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

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ABSTRACT (186 WORDS)

During the COVID-19 pandemic, the federal and state governments has ignored racial and ethnic minorities’ unequal access to employment and health care that results in racial inequities in COVID-19 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 preventing 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 community in implementing an equitable pandemic response.

I. INTRODUCTION

Historically, the federal and state government’s legal and policy response to pandemics has ignored racial inequities in employment and health care that cause racial inequities in infection and death.1 Research shows that only

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1 Ruqaiijah Yearby, Structural Racism and Health Disparities: Reconfiguring the Social Determinants of Health Framework to Include the Root Cause, 48 J. OF L. MED. & ETHICS 518, 520 (2020); Ruqaiijah Yearby & Seema Mohapatra, Law, Racism and the COVID-19 Pandemic, OXFORD J. LAW AND THE BIOSCIENCES (May 30, 2020); Philip Blumenshine et. al., Pandemic Influenza Planning in the United States from a Health
16.2% of Latinos and 19.7% of Blacks have jobs that they perform from home. This means that only 1 in 6 Latinos and 1 in 5 Black workers can telework. Additionally, “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.

During the COVID-19 pandemic, the government has not only continued to ignore these inequalities in employment and health care, but the state and federal government has also enacted laws and implemented policies that further exacerbate these inequalities, harming racial and ethnic minorities. Although these laws seem race “neutral,” they exemplify systemic racism, wherein racial and ethnic minorities are deemed inferior to White people, and thus, are not provided the same access to key resources such as adequate employment and health care.

Systemic racism has negatively influenced 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 and health care treatment. 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 at home and they cannot afford to miss work even when they are sick. Furthermore, the jobs often do not provide health insurance, and thus, racial and ethnic minorities lack access to appropriate treatment during the COVID-19 pandemic.

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Yarby & Mohapatra, supra note 1.

Supra note 1.
pandemic. Due to increased workplace exposure and lack of access to treatment, racial and ethnic minorities have disproportionately been infected and died from COVID-19. One powerful example of this is demonstrated by how meat and poultry processing workers have fared in this pandemic.

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. The meat and poultry processing industry employs an estimated 525,000 workers in 3500 facilities nationwide. Meat and poultry plants have been hotspots for COVID-19 infections and deaths. In fact, research shows that between 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. Racial and ethnic minorities account for 87% of these COVID-19 cases, even though they only account for 50% of meat and poultry processing workers. These racial inequities in infections and deaths are a result of systemic racism in the government’s pandemic response. 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, resulting in worker deaths and record profits.

Furthermore in health care, the government has designated hospitals as the main place for COVID-19 testing and treatment, however, this ignores that racial and ethnic minorities lack equal access to quality hospital care, resulting in racial inequities in COVID-19. For example, Leonard Green & Partners, a private equity, bought control of a hospital company named Prospect Medical Holdings for $205 million and extracted $400 million by loading up the company with debt. Prospect CEO Sam Lee, who owns about 6 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.


10 Peter Elkind and Doris Burke, Investors Extracted $400 million from a hospital Chain that sometimes couldn’t pay for medical supplies or gas for ambulances,
20% of the chain, made $128 million and a second executive with an ownership stake took home $94 million.11 Many of Prospect’s facilities are in low-income, predominately Black and Latino areas that have been disproportionately impacted by COVID-19. In March, Prospect’s New Jersey hospital made national headlines for the first COVID-19 death of a U.S. emergency room doctor. Before his death, the doctor “told a friend he’d become sick after being forced to reuse a single mask for four days.”12 At a Prospect hospital in Rhode Island, a locked ward for elderly psychiatric patients had to be evacuated and sanitized after poor infection control spread COVID-19 to 19 of its 21 residents, resulting in 6 deaths.13 The virus also killed the head of the housekeeping department and sickened a half-dozen members of the housekeeping staff, which had been given limited personal protective equipment.14 Hence, as a result of the government’s decision to make hospitals integral in the delivery of care during the pandemic, racial and ethnic minorities lack access to testing and treatment, which has resulted in racial inequities in COVID-19 infections and deaths.

The health justice framework provides a community-informed agenda to transform the government’s emergency preparedness responses to eradicate systemic racism and 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.”15 It offers three principles (structural, supports, and community engagement) to improve the government’s emergency preparedness response in order to address and eliminate racial inequities in COVID-19. First, emergency preparedness laws and policies must address systemic racism by structurally changing the systems that cause racial inequalities in access to key resources.16 Second, these emergency


11 Id.
12 Id.
13 Id.
14 Id.
16 Angela Harris & Aysha Pamukcu, The Civil Rights of Health: A New Approach to Challenging Structural Inequality (draft dated March 11, 2019), 67 UCLA L. REV. 758, 806 (2020), ( “health 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.”); Wiley, infra. at 85 (“[Achieving health justice] will take organizing
preparedness laws and policies must be accompanied by supports and protections, so that racial and ethnic minorities can stay home when they are sick.\textsuperscript{17} 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.\textsuperscript{18} 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.\textsuperscript{19}

In this essay, we examine how the interplay of systemic racism, the governmental pandemic response, and unequal access to resources have resulted in racial inequities in COVID-19 infections and deaths. We argue that these problems can be fixed by integrating the health justice framework into the federal and state government’s pandemic response.\textsuperscript{20} This essay proceeds as follows: Part II discusses two forms of systemic racism (structural and interpersonal), how they negatively influence the federal and state government’s 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 III demonstrates how systemic racism in the government’s pandemic response has resulted in industry influenced

\begin{itemize}
  \item 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).
  \item Wiley, \textit{supra} note 12, at 95-96 (“interventions [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”).
  \item Harris & Pamukcu, \textit{supra} note 12, at 765 (describing “the emergent ‘health justice’ movement [as] a framework that places the empowerment of vulnerable populations at the center of action’’); Wiley, \textit{supra} note 12, at 101 (“the 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”).
\end{itemize}
decisions regarding who will be an essential worker, lax enforcement of health and safety laws, and the issuance of Executive Order 13917\textsuperscript{21} that prioritizes profits over the lives of workers, which have resulted in racial inequities in COVID-19 infections and deaths. 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 IV explores examples of systemic racism in health care and how they 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.

