Exploring the Legal and Societal Ramifications of COVID-19 on Marginalized Populations
Diversity & Inclusion CLE

Thursday, Sept. 24, 2020

4 – 5:15 p.m. eastern

Online via Zoom

CLE CREDIT: Because of COVID-19 related restrictions, this CLE will be offered in a virtual setting, via Zoom. A code will be provided at a particular point in the program, which can be used to claim CLE credit for participation. You will be provided with an Attorney CLE Affirmation form for the code and credit. Syracuse University College of Law has been certified by the New York State Continuing Legal Education Board as Accredited Providers of Continuing Legal Education in the State of New York. Exploring the Legal and Societal Ramifications of COVID-19 on Marginalized Populations complies with the requirements of the New York State Continuing Legal Education Board for 1.0 credits towards the professional practice requirement. This program is appropriate for newly admitted and experienced attorneys. This is a single program. No partial credit will be awarded.

COLLEGE OF LAW
Legal and Societal Ramifications of COVID-19 on Marginalized Populations
Panel Discussion
September 24, 2020
4 pm – 5:15 pm ET

Duration: 60 Minutes
1 credit Diversity, Inclusion and Elimination of Bias Credit (NY)

Summary: Explore the legal, societal, and financial impact of COVID-19 on marginalized populations. As the world is facing a pandemic, communities of color, and in particular the elderly members of those populations, have been disproportionately impacted by COVID-19. This, however, is not random nor unique. Health and social disparities within Black and Brown communities, caused by structural racism, exist and play a role in the devastating effects of COVID-19. Further, the treatment of the elderly, as demonstrated in the responses to COVID-19 and its implication, bring to the forefront deeply rooted ageism that goes beyond the global pandemic. Panelists, in medical and legal fields, will discuss why these disparities exist, the intersectionality of race and age, and how to best serve these marginalized populations, through advocacy and policy.

Moderator: Fulvia Vargas, J.D., L'15

Panelists: Sharon A. Brangman, M.D., F.A.C.P., A.G.S.F., SUNY Upstate Medical University
Daryll C. Dykes, Ph.D., M.D., J.D., Upstate Orthopedics
Professor Nina A. Kohn, J.D., Syracuse University College of Law

Timed Agenda

4:00 - 4:05 pm: Welcome and Introductions: Fulvia Vargas, J.D., Class of 2015

4:15- 5:05 pm: Panel Discussion, "Legal and Societal Ramifications of COVID-19 on Marginalized Populations", moderated by Fulvia Vargas
- Structural Racism
- Health Law
- Elder Law

5:05-5:15 pm Questions from audience

5:15 pm Closing Reflections – Kristen Duggleby, Director of Alumni Relations

Outline of Presentation
- Introduction
- Health Issues in Black and Brown Communities
- Intersectionality of Race and Age

- How to Properly Serve these Populations
- Q&A

Reading:

Issac Chotiner, "How Racism is Shaping the Coronavirus Pandemic"
https://www.newyorker.com/news/q-and-a/how-racism-is-shaping-the-coronavirus-pandemic/amp

Governor Andrew Cuomo, Executive Order Continuing Temporary Suspension and Modification of Laws Relating to Disaster Emergency
https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/EO202.30.pdf

Nina Kohn, "Addressing the crisis in long-term care facilities"
https://www.newyorker.com/news/q-and-a/how-racism-is-shaping-the-coronavirus-pandemic/amp

Nina Kohm, "The pandemic exposed a painful truth: America doesn't care about old people"
https://www.washingtonpost.com/outlook/nursing-home-coronavirus-discrimination-elderly-deaths/2020/05/07/751fc464-8fb7-11ea-9e23-6914ee410a5f_story.html

Nina, Kohn "Nursing homes need increased staffing, not legal immunity
https://www.washingtonpost.com/outlook/nursing-home-coronavirus-discrimination-elderly-deaths/2020/05/07/751fc464-8fb7-11ea-9e23-6914ee410a5f_story.htmlJoint New York State and

Assembly Public Hearing on Residential Care Facilities and COVID-19 – Testimony of Nina A. Kohn

Ruqaiijah Yearby, Law, Structural Racism, and the COVID-19 Pandemic
https://doi.org/10.1093/jlb/lsaa036

Panelists and Program Moderator

Sharon A. Brangman, M.D., F.A.C.P., A.G.S.F., SUNY Upstate Medical University

Dr. Brangman is a graduate of Syracuse University and earned her medical degree from SUNY Upstate Medical University in Syracuse, New York. She completed internship, residency, and geriatric fellowship programs at Montefiore Medical Center in the Bronx, New York. She is board certified in internal medicine, geriatric medicine, and hospice and palliative medicine.

Dr. Brangman is a SUNY Distinguished Service Professor and was recently named the Inaugural Chair of the Department of Geriatrics at SUNY Upstate Medical University. Prior to this appointment, she had been the Division Chief of Geriatrics for 20 years. She serves as the fellowship director for geriatric medicine. Dr. Brangman is director of the Center of Excellence for Alzheimer's Disease, is also Medical Director of the Transitional Care Unit on the Upstate Community Campus, and is Medical Director of Greenpoint/The Hearth Senior Living Communities in Syracuse, New York. She is the director of the Nappi Longevity Institute, also at Upstate Medical University.

Dr Brangman has received many honors, including Best Doctors of Northeast Region, the Chancellor's Award for Faculty Service and Hartford Geriatrics Leadership Scholars Award. Dr Brangman was a member of the Board of Directors of the American Geriatrics Society for ten years, and completed terms as President and Chair of the Board. She is also a past Chair of the Board of the Association of Geriatric Academic Program Directors, which she completed after serving a term as its President.

Dr. Daryll Dykes, Ph.D., M.D., J.D., Upstate Orthopedics

Dr. Daryll Dykes is an internationally recognized orthopedic surgeon specializing in adult and pediatric spine surgery. He is a native of Syracuse and a 1988 alumnus of Syracuse University's

College of Arts and Sciences. He earned his M.D. degree and Ph.D. in Biochemistry and Molecular Biology at Upstate Medical University where his many honors included the President's Award for Excellence in Research. He completed his orthopedic residency at the University of Minnesota Medical School and his spine surgery fellowship at Twin Cities Spine Center. He also is the *magna cum laude* graduate and valedictorian of his law school class at William Mitchell College of Law in St. Paul, Minnesota.

In 2015, Dr. Dykes was selected for the prestigious Robert Wood Johnson Foundation Health Policy Fellowship in Washington, D.C., where he served as a senior staff member on the U.S. House of Representatives' Committee on Energy and Commerce—the congressional committee with the broadest legislative and oversite jurisdiction over health and healthcare in the United States. In this role, Dr. Dykes made key contributions to author and pass major health-related bills, including the *21st Century Cures Act* (Pub.L. 114—255) and the *FDA Reauthorization Act of 2017* (Pub.L. 115—52). Dr. Dykes then served as a senior health policy advisor at the U.S. Food and Drug Administration where he assisted in the implementation of legislation that he had previously worked on in Congress.

In 2018, Dr. Dykes joined the Orthopedic Surgery faculty at SUNY Upstate Medical University with research interests at the intersection of medicine, law, and public policy as determinants of health equity, life expectancy and health-related quality of life. As Upstate's Chief Diversity Officer, he serves on the University's executive leadership team and the College of Medicine Dean's Executive Committee. Dr. Dykes is a founding member of the Lumbar Spine Research Society and holds leadership roles in several professional organizations, including the American Academy of Orthopedic Surgeons, the U.S. Bone and Joint Initiative, and the Scoliosis Research Society. He is a Diplomat of the American Board of Orthopaedic Surgery and a Fellow of the American Orthopaedic Association and American College of Legal Medicine.

Professor Nina Kohn

Nina A. Kohn is the David M. Levy Professor of Law and Faculty Director of Online Education at Syracuse University College of Law, a faculty affiliate with the Syracuse University Aging Studies Institute, and a member of the American Law Institute. She is also the Solomon Center Distinguished Scholar in Elder Law with the Solomon Center for Health Law and Policy at Yale Law School. She has served as a Visiting Professor at Yale Law School and at the University of Maine School of Law.

In her prior role as Associate Dean for Online Education, Kohn developed the College of Law's online JD program (JDinteractive), the nation's first fully interactive online JD program. In her current role as Faculty Director of Online Education, she guides the program's ongoing development and supports faculty teaching online.

Professor Kohn's scholarly research focuses on elder law and the civil rights of older adults and persons with diminished cognitive capacity. Her work has appeared in diverse fora including the *Harvard Civil Rights-Civil Liberties Law Review, the Washington University Law Review, and the Washington Post*. Her recent articles have addressed family caregiving, supported and surrogate decision-making, financial exploitation of the elderly, vulnerability and discrimination in old age, the practical and constitutional implications of elder abuse legislation, the potential for an elder rights movement, and legal education.

She authored the textbook *Elder Law: Practice, Policy & Problems* (Wolters Kluwer, 2d ed. 2020). Consistent with her research interests, Professor Kohn has taught elder law, family law, trusts and estates, torts, and an interdisciplinary gerontology course.

Professor Kohn has served in a variety of public interest roles, including as Reporter for the Third Revision of the Uniform Guardianship and Protective Proceedings Act. She currently serves as the Reporter for the Uniform Law Commission's Study Group on the Uniform Health Care Decisions Act, Co-Chair of the Elder Rights Committee of the Individual Rights and Responsibilities Section of the American Bar Association; Co-Director of the Aging, Law, and Society Collaborative Research Network; and Vice Chair of the Association of American Law Schools' Section on Mental Disability.

Professor Kohn earned an A.B. summa cum laude from Princeton University and a J.D. magna cum laude from Harvard University. She clerked for the Honorable Fred I. Parker of the United States Court of Appeals for the Second Circuit. Following her clerkship, she was awarded a fellowship by the Skadden Fellowship Foundation to provide direct representation to nursing home residents and frail elders. She is a past recipient of Syracuse University College of Law's *Res Ipsa Loquitur* award recognizing excellence in teaching, and Syracuse University's Judith Greenberg Seinfeld Distinguished Faculty Fellowship.

Fulvia Vargas, L'15

Ms. Vargas-De Leon is a 2015 graduate of the College of Law. While in law school, Ms. Vargas-De Leon was president of the Latin American Law Student Association, a Syracuse Public Interest Network Fellow, and part of the inaugural class of Pro Bono Scholars in New York Currently, she is the Bronx Legal Services' Staff Attorney for the Legal Hand sites in the Bronx. In this role, Ms. Vargas-De Leon provides advice to community members in various areas of civil law and hosts workshops to educate community and volunteer members on their rights in the areas of housing, labor and employment and public benefits. She has worked in civil law for the last 5 years, first as a Staff Attorney with Legal Services of Central New York and later with the New York Legal Assistance Group's Mobile Legal Help Center. As an attorney, she has dedicated her career to

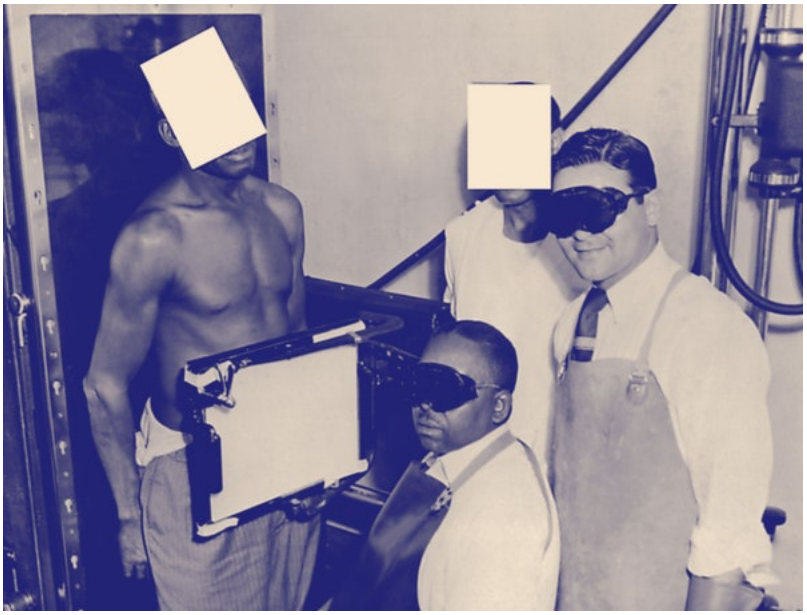
advocating for underserved communities with a particular focus on employment discrimination and wage and hour violations.

THE NEW YORKER

Q. & A.

HOW RACISM IS SHAPING THE CORONAVIRUS PANDEMIC

By Isaac Chotiner May 07, 2020



The historian Evelynn Hammonds talks about how false theories of "innate difference

and deficit in black bodies" have shaped American responses to disease, from yellow fever to syphilis to COVID-19.

Photograph Courtesy CDC / Alamy

Evelynn Hammonds, who chairs Harvard's department of the history of science, has spent her career studying the intersection of race and disease. She wrote a history of New York City's attempt, a century ago, to control diphtheria, and is currently at work on a book of essays on the history of race, from Jefferson to genomics. Hammonds's area of expertise is especially relevant today: while the data is incomplete, at this point in time, African-Americans represent nearly a third of U.S. deaths from the coronavirus pandemic and thirty per cent of COVID-19 cases, despite making up only about thirteen per cent of the population. Hammonds noted recently, "This new development of what has happened with the pandemic with respect to African-American communities" is "perhaps an old development."

