the government's pandemic response, which further exacerbated inequalities in employment and health care. Because emergencies typically exacerbate long-standing and interconnected inequalities in employment and health care, legal and policy responses must address these root problems. We need to see sweeping supports such as universal health insurance if we are going to provide people of color with a chance to even the playing field. Medicaid and other health care coverage should be expanded so that COVID-19 treatment is covered for more people, including undocumented immigrants. The health insurance system in the United States "enables a tiered and sometimes racially segregated health care delivery structure to provide different quality of care to different patient populations."[309] Tiered systems of Medicare, Medicaid, private insurance, and self-pay should be replaced with some form of universal single-payer health care. This will help ensure more equitable care and ultimately achieve health justice by addressing underlying racism that thwarts access to health, increasing the risk of infections and death for low-income individuals and people of color.

There are some bright spots in some of the governmental testing and vaccine responses, which should be adopted in other states to address systemic racism. Some governments have already begun to ensure that predominantly Black and Latino communities have access to testing, such as in North Carolina, where they arranged for testing facilities available to Latino farmworkers. Some areas, like DC, are targeting certain ZIP codes with more low-income and underserved people.[310] Residents of these areas had earlier access to vaccination appointments than non-residents. New York and California tried similar

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https://news.yale.edu/2020/12/08/nunez-smith-lead-biden-health-equity-task-force.

[308] Julian Kaplan, *A $15 Minimum Wage Would Lift Millions Out of Poverty with 'Limited Negative Effects' on Aggregate Income, Morgan Stanley Says*, YAHOO!NEWS (Mar. 12, 2021), https://news.yahoo.com/15-minimum-wage-lift-millions-154536866.html.

[309] Hardeman, *supra* note 250, at 198.

[310] Off. of the Mayor, *DC Health to Make Additional Vaccination Appointments Available to Residents of Wards 1, 4, 5, 7, and 8 on Saturday, January 16*, GOV'T D.C. MURIEL BOWSER, MAYOR (Jan. 15, 2021), https://mayor.dc.gov/release/dc-health-make-additional-vaccination-appointments-available-residents-wards-1-4-5-7-and-8.

approaches, but in some cases, people from those ZIP codes were not the ones who were able to get vaccinated.[311] It is a delicate balance between ensuring access to vulnerable ZIP codes and asking for proof of residency and other tracking measures, which may dissuade both undocumented individuals and those who have been interacted with the justice system.

Other states like Montana and Utah prioritized Native Americans and other racial ethnic groups at an elevated risk of COVID-19 complications in Phase 1B and Phase 1C, respectively.[312] Many states set up hotlines to help people sign up for vaccines who may have trouble navigating online sign ups. Others increased vaccination clinics in underserved areas.[313] For example, Colorado aimed to establish vaccine clinics in areas with a high minority population. Those were good efforts, but the federal government's initial lack of attention and response to vaccinations harmed Black and Latino populations the most, so it must now act intentionally to address these inequities.

To address interpersonal racism, public health professionals and health care providers in charge of educating low-income communities and communities of color about healthy behaviors must be trained to address their own prejudice. Specifically, they need to receive education about interpersonal racism during their professional programs and at least yearly once they enter practice. Also, underrepresented minority physicians must be added to the physician workforce in all specialties, and financial support for training, recruiting, and retaining such physicians is needed to improve the lives of minority communities and ensure culturally sensitive care. In light of the dearth of high-quality health care services in low-income communities and communities of color, equal access to health care facilities must be realized. Using cancer cases as an example, only two of the twelve Chicago hospitals designated as quality cancer care centers are in the predominantly Black South Side of Chicago,[314] despite higher rates of exposure to carcinogens.[315] "Black women in Chicago were almost 40% less likely than

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311 Abby Goodnough & Jan Hoffman, *The Wealthy Are Getting More Vaccinations, Even in Poorer Neighborhoods*, N.Y. TIMES (Mar. 4, 2021), https://www.nytimes.com/2021/02/02/health/white-people-covid-vaccines-minorities.html.

312 Jennifer Tolbert, Jennifer Kates & Josh Michaud, *The COVID-19 Vaccine Priority Line Continues to Change as States Make Further Updates*, KAISER FAM. FOUND. (Jan. 21, 2021), https://www.kff.org/policy-watch/the-covid-19-vaccine-priority-line-continues-to-change-as-states-make-further-updates/.

313 Nambi Ndugga, Samantha Artiga & Olivia Pham, *How Are States Addressing Racial Equity in COVID-19 Vaccine Efforts?*, KAISER FAM. FOUND. (Mar. 10, 2021), https://www.kff.org/racial-equity-and-health-policy/issue-brief/how-are-states-addressing-racial-equity-in-covid-19-vaccine-efforts/.

314 Pallok et al., *supra* note 303.

315 AM. CANCER SOC'Y, CANCER FACTS & FIGURES FOR AFRICAN AMERICANS 2019–2021, at 20 (2019), https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/cancer-facts-and-figures-for-african-americans/cancer-facts-and-figures-for-african-americans-2019-2021.pdf.

white women to receive breast care at a breast imaging center of excellence."[316] In these areas, the lack of specialists and adequate equipment in hospitals results in inferior care.[317] Vulnerable communities should also have access to free coronavirus testing and vaccinations via mobile sites.

Second, emergency preparedness laws and policies mandating healthy behaviors must be accompanied with financial supports and accommodations to enable racial and ethnic minorities compliance, while minimizing harms. Racial and ethnic minorities need financial supports to pay for treatment if they are infected with COVID-19. Because these minorities do not have health insurance, the government needs to make sure that their treatment is covered. As mentioned in Part II.D, racial and ethnic minorities also need paid sick leave that will provide them with paid time off that will cover the time that they need to get tested, await their test results, and stay at home if they test positive.

Third, racial and ethnic minorities must be engaged and empowered to take the lead in developing interventions to achieve health equity, which helps ensure that the design and implementation of interventions intended to benefit them are actually tailored to their needs. Blacks, Latinos, Native Americans, people with disabilities, and other communities who have suffered disproportionately more from this pandemic must be empowered and engaged to develop and implement broad systemic change. We encourage robust community involvement in developing these solutions because these vulnerable communities will otherwise continue to be denied access to quality health care. Just as the Black Lives Matter and the MeToo movements were community-based, the movement for health justice must come from the communities impacted by health inequities. We need community involvement in developing these solutions because these vulnerable communities will otherwise continue to be denied access to quality health care.

CONCLUSION

The COVID-19 pandemic has laid bare the inequalities in employment and health care, which have caused racial inequities in infections and deaths. These inequalities are a result of systemic racism, wherein the pandemic responses of federal and state governments, as well as companies, have disempowered and devalued the lives of racial and ethnic minorities. This Essay attempts to outline how systemic racism played out in COVID-19, using examples in employment and health care.

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316 Pallok, *supra* note 303, at 1490.

317 *Id.* at 1490–91.

Systemic racism is not a simple problem, and thus, there is not a simple solution. However, attention needs to be paid to this issue, and broad change is needed unless we want to repeat these inequities in future health emergencies. As a first step, the government must eradicate these inequalities by actively addressing systemic racism, which has not only influenced its pandemic response, but also destroyed trust in the government.

Specifically, federal and state governments must structurally remediate the inequalities in employment and health care, provide financial supports and accommodations, and engage and empower racial and ethnic minorities most impacted by COVID-19 to develop, implement, and evaluate new emergency preparedness laws and policies that aim to eradicate racial inequities.