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

Over ten years ago, Blumenshine et al. hypothesized that there were racial and ethnic 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 at home; and lack of access to a regular source of health care as well as appropriate treatment during pandemics.\textsuperscript{22} 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.\textsuperscript{23} 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.\textsuperscript{24}

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,\textsuperscript{25} federal and state

\begin{itemize}
\item\textsuperscript{21} Exec. Order No. 13917, 85 Fed. Reg. 26,313 (May 1, 2020).
\item\textsuperscript{23} Quinn et al., supra note 22.
\item\textsuperscript{24} Id. (“They also found that racial and ethnic minorities suffered from health conditions that were risk factors for H1N1”).
\item\textsuperscript{25} Dennis Andrulis, et al., H1N1 Influenza Pandemic and Racially and Ethnically Diverse Communities in the United States: Assessing the Evidence of and Charting Opportunities for Advancing Health Equity, US Department of Health and Human Services, Office of Minority Health p. 13 (Sept. 2012), DOI: 10.13140/RG.2.2.20511.10402, https://www.researchgate.net/publication/340390150_H1N1_Influenza_Pandemic_and_Ra
\end{itemize}

Draft manuscript not to be cited or copied without permission from the author.
governments have ignored these factors during the COVID-19 pandemic. Instead, the governmental pandemic response includes stay at home orders and social distancing recommendations that do not address the lived experiences of racial and ethnic minorities who are disproportionately essential workers. 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 November 30, 2020, Native Americans and Alaska Natives have two times the rate of infections, four times the rate of hospitalizations, and three times the deaths of Whites.\textsuperscript{26} Blacks have almost four times the rate of hospitalization and three times the deaths of Whites, while Latinos have four times the hospitalization and three times the deaths of Whites.\textsuperscript{27} These racial inequities in infections, hospitalizations, and deaths are result of systemic racism, which increases racial and ethnic minorities exposure to the disease and prevents equal access to testing and treatment. The inequities will not go away, unless the government improves its pandemic response by trying to achieve health justice through addressing systemic racism, providing financial supports, and engaging community members in the development of pandemic response laws.

\textbf{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 disempower and devalue other groups and differentially allocate societal resources.\textsuperscript{28} Systemic racism includes structural and interpersonal racism.\textsuperscript{29} Structural racism refers to the way laws are used to provide advantages to Whites, while disadvantaging


\textsuperscript{27} Id.


\textsuperscript{29} Id.; see also Kira Banks & Jadah Stephens, \textit{Reframing Internalized Racial Oppression and Charting a way forward}, SOCIAL ISSUES AND POLICY REVIEW (Wiley Editing Services eds., 2018); Courtney D. Cogburn, \textit{Culture, Race, and Health: Implications for Racial Inequities and Population Health}. 97(3) THE MILBANK QUARTERLY 736-761 (2019).
racial and ethnic minorities by limiting their equal access to key resources (employment and health care).\textsuperscript{30} 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.\textsuperscript{31} 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 anti-discrimination laws.\textsuperscript{32}

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, in order to prevent, detect, manage, and contain the spread of COVID-19 public health officials need to identify who is infected with COVID-19 and contact potentially infected individuals, which is known as contract tracing.\textsuperscript{33} However, during the COVID-19 pandemic, government officials have not followed this protocol, particularly as it pertains to workplace infections. A 2014 Occupational Safety and Health Administration (OSHA) rule requires employers to record and report worker hospitalizations within 24 hours of the event.\textsuperscript{34} Yet, OSHA and many states have either explicitly stated that employers do not have to record and report employee’s COVID-19 infections,\textsuperscript{35} or refused to release the information.\textsuperscript{36} Because most Black and Latino workers cannot work from

\textsuperscript{30} Yearby, supra note 1, at 520.
\textsuperscript{32} Leith Mullings & Amy J. Schulz, \textit{Gender, Race, Class & Health: Intersectional Approaches} 3, 12 (2005).
\textsuperscript{34} 29 C.F.R. §1904.2(a)(1), 1904.7(a), and 190439(a)(2) (2014).
\textsuperscript{36} Brianne Pfannenstiel, \textit{Iowa officials won’t disclose coronavirus outbreaks at meatpacking plants unless media asks} (May 28, 2020), https://www.desmoinesregister.com/story/news/politics/2020/05/27/iowa-wont-disclose-
home, they are more likely than Whites to be exposed to COVID-19 in the workplace, which they will spread throughout their communities without any prevention, detection, management, and containment strategies because the government is not requiring employers to report, record, or track these infections.

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**

To address these inequities, the government should adopt a health justice framework to assist them in creating a structurally supportive and empowering pandemic response that will remediate past harms, engage and empower racial and ethnic minorities, and provide legal protections and financial supports to mitigate the effects of long-standing systemic racism.

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37 Gould & Shierholz, supra note 2.
B. Health Justice

To address the problem of systemic racism in the governments’ COVID-19 response, the government should adopt the health justice framework, which requires not only protection from harm, but also affirmative actions to provide material and institutional support to address racial inequities in COVID-19 infections and deaths.\(^{39}\) The framework includes three broad principles that are structural, supportive, and empowering to prevent and eliminate racial inequities during and after the COVID-19 pandemic.\(^{40}\)

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, economic relief bills, and the enforcement of laws governing employment and health care that further exacerbate 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 by providing racial and ethnic minorities with the same benefits and protections as Whites, such as paid sick leave.

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.\(^{41}\) Specifically, governments must provide racial and ethnic minority workers with financial supports, such as hazard pay and health insurance.

Third, racial and ethnic minorities must be engaged and empowered to take the lead in developing interventions to achieve health equity, which helps to ensure that the design and implementation of interventions intended to benefit them are actually tailored to their needs.\(^{42}\)

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

\(^{39}\) Benfer, supra note 15.

\(^{40}\) Benfer et al., supra note 16.

\(^{41}\) Wiley, supra note 16, at 95-96 (“interventions [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”).

\(^{42}\) Harris & Pamukcu, supra note 16, at 758-760 (“the experience of exercising self-determination, whether at the individual or collective level, has a protective effect on public health”); Wiley, supra note 16, at 101 (“the 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.”). Harris & Pumukcu, infra, at 806 (“[H]ealth justice … calls for subordinated communities to speak and advocate for themselves. Embracing social movements as partners … addresses the internal limitations of public health and law; it also helps forestall unintended harmful consequences of the initiative itself.”).
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. Using the meat and poultry processing industry, the next section discusses how systemic 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.