READ *THE NEW YORKER'S* COMPLETE NEWS COVERAGE AND ANALYSIS OF THE CORONAVIRUS PANDEMIC.

I spoke by phone with Hammonds, who is currently hosting a series of Webinars with academics and experts at Harvard on African-Americans and epidemics in American history, from the eighteenth century to the present day. As she stated in one of the sessions, "I can't imagine saying that we have to wait until this pandemic has passed to make clear what kinds of structural inequalities and implicit and explicit biases are at work." During our conversation, which has been edited for length and clarity, we discussed why African-Americans were once thought to be immune to various diseases, how

this belief morphed into the fear that they were spreaders of contagion, and what lessons can be learned from a Civil War-era smallpox outbreak.

Have you been thinking about the coronavirus in a historical context, and, if so, what specific context?

I think any historian who has worked on the history of disease has been thinking about the coronavirus in historical contexts, and there are many, many resonances that kept appearing in press reports of all kinds. About four weeks ago, I began to be particularly interested in the fact that I wasn't hearing about the pandemic having an impact on African-American communities. You heard stories that said this disease affects us all, but, knowing what we know about the ways in which epidemic diseases always lay bare and make visible inequalities in a society, I was surprised that I wasn't hearing very much about what was happening for African-Americans and Latinos, and also very poor people in general. Then the news burst on the scene that, in many of the hardest-hit areas, African-Americans were disproportionately impacted. And at that point I was having a conversation with Henry Louis Gates, Jr., and I decided to host a Webinar on the impact of epidemic disease on African-Americans from 1793 to the present.

Why did you decide to start in 1793?

Because there was a very serious outbreak of yellow fever in Philadelphia from 1792 to 1793. At the time, Philadelphia was the seat of government. Benjamin Rush was a signer of the Declaration of Independence, a leading person in Philadelphia, but he was also a physician. He wrote a lot about his theories, about the spread of yellow fever and how it should be treated. I think the population of Philadelphia at the time was about fifty thousand, and over five thousand people died. That's quite significant. And one of the things that came to the fore in that moment was the widespread belief among whites that African-Americans were immune to yellow fever. And so, because of that belief, Rush enlisted two African-American

leaders of the community, Richard Allen and Absalom Jones, and encouraged them to help treat the sick. He taught them how to perform some nursing and to help treat the sick based on his theories of how you treat yellow fever. And they did this, and they travelled around the city, and they did a lot of this work, as many white élites had left town. [*Other members of Philadelphia's free black community also worked as volunteers during the epidemic.*]

And then at the end of the epidemic, a newspaper editor, Matthew Carey, wrote an article saying that, yes, they were immune, but that these black people who were supposedly helping sick people in Philadelphia were actually robbing them. Absalom Jones and Richard Allen then wrote a pamphlet, which is one of the earliest pamphlets written by African-Americans in the United States, and they argued that they had been misrepresented, that they had helped as many people as they could. And, by the way, they found that many of the black people in Philadelphia also did suffer from yellow fever, and some died. It's an early instance of that notion that black bodies are different bodies, and therefore are not susceptible to diseases in the same way as whites, and the belief became quite visible and prominent in a medical discussion of an outbreak. So, to me, that was an important moment. It was also an important moment because African-Americans really spoke up for themselves and challenged those prevailing views.

Was Rush's decision because he thought that they were immune, too, or was he trying to dispel the myth?

Oh, no, he thought they were immune, too.

Throughout American history, and certainly through the eras of slavery and Jim Crow, it seems that going on side by side with this dislike of African-Americans was also this fear of them as physical presences or bodies.

That's right. And so, moving forward in time, you see this idea of black bodies being a "threat" to the white population. By the early twentieth century, there's a famous article published in the *American Journal of Public Health* called "Germs." Actually, it was first published in the Atlanta *Constitution*, and it was called "Germs Know No Color Line." The doctor who wrote it was making an argument that suggested whites should be concerned about the health of African-Americans, not because they cared about African-Americans but because these people worked for them. They raised their children, they cooked for them. They were in and out of their houses. They did their laundry. And, since germs know no color line, these people who are so intimately involved in your lives will be bringing these germs and disease into your houses. So you should care about their health, not for their sake but for your own sake. It manifested the view that black bodies are dangerous, white people should protect themselves from black bodies, and black bodies and black people spread disease.

Another event that I know has captured your interest is the outbreak of smallpox toward the middle of the nineteenth century. Can you talk about that a little bit?

Right around the time of emancipation, with the war still going on, African-Americans really became a kind of refugee population. They were leaving plantations in the South, and they left with very little to take care of themselves. They had little food, they had little clothing, they had no housing, they didn't really have destinations. Where were

they going? And many people followed the Union troops.

At the time, a smallpox epidemic broke out. White physicians knew how to treat smallpox. They knew about vaccination. But they isolated the black people who were following the troops as refugees. And by isolating the African-Americans, or I should say by isolating the newly freed African-Americans, the disease spread very quickly among them. So the outbreak of smallpox was not controlled, and many of those African-Americans suffered and died. And, in fact, a historian named Margaret Humphreys said something to the effect of: the path to freedom was paved with death, and destitution, and suffering. So it was very striking that freedom came with the spread of a very serious and highly contagious disease, at a moment when there was no federal or state infrastructure to care for them.

That's the origin of that epidemic and outbreak. And the fact that African-Americans were leaving the South was the impetus for the Freedmen's Bureau. There was a medical division of the Freedmen's Bureau, which was established by the federal government, and the medical division was set up to provide health care for African-Americans. They built makeshift hospitals. They provided nursing and care and treatment as best they could. But, certainly in the political controversies during Reconstruction, Southerners reacted strongly to the federal government spending funds to take care of black people. And, as you know, the Southerners won arguments in Reconstruction, and therefore the federal government retreated from a national effort to provide health care to African-Americans. At the same time, a small group of educated African-Americans was involved in trying to provide care for this newly freed population, which had so very little. And they, too, argued to the federal government that now they were citizens, they wanted the government to provide health care to them. It was a moment where citizenship was tied to health care in a way that hadn't really been articulated before.

What stuck out about the response of white Americans to this outbreak?

There were reports in white newspapers that said, "See what freedom has brought to the slaves? They bring with them disease, and that proves that they are not fit for freedom." And, certainly, by the end of the nineteenth century there was this notion that African-Americans' bodies were not fit for civilization. In fact, the burden of the diseases that they increasingly were suffering from, in particular tuberculosis, meant to some white observers that they were not going to live long into the future as a people. Frederick Hoffman, who was a statistician for the Prudential Insurance Company, wrote that, yes, they're going to die out. They're uninsurable because they, as a people, are going to die out under the burden of disease.

The last point I want to make is that this notion, this kind of extinction thesis, was something that really came to prominence in the late nineteenth century for African-Americans. But it's something that had been spoken about in medical circles, in the white medical circles, earlier with respect to Native Americans, who certainly at the moment of first contact with the early colonists in Massachusetts and Virginia seemed to be suffering from and dying of high rates of diseases that did not affect the white colonists in the same way.

So the notions that these bodies are different—that Native American bodies were different, and that the bodies of African-Americans were fundamentally different—gets deeply sedimented into medical theory and practice. And I think that's something from the nineteenth century that is still with us.

What specifically did you mean by "extinction thesis"?

There were white élites saying that there's so much disease in the African-American community—high rates of tuberculosis, high rates of pneumonia, high rates of other kinds of diseases, including sexually transmitted diseases—that this group of people can't possibly live as long as whites would live, and that at some point they're going to simply die out under the burden of disease.

It's amazing how there's no internal consistency between that idea and what you were talking about regarding 1793, but the ultimate effect is the same.

Yes. And so, again, they're saying that black people have different bodies, different biology, different physiology, as well as extending that to cultural difference, being intellectually different and deficient.

So then you have the flu epidemic of 1918, which takes place in an interesting historical period. You have the First World War, and an uptick in xenophobia going on around then, right in the heart of the Jim Crow era.

Vanessa Northington Gamble wrote a really wonderful paper pointing to the fact that the expectation of observers in the 1918 influenza epidemic was that black people would suffer disproportionately from it and die, in part because it was already well known that African-Americans had high rates of respiratory disease. But it didn't work out that way. African-Americans did not seem to be dying at higher rates than whites—or at least that's what white and African-American observers noticed. It's very difficult to nail it down because we're talking about respiratory diseases, but a lot of the white observers and black observers were surprised at that. It was a puzzle that African-Americans didn't have higher rates of influenza.

Are there other twentieth-century events that you think about in this context?

I would turn to next to the Tuskegee syphilis studies, where the United States public-health service was engaged in studying the effects of syphilis and advanced syphilis on African-American men who lived in Tuskegee, Alabama. It was a very flawed study in many, many ways. It is not clear that the cases and controls were kept separate. The medical care given to people in the study was insufficient. So it wasn't rigorously done, but it continued for forty years, because at the core of it was the notion that syphilis must be a different disease in black people. It continued even after people knew

that penicillin could be used as a treatment. So here we go again, carrying that theory forward of a kind of innate black pathology, an innate difference and deficit in black bodies that would be manifested in susceptibility and/or immunity to disease.

And over time you see very little that dislodges that view, despite growing evidence of the role of social conditions in the production of disease or, as people now talk about, the social determinants of health. Still there's a view that there is something specific about black bodies that's different than white bodies, and that just continues, and that's certainly part of what I think is a subtext of the discussion about the impact of the COVID-19 pandemic on black communities.

How do you think that is a subtext?

It's a subtext in the sense that, when the news came out that African-Americans were disproportionately affected by the coronavirus, immediately some observers said it is because, you know, black people have these preëxisting conditions, like high rates of hypertension and high rates of diabetes and high rates of obesity. And there was at least one commentator who said, Oh, they just don't take care of themselves. And that's why they're more vulnerable to the disease. So it's something that black people either do or that's in their bodies that makes them more susceptible to disease, rather than observers looking directly at the social conditions that, in fact, have produced higher rates of obesity and hypertension and other comorbidities that seem to have an impact on who's more susceptible to the coronavirus. So, again, a narrative of black bodies being different, and deficits in black people's behavior being responsible for them being more vulnerable to disease, harkens back to some of the themes of the earlier epidemics.

It seems like the point that is important to get across now is that bodies, speaking in a macro sense of different populations, are different, but they're different because society has created these inequalities, which, as you say, lead to comorbidities, and those conditions then affect death rates. It's not that the bodies are inherently different.

Yes, exactly. It's the social conditions that continue to produce these vulnerabilities in certain populations, not that the people somehow are inherently biologically different. But, again, if you think about this in terms of the vulnerabilities that people have based on the social conditions that they live in, they may live in communities with high density, they may live in houses where there are lots of people living in small spaces, they may do work where they're more exposed to something like a coronavirus. Those are the conditions that make them more vulnerable. It's not that their bodies are somehow inherently different.

Is there a paradox here, in that you are talking about an obsession with black bodies when the greatest fear now might be that people just don't even care enough about these inequalities to be obsessed?

I don't think it's a paradox. I think it is coming from the same thing. But I do think that what it represents in terms of this society's investment in public health. There are places in this country where whites, who are the larger part of the population, do not want to invest in a public-health infrastructure that would respond to the needs of the most vulnerable in their community. And that's a reaction to government authority. We have a fragmented public-health system, which makes people on the margins much more vulnerable to outbreaks of all kinds of diseases than the majority population is.

A previous version of this piece misspelled Matthew Carey's name.

A Guide to the Coronavirus

- Twenty-four hours at the epicenter of the pandemic: nearly fifty *New Yorker* writers and photographers fanned out to document life in New York City on April 15th.
- Seattle leaders let scientists take the lead in responding to the coronavirus. New York leaders did not.
- Can survivors help cure the disease and rescue the economy?
- What the coronavirus has revealed about American medicine.
- Can we trace the spread of COVID-19 and protect privacy at the same time?
- The coronavirus is likely to spread for more than a year before a vaccine is widely available.
- How to practice social distancing, from responding to a sick housemate to the pros and cons of ordering food.
- The long crusade of Dr. Anthony Fauci, the infectious-disease expert pinned between Donald Trump and the American people.
- What to read, watch, cook, and listen to under quarantine.

Isaac Chotiner is a staff writer at The New Yorker, where he is the principal contributor to Q. & A., a series of interviews with major public figures in politics, media, books, business, technology, and more. *Read more »*

More: Coronavirus Racism Interviews Epidemics History Public Health

State of New York

Executive Chamber

No. 202.30

EXECUTIVE ORDER

Continuing Temporary Suspension and Modification of Laws Relating to the Disaster Emergency

WHEREAS, on March 7, 2020, I issued Executive Order Number 202, declaring a State disaster emergency for the entire State of New York; and

WHEREAS, both travel-related cases and community contact transmission of COVID-19 have been documented in New York State and are expected to be continue;

NOW, THEREFORE, I, Andrew M. Cuomo, Governor of the State of New York, by virtue of the authority vested in me by Section 29-a of Article 2-B of the Executive Law to temporarily suspend or modify any statute, local law, ordinance, order, rule, or regulation, or parts thereof, of any agency during a State disaster emergency, if compliance with such statute, local law, ordinance, order, rule, or regulation would prevent, hinder, or delay action necessary to cope with the disaster emergency or if necessary to assist or aid in coping with such disaster, I hereby temporarily suspend or modify, for the period from the date of this Executive Order through June 9, 2020 the following:

- Clause (b) of subparagraph (v) of paragraph (1) of subdivision (c) of section 415.26 , paragraph (8) of subdivision (a) of section 487.9 and paragraph (5) of subdivision (a) of section 488.9 of Title 18 of the NYCRR; and subdivision (7) of section 4656 of the Public Health Law are modified to the extent necessary to require that the operator and administrator of all nursing homes and all adult care facilities, including all adult homes, enriched housing programs and assisted living residences to test or make arrangements for the testing of all personnel, including all employees, contract staff, medical staff, operators and administrators, for COVID-19, twice per week, pursuant to a plan developed by the facility administrator and filed with the Department of Health no later than 5:00 p.m. on Wednesday, May 13, 2020. Any positive test result shall be reported to the Department of Health by 5:00 p.m. of the day following receipt of such test result, in a manner determined by the Commissioner of Health. Nothing herein shall prohibit staff of the Department of Health, or the local health department in the jurisdiction of the nursing home or adult care facility, from having unrestricted access to the facility where such access is determined necessary in the discretion of the Commissioner of Health for purposes of testing all personnel for COVID-19, and provided further that in such circumstances the operator and administrator shall cooperate fully with Department of Health and local health department staff to facilitate such testing.

IN ADDITION, by virtue of the authority vested in me by Section 29-a of Article 2-B of the Executive Law to issue any directive during a disaster emergency necessary to cope with the disaster, I hereby issue the following directives for the period from the date of this Executive Order through June 9, 2020:

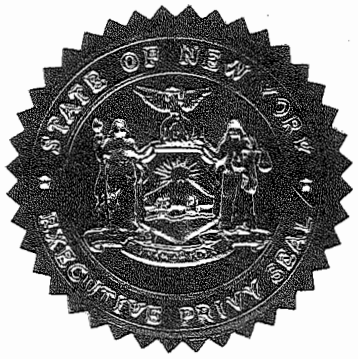
- No later than May 15, 2020, both the operator and the administrator of all nursing homes and adult care facilities must provide to the Department of Health a certification of compliance with this Executive Order and directives of the Commissioner of Health, and all other applicable Executive Orders and directives of the Commissioner of Health.

    - The Commissioner of Health is authorized to suspend or revoke the operating certificate of any nursing home or adult care facility if it is determined that such facility has not complied with this Executive Order, or any regulations or directives issued by the Commissioner of Health, and if determined to not be in compliance, notwithstanding any law to the contrary the Commissioner may appoint a receiver to continue the operations on 24 hours' notice to the current operator, in order to preserve the life, health and safety of the people of the State of New York. Any false statement in the attestation shall be punishable under the provisions of Penal Code 210.45.

    - Any nursing home or adult care facility which does not comply with this Executive Order shall be subject to a penalty for non-compliance of $2,000 per violation per day, as if it were a violation of section 12 of the public health law, and any subsequent violation shall be punishable as if it is a violation of section 12-b of the public health law, with a penalty of $10,000 per violation per day.

    - Any personnel of a nursing home or adult care facility who refuse to be tested for COVID-19 pursuant to a plan submitted to the Department of Health shall be considered to have outdated or incomplete health assessments and shall therefore be prohibited from providing services to such nursing home or adult care facility until such testing is performed.

- Any article 28 general hospital shall not discharge a patient to a nursing home, unless the nursing home operator or administrator has first certified that it is able to properly care for such patient. Provided further, that any article 28 general hospital shall not discharge a patient to a nursing home, without first performing a diagnostic test for COVID-19 and obtaining a negative result.



GIVEN under my hand and the Privy Seal of the State in the City of Albany this tenth day of May in the year two thousand twenty.

BY THE GOVERNOR

Secretary to the Governor

Addressing the crisis in long-ter care facilities

BY NINA A. KOHN, OPINION CONTRIBUTOR — 04/23/20 03:00 PM EDT
THE VIEWS EXPRESSED BY CONTRIBUTORS ARE THEIR OWN AND NOT THE VIEW OF THE HILL

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Bodies are piling up in long-term care facilities across the country and spiraling death rates show no signs of subsiding. These facilities are prime breeding grounds for infection. In addition to residents' inherent vulnerability, measly sick leave policies encourage staff to come to work sick, and low pay leads direct care workers to hold multiple jobs — often at other long-term care facilities.

The result is staff are nearly perfect vectors for COVID-19, as outbreak patterns in Seattle suggest. Indeed, even prior to the pandemic, most nursing homes — including those earning "five stars" on the federal government's Nursing Home Compare website — had documented infection control problems.

The federal response to COVID-19 will do little to improve nursing home residents' odds of survival. Rather than ramping up efforts to protect residents, the Centers for Medicare and Medicaid (CMS), which oversees nursing homes, has responded to the novel coronavirus with guidance that prevents meaningful oversight.

In normal times, there are three key sources of oversight for nursing homes: state surveyors, ombudsmen and family members of residents.

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CMS has now banned visits by family and ombudsmen except in very limited situations. It has also hobbled surveyors' efforts by, among other things, waiving key disclosure requirements related to staffing that are used to assess compliance with quality of care standards. Even enforcement tools have been deliberately idled: CMS has suspended enforcement of most regulatory violations by nursing homes, as well as processes for responding to complaints raised by residents or family members.

As bad as the situation is in nursing homes, conditions may not be much better in assisted living facilities, which are home to approximately 1 million individuals. Unlike nursing homes, these facilities are not subject to robust federal regulation. Also, because many states have limited requirements for what care must be provided, we can expect not only problems with infection control but also that facilities will respond to staffing crises precipitated by COVID-19 by reducing services on which residents rely.

The current situation exposes the need for enhanced regulatory oversight of long-term care. Protecting assisted living residents will require more states to adopt and enforce reasonable quality of care standards. Protecting residents of nursing homes, by contrast, largely requires more meaningful enforcement of existing requirements. Although CMS requires nursing homes to have reasonable infection control practices, the penalties for deficiencies are increasingly so minor that it is more cost effective to accept the consequences of violations than to prevent them.

In addition, the crisis should prompt reconsideration of the federal government's steadfast refusal to require the minimum staffing requirements needed to avoid the systemic neglect that puts patients at risk for infection.

Fortunately, even in this bleak environment, steps could be taken now to improve the odds of survival and wellbeing in the nation's long-term care facilities. First, states could — as Canadian provinces have — prohibit staff from working in more than one long-term care facility, which would reduce the risk of staff spreading the virus.

Second, providers who have not already done should institute consistent staffing assignments that minimize the risk of contagion within facilities. Especially when personal protection equipment (PPE) is limited, as is appallingly the current norm, controlling spread also requires minimizing the extent to which staff serve multiple groups of residents. Unfortunately, guidance from the Centers for Disease Control and Prevention (CDC) has emphasized the need to segregate residents but not the need for separate staffing teams.

Third, states, communities, non-governmental organizations and families could invest in cell phones, tablets, or other communication devices that residents could use to connect with the outside world. Residents may be the only people in a position to report the conditions they face; such devices may enable some to alert those who could help. In addition, with communal meals and activities banned as part of social distancing, the plague of loneliness is increasingly dire, but residents often lack access to phones and smart technology that could provide a sense of connection.

Fourth, better tools could help some residents leave dangerous facilities. For many residents leaving is not feasible: their needs are too great to be met outside a facility at a time when home health resources are limited, they lack family willing to take them in, or they pose an unreasonable risk of infection to would-be caregivers. In limited cases, however, it may be reasonable for a resident to move in with family or friends. Public health organizations and others could assist families navigating these decisions by creating decision-aids, such as those developed in Ottawa, to walk them through options.

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Finally, family members and others who care about residents must make it clear to facility directors and owners that they are paying attention to what is happening inside homes. Family members should ask facilities about their infection control protocols and staffing patterns. Those who are health care agents for nursing home residents should not be afraid to request access to medical records, as federal law entitles them to do, if facilities are not forthcoming with information about the care being provided.

The crisis in long-term care facilities is horrific and is unlikely to get better soon. Although long-term solutions are critical, we must not ignore the concrete steps that could be taken now to save lives and improve the well-being of current residents. Individuals who live in long-term care facilities matter even in times of crisis.

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TAGS **CMS** **LONG TERM CARE** **LONG-TERM CARE FACILITIES** **NURSING HOMES** **HEALTHCARE** **CORONAVIRUS** **COVID-19** **COVID19** **PANDEMIC**

The Washington Post
Democracy Dies in Darkness

The pandemic exposed a painful truth: America doesn't care about old people

We speak of the elderly as expendable, then fail to protect them.

By **Nina A. Kohn**

Nina A. Kohn, the David M. Levy professor of law at Syracuse University and a visiting professor at Yale Law School, studies the civil rights of older adults.

May 8, 2020 at 8:49 a.m. EDT

When the novel coronavirus first emerged, the U.S. response was slowed by the common impression that covid-19 mainly killed older people. Those who wanted to persuade politicians and the public to take the virus seriously needed to emphasize that "It isn't only the elderly who are at risk from the coronavirus," to cite the headline of a political analysis that ran in The Washington Post in March. The clear implication was that if an illness "merely" decimated older people, we might be able to live with it.

Of course, older adults are at heightened risk, even though covid-19 strikes younger people, too. But across America — and beyond — we are losing our elders not only because they are especially susceptible. They're also dying because of a more entrenched epidemic: the devaluation of older lives. Ageism is evident in how we talk about victims from different generations, in the shameful conditions in many nursing homes and even — explicitly — in the formulas some states and health-care systems have developed for determining which desperately ill people get care if there's a shortage of medical resources.

It's become clear that nursing homes are particularly deadly incubators: Fifteen states reported (as of Friday) that more than half of their covid-19 fatalities were associated with long-term-care facilities. Meanwhile, the World Health Organization says that as many as 50 percent of all deaths in Europe have occurred in such places. Hans Kluge, the WHO's top official for Europe, called this "an unimaginable human tragedy."

Yet this is not an inevitable tragedy. Policymakers and health-care providers have long accepted the preventable suffering of older adults in long-term-care institutions. The U.S. Department of Health and Human Services found that about 20 percent of Medicare beneficiaries in skilled nursing facilities suffer avoidable harm. And for decades, government data has shown that nursing homes can be infection tinderboxes: Almost two-thirds of the approximately 15,600 nursing homes in the United States have been cited for violating rules on preventing infections since 2017, according to a Kaiser Health News analysis of state inspection results.

In few areas is the disconnect between law and practice so striking as in nursing homes. Enforcement seldom amounts to more than a slap on the wrist. When inspectors find that a facility has violated regulations designed to protect residents, states rarely impose a fine. The home is simply directed to correct the situation, and states often don't confirm that the corrections have been made. The rare fines are usually small and toothless. The average nursing home fine dropped from $41,260 in 2016, President Barack Obama's last year in office, to $28,405 in 2019 — after the industry pushed for a change in the way penalties are calculated — according to Kaiser Health News. Fines on that scale are "not changing behavior in the way that we want," Ashish Jha, the incoming dean of the Brown University School of Public Health, told Kaiser. Moreover, experts widely agree that, simply to avoid neglect, nursing homes must provide slightly more than four hours of nursing staff time per resident per day, yet most provide less.

Given today's emergency situation, regulators should be intervening to save lives in nursing homes. They could funnel protective equipment to them, ensure that staffing levels are sufficient and prohibit staff from working in more than one long-term-care facility — an obvious vector for infection that health officials in other countries have cut off. (One study found that roughly 17 percent of long-term-care workers held a second job.)

But that's not what is happening. To the contrary, some states, including New York and New Jersey, have responded to concerns about overcrowded hospitals by mandating that already besieged nursing homes accept covid-19-positive patients — both new and returning residents. The Centers for Medicaid and Medicare Services, the federal agency responsible for overseeing nursing homes, has waived training requirements for caregivers and indefinitely suspended most nursing home inspections. Waivers designed to cut red tape to swiftly protect residents would be one thing, but these moves instead leave residents at the largely unsupervised mercy of overwhelmed institutions.

It's hard to see the lack of protection for nursing home patients — both before and during the coronavirus crisis — as anything except evidence that older people's lives are deemed less worthy than those of younger people. In comparison, child-care centers that violate state regulations designed to protect children commonly have their licenses revoked and their facilities closed. (A report by federal inspectors released Thursday found that a nursing home in Andover, N.J., where more than 50 residents have died, had placed residents in "immediate jeopardy." It forced healthy residents to share rooms with people who had covid-19 symptoms and used nonfunctioning thermometers to check staff. The home had a history of serious health violations but had been fined a mere $21,578 over three years.)

Ageism is most explicit in official policies governing whose lives should be saved if equipment or medical staff become scarce during the pandemic. While even New York City seems to have (for now) escaped the brutal triaging questions that doctors in Italy faced — who gets the lone remaining ventilator? — states and health-care systems have plans for such situations. All prioritize patients who are likely to benefit from treatment over those who are unlikely to benefit, but many also rate them based on age — with younger patients getting the nod. Louisiana, for example, has long advised hospitals to employ a triage system for disasters that deprioritizes anyone age 65 or older. In April, Pennsylvania issued interim guidance that directs hospitals to rank patients based on broad "life stages": age 12 to 40, age 41 to 60, age 61 to 75, older than 75.