III. SYSTEMIC RACISM IN EMPLOYMENT

As of December 11, more than 50,123 meat and poultry processing workers have tested positive for COVID-19 and 255 have died. Racial and ethnic minorities account for 87% of COVID-19 cases among meat and poultry processing workers, even though they only account for 50% of meat and poultry processing workers. Meat and poultry processing plants have

43 Ruqaiijah Yearby & Seema Mohapatra, The Health Justice Framework and Systemic Racism Model (2020) [applying the Health Justice Framework from Benfer et al., supra note 16; Wiley, supra note 16, at 47; Benfer, supra note 15; Yearby & Mohapatra, supra note 34; Siegler, Komro, & Wagenaar, supra note 34.

44 Benfer, supra note 15.


46 Waltenburg et al., supra note 7, at 888; Fremstad, Rho, & Brown, supra note 9.
been the site of many of the largest COVID-19 outbreaks in the United States.\(^{47}\) However, the federal and state government’s pandemic response has not protected meat and poultry processing workers. In fact, structural racism illustrated by political decisions influenced by meat and poultry trade associations, the failure to enforce health and safety standards, and the government’s ineffective pandemic response has led to racial inequalities in employment.\(^{48}\) These inequalities, such as lack of paid sick leave and punitive attendance policies, increase workers workplace exposure to COVID-19, which has resulted in racial inequities in COVID-19 infections and deaths. To rectify these problems, the 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 Meat Institute, 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.\(^{49}\) As a result of these lobbying

\(^{47}\) Kauffman, supra note 32.


efforts, the DHS list included these workers, yet the DHS list was only supposed to be advisory. 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. 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. 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. Yet, these same trade associations did not use their influence to ensure that these workers, who 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.

For example, the government enacted the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) giving workers health coverage for COVID-19, increased unemployment benefits, and paid sick leave. However, the CARES Act left out meat and poultry processing workers. This is because the CARES Act only applied to businesses with less than 500 workers, and most meat and poultry producers employ more than 500 workers. In fact, JBS employees 3,000 workers at one plant, but has not provided the workers with paid sick leave or covered payments for COVID-19 testing. Additionally, roughly 52% of meat and poultry workers are


51 Email from Fretz, supra note 45.


53 Id.


undocumented immigrants, so the CARES Act does not cover them. 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. 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. Thus, laws advantaged the companies, while disadvantaging racial and ethnic minorities. This further exacerbated the inequalities in employment, such as lack of paid sick leave and punitive attendance polices, for these workers.

Many laws that expanded collective bargaining rights either explicitly excluded racial and ethnic minorities or allowed unions to discriminate against racial and ethnic minorities. 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, forcing them to go to work even when they were sick, increasing disparities in their exposure to viruses, like COVID-19. Without paid sick leave, working people are 1.5 times more likely to go to work with a contagious disease and three times more likely to go without medical care compared to those with paid sick days. 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.

Additionally, before the COVID-19 pandemic, meat and poultry processing companies’ standard attendance policy was punitive, issuing points for those who missed work, which was used as a reason for firing workers. These policies have persisted throughout the COVID-19 pandemic.

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57 Taylor, Boulos, & Almond, supra note 8.


59 Yearby & Mohapatra, supra note 1.


61 Schlitz, supra note 52; 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 (Apr 16, 2020, 6:47 AM), https://www.businessinsider.com/south-dakota-slaughterhouse-coronavirus-responsibility-bonus-2020-4; Unknown, 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, The Washington Post (April 24, 2020),
as some of the biggest meat and poultry processing companies (JBS, Smithfield, and Tyson) actively penalize workers for taking time off, even if it is for illness. 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. The companies also require workers to continue to work as they were awaiting test results. One Tyson plant does not approve prearranged absences for things such as testing, unless it does not affect the production needs of the plant. 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.

Furthermore, excused absences for COVID-19 are only given if a worker has physician documentation of a positive COVID-19 test, otherwise the worker is accessed points, which can be used to fire them. This was confirmed by JBS Spokesperson Nikki Richardson, who noted that “points were not assessed against team members for absences due to documented illness.” 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.

For instance, at the JBS Greeley, CO plant where 6 workers died and 290 were infected with COVID-19 (nearly two-thirds of all Colorado COVID-19 cases), the attendance policy allowed for 6 points for absences before


62 Schlitz, supra note 52.
63 Id.
64 Id.
66 Id.
67 Id. (emphasis added).
68 Schlitz, supra note 52.
70 Shelly Bradbury, How Coronavirus Spread Through JBS's Greeley Beef Plant (July
firing, which was less than the 7.5 points allowed before the pandemic.\textsuperscript{71} Workers could only recoup points by getting physician documentation of a positive COVID-19 test and calling an English-only attendance hotline,\textsuperscript{72} 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. To address this problem, JBS promised to provide workers with free COVID-19 tests after COVID-19 outbreaks at the plant. However, instead, JBS offered the low-wage and uninsured workers COVID-19 tests at its plant if they paid $100, which workers declined.\textsuperscript{73}

Thus, meat and poultry processing workers were forced to continue to go 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 systemic racism because meat and poultry processing companies used the law to ensure their workers were deemed essential, but have not provided with paid sick leave that might disrupt production. Additionally, meat and poultry processing companies have enforced policies that penalize these workers for missing work even when they are sick. This inequality in employment benefits has advantaged companies 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.\textsuperscript{74}

\section*{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 and otherwise harmed at work. During the COVID-19 pandemic, state health departments and OSHA have been in charge of regulating the health and safety of workers.\textsuperscript{75} State health departments retain the primary public health power to enact laws to protect the health and safety of their citizens,\textsuperscript{76} 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.\textsuperscript{77}

\begin{thebibliography}{99}
\bibitem{footnote1} Schlitz, \textit{supra} note 52.
\bibitem{footnote2} \textit{Id.}
\bibitem{footnote3} Brown, \textit{supra} note 52.
\bibitem{footnote4} Yearby, \textit{supra} note 10.
\bibitem{footnote6} \textit{Jacobson}, \textit{supra} note 75.
\end{thebibliography}
Under the OSH Act, employers must provide employees with personal protective equipment and develop a respiratory protection standard to prevent occupational disease. Moreover, under OSHA’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. 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 “the only standard sanitation requirement Tennessee OSHA can govern is that employers provide soap and water for employees” because “by TOSHA standards, face masks are not considered personal protective equipment, and the standard does not require an employer provide them.” The failure to require face masks is in direct contravention of the OSHA Act that requires employers to provide personal protective gear, including respirators at no cost to the employee, to address respiratory issues, which cannot be addressed simply by washing one’s hands. 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 1st to 566 on May 23rd as a result of infections among essential workers.