If these policies were really about saving the most years of life, they would take into account other characteristics that predict mortality, such as gender, socioeconomic status or race. But they don't, because society has rightly concluded, in those cases, that making life-or-death decisions based on identities people can't really control is invidious. So we are left with sweeping judgments that unjustifiably group 61-year-olds with 75-year-olds (any of whom may have decades of life left).

A few advocacy groups have pointed out that such schemes appear to be illegal under the Age Discrimination Act of 1975. Justice in Aging has warned Massachusetts's governor, for instance, that "bias against older adults in the provision of health care violates federal law." But these groups tend to be less robustly activist than, for example, disability-rights organizations that protest policies that ration care based on "quality of life." And complaints about age-based rationing get shrugged off.

Age-based triaging is also often justified not just by the raw number of years saved — in theory — but by the concept that people should get the chance to experience as many of life's meaningful stages as possible. But neither the state nor health-care providers have the moral authority to decide who has led a "full" life and who hasn't.

Talk of age-based rationing also subtly reinforces the idea that shortages of equipment and other resources are inevitable, and that older people will "make way" for more deserving patients. In the absence of vocal objection, this reduces pressure on policymakers to pull out all the stops to provide such resources.

Inequalities rooted in ageism have caused the coronavirus to spread, and many policy responses take for granted that older lives are worth less than younger ones. These moral blind spots compromise the fight against the pandemic and diminish us all.

Twitter: @NinaKohn

Nursing homes need increased staffing, not legal immunity

BY NINA A. KOHN AND JESSICA L. ROBERTS, OPINION CONTRIBUTORS — 05/23/20 11:00 AM EDT
THE VIEWS EXPRESSED BY CONTRIBUTORS ARE THEIR OWN AND NOT THE VIEW OF THE HILL

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With nursing homes accounting for the majority of COVID-19 deaths in many states, the long-term care industry has joined with other health care providers to successfully lobby for protection from lawsuits. The result: Nineteen states have granted nursing homes new immunity from civil liability either by executive order or statute.

All of these new measures shield health care providers — usually defined as both individuals and the institutions where they work — from liability for negligence. New Jersey and New York even protect against certain forms of criminal liability. Moreover, while some only prevent COVID-19 patients and their representatives from holding providers liable, others could foreclose almost all lawsuits against nursing homes during the COVID-19 disaster.

The industry justifies these measures as essential to protect against liability that would threaten their operation. For example, the Florida Health Care Association, writing to Gov. Ron DeSantis (R), argued that immunity was "necessary" so that facilities could provide care "without fear of reprisal."

This rhetoric exaggerates the industry's vulnerability to litigation. Even

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without legal immunity, COVID-19 could ravage a nursing home — killing most residents — without the facility being liable. This is because, consistent with established tort law doctrines, facilities that operate reasonably are unlikely to be liable for COVID-19 related harms, including residents' deaths.

Nursing homes are generally only liable for harm to residents if they fail to act reasonably under the circumstances and that failure leads to foreseeable physical harm. This standard already favors facilities struggling with COVID-19. First, when deciding liability, courts typically consider the underlying circumstances, which include the institution's resources and external factors (such as COVID-19). Conduct that would be negligent in normal times may be permissible during a pandemic. Second, whether health care providers are liable depends in large part on what similar entities would have done in the same situation. Indeed, establishing that a facility complied with professional standards is generally sufficient to defeat a medical malpractice claim. Consequently, nursing homes may be able to escape liability even for seemingly deplorable conditions if they show that they acted like other homes did in the face of the pandemic.

This truth exposes the real impact of the new immunity provisions: protecting providers who act unreasonably and fail to follow industry norms. True, immunity may save institutions money by deterring lawsuits, which can be costly to defend even if unsuccessful. But it also places the good actors in the industry at a competitive disadvantage relative to providers willing to cut costs by sacrificing resident care and safety.

It is hard to see how protecting nursing homes from liability — especially when the benefits accrue primarily to bad actors — outweighs the interest of residents, their families and the public in holding these institutions accountable. Although highly regulated, nursing homes rarely face fines or other significant penalties. Moreover, the Centers for Medicare and Medicaid services has responded to the pandemic by suspending enforcement actions against homes and waiving key regulatory requirements. In this context, private lawsuits are a key source of accountability and the new immunity measures eviscerate one of the only meaningful checks on nursing homes' conduct.

There is less justification for granting immunity to nursing homes than to hospitals and other acute care providers. Hospitals justify their push for immunity on the grounds that courts should not second-guess the ethically charged resource allocation decisions made rapidly in response to a crush of COVID-19 patients. By contrast, the primary concern for nursing homes is that they will be held liable for inadequate infection control — a problem that typically reflects more deliberative choices over time.

The pandemic has exposed the staffing shortages and poor conditions that already plagued long-term care. The industry could use this historic moment to push for the resources that would help protect residents and workers now and in the future, including funding that would help facilities maintain a sustainable, full-time staff. Experts agree that most nursing homes were dangerously understaffed even before the epidemic and the industry's heavy reliance on part-time staff (an

estimated 15 to 17 percent work multiple jobs) has been linked to COVID-19 spreading between facilities. Increased funding tied to higher staffing levels and fair compensation for direct care workers could help address these systematic problems.

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Unfortunately, the nursing home industry is squandering this political opportunity by lobbying for what some members want to protect their bottom line — and not what all could use to protect residents.

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JOINT NEW YORK SENATE AND ASSEMBLY PUBLIC HEARING ON RESIDENTIAL CARE FACILITIES AND COVID-19

Testimony of Nina A. Kohn
August 10, 2020

Thank you, Chairpeople, Senators, and Assembly Members for this opportunity to testify. My name is Nina Kohn. I am professor at Syracuse University College of Law, and the Solomon Center Distinguished Scholar in Elder Law at Yale Law School. My research focuses on the civil rights of older adults, including those in congregate care settings.

My testimony will focus on policies and practices that make residents of residential care facilities vulnerable to COVID-19 and its impacts, and policies that could improve their well-being going forward.

One source of vulnerability is facilities' over-reliance on part-time staff and staff who work in multiple jobs—as an estimated 15-17% long-term care staff do. Adopting a one-site rule limiting staff to working in one care facility during the pandemic, as Canadian provinces have done, could reduce infection spread between facilities. Indeed, a new study estimates that eliminating staff linkages could reduce COVID-19 infections in nursing homes by 44 percent. A one-site policy, however, must be paired with policies incentivizing hiring full-time direct care workers, or it risks creating a worker shortage and financial distress for caregivers.

Another factor that makes residents vulnerable is a lack of accountability for facilities—including around infection control. This gap is well-documented in nursing homes. Even when state inspectors find that a nursing home violated regulations designed to protect residents, the home is often merely directed to correct the situation, and the state may not even confirm that corrections are made. The rare fines are typically so small as to be toothless—this is a problem nationwide, but especially in New York where average fines are well below the national average.

Going forward, the state must impose consequences for regulatory violations that put residents at risk that actually deter bad behavior. This includes fully rolling back Section 3082 of this year's budget bill, which rewards neglect and dangerous behavior by granting facilities, owners and administrators astonishingly broad immunity for unreasonably causing foreseeable harm to residents. Given the anemic nature of the public enforcement system, the deterrent effect created by possible liability is critical to protect residents.

Another factor increasing resident vulnerability is insufficient direct care staff. Most nursing homes, and especially for-profit facilities, were dangerously understaffed even before the epidemic. Now, research links nurse staffing levels to facilities' ability to control COVID-19 outbreaks, and staffing levels more broadly to the presence of COVID-19 in facilities. Minimum staffing requirements like those proposed in the Safe Staffing Quality Act are essential to ensure that facilities have the staff needed to avoid systemic neglect. Any increased funding for facilities during this crisis therefore should be conditioned on adequate direct care staffing levels and appropriate staff mix.

Another factor that endangers residents is isolation. Isolation is itself a harm, causing unprecedented loneliness, psychological suffering, and poor health outcomes. It is also a risk factor for abuse and neglect. Research shows that the presence of non-staff in residential care facilities is protective for residents.

The ombudsmen program could be a powerful tool to counter isolation and strengthen oversight, but current policies undermine it. Rather than helping ensure that ombudsmen can safely go into facilities, the New York Department of Health has encouraged "remote advocacy." This is a farce for the residents who most need ombudsmen. It enables facilities and staff to effectively block access to the very people who might report their bad behavior.

Going forward, ombudsmen should be prioritized for personal protective equipment (PPE) and encouraged—perhaps even required—to regularly visit all residential care facilities even amid the pandemic. To further this, the state should promulgate protocols that (unlike current Department of Health protocols) do not allow facilities to act as gatekeepers for ombudsmen. In addition, the state should invest in expanding the ranks of professional ombudsmen as the pandemic has exposed the danger of overreliance on volunteers.

Combatting isolation also requires recognizing residents' right to associate with family and friends. The state must unambiguously require facilities to facilitate virtual visits—by phone or by video-conference—when in-person is infeasible, and rescind guidance that gives facilities discretion to deny residents in-person visits. That discretion allows poorly performing facilities to avoid scrutiny by further depriving residents of their civil and human rights—and, in many cases, by also depriving residents of essential family caregivers. Instead, the state should require facilities to allow in-person visitation in accordance with reasonable protocols adopted by the state. In doing so, New York should consider the evidence-based protocol created by an institute at Canada's Ryerson University in collaboration provider and advocacy groups.

Finally, Covid-19 shows the danger of under-funding of home and community-based care, and the over-reliance on congregate care to begin with.

2020

Law, Structural Racism, and the COVID-19 Pandemic

Ruqaiijah Yearby

Seema Mohapatra

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Seema Mohapatra, J.D., M.P.H. is a tenured associate professor of law and Dean's Fellow at Indiana University Robert H. McKinney of Law. Professor Mohapatra's research has focused on the equity issues, centering race and gender, in bioethics, public health law, and biotechnology and the law, particularly assisted reproduction. She earned her B.A. in Natural Sciences, with a minor in Women's Studies from the Johns Hopkins University, M.P.H. in Chronic Disease Epidemiology from Yale University School of Public Health, and her J.D. from Northwestern University School of Law. During the COVID-19 pandemic, her research has focused on worker's rights issues related to health disparities, discrimination potential in proposed public health interventions such as immunity passports and mandatory masking requirements, and reproductive justice issues raised by the pandemic.

Law, Structural Racism, and the COVID-19 Pandemic

Ruqaiijah Yearby, J.D., M.P.H. * and Seema Mohapatra, J.D., M.P.H.**

ABSTRACT (187 WORDS)

Racial and ethnic minorities have always been the most impacted by pandemics because of: disparities in exposure to the virus; disparities in susceptibility to contracting the virus; and disparities in treatment. This article explains how structural racism, the ways in which laws are used to advantage the majority and disadvantage racial and ethnic minorities, has caused these disparities. Specifically, this article focuses on how employment, housing, health care, and COVID-19 relief laws have been manipulated to disadvantage racial and ethnic minorities, making minorities more susceptible to COVID-19 infection and death. This article uses Blumenshine's 2008 framework to outline how structural racism causes racial and ethnic minorities' disparities in exposure to viruses, in susceptibility to contracting viruses, in treatment of viruses, and in infection and death rates. This article discusses how historical and current practices of structural racism in existing employment, housing, and health care laws and the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) cause disparities in COVID-19 infections and deaths. This article suggests legal solutions to address structural racism as well as public health solutions to help mitigate the racialized effects of the disease.

During the 1918 flu pandemic, "American Indians experienced a disease specific mortality rate of four times that of other ethnic groups," while during the 2009 H1N1 pandemic American Indian and Alaska Natives' mortality rate from H1N1 was four times that of all other racial and ethnic minority populations combined.[1] During the COVID-19 pandemic, although Native Americans are only 11% of the population in New Mexico, they account for nearly 37% of the

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[1] 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).

COVID-19 infections and 26% of the deaths.[2] Racial and ethnic minorities are disproportionately impacted during pandemics, not due to any biological difference between races, but rather as a result of social factors.[3]

In fact, Blumenshine et al. hypothesized in 2008 that racial and ethnic disparities in infection and death during pandemics were due to three factors: disparities in exposure to the virus; disparities in susceptibility to contracting the virus; and disparities in treatment.[4] Specifically, racial and ethnic minorities face increased risk of exposure because they work in low wage jobs that do not provide the option to work at home and they cannot afford to miss work even when they are sick. They also experience increased risk of susceptibility to pandemics because of preexisting health conditions, such as cardiovascular disease. Finally, racial and ethnic minorities report lacking access to a regular source of health care as well as appropriate treatment during pandemics, causing disparities in treatment.

When the 2009 H1N1 pandemic occurred, a group of researchers empirically showed that Blumenshine's factors were associated with racial and ethnic minorities increased hospitalization

[2] Kate Stafford, et al., *Racial toll of virus grows even starker as more data emerges,* Associated Press (Apr. 18, 2020), available at https://apnews.com/8a3430dd37e7c44290c7621f5af96d6b. Stafford, et al., *supra* note 3.
[3] Seema Mohapatra and Lindsay F. Wiley, *Feminist Perspectives in Health Law*, 47 J. L., MED. & ETHICS, 47 S2, 103 (2019); Rachel Rebouche and Scott Burris, "*The Social Determinants of Health*", *in* OXFORD HANDBOOK OF U.S. HEALTH LAW 1097-1112 (I. Glenn Cohen et al., eds., Oxford: Oxford University Press, 2017: 1097-1112); DOROTHY ROBERTS, FATAL INVENTION: HOW SCIENCE, POLITICS, AND BIG BUSINESS RE-CREATE RACE IN THE TWENTY-FIRST CENTURY 23-25 (2011) (Roberts is critical of "the delusion that race is a biological inheritance rather than a political relationship").
[4] Philip Blumenshine et. al., Pandemic Influenza Planning in the United States from a Health Disparities Perspective, 14(5) EMERGING INFECTIOUS DISEASES 14, no. 5709–15, (May 2008): 709–15, available at:) https://doi.org/10.3201/eid1405.071301.;Robert J. Blendon, et. al., Public Response to Community Mitigation Measures for Pandemic Influenza, 14 (5) EMERGING INFECTIOUS DISEASES 14, no. 5778–86, (May 2008): 778–86, available at:) https://doi.org/10.3201/eid1405.071437.; Sandra Crouse Quinn et. al.,. Racial Disparities in Exposure, Susceptibility, and Access to Health Care in the US H1N1 Influenza Pandemic, AM. J. PUBLIC HEALTH 101, no. 2285- 93 (February 2011), 285–93, available at:). https://doi.org/10.2105/AJPH.2009.188029.

and death from H1N1.[5] Racial and ethnic minorities were unable to stay at home, suffered from health conditions that were risk factors for H1N1, and lacked access to health care for treatment, which increased their H1N1 infection and death rates as evidenced by health and survey data.[6] For instance, health data from Boston and Chicago showed that African Americans and Latinos were overrepresented among hospitalizations for H1N1; while in Oklahoma, rates for African Americans were 55% compared to 37% for Native Americans and 26% of Whites.[7] In California, Latinos were twice as likely to be hospitalized and die from H1N1 compared to whites.[8] In Texas, Latinos accounted for only 37% of the population, but represented 52% of H1N1 deaths in the first 6 months of the pandemic. A national survey showed that racial and ethnic minorities were unable to practice social distancing or stay at home during the H1N1 pandemic because they could not work at home and lacked paid sick leave or access to health care.[9]

Unsurprisingly, these racial and ethnic disparities are being replicated in COVID-19 infections and death rates. African Americans make up just 12% of the population in Washtenaw County, Michigan but have suffered a staggering 46% of COVID-19 infections.[10] In Chicago, Illinois, African Americans account for 29% of population, but have suffered 70% of COVID-19

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[5] Sandra Crouse Quinn et. al.,. *Racial Disparities in Exposure, Susceptibility, and Access to Health Care in the US H1N1 Influenza Pandemic*, AM. J. PUBLIC HEALTH 101, no. 2285- 93 (February 2011), 285–93, available at: https://doi.org/10.2105/AJPH.2009.188029.

[6] *Id.*

[7] Sandra Crouse Quinn et. al.,. *Racial Disparities in Exposure, Susceptibility, and Access to Health Care in the US H1N1 Influenza Pandemic*, AM. J. PUBLIC HEALTH 101, no. 2285- 93 (February 2011), 285–93, available at: https://doi.org/10.2105/AJPH.2009.188029.

[8] Monica Schoch-Spana, et al., *Stigma, Health Disparities, and the 2009 H1N1 Influenza Pandemic: How to Protect Latino Farmworkers in Future Health Emergencies,* Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science 8(3): 243-253 (2010).

[9] Sandra Crouse Quinn et. al.,. *Racial Disparities in Exposure, Susceptibility, and Access to Health Care in the US H1N1 Influenza Pandemic*, AM. J. PUBLIC HEALTH 101, no. 2285- 93 (February 2011), 285–93, available at: https://doi.org/10.2105/AJPH.2009.188029; Supriya Kumar, et al, *The Impact of Workplace Policies and Other Social Factors on Self-Reported Influenza-Like Illness Incidence During the 2009 H1N1 Pandemic,* 102 (1) Am. J. Pub. Health (Jan. 2012): 132-140.

[10] Kate Stafford, et al., *Racial toll of virus grows even starker as more data emerges*, ASSOCIATED PRESS (Apr. 18, 2020), available at https://apnews.com/8a3430dd37e7c44290c7621f5af96d6b.

related deaths of those whose ethnicity is known.[11] In Washington, Latinos represent 13% of the population, but account for 31% of the COVID-19 cases, while in Iowa Latinos comprise are 6% of the population but 20% of COVID-19 infections.[12] The African American COVID-19 death rates are higher than their percentage of the population in racially segregated cities and states including Milwaukee, Wisconsin (66% of deaths, 41% of population),[13] Illinois (43% of deaths, 28% of infections, 15% of population),[14] and Louisiana (46% of deaths, 36% of population).[15] These racial and ethnic disparities in COVID-19 infections and deaths are a result of historical and current practices of racism that cause disparities in exposure, susceptibility and treatment.

There are three different levels of racism: institutional, interpersonal, and structural. Institutional racism operates through "neutral" organizational practices and policies that limit racial and ethnic minorities equal access to opportunity. Interpersonal racism operates through individual interactions, where an individual's conscious and/or unconscious prejudice limits racial and ethnic minorities' access to resources.[16] Structural racism operates at a societal level and refers to the way laws are written or enforced, which advantages the majority, and disadvantages racial and ethnic minorities in access to opportunity and resources.[17] In this article, we focus on historical

[11] Elliot Ramos and& Maria Ines Zamudio, *In Chicago, 70% of Cases COVID-19 Deaths Are Black,* CHICAGO NPR – WBEZ (Apr. 5, 2020), available at https://www.wbez.org/stories/in-chicago-70-of-covid-19-deaths-are-black/dd3f295f-445e-4e38-b37f-a1503782b507

[12] Miriam Jordan and Richard Oppel Jr, *For Latinos and Covid-19, Doctors Are Seeing an 'Alarming' Disparity,* NEW YORK TIMES (May 9, 2020), available at: https://www.nytimes.com/2020/05/07/us/coronavirus-latinos-disparity.html.

[13] Teran Powell, *Milwaukee's Covid-19 spread highlights the disparities between white and blacks,* THE GUARDIAN (Apr. 14, 2020), available at https://www.theguardian.com/world/2020/apr/14/milwaukees-covid-19-spread-highlights-the-disparities-between-white-and-black.

[14] Jerry Nowicki, *COVID-19 shows racial health disparities in Illinois*, THE SOUTHERN ILLINOISAN (Apr. 11, 2020), available at https://thesouthern.com/news/local/state-and-regional/covid-19-shows-racial-health-disparities-in-illinois/article_14a890fc-9d2b-5b09-8198-5ed14774fbd8.html

[15] CDC, Provisional Death Counts for Coronavirus Diseases: Weekly States-Specific Data Updates by Select Demographic and Geographic Characteristics (Apr. 14, 2020), available at https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/ CDC, *supra* note 2.

[16] Ruqaiijah Yearby, *Internalized Oppression: The Impact of Gender and Racial Bias in Employment on the Health Status of Women of Color,* 49 SETON HALL LAW REV. 1037-1066 (2019).

[17] Ruqaiijah Yearby, *Structural Racism and Health Disparities: Moving Beyond the Social Determinants of Health to Achieve Racial Equity,* J. OF LAW MED. AND ETHICS (forthcoming 2020).

and current practices of structural racism that cause disparities in exposure, susceptibility, and treatment during the COVID-19 pandemic. More specifically, we discuss how structural racism in employment causes disparities in exposure; structural racism in housing causes disparities in susceptibility; and structural racism in health care causes disparities in treatment.

This article proceeds as follows: Part II examines how gaps in the Fair Labor Standards Act and the CARES Act have resulted in disparate working conditions that contribute to racial and ethnic minorities' greater exposure to COVID-19. Part III reviews the gaps in Title X of the Housing and Community Development Act of 1992 and the CARES Act that leave racial and ethnic minorities without working water and vulnerable to toxins that cause respiratory illness, a risk factor for COVID-19 infections. These housing conditions make racial and ethnic minorities more susceptible to contracting COVID-19. Part IV discusses how the enforcement of Title VI of the Civil Rights Act of 1964 and the language of the Patient Protection and Affordable Care Act (ACA) and the CARES Act prevents racial and ethnic minorities from accessing quality health care treatment for health conditions and COVID-19. Finally, in Part V, we suggest legal solutions to address structural racism as well as public health solutions to help mitigate the racialized effects of the disease.

II. COVID-19 DISPARITIES IN EXPOSURE: STRUCTURAL RACISM IN EMPLOYMENT

A recent New York Times analysis of census data crossed with the federal government's essential workers guidelines found that "one in three jobs held by women has been designated as essential during this pandemic, and nonwhite women are more likely to be doing essential jobs

than anyone else."[18] Furthermore, the Centers for Disease Control and Prevention (CDC) found that African Americans account for 30% of all licensed practical and vocational nurses, while Latinos account for 53% of all agricultural workers, jobs deemed "essential" during the COVID-19 pandemic.[19] Consequently, many racial and ethnic minorities are unable to shelter at home and socially distance themselves in part because they are employed in "essential jobs" that require them to interact with others, increasing racial and ethnic minorities' exposure to COVID-19.

Racial and ethnic minorities' disparities in exposure to COVID-19 are due in part to structural racism in employment. During the Jim Crow era (1875-1968), employment laws were enacted that provided protections for white workers and disadvantaged racial and ethnic minorities. For example, many laws that expanded collective bargaining rights either explicitly excluded racial and ethnic minorities, or allowed unions to discriminate against racial and ethnic minorities.[20] These employment laws benefited whites by providing them 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 and increasing disparities in their exposure to pandemic viruses, like COVID-19. Although the Jim Crow Era ended in 1968, many racial and ethnic minorities still do not have paid sick leave[21] and other employment laws still limit racial and ethnic minorities' access to equal pay, which causes disparities in exposure to

[18] Campbell Robertson and Robert Gebeloff, *How Millions of Women Became the Most Essential Workers in America*, N.Y. Times, April 18, 2020, sec. U.S. https://www.nytimes.com/2020/04/18/us/coronavirus-women-essential-workers.html.

[19] The Centers for Disease Control and Prevention, COVID-19 in Racial and Ethnic Minority Groups, available at https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html.

[20] Danyelle Solomon, et al, Systematic Inequality and Economic Opportunity, The Center for American Progress (Aug. 2019), available at https://www.americanprogress.org/issues/race/reports/2019/08/07/472910/systematic-inequality-economic-opportunity/

[21] Supriya Kumar, et al, *The Impact of Workplace Policies and Other Social Factors on Self-Reported Influenza-Like Illness Incidence During the 2009 H1N1 Pandemic,* 102 (1) Am. J. Pub. Health (Jan. 2012): 132-140.

COVID-19. The plight of agricultural workers and home health care workers are illustrative of this point.

Agricultural workers tend to be immigrants from countries such as Mexico, Central America, and the Caribbean who work in 42 of the 50 states, including California, Illinois, Texas, and Washington.[22] Almost a third of agricultural workers have incomes below the poverty level and do not have paid sick leave. This is because agricultural workers are not fully covered by the Fair Labor Standards Act of 1938 (FLSA).[23] The FLSA limited the work week to 40 hours and established federal minimum wage and overtime requirements, but exempted from these protections domestic, agricultural, and service workers, who are predominately racial and ethnic minorities.[24] In 1966, the minimum wage requirements were applied to *most* agricultural workers, yet the workers still do not receive overtime and are paid fifty cents less than the minimum wage.[25] Also, instead of the minimum wage, some workers are still paid based on each piece of food they pick.[26] The failure to provide agricultural workers with higher wages and overtime pay is due to structural racism. The initial failure to cover these workers under the FLSA benefited white workers by boosting their wages, while limiting the wages of immigrants. The current lack of protections under the FLSA benefit white farmers by limiting their employee costs, while harming minority workers that cannot afford to miss work even when they are sick. Minority workers

[22] Monica Schoch-Spana, et al., *Stigma, Health Disparities, and the 2009 H1N1 Influenza Pandemic: How to Protect Latino Farmworkers in Future Health Emergencies,* Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science 8(3): 243-253 (2010).
[23] Fair Labor Standards Act of 1938, 29 U.S.C. §§201-19 (2020).
[24] Danyelle Solomon, et al, Systematic Inequality and Economic Opportunity, The Center for American Progress (Aug. 2019), available at https://www.americanprogress.org/issues/race/reports/2019/08/07/472910/systematic-inequality-economic-opportunity/
[25] Autumn Canny, Lost in a Loophole: The Fair Labor Standards Act's Exemption of Agricultural Workers for Overtime Compensation Protections, 10 Drake J. Agric. L. 355- (2005).
[26] U.S. Department of Labor, Wage and Hour Division, Agricultural Employers Under the Fair Labor Standards ACT: Fact Sheet #12, available at https://www.dol.gov/agencies/whd/fact-sheets/12-flsa-agriculture.

forced to work even when they are sick increases the risk of exposure to viruses for all agricultural workers because they work in close quarters.

Home health care workers, who are considered domestic workers, are also left unprotected. Two-thirds of home health care workers are women of color.[27] Although the Medicaid program[28] primarily funds home health care workers, the wages of these workers are so low that one in five (20%) home care workers are living below the federal poverty line, compared to 7% of all U.S. workers, and more than half rely on some form of public assistance including food stamps and Medicaid.[29] They also do not have paid sick leave. Even though the Department of Labor (DOL) issued regulations in 2015 that for the first time made the FLSA apply to *most* home health care workers,[30] many workers still remain unprotected. The DOL under the Trump Administration has issued guidance suggesting that home health care workers employed by home health care companies, also referred to as nurse or caregiver registries, are independent contractors.[31] This is significant because the FLSA does not cover independent contractors. These practices have disadvantaged home health care workers by limiting their wages and access to paid sick leave.