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 2005, OSHA has been developing an airborne infectious disease rule that

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80 Id.
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.\textsuperscript{84} Although the rule was shelved in 2017,\textsuperscript{85} 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.\textsuperscript{86}

In March, members of Congress\textsuperscript{87} and numerous unions\textsuperscript{88} 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.\textsuperscript{89} 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.\textsuperscript{90}

Instead of publishing an ETS, OSHA has 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.\textsuperscript{91} The guidance recommends the creation of a COVID-19 assessment and control plan, which includes providing PPE and implementing social distancing.\textsuperscript{92} The guidance also explicitly states that employers should “work with the appropriate state and local public health

\textsuperscript{85} Id.
\textsuperscript{86} 29 U.S.C. § 655(c) (2012).
\textsuperscript{88} Richard L. Trumka (and various organizations), \textit{A Petition to Secretary Scalia for an OSHA Emergency Temporary Standard for Infectious Disease} (Mar. 6, 2020), https://aflcio.org/statements/petition-secretary-scalia-osa-emergency-temporary-standard-infectious-disease.
\textsuperscript{90} Id.
\textsuperscript{91} OSHA Guidance, supra note 33.
\textsuperscript{92} Id.
officials and occupational safety and health professionals,” to develop plans for operating and addressing COVID-19 outbreaks.93 There are several problems with the guidance and OSHA’s actions.

First, the guidance is not mandatory.94 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 they can do is “contact an employer and send an advisory letter outlining the recommended protective measures.”95 Second, the guidance fails to recommend testing of 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, as mentioned in Section IIA, OSHA is not enforcing the reporting requirements for COVID-19 infections, hospitalizations, and deaths.96 Third, the guidance was issued long after severe industry outbreaks occurred.97 By March 30th, the federal government was aware that the Canadian meat processing plant Olymel 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 28th.98 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.99 The failure to enforce the respiratory requirement and general duty clause, finalize the airborne infectious disease rule, issue an

93 Id.
94 Id.
98 E-mail from Potts, supra note 45, at 274-5.
ETS, and publish guidance that is mandatory is an example of structural racism because it has 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.

In mid-April 2020, 18.2% of Iowa meat and poultry processing plant workers were infected with COVID-19, the highest percentage of these workers infected by COVID-19 nationwide. In fact, at one point in April not only were 90% of all COVID-19 cases in Waterloo, Iowa (Black Hawk County) tied to the Tyson meat processing plant where managers and supervisors had a betting pool on which worker would test positive for COVID-19, but Black Hawk County also had the most COVID-19 cases in Iowa. 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, 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.” 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. By mid-May, Iowa still had the highest percentage of COVID-infected meat and poultry processing workers nationwide, with 1784 meat processing plant workers infected. The state cited Iowa Premium Beef Plant $957 for a


104 Id.

105 Id.

106 Id.
record keeping violation, where 338 out of 850 workers tested positive for the virus, making it the first hotspot for COVID-19 in Iowa.107 Yet, neither the state nor OSHA has cited any of these Iowa facilities for violations of the general duty standard for keeping the workplace free from recognized hazards that cause death or serious harm.108 In fact, Iowa passed a business liability law that protects businesses, including meat and poultry processing companies from being sued for COVID-19 infections.109 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, increasing their risk for COVID-19 infections, hospitalizations, and death; while benefitting 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, which has been made worse by the government’s emergency preparedness laws, policies, and interventions that prioritize profit over safety.


By April, 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.110 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.111 One day later, NAMI sent a

109 Id.; see also IA Senate File 2338 (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.
110 Dyal et al., supra note 96.
111 E-mail from Dale Moore, Exec. Vice President, Am. Farm Bureau Fed’n, to Joby Young, Chief of Staff, U.S. Dep’t of Agric. 122 (Apr. 18, 2020, 12:49:23 PM), https://www.citizen.org/wp-content/uploads/2020-OSEC-04055-F_2nd-Interim_Item-1_Redacted.pdf; E-mail from Julie Anna Potts, President & CEO, N. Am. Meat Inst., to
draft executive order to the President to use to keep food processing, production, and supply companies open.\textsuperscript{112} Nine days later, President Donald 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.\textsuperscript{113} Alluding to the powers granted by the Defense Production Act of 1950, the President delegated authority to the USDA to regulate and ensure that meat and poultry processing plants stayed open or re-opened during the COVID-19 pandemic to guarantee that there were no meat shortages, even as these plants were becoming COVID-19 hotspots.\textsuperscript{114}

The issuance of the Order and the actions of the USDA have provided advantages to companies allowing them to stay open and continue production,\textsuperscript{115} while disadvantaging racial and ethnic minority workers by limiting protection from workplace exposure. 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.\textsuperscript{116} In mid-June, the USDA noted “the total pork exports to mainland China in April reached their highest monthly total since the agency began keeping track 20 years ago”\textsuperscript{117} and as of July 2, beef (5%) and poultry (14%) production were up compared to a year ago.\textsuperscript{118} More specifically, even as worker infections and deaths continued to rise, Tyson increased production of meat, pork, chicken, and prepared foods. As a result, Tyson announced a net income of $692 million

\begin{thebibliography}{9}
  \bibitem{E-mail} E-mail from Julie Anna Potts, President & CEO, N. Am. Meat Inst., to Stephen Censky, Deputy Sec’y of Agric., U.S. Dep’t of Agric. 354 (Apr. 21, 2020, 9:07:11 AM), https://www.citizen.org/wp-content/uploads/2020-OSEC-04055-F_2nd-Interim_Item-1_Redacked.pdf.
  \bibitem{exec} Id.
  \bibitem{exec2} Exec. Order 13917, \textit{supra} note 17.
  \bibitem{meat} Michael Corkery and David Yaffe-Bellany, \textit{As Meat Plants Stayed Open to Feed Americans, Exports to China Surged} (June 23, 2020), https://www.nytimes.com/2020/06/16/business/meat-industry-china-pork.html (the “[meat] industry publicly lobbied the Trump administration to intervene with state and local officials or risk major meat shortages across American grocery stores”).
\end{thebibliography}
up from $369 million last year, and expects a revenue of $42 billion. These profits were made at the expense of worker lives. To date, over 11,000 Tyson workers have been infected with COVID-19; in addition to the major COVID-19 outbreak in Iowa, discussed in section IIIB. Instead, of using the money to compensate or protect workers, they have used the Order to challenge worker and family requests for compensation and safety protections. Nevertheless, Tyson is not alone.