The failure to provide home health care workers with higher wages and paid sick leave is due to structural racism. The initial failure to cover these workers under the FLSA benefited white workers by boosting their wages, while limiting the wages of racial and ethnic minorities, particularly women of color. Seventy-seven years later, when most home health care workers were finally covered by the FLSA, companies began classifying them as independent contractors. This

[27] PHI, US Home Care Workers: Key Facts *supra* note 60 at 3 (2018)..
[28] Medicaid is a joint federal and state partnership, which the states administer. 42 U.S.C. §§ 1396, 1396a(a)(1)–(2), (5) (2006 & West Supp. 2018).
[29] PHI, US Home Care Workers: Key Facts *supra* note 60 at 5-6 (2018).
[30] 80 F.R. 55029-30 (Sept. 14, 2015).
[31] Wage and Hour Division, U.S. Department of Labor, Field Assistance Bulletin No. 2018-4 (July 13, 2018); Labor and Employment Group of Ballard Spahr, LLP, Labor Classification in the Home Health Care Industry: A sign of What's to Come? (Jul. 16, 2018)

benefits home health care companies by lowering employment costs because among other things companies then do not have to pay workers minimum wage or overtime pay. As a result of low wages and lack of paid sick leave, home health care workers must continue to work in close proximity to patients that are often vulnerable to COVID-19, increasing home health care workers exposures to COVID-19.

During the COVID-19 pandemic, many low-wage workers[32] have been deemed as "essential" including agricultural workers[33] and home care workers, yet they do not have adequate wages or personal protective gear.[34] The federal government is also currently seeking to lower the wages of immigrant agriculture workers during the COVID-19 pandemic, at the same time it is increasing visa approvals to ensure that US farmers have enough immigrant workers for spring planting.[35] Additionally, unlike health care workers providing care in institutional settings, home care workers have not been provided with masks. In fact, one worker said "she had been making protective masks out of paper towels" and "hand sanitizers out of supplies she bought herself."[36]

The Coronavirus Aid, Relief, and Economic Security Act (CARES Act),[37] the largest economic relief bill in U.S. history, has approved $2.2 trillion to help businesses and individuals affected by the pandemic and economic downturn, giving workers health coverage for COVID-

[32] Service sector jobs, such as cashiers, waitstaff and care aides, are the poorest workers and least likely to be able to avoid viral exposure. Beatrice Jin and Andrew McGill, "*Who Is Most at Risk in the Coronavirus Crisis: 24 Million of the Lowest-Income Workers*." Politico, March 21, 2020, available at https://politico.com/interactives/2020/coronavirus-impact-on-low-income-jobs-by-occupation-chart/. 24 million workers are low-wage workers (get paid less than $11.50 per hour). *Id.*

[33] Alejandra Borunda, *Farm Workers risk Coronavirus Infection to Help the US Fed,* National Geographic (Apr. 10, 2020).

[34] Christoher Ingraham, *Why many 'essential' workers get paid so little according to experts,* Washington post (Apr. 6, 20202).

[35] Franco Ordonez, *White House Seeks to Lower Farmworker Pay to Help Agricultural Industry,* NPR (Apr. 10, 2020).10, 2020), https://www.npr.org/2020/04/10/832076074/white-house-seeks-to-lower-farmworker-pay-to-help-agriculture-industry

[36] Andrew Donlan, '*I Deserve to Be Respected': Home Care Workers Make Emotional Plea for Better Treatment*, HOME HEALTH CARE NEWS (Apr. 15, 2020).

[37] PUB. LAW. NO. 116- 138. Tit. III (2)(b) § 3211 (b) 236 (2020) 4.

19, increased unemployment benefits, and paid sick leave.[38] But the CARES Act does not cover most agricultural workers and home health care workers. Because roughly 50% of agriculture workers are undocumented immigrants, employment relief or the expanded health care protections provided by the CARES Act does not cover them.[39] Home care workers are also not covered by the CARES Act because home care industry advocates argued that there would be a worker shortage if home health workers were included.[40] Thus, the CARES Act is an example of structural racism because it primarily advantages white workers, while disadvantaging racial and ethnic minorities who do not receive the protections of the CARES Act.

As illustrated by the treatment of agricultural and home health care workers, structural racism increases racial and ethnic minorities exposure to the COVID-19 virus. Neither the employment laws, nor the CARES Act, ensure that racial and ethnic minority workers receive minimum wage and access to paid sick leave. Consequently, these workers, many of whom have been deemed "essential workers," cannot stay at home, increasing their exposure to COIVD-19. Racial and ethnic minorities also experience increased susceptibility to contracting COVID-19 because of poor housing conditions resulting from structural racism.

III. DISPARITIES IN SUSCEPTIBILITY TO CONTRACTING COVID-19: STRUCTURAL RACISM IN HOUSING

Racial and ethnic minorities are more susceptible to contracting viruses because of residential segregation due to structural racism. The federal government created the Federal

[38] Erica Warner et al., *Senate Approves $2.2 Trillion Corona Virus Bill Aimed At Slowing Economic Free Fall*, WASHINGTON POST (Mar. 25, 2020), https://www.washingtonpost.com/business/2020/03/25/trump-senate-coronavirus-economic-stimulus-2-trillion/

[39] Alejandra Borunda, *Farm workers risk Coronavirus Infection to Help the US Fed,* National Geographic (Apr. 10, 2020). Borunda, *supra* note 54.

[40] Andrew Donlan, '*I Deserve to Be Respected': Home Care Workers Make Emotional Plea for Better Treatment*, Home Health Care News (Apr. 15, 2020). *supra* note 74. Some home care companies have voluntarily implemented paid sick leave, and bonus pay, but not all. *Id.* Thus, home care workers, who live in poverty, do not have health insurance, and work in close contact with those most likely to contract COVID-19 without protective gear, are exempted from additional pay and paid sick leave. *Id*

Housing Administration (FHA) in 1933, which subsidized housing builders as long as none of the homes were sold to African Americans, a practice that was called redlining.[41] The FHA also published an underwriting manual that stated that housing loans to African Americans would not be insured by the federal government. The FHA policies, examples of structural racism, advantaged whites seeking to buy homes by creating the suburbs, while relegating African Americans to racially segregated neighborhoods. Racially segregated neighborhoods that are predominately African American usually have less economic investment and fewer resources, such as places to exercise or play, which is associated with higher rates of cardiovascular disease risk for African American women.[42] These neighborhoods also have more pollution, noise, and overcrowded housing stock associated with asthma, obesity, and cardiovascular disease,[43] which increase the susceptibility of contracting COVID-19.[44]

In 1992, the federal government enacted Title X of the of the Housing and Community Development Act authorizing the federal government to provide grants to reduce lead paint hazards in non-federal housing. This is the only federal housing law addressing housing-related health hazards, even though decades of research has shown that racially segregated African American neighborhoods have "poorer housing stock and code violations for asbestos, mold and

[41] Richard Rothstein, The Color of Law (2017).
[42] Lee Mobley, et al., *Environment, Obesity, and Cardiovascular Disease Risk in Low-Income Women,* 30 AM J. PREVENTATIVE MED. 327, 327 (2006).
[43] R.E. Walker et al., "Disparities and Access to Healthy Food in the United States: A Review of Food Deserts Literature*,"* Health & Place 16, no. 5 (2010): 876-884, at 881; N.I. Larson, et al., "Neighborhood Environments: Disparities in Access to Healthy Foods in the U.S.," American Journal of Preventative Medicine 36, no. 1 (2009): 74-81, at 74 (2009); L.B. Lewis et al., "African Americans' Access to Healthy Food Options in South Los Angeles Restaurants," American Journal of Public Health 95, no. 4 (2005): 668-73, at 672 I.G. Ellen et al., "Neighborhood Effects on Health: Exploring the Links and Assessing the Evidence," Journal of Urban Affairs 23, no. 3-4 (2001): 391-408, at 393; A.V. Diez Roux, "Investigating Neighborhood and Area Effects on Health," American Journal of Public Health 91, no. 11 (2001): 1783-9, at 1786.
[44] Philip Blumenshine et. al., Pandemic Influenza Planning in the United States from a Health Disparities Perspective, 14(5) EMERGING INFECTIOUS DISEASES 14, no. 5709–15, (May 2008): 709–15, available at:) https://doi.org/10.3201/eid1405.071301

cockroaches," which has been linked to increased rates of respiratory illness, such as asthma.[45]Hence, it is unsurprising that housing in racially segregated neighborhoods is more likely to have severe health-related housing violations, increasing racial and ethnic minorities exposure to hazards that increase susceptibility to COVID-19.[46]

Examples of severe health-related housing violations include: "plumbing that does not have hot and cold water; a flushing toilet, and a bathtub or shower; kitchen facilities that do not have a sink with a faucet; a stove or range oven and a refrigerator; and more than 1.5 persons per room (i.e. 4 people living in an apartment with only two total rooms)."[47] African-American and Latinx households are almost twice as likely to "lack complete plumbing than white households, and Native American households are 19 times more likely to lack complete plumbing."[48] Without plumbing, racial and ethnic minorities cannot wash their hands or bodies to prevent the spread of COVID-19.

Some specific data linking housing to COVID-19 data is illustrative. In St. Louis, Missouri, African Americans account for 69% of COVID-19 infections and only 49% of the population.[49]In Missouri, the predominately African American area of St. Louis city had the most housing units with one or more severe health related housing violations (41.5%), compared to St. Louis County, a predominately white area (30%), Missouri (29.6%), and the United States (35.6%). More

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[45] Eugene Scott, "*4 Reasons Coronavirus Is Hitting Black Communities so Hard*.", WASHINGTON POST. Accessed , (April 10, 2020.), https://www.washingtonpost.com/politics/2020/044/10/4-reasons-coronavirus-is-hitting-black-communities-so-hard/; Emily Benfer, *Health Justice: A Framework (and Call to Action) for the Elimination of Health Inequity and Social Injustice,* 65 AM. U. L. REV. 275, 275 (2015).; National Center for Healthy Housing, Timeline, available at https://nchh.org/sample-shortcodes/sample-timeline/.

[46] St. Louis Partnership for a Health Community, et al., Community Health Status Assessment 38 (Dec. 11, 2017) *supra* note 14.

[47] *Id.*

[48] Dig Deep & U.S. Water Alliance, Closing The Water Access Gap In the United States: A National Plan 4 (2019), http://closethewatergap.org/ (page 4 of report)

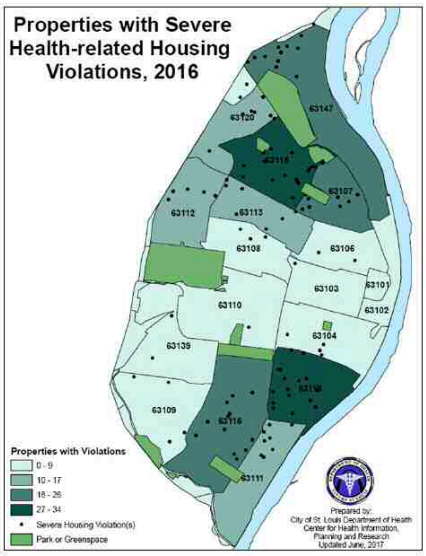
[49] City of St. Louis Department of Health, *COVID-19 Cases by Demographic Groups* (Apr. 19, 2020), *available at*, https://www.stlouis-mo.gov/covid-19/data/demographics.cfm; St. Louis Partnership for a Health Community, et al, Community Health Status Assessment 8 (Dec. 11, 2017).

specifically, as shown in Figure 1, housing properties located in St. Louis city zip code 63115 ranked in the highest quartile of violations and had one of the highest percentages of families living in poverty. Not surprisingly, this is the zip code with the most cases of COVID-19 infections in St. Louis city.

Demonstrated by Figure 2, COVID-19 infection rates in St. Louis are highest in predominately African American neighborhoods. As of April 19, 2020, there were 95 cases of COVID-19 in zip code 63115,[50] which as mentioned above has the highest rates of severe health-related housing violations. This zip code is also extremely racially segregated. Shown in Figure 3, ninety-eight percent of the population in zip code 63115 is African American, one percent White, and one percent other.[51] This is also true for zip code 63113, with the second highest cases of COVID-19 infection, 69. Ninety-seven percent of the population is African American, two percent White, and one percent other.

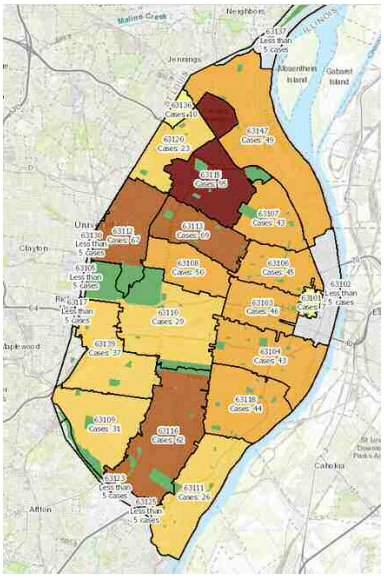
[50] City of St. Louis Department of Health, COVID-19 Cases by Zip Code (Apr. 19, 2020), available at https://www.stlouis-mo.gov/covid-19/data/zip.cfm.*supra* note 14.
[51] St. Louis Partnership for a Health Community, et al., Community Health Status Assessment 9 (Dec. 11, 2017) *supra* note 14.

Figure 1 – St. Louis Severe Health Related Housing Violations



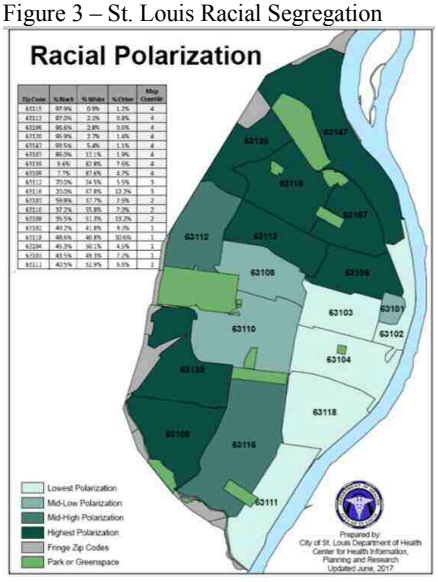
St. Louis Department of Health, St. Louis Community Health Status Assessment, 2017. This image is not covered by the terms of the Creative Commons license of this publication. For permission to reuse, please contact the rights holder.

Figure 2 – St. Louis COVID-19 Infections



St. Louis COVID-19 Infections
St. Louis Department of Health, St. Louis City of St. Louis Department of Health COVID-19 website, 2019. *This image is not covered by the terms of the Creative Commons license of this publication. For permission to reuse, please contact the rights holder.*

Figure 3 – St. Louis Racial Segregation



St. Louis Racial Polarization
St. Louis Department of Health, St. Louis Community Health Status Assessment, 2017. This image is not covered by the terms of the Creative Commons license of this publication. For permission to reuse, please contact the rights holder.

These problems are not limited to St. Louis. In Michigan, African Americans account for 33% of all COVID-19 infections and 41% of the deaths, although they represent only 14% of the population.[52] In Detroit, COVID-19 deaths have reached 538 in part because of housing factors. The city has poor air quality and prior to the pandemic, many homes did not have water, inhibiting residents from washing their hands.[53] Although the Detroit mayor has worked with the water department to restore water for $25 a month, this is not a viable solution in a city where many of the workers have lost their jobs, so they cannot afford to turn the water back on.[54] Without water, they cannot wash their hands or body to prevent the spread of COVID-19.

Although the CARES Act created a federal moratorium on evictions for federally assisted housing and federally backed mortgages, it does not address health-related housing violations such as access to clean water, leaving racial and ethnic minorities more susceptible to COVID-19 infection because they are unable to wash their hands.[55] Thus, the lack of federal law addressing housing-related health hazards is an example of structural racism. The lack of law advantages landlords who make money renting these apartments, while disadvantaging racial and ethnic minorities who are forced to live in buildings with health violations. Living in housing with severe health-related housing violations, such as access to water, increases racial and ethnic minorities susceptibility to COVID-19 because they cannot wash their hands or body to prevent the spread of COVID-19. Racial and ethnic minorities also do not have access to quality health care, which increases disparities in treatment for COVID-19.

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[52] *COVID-19 has already killed more Detroiters than homicides have in the past two years* , FOX 2 DETROIT (Apr. 16, 2020), available at https://www.fox2detroit.com/news/covid-19-has-already-killed-more-detroiters-than-homicides-have-in-the-past-two-years-combined

[53] *Id.*

[54] *Id.*

[55] PUB. LAW. NO. 116- 138. Tit. III (2)(b) § 3211 (b) 236 (2020) 4.

IV. COVID-19 DISPARITIES IN TREATMENT: STRUCTURAL RACISM IN HEALTH CARE

Disparities in treatment are a result of structural racism during the Jim Crow era, which continues today. In 1946, the federal government enacted the Hill-Burton Act to provide funding for the construction of public health care facilities.[56] Although the Act mandated that adequate healthcare facilities be made available to all state residents regardless of race, it allowed states to construct racially separate and unequal facilities. The Hill Burton Act used racial and ethnic minorities' tax money for the construction of health care facilities that provided care to whites, but barred racial and ethnic minorities from receiving care. Lacking access to care, African Americans have higher rates of untreated respiratory disease and cardiovascular disease, which are risk factors for COVID-19.[57] Even though Title VI of the Civil Rights Act of 1964 was passed to equalize access to quality health care for all races, the U.S. Department of Health and Human Services (HHS) has not applied Title VI to hospital closures linked to race[58] or physician treatment decisions based on race.[59] Additionally, laws banning immigrants from accessing health care benefits under the Patient Protection and Affordable Care Act (ACA) and the CARES Act, limit racial and ethnic

[56] *See* Hospital Survey and Construction Act, 42 U.S.C. § 291e(f) (2020).

[57] Ruqaiijah Yearby, *Racial Disparities in Health Status and Access to Healthcare: The Continuation of Inequality in the United States Due to Structural Racism*, 77 AM. J. L & ECON. & SOC. 1113, 1129-38 (2018).

[58] *See* Ruqaiijah Yearby, *When is a Change Going Come?: Separate and Unequal Treatment in Health Care Fifty Years After Title VI of the Civil Rights Act of 1964*, 67 SMU L. Rev. 287, 324-329 (2014); 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);

[59] 42 US § 2000d-1 (2018). Physicians receiving payments under Medicare Part B are exempted from compliance with Title VI because these payments are not defined as federal financial assistance. DAVID BARTON SMITH, HEALTH CARE DIVIDED: RACE AND HEALING A NATION 161-164 (1999). Thus, physicians can continue to discriminate based on race. *Id.*

minorities access to health care. As a result, racial and ethnic minorities lack access to treatment for COVID-19 and other health conditions.[60]

In 2006, Sager and Socolar reported that, as the African American population in a neighborhood increased, the closure and relocation of hospital services increased for every period from 1980 to 2003, except between 1990 and 1997.[61] These findings were shown again in 2009, 2011, 2012, and 2014.[62] As a result of these closures, African Americans' access to health care is limited. As hospitals closed in predominately African American neighborhoods, physicians connected to the hospitals left the area and the remaining hospitals' resources were strained, causing the care provided to gradually deteriorate.[63] Research shows that hospital closures decreased beds in African American neighborhoods, while increasing beds in white neighborhoods

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[60] Ruqaiijah Yearby, *Breaking the Cycle of "Unequal Treatment" with Healthcare Reform: Acknowledging and Addressing the Continuation of Racial Bias,* 44 CONN. L. REV. 1281, 1288 (2012). *See also* David Williams and C. Collins, *Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health*, Public Health Rep. 116 (5), 404–416 (2001) (noting that racial residential segregation is a fundamental cause of racial disparities in health.) African Americas are disproportionately likely to undergo surgery in low-quality hospitals, which is linked to higher mortality rates for African Americans compared to Whites. Justin Dimick, et al., *Black Patients More Likely Than Whites to Undergo Surgery at Low-Quality Hospitals in Segregated Regions,* 32 HEALTH AFF. 1046, 1050-1051 (2013). Research has also shown that residential segregation is associated with an increase in lung cancer mortality rates for African Americans. Awori Hayanga, *Residential Segregation and Lung Cancer Mortality in The United States*, 148 JAMA SURGERY 37, 37 (2013).Moreover, residential segregation has been associated with increased hospital closures. *See* DAVID BARTON SMITH, HEALTHCARE DIVIDED: RACE AND HEALING A NATION 200 (1999). *supra* note 35 (citing David G. Whiteis, *Hospital and Community Characteristics in Closures of Urban Hospitals, 1980-87,* 107 PUB. HEALTH REP. 409-416 (1992)).

[61] ALAN SAGER & DEBORAH SOCOLAR, CLOSING HOSPITALS IN NEW YORK STATE WON'T SAVE MONEY BUT WILL HARM ACCESS TO CARE 27–31 (2006), *available at* http://dcc2.bumc.bu.edu/hs/Sager Hospital Closings Short Report 20Nov06.pdf.

[62] Michelle Ko, et al, *Residential Segregation and the Survival of US Urban Public Hospitals,* 7 MED. C. RES and. & REV 243 (2014); Renee Hsia, et al, *System-Level Health Disparities In California Emergency Departments: Minorities And Medicaid Patients Are At Higher Risk Of Losing Their Emergency Departments,* 59 ANN. EMERGENCY MED. 359 (2012); Renee Hsia and Yu-Chu Shen, *Rising Closures Of Hospital Trauma Centers Disproportionately Burden Vulnerable Populations,* 30 HEALTH AFFAIRS 1912 (2011); and Yu-Chu Shen, et al, *Understanding The Risk Factors Of Trauma Center Closures: Do Financial Pressure And Community Characteristics Matter?,* 47 MED. CARE 968 (2009).

[63] *See* 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 . . . ").

where the hospitals re-opened.[64] Thus, the failure to regulate hospital closures under Title VI even though they have been linked to race is an example of structural racism. The hospital closures have benefited white communities by increasing access to health care, while harming African American communities by limiting access to health care.

Racial and ethnic minorities have also long been subject to interpersonal racism and poor treatment by health care providers because of structural racism.[65] One study revealed that "69 percent of medical students surveyed exhibited implicit preferences for white people" and "other studies have found that physicians tend to rate African American patients more negatively than whites on a number of registers, including intelligence, compliance, and propensity to engage in high-risk health behaviors."[66] African Americans often sense this interpersonal racism against them, which results in delays seeking care, an interruption in continuity of care, non-adherence, mistrust, reduced health status, and avoidance of the healthcare system.[67]

When African Americans do seek care, they receive poorer quality of care than whites. According to a study conducted by Harvard researchers, African-American Medicare patients received poorer basic care than Caucasians who were treated for the same illnesses.[68] The study showed that only 32% of African-American pneumonia patients with Medicare were given antibiotics within six hours of admission, compared with 53% of other pneumonia patients with Medicare.[69] Also, African-Americans with pneumonia were less likely to have blood cultures done

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[64] *Id.*
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[66] Kimani Paul-Emile, *Patients' Racial Preferences and the Medical Culture of Accommodation*, 60 UCLA L. REV. 462, 493 (2012)).
[67] Janice Sabin, et al, *Physicians' Implicit and Explicit Attitudes About Race by MD Race, Ethnicity, and Gender*, 20 J. HEALTHCARE POOR & UNDERSERVED 896, 907 (2009).
[68] John Z. Ayanian et al., *Quality of Care by Race and Gender for Congestive Heart Failure and Pneumonia*, 37 MED. CARE 1260, 1260–61, 1265 (1999).
[69] *Id.* at 1265.

during the first two days of hospitalization [70] Other studies have shown that lower death rates are associated with prompt administration of antibiotics and collection of blood cultures. [71] Yet, these life-saving therapies are often withheld from elderly African Americans. This is an example of structural racism. Because HHS does not apply Title VI to health care providers, physicians are allowed to limit African Americans' access to quality health care based on interpersonal racism. This benefits whites receiving quality care, while harming African Americans left without access to quality health care.

Structural racism also prevents other racial and ethnic minorities from accessing health care services. Agricultural workers who are primarily immigrants do not have health insurance and are poor, thus they forgo health care.[72] Additionally, other undocumented immigrants in the United States, most of whom originally hail from Mexico, Central America or Asia, do not have access to health care under the ACA.[73] Moreover, regardless of whether immigrants are documented or not they often forgo care because of punitive immigration policies,[74] such as increased ICE enforcement.[75] This is an example of structural racism. The government and

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[70] *Id*.
[71] *Id.*; *see also* Manreet Kanwar et al., *Misdiagnosis of Community-Acquired Pneumonia and Inappropriate Utilization of Antibiotics: Side Effects of the 4-h Antibiotic Administration Rule*, 131 CHEST 1865, 1865 (2007) (discussing the association between timely antibiotic therapy and improved health outcomes in patients with community-acquired pneumonia); Mark L. Metersky et al., *Predicting Bacteremia in Patients with Community-Acquired Pneumonia*, 169 AM. J. RESPIRATORY & CRITICAL CARE MED. 342, 342 (2004) ("[P]erformance of blood cultures on Medicare patients hospitalized with pneumonia has been associated with a lower mortality rate.").
[72] Monica Schoch-Spana, et al., *Stigma, Health Disparities, and the 2009 H1N1 Influenza Pandemic: How to Protect Latino Farmworkers in Future Health Emergencies,* Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science 8(3): 243-253 (2010).
[73] *See* Medha D. Makhlouf, *Health Justice for Immigrants*, 4 U. PA. J.L. & PUB. AFF.235 (2019).
[74] Wendy E. Parmet, Trump's immigration policies will make the coronavirus pandemic worse, STAT (Mar. 4, 2020), https://www.statnews.com/2020/03/04/immigration-policies-weaken-ability-to-fight-coronavirus/
[75] Wendy E. Parmet, *In the Age Of Coronavirus, Restrictive Immigration Policies Pose a Serious Public Health Threat*, HEALTH AFFAIRS (April 18, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200418.472211/full/. Monica Schoch-Spana, et al., *Stigma, Health Disparities, and the 2009 H1N1 Influenza Pandemic: How to Protect Latino Farmworkers in Future Health Emergencies,* Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science 8(3): 243-253 (2010).

employers save money by not providing health insurance, while immigrants are harmed because it limits their access to health care. Racial and ethnic disparities in access to quality health care have continued during the COVID-19 pandemic.