After the Executive Order was issued, JBS reported $581.2 million in net profits in the third quarter of 2020 beating analyst’s forecasts. The JBS plant in Greeley, Colorado, where 6 workers died and 290 were infected with COVID-19 (nearly two-thirds of all Colorado COVID-19 cases) was fined $15,615 for worker infections and deaths. This is .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. It is also miniscule compared to the $21.4 million fine OSHA levied against BP after an explosion killed fifteen workers and the $81 million OSHA fine for failing to abate these hazards. Nevertheless, JBS has used the Order to challenge the fine, arguing that they complied with the OSHA/CDC guidance, even as they enforced attendance policies that penalized workers for staying at home

120 Douglas, supra note 41.
123 Nieberg, supra note 65.
124 Bradbury, supra note 66.
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, as discussed in Section IIIA.\textsuperscript{128} 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 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 re-open 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.\textsuperscript{129} This is demonstrated by the COVID-19 outbreak at the Smithfield plant in Sioux Falls, South Dakota.

On April 16th, it was announced that there were 735 COVID-19 infections at the Smithfield meat processing plant in Sioux Falls, South Dakota, making it the largest COVID-19 hotspot at that point.\textsuperscript{130} Yet, the first case of COVID-19 detected in the plant was on March 24, 2020, twenty-three days before the announcement.\textsuperscript{131} The plant did not totally halt production until April 14th, and by that time it had become the COVID-19 hotspot for the entire state.\textsuperscript{132} The South Dakota Department of Health and the CDC completed an inspection of the facility\textsuperscript{133} on April 22\textsuperscript{nd} because at the time

\begin{flushleft}
\textsuperscript{128} Schlitz, \textit{supra} note 52.
\textsuperscript{130} Jankowicz, \textit{supra} note 57.
\textsuperscript{131} Memorandum from Michael Grant et al., \textit{supra} note 93, at 1.
\textsuperscript{132} Id. at 1-2.
\textsuperscript{133} Id. at 1.
\end{flushleft}
the outbreak was one of the largest in the United States. After the report was issued, Smithfield continuously emailed the USDA using the CDC’s findings as support for re-opening the plant even as employee test results were still pending, an OSHA investigation was being conducted, and the South Dakota Governor was trying to get Smithfield to comply with state health and safety laws. In response to these emails from Smithfield, the USDA issued a letter dated May 6th stating that the facility should be re-opened. The facility in fact did re-open on May 6th. 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. The OSHA citation and notification of penalty letter for the plant shows that COVID-19 infections continued to spread throughout the plant until June 16th, more than 30 days after the plant re-opened.

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135 Id.


139 OSHA Smithfield Citation, supra note 134.
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 26th, 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 were asking state and local health departments to follow. However, the USDA emphasized that:

the 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. If there are illnesses they may require more stringent social distancing recommendations and/or quarantines. We will rely on them (health departments) to make the best decisions based on public health. Emphasis added.

After the Executive Order, the USDA’s stance changed as it worked to support the needs of meat and processing plants, assisting them to stay open and re-open 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. In fact, after the Order, the USDA never deferred to the state health departments requirements again.

By May 5th, citing the powers granted under the Executive 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 1st that included written documentation of their operations and health and safety protocols based on the OSHA/CDC guidance. 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.


141 Id.


requesting assistance with state and local health departments wanting to close facilities due to COVID-19 outbreaks, requiring all employees be tested, and implementation of a six-foot physical distancing requirement. In response to one of the emails, the USDA intervened in a state’s decision to re-open and meat processing plant. Specifically, the USDA pressured Illinois into re-opening the Smithfield Kane County, Illinois meat processing plant that had closed due to a COVID-19 outbreak. Since the Executive 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. Specifically, there were 16,233 confirmed cases of COVID-19 infections for meat and poultry processing workers and 86 COVID-19 related deaths in 239 plants. Of the 9,919 (61%) cases with racial and ethnic data, 56% of COVID-19 cases occurred in Latinos, 19% occurred in non-Latino Black, 13% in non-Latino whites, and 12% in Asians. Yet, even the CDC acknowledged that the actual numbers of COVID-19 infections and deaths for meat and poultry processing workers were probably higher because only 23 states submitted data and “only plants with at least one laboratory-confirmed of COVID-19 among workers were included.” Furthermore, policies to keep open meat and poultry processing plants with COVID-19 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). Research further shows that having a meat or poultry processing

146 Id.
147 Id.
148 Id.
plant in the county is associated with a 51 to 75% increase in COVID-19 cases and 37 to 50% increase in deaths of all people in the county, not just those who worked at the plant.\textsuperscript{150} Plant closures decreased county-wide COVID-19 infections and deaths. In the first week, closures resulted in lower county COVID-19 rates, and by week 2 the COVID-19 rates for counties with plants that had been closed were roughly the same as counties without plants.\textsuperscript{151} If the plants remained closed for 3 to 4 weeks, the counties with these closed plants had lower COVID-19 rates than counties without plants. 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’ COVID-19 infections and deaths, leading to racial inequities.\textsuperscript{152}

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.\textsuperscript{153} 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 a COVID-19 outbreak.\textsuperscript{154} The line speed waivers conflicts the 2014 Modernization of Poultry Slaughter Inspection rule that set a maximum speed and did not allow for waivers.\textsuperscript{155} 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 COVID-19 infections. Research shows that these waivers are associated with increased rates of COVID-19 infections. 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 without a plant.\textsuperscript{156} For plants issued waivers in 2020,

\begin{flushleft}
\textsuperscript{150} Taylor, Boulos, and Almond, \textit{supra} note 8.
\textsuperscript{151} \textit{Id.} at 4.
\textsuperscript{154} \textit{Id.}
\textsuperscript{156} Taylor, Boulos, and Almond, \textit{supra} note 8, at 3.
\end{flushleft}
the rate of COVID-19 cases in counties with a meat and poultry plant was quadruple compared to counties without a plant.\textsuperscript{157}

Since the Executive Order and 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 re-opening of facilities where racial and ethnic minorities were unnecessarily infected with COVID-19 and died. To stop racial inequities in COVID-19 infections and deaths, resulting from political decisions influenced by meat and poultry trade associations, the failure to enforce health and safety standards, and the government’s ineffective pandemic response has led to racial inequalities in employment, the federal and state government should use the health justice framework.

\textbf{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: structural remediation, financial supports and accommodations, and engaging and empowering racial and ethnic minorities disproportionately harmed by systemic racism in employment. These solutions build on our prior work and the work of David Michaels and Gregory Wagner, former senior OSHA officials.\textsuperscript{158}

First, the emergency pandemic legal and policy response must eradicate systemic racism by providing paid sick leave to all workers, even if they are 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.”\textsuperscript{159} Cities, such as Oakland, California, are already requiring that employers provide paid sick leave to essential workers during the pandemic.\textsuperscript{160} 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, with retaliation protection. The government also needs to prohibit the use of punitive attendance policies for all essential workers.

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{157} \textit{Id. at Table S5, Appendix.}
\item \textsuperscript{158} Yearby, \textit{supra} note 93; Yearby & Mohapatra, \textit{supra} note 1; Yearby & Mohapatra, \textit{supra} note 16; Michaels & Wagner, \textit{supra} note 122.
\item \textsuperscript{159} Benfer & Wiley, \textit{supra} note 60.
\end{itemize}
\end{footnotesize}
The government must also use the law to protect the lives of all essential workers. Hence, the government must enforce the health and safety laws to ensure that racial and ethnic minorities are not exposed to COVID-19 in the workplace. OSHA and states must adopt an ETS based on the 2005 proposed airborne infectious disease rule to protect workers. This should be followed immediately with the publication of a final rule based on the 2005 proposed airborne infectious disease rule with increased fines, including penalizing those who are serial violators. Some states are already leading the way. Virginia was the first state to enact a workplace COVID-19 safety standard, while California, Michigan, and Oregon have also enacted workplace laws, strengthened recording and reporting requirements, and issued larger fines that OSHA. These laws should be used as a model for changes in the federal response. Moreover, as proposed by David Michaels and Gregory Wagner, federal and state governments must also expedite workplace COVID-19 case reporting and response to COVID-19 outbreaks; improve the health and safety inspection process by hiring enough inspectors conduct in-person inspections and issuing citations promptly; amplifying

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inspection results by using press releases and social media; and supporting free workplace testing.\textsuperscript{163}

Finally, information from inspections and testing should be disaggregated by race, ethnicity, job duty, and occupation and 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 contract tracing and the mitigation of outbreaks in workplaces. All of 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 predominately racial and ethnic minorities, finally receive some of the same employment benefits as White workers.

Second, the government must provide financial support and accommodations to address the harms caused by the government's pandemic response and racial equalities in employment. Specifically, the government should use economic relief laws to require corporations to provide essential workers with financial supports until the end of the COVID-19 pandemic, such as hazard pay, savings accounts, and survivorship benefits for essential worker's families, which should all increase as the company’s net profit increases. 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.”\textsuperscript{164} The federal government should also provide the workers with a guaranteed basic income until the end of the pandemic. 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.\textsuperscript{165} The ideas of a guaranteed basic minimum income and paid sick leave are 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.\textsuperscript{166} Thus, for almost 20 years, Alaska has

\begin{flushright} \textsuperscript{163} Michaels & Wagner, \textit{supra} note 158. \\
\textsuperscript{166} Michael J. Coren, \textit{When you give Alaskans a Universal Basic Income, They Still Keep they still keep working} (Feb. 13, 2018), https://qz.com/1205591/a-universal-basic-
provided guaranteed support for residents, helping to address poverty, with no change in full-time employment. This financial relief should be provided to all essential workers regardless of immigration or worker status.

The federal and state government should also 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 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 worker’s compensation laws provide coverage for workplace infectious disease outbreaks. Virginia’s law specifically notes that an infectious or contagious disease is covered under worker’s compensation, yet many states have not provided such clarification. Even though many states, like in 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 COVID-19 infections and deaths, must include financial supports and accommodations including, but not limited to hazard pay, death benefits, workers’ compensation for COVID-19 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 government must engage and empower racial and ethnic minorities in the development, implementation, tracking, and evaluation of emergency 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.” The councils will used in the food and apparel manufacturing, warehousing and storage, and restaurant industries. Third-

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party organizations, such as nonprofits and unions, will support the councils by educating the council members about health orders and helping them report violations. 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 David Michaels and Gregory 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. The federal government should also develop a national COVID-19 worker protection plan, which requires all employers to develop and implement infection control plans and provides better protection for workers raising safety concerns. Racial and ethnic minorities and other essential workers must be a part of these changes. Thus, there should be 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 will 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 and deaths. As discussed in the next section, the government must also address systemic racism in health care, which results in racial inequities in COVID-19 infections and deaths.

IV. SYSTEMIC RACISM IN HEALTH CARE

Equal access to quality health care is also limited by systemic racism, particularly structural and interpersonal racism. Both structural and interpersonal racism have harmed racial and ethnic minorities pre-pandemic and during the pandemic. Unfortunately, there is reason to fear that these harms will continue after the pandemic as well. This section provides an analysis of how racial inequities in COVID-19 have played out in the health care arena. This section 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 allocation decisions, and physician bias. The lack of an adequate

\footnotesize{\textsuperscript{170} Id.}  
\footnotesize{\textsuperscript{171} Id.}  
\footnotesize{\textsuperscript{172} Michaels and Wagner, supra note 158.}  
\footnotesize{\textsuperscript{173} Id.}
governmental pandemic response including lack of testing, treatment, and financial support led to racial and ethnic minorities faring worse during the pandemic. There was even a lack of data collection to properly and fully document the racial inequities in COVID-19 infections and deaths. Sadly, this is nothing new. The reality is that many people of color have unequal access to health care, which led to disparities in access to treatment leading to racial inequities in COVID-19 infections and deaths. Even as a vaccine has been approved for use for an emergency use authorization, there is a concern about how racial and ethnic minorities will view the vaccine due to a history of mistreatment in health care by public health officials prior to and during the pandemic. There is also a concern that racial and ethnic minorities will not be able to access vaccines and any COVID-19 treatments, which can be addressed by adopting the health justice framework.

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.¹⁷³ Racism has led to segregated living conditions where access to health care facilities and high-quality health care providers is limited.¹⁷⁴ Research studies show 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 harmed low-income communities and communities of color.¹⁷⁵ Hospitals and physician offices in many racially segregated communities result in lack of access to health care services.¹⁷⁶ The remaining hospitals in these areas are thus overburdened, which results in poorer care

¹⁷⁴ Id.
than in other areas.177 “Neutral” decisions to close hospitals in low-income communities and communities of color often failed to consider the need for the equal distribution of health care facilities among all communities, leaving these marginalized communities without access to health care and provider services.178 The governments’ decision to use hospitals as COVID-19 testing and treatment sites, while closing clinics and other community based health care facilities was seemingly race “neutral”. Nevertheless, the closed health care facilities were disproportionately located in predominately Black, Latino, and Native American neighborhoods, limiting racial and ethnic minorities’ access to coronavirus testing and treatment during the pandemic.

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.179 These inequities are in part due to structural racism, where neutral polices used to identify COVID-19 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. Additionally, many facilities and doctors’ offices that provide non COVID-related care closed temporarily due to state and local COVID-19 restrictions. This is also a race neutral decision. However, due to systemic inequities in housing, education, health care, and employment, Black, Latinx, and Native communities suffer from a higher proportion of chronic illnesses and pre-existing conditions than White people. Thus, these populations were not able to access care, and they are also in groups more likely to have transportation barriers from finding care outside their areas.

B. Systemic Racism, Allocation of Care 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. These allocation decisions about who should get what resources are familiar

177 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. Healthcare L. 1023, 1033–35 (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 . . . ”).

178 Many of these “neutral” decisions were tied more to the race of the community residents than economic reasons. See Ruqaiijah Yearby, Breaking the Cycle of “Unequal Treatment” with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias, 44 U. Conn. L. Rev. 1281, 1301–06 (2012).

179 Id.
in the health care system. The United States allocates all sorts of health care access depending on status and ability to pay.

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. Insurance coverage differs greatly by race with Black, Latino, and Native Americans often uninsured or underinsured. In fact, some researchers have deemed the lack of health insurance an epidemic much like COVID-19. Ninety-one percent of disproportionately 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. These racially segregated counties have much higher rates of COVID-19 infection and deaths than majority white counties. 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. Many that live in states that did not expand Medicaid under the ACA are stuck with no insurance and are struggling to meet their financial needs, and often health care is relegated to a luxury item. 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. During COVID-19, the lack of Medicaid expansion has limited Black, Latino, and Native Americans access to health care. Additionally, alarming numbers of people lost their jobs during the pandemic and as a result lost access to employer sponsored insurance. Purchasing

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COBRA or other insurance depends on financial resources, which are much lower in African American and Latino populations than White populations.\textsuperscript{186}

2. Differential Protection Within Health Care Providers

In terms of 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 and workers in nursing homes. Even within the health care system, there was a hierarchy in terms of who gets N95 and surgical masks and who must supply their own PPE. 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. Medical assistants, nurses, and other allied health staff are more often people of color and from low-income backgrounds. So within a hospital setting, it was not unusual to have some health care providers with adequate PPE and others with makeshift protection. One stark statistic revealed that Filipino-Americans, who make up 4\% of U.S. nurses, accounted for 31.5\% of COVID-related nurse deaths.\textsuperscript{187} The reasons why need to be explored but there is speculation that this is in part due to a colonial and cultural history that result in Filipino-American nurses from complaining, even if they were sick, given inadequate PPE, or given more dangerous jobs in nursing than other nurses.\textsuperscript{188} This is an example of how work and health care intersect and how certain people of color face barriers to protect themselves due to their lack of power.

3. Crisis Standards of Care

During pandemics and emergency situations, health care resources are allocated more “equitably” through crisis standards of care (CSC) based on maximizing benefits, saving lives, and/or saving life years. The COVID-19 pandemic in the U.S. has prompted the creation and revision of CSC by many state health departments and health care systems/institutions. According to several systematic reviews, currently twenty-nine states have implemented crisis standards of care, which have been influenced by the University of Pittsburgh standard, the 2020 Emanuel et al allocation standard published in the New England Journal of Medicine, and the 2020 Massachusetts Crisis


\textsuperscript{188} Id.
standards of care. Of the twenty-nine CSC, fifteen were updated in 2020 and eight address the COVID-19 pandemic. Twenty-one CSC use the Sequential Organ Failure Assessment or Modified Sequential Organ Failure Assessment, which numerically quantifies the number and severity of failed organs using four parameters, while the Modified Sequential Organ Failure Assessment can predict organ failure using one laboratory measure. Furthermore, nineteen explicitly stated that resource allocations “should be made without regard to race, ethnicity, disability, and other identity-based factors,” twenty-four “explicitly stated the ethical principles on which resource allocation decisions should be made,” sixteen included health equity as an ethical consideration, and

Although these nineteen CSC mandated race neutrality, these CSC ignore the significance of racism in defining maximizing benefits and racism’s impact on disparities in life years and access to life saving treatment. All CSC base the allocation of health care on some definition of maximizing benefits using life expectancy, Sequential Organ Failure Assessment, or saving life years, which advantages Whites and disadvantages racial and ethnic minorities, because whites tend to have a great life expectancy than racial and ethnic minorities. Thus, the crisis standards of care would provide care to whites, while limiting racial and ethnic minorities’ equal access to health care, an example of structural racism. Additionally, the creation of CSC neither included racial and ethnic minorities, nor addressed their current barriers to accessing hospital care. This exclusion from crafting the crisis standards of care have not only imposed substantial material harm because racial and ethnic minorities cannot access hospitals in which the care is being provided, but the exclusion also reinforces the notion that racial and ethnic minorities are ill equipped to make choices about limited resources.

4. Vaccine and Treatment Allocation

As a vaccine for COVID-19 becomes available, there is a real concern about how racial and ethnic minorities will fare in getting access to the vaccine. Due to centuries of mistreatment in the health care system, many African Americans and Latinos are rightfully distrustful of the vaccine, in larger percentages than White people. Dr. Anthony Fauci, infectious

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189 Emily Cleveland Manchanda, Charles Sanky, and Jacob Appel, Crisis Standards of Care in the USA: A systematic review and Implications for Equity Amidst COVID-19, J. OF RACIAL AND ETHNIC DISPARITIES (August 3, 2020).

190 Id.


192 Manchanda, Sanky, and Appel, supra note 189.

193 Id.

194 Nada Hassanein, There's skepticism in Black, Latino communities about COVID-19
disease expert and the famous government “face of science” during the pandemic, has been touting the fact that Dr. Kizzmekia Corbetta, a Black doctor helped develop the vaccine to try to sway public opinion. Additionally, the first person who received the COVID-19 vaccine in the United States was Sandra Lindsay, a Black nurse in New York City, who received the vaccine from a Black physician on camera. 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. However, there need to large scale public health campaigns tailored to Black and brown populations to help gain the trust of these populations.

The way to ethically proceed with a vaccine is difficult. If Black people and other minorities get the vaccines before others, there is a fear that they will be guinea pigs, a la Tuskegee. If these groups are made to wait, there is a fear that those who have fared the worst in the pandemic will be ignored. This conundrum is being worked through right now but it is important that members of the community be involved in effecting policy related to vaccines and treatments. Donald Trump and his associates like Rudy Giuliani received monoclonal antibody treatments, with Giuliani saying the quiet part out loud that he got special “celebrity” treatment. 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 terms of how treatments and vaccines are being allocated.

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

Even prior to the pandemic, access to physician care has been worse for African Americans and Latinx individuals, especially those who live in segregated areas. For example, a 2012 study found that segregated areas where African Americans and Latinx individuals lived lacked adequate access to primary care physicians. Prior to the Affordable Care Act

vaccines, but women of color can help swing the momentum, USA TODAY, Dec 14, 2020, https://news.yahoo.com/theres-skepticism-minority-communities-covid-110022525.html


196 Allana Akhtar, Meet Sandra Lindsay, a nurse in New York City who was the first person in America to get the COVID-19 vaccine, BUSINESS INSIDER, Dec 14, 2020, available at: https://www.businessinsider.com/meet-sandra-lindsay-first-us-person-get-covid-19-vaccine-2020-12


199 Darrell J Gaskin et. al., Residential Segregation and the Availability of Primary
becoming law, African Americans were twice as likely not to be able to access health insurance as White Americans.\textsuperscript{200} Even though the Affordable Care Act 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.

Additionally, many African Americans have reported feeling discriminated against in health care settings. This racism has many causes. One is the lack of health care providers that are also African American. Another is the lack of culturally competent care and training that providers receive in medical school. Medical doctors often hold implicit and explicit biases that show up in a patient encounter, which is evidence of interpersonal racism. Black people are much less likely to encounter a physician who is also Black than White Americans 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\%.\textsuperscript{201} 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.

When medical care is an expensive proposition and medical encounters are tinged with racism, it is no surprise that African Americans delay or avoid seeking health care until absolutely necessary.\textsuperscript{202} We see that anecdotally even when African Americans sought COVID-19 care, their symptoms were often dismissed. 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.”\textsuperscript{203} Indeed, Kaiser Health News reported that “doctors may be less likely to refer African Americans for testing when they show up for care with signs of infection.”\textsuperscript{204}

\begin{thebibliography}{99}

\item Janice Sabin et al., \textit{Physicians’ Implicit and Explicit Attitudes About Race by MD Race, Ethnicity, and Gender}, 20 \textit{J. Healthcare Poor & Underserved} 896, 907 (2009).\textsuperscript{202}
\item John Eligon and Audra D. S. Burch, \textit{Questions of bias in COVID-19 treatment add to the mourning for black families}. The New York Times The
\end{thebibliography}
B. Health Justice: Eradicating Systemic Racism in Health Care

The governmental pandemic response only made the disparities in health care access worse for racial and ethnic minorities. Instead of bolstering more support for these communities in terms of financial supports, increased health care and testing access, and culturally competent care, it seemed that states and the federal government buried its 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, African Americans 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) deployment of emergency reserve 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 twelve 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-elect Biden has appointed people to manage the COVID-19 response who are interested in health equity. However, with a majority Republican Senate, President Biden may not be able to overhaul the system. Just as the movements for Black Lives Matter and the MeToo Movement were community based, the movement for health justice must come from the communities impacted by health inequities and disparities. Black, Latinx, Native American, people with disabilities, and other communities who have suffered disproportionately more from this pandemic must organize and mobilize to demand broad systemic change.

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, economic relief bills, and the enforcement of laws governing employment and health care that further exacerbate 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 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.

https://news.yale.edu/2020/12/08/nunez-smith-lead-biden-health-equity-task-force
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.” 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 COVID-19 infections and death for low-income individuals and people of color.

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 as well as 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 and communities of color, equal access to health care facilities must be realized. Using cancer case as an example, in Chicago, only two of the 12 Chicago hospitals designated as quality cancer care centers are in the predominantly Black South Side of Chicago, despite higher rates of exposure to carcinogens. “Black women in Chicago were almost 40% less likely than White women to receive breast care at a breast imaging center of excellence.” In these areas, the lack of specialists and adequate equipment in hospitals results in inferior care. Marginalized 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 due not health insurance, the government needs to make sure that

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206 Hardeman, supra note 185.
207 Pallok, supra note 201.
209 Pallok, supra note 201.
210 Id.
their treatment is covered. As mentioned in Section IIID, 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 to ensure that the design and implementation of interventions intended to benefit them are actually tailored to their needs. We encourage robust community involvement in developing these solutions because these marginalized communities will otherwise continue to be denied access to quality health care. For example, some governments have worked to ensure that predominately Black and Latino communities have access to testing, such as North Carolina where they arranged for testing facilities available to Latino farmworkers. We need community involvement in developing these solutions because these marginalized 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 COVID-19 infections and deaths. These inequalities are a result of systemic racism, wherein the federal and state government as well as companies pandemic responses have disempowered and devalued the lives of racial and ethnic minorities.

This essay attempts to outline how systemic racism played out in the COVID-19 using examples in employment and health care. This is not a simple problem. 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 emergencies.

Furthermore, the government must eradicate these inequalities by actively addressing systemic racism, which has not only influenced its pandemic response, but also eradicated trust in the government. To accomplish this task the federal and state government 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.

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