Although the CARES Act provides Medicaid coverage for COVID-19 related testing and treatment, it has not addressed racial and ethnic disparities in access to health care.[76] As discussed above, the health care provisions of CARES Act do not cover many essential workers, who are racial and ethnic minorities. Furthermore, racial and ethnic minorities lack access to COVID-19 tests and testing sites. For example, lack of access to health care services is having a deadly impact on African Americans in St. Louis. In St. Louis, as of April 20, 2020, all but 3 deaths from COVID-19 have been African Americans.[77] The zip code with the most cases of COVID-19 viruses in St. Louis city (63115) is predominately African American (98%) and currently lacks a public testing site for COVID-19.[78] Research shows that by 2010 St. Louis only had one hospital in a predominately African American neighborhood, compared to 18 in the 1970s.[79] Because of these hospital closures, St. Louis only has one hospital in a predominately African neighborhood to treat those infected with COVID-19.[80]

[76] PUB. LAW. NO. 116- 138. Tit. III (2)(b) § 3211 (b) 236 (2020) 4.
[77] Paulina Cachero, *All but 3 people who died from COIVD-19 in St. Louis, Missouri, were black,* Business Insider (Apr. 12, 2020), available at https://www.businessinsider.com/all-but-three-people-who-died-from-covid-19-in-st-louis-were-black-2020-4
[78] City of St. Louis Department of Health, COVID-19 Public testing Locations (Apr. 19, 2020), available at https://www.stlouis-mo.gov/covid-19/data/test-locations.cfm
[79] ALAN SAGER & DEBORAH SOCOLAR, CLOSING HOSPITALS IN NEW YORK STATE WON'T SAVE MONEY BUT WILL HARM ACCESS TO CARE 30 (2006), *available at* http://dcc2.bumc.bu.edu/hs/Sager Hospital Closings Short Report 20Nov06.pdf.
[80] ALAN SAGER & DEBORAH SOCOLAR, CLOSING HOSPITALS IN NEW YORK STATE WON'T SAVE MONEY BUT WILL HARM ACCESS TO CARE 30–31 (2006), *available at* http://dcc2.bumc.bu.edu/hs/Sager Hospital Closings Short Report 20Nov06.pdf.

There have also been numerous reports of African Americans seeking testing and treatment for COVID-19, who have been turned away.[81] Unfortunately, some of those turned away have died.[82] Throughout this article, we have highlighted how structural racism has caused racial and ethnic disparities in exposure, susceptibility, and treatment of COVID-19. The last section provides suggests for addressing structural racism as well as public health solutions to help mitigate the racialized effects of the disease.

V. LEGAL AND PUBLIC HEALTH SOLUTIONS

A study in 2008 predicted that racial and ethnic disparities in work place protections, housing, and access to health care and other structural factors would make it difficult for minority populations to follow mitigation efforts such as social distancing.[83] The 2009 H1N1 pandemic and the COVID-19 pandemic have shown that these predictions are true. Without legal protections and public health plans, racial and ethnic minorities are more exposed, susceptible, and more likely to suffer and die during pandemics. The main purpose of this article was to describe how this has actually occurred during the COVID-19 pandemic. We must take steps to provide legal protections and public health plans that address the specific needs of racial and ethnic minorities. Below we highlight some areas we believe should be priorities to address structural racism. This is not a comprehensive list. Rather, we identify some tangible approaches that may help ensure the same inequities in the next disaster or outbreak.

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[81] Jasmin Barmore, *5-year-old with rare complication becomes first Michigan child to die of COVID-19*, The Detroit News (Apr. 20, 2020).
[82] Shamar Walters and David K. Li, *New York City Teacher Dies From Covid-19 After She Was Denied Tests, Family Says,* NBC News (April 29, 2020), Detroit Man With Virus Symptoms Dies After 3 Ers Turn Him Away, Family Says: "He Was Begging For His Life", CBS New (April 22, 2020 https://www.cbsnews.com/news/coronavirus-detroit-man-dead-turned-away-from-er/
[83] Robert J. Blendon, et. al., *Public Response to Community Mitigation Measures for Pandemic Influenza*, 14 (5) EMERGING INFECTIOUS DISEASES 14, no. 5778–86, (May 2008): 778–86, available at:) https://doi.org/10.3201/eid1405.071437.

A. Addressing Structural Racism: Short and Long Term Legal Solutions

At a minimum, government plays a big role in implementing short-term and long-term solutions to address structural racism by changing the employment, housing, and health care laws.

Currently, some states are trying to provide some short-term solutions for low-wage workers by providing extra compensation. For example, California is providing financial support for undocumented immigrants affected by this pandemic, while some governors sought and received Center for Medicare and Medicaid Services (CMS) approval to give home care workers additional pay.

In particular, the Arkansas governor received approval from CMS to use some CARES Act funding to provide payments to direct care workers.[84] Eligible workers, all direct care workers except those working in nursing homes and hospitals,[85] will receive a bonus of $125 per week for part-time workers (20 to 39 hours) and $250 per week for full-time workers (40 or more hours).[86] If the worker is employed in a facility "where someone has tested positive for COVID-19, they will get an additional $125 a week for working one to 19 hours a week, $250 for those working 20

[84] Elisha Morrison, *CMS approves some healthcare worker bonuses,* BENTON COURIER (Apr. 16, 2020), available at https://www.bentoncourier.com/covid-19/cms-approves-some-healthcare-worker-bonuses/article_3946adc8-800c-11ea-944a-1b151690787e.html

[85] KATV, *Governor announces bonus pay for some health workers: COVID-19 death toll rises to 34,* (Apr. 15, 2020), available at https://katv.com/news/local/governor-announces-bonus-pay-for-health-workers-at-long-term-care-facilities. "Eligible workers include: Registered Nurses; Licensed practical nurses; Certified nurse aides; Personal care aides assisting with activities of daily living under the supervision of a nurse or therapist; Home health aides assisting with activities of daily living under the supervision of a nurse or therapist; Nursing assistive personnel; Direct care workers providing services under home and community-based waiver; Intermediate Care Facility direct care staff including those that work for a state-run Human Development Center; Assisted Living direct care staff members; Hospice service direct care workers; and Respiratory therapists." *Id.*

[86] Elisha Morrison, *CMS approves some healthcare worker bonuses,* Benton Courier (Apr. 16, 2020), available at https://www.bentoncourier.com/covid-19/cms-approves-some-healthcare-worker-bonuses/article_3946adc8-800c-11ea-944a-1b151690787e.htmlMorrison, *supra* note 81.

to 39 hours and $500 a week for those working 40 hours or more."[87] The payments will be retroactive to April 5th and will continue until at least May 30.[88]

The New Hampshire governor has also decided to use some of the CARES Act funding to provide direct care workers and others working in Medicaid-funded residential facilities, with weekly $300 payments for working during the COVID-19 pandemic until the end of June.[89] Twelve states and the District of Columbia have already passed laws to increase wages for direct care workers above the set Medicaid rate before the COVID-19 pandemic,[90] which they could use to increase the wages of home care workers. Other states should use the examples set by Arkansas and New Hampshire and seek CMS approval to use CARES Act funding to increase the wages of home care workers.

Although admirable, these are not the universal solutions. It may be time to consider that all workers deemed as essential should receive a guaranteed basic minimum income and paid sick leave until the end of the pandemic, i.e. the last confirmed death from COVID-19.[91] Providing essential workers with a guaranteed basic minimum income and paid sick leave would allow sick workers to stay at home decreasing disparities in exposure to COVID-19 for racial and ethnic minorities who often cannot afford to stay home when they are sick. Additionally, low-wage workers, who are primarily racial and ethnic minorities, should receive savings accounts to help

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[87] *Id.*
[88] The governor will extend the payments an additional 30 days if COVID-19 cases on May 30th exceed 1,000. *Id.*
[89] Mia Summerson, *NH moves to boost pay for long-term care workers,* SENTINEL SOURCE (Apr. 14, 2020), available at https://www.sentinelsource.com/news/local/nh-moves-to-boost-pay-for-long-term-care-workers/article_78db684f-a0a6-5eaf-bf0d-29caae8811b4.html
[90] The states include: Arizona, California, Colorado, the District of Columbia, Illinois, Indiana, Maine, Minnesota, Montana, New York, Pennsylvania, Rhode Island, and Washington. Ruqaiijah Yearby, et al, *State Wage Pass Through Laws for Direct Care Workers* (Dec. 16, 2019), unpublished manuscript tracking state laws that increase wages for direct care workers providing care to elderly Medicaid patients as of December 1, 2019.
[91] Kimberly Amandeo, *Universal Basic Income, Pros and Cons With Examples*, THE BALANCE (Dec. 13, 2019) available at https://www.thebalance.com/universal-basic-income-4160668.

equalize their pay compared to white workers that have benefitted from employment law protections. These benefits should also include survivorship benefits for essential workers without life insurance to ensure that upon their death, their families can still survive.

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. [92] Thus, for almost 20 years Alaska has provided guaranteed support for residents, helping to address poverty, with no change in full-time employment. In 2010, 2011, and 2012, researchers studying racial and ethnic disparities in hospitalization and death rates from H1N1 noted that the best way to decrease disparities in exposure to H1N1 was to provide low-wage workers with paid sick leave.[93] Specifically, they noted that the United States needs comprehensive "paid sick-leave legislation that enables low-income and private-sector workers to adhere to social-distancing recommendations even when they lack paid sick leave." These short-term policies can be added to the next round of COVID-19 relief legislation. In terms of long-term solutions to address structural racism in employment and disparities in exposure to viruses, the FLSA should apply to all domestic, agricultural, and service workers, even if they are deemed as independent contractors. Moreover, these workers should have paid sick leave and a guaranteed basic income that ensures that workers are above the poverty level.

To address structural racism in housing and disparities in susceptibility, the federal government needs to enact legislation to address health-related housing violations. In 2020, there

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[92] Michael Coren, *When you give Alaskans a universal basic income, the still keep working,* QUARTZ (Feb. 13, 2018), available at https://qz.com/1205591/a-universal-basic-income-experiment-in-alaska-shows-employment-didnt-drop/

[93] Sandra Crouse Quinn et. al.,. *Racial Disparities in Exposure, Susceptibility, and Access to Health Care in the US H1N1 Influenza Pandemic*, American Journal of Public Health 101, no. 2 (February 2011), 285–93, available at: https://doi.org/10.2105/AJPH.2009.188029;

is no reason why all those residing in the United States should not have access to clean running water; plumbing with hot and cold water; a flushing toilet, and a bathtub or shower; and kitchen facilities that includes a sink with a faucet, a stove or range oven, and a refrigerator. In the short-term, the state and local governments need to proactively use existing law to address health related housing violations, such as access to water. In the long-term, state and federal governments need to enact laws and provide grants to ensure that all housing has access to clean running water; plumbing with hot and cold water; a flushing toilet, and a bathtub or shower; and kitchen facilities that includes a sink with a faucet, a stove or range oven, and a refrigerator. In addition, the next round of COVID-19 relief legislation should include language that mandates access to clean water (bottled or tap) for residents in the areas most affected by COVID-19, which will decrease disparities in susceptibility to the virus by stopping the spread.

In order to address disparities in treatment and structural racism that limits racial and ethnic minorities' access to health care, the federal government must provide low cost or free expanded health care options for undocumented immigrants and racial and ethnic minorities who live in states that did not expand Medicaid. As a short-term solution, in the next round of COIVD-19 relief, all essential workers should be granted access to health care for treatment of COVID-19 and any other health ailments without fear of ICE enforcement. Moreover, as a long-term solution, the federal government needs to fully enforce Title VI by holding hospitals and health care providers responsible for racism, which increases racial and ethnic disparities in treatment.

B. Public Health Mitigation of Health Inequities

The inequities we are seeing in this pandemic are predictable, and the US has failed to plan properly to protect racial and ethnic minority populations. Health researchers have long predicted

that existing inequities would worsen a pandemic.[94] Had their recommendations and similar advice by other researchers in past pandemics been taken, perhaps the inequities we described above due to COVID-19 would not have been so vast. For example, detailed race/ethnicity reporting related to virus hospitalization and deaths and "targeted, culturally appropriate risk communication, using trusted spokespersons and channels" that engages "both national and local organizations that represent minority populations …to get the message to at-risk groups" [95] could help with COVID-19 spread.

Although, jurisdictions are just beginning to collect racialized data concerning COVID-19 infections and deaths, there needs to be a better developed public health action plan on how to use the data that is being collected to address disparities in exposure, susceptibility, and treatment. Additionally, health care providers need to be educated to ensure "that they recognize higher-risk individuals and aggressively deliver adequate care to them."[96] Ruha Benjamin notes "a "lack of trust" on the part of Black patients is not the problem with the health care system; rather "it is a lack of trustworthiness" by the health care system and medical industry.[97]

In this piece, we highlight some structural problems causing the increased death and illness of minority populations of COVD-19. At a minimum, for health justice for these communities, minority groups and minority-led organizations need to be engaged about how to develop fair allocation policies for testing, PPE, ventilators, clinical trial enrollment, future treatment and vaccine access.

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[94] Philip Blumenshine et. al., *Pandemic Influenza Planning in the United States from a Health Disparities Perspective,* 14(5) EMERGING INFECTIOUS DISEASES 14, no. 5709–15, (May 2008): 709–15, available at:) https://doi.org/10.3201/eid1405.071301.
[95] *Id.*
[96] *Id.*
[97] Ruha Benjamin, "*Assessing Risk, Automating Racism,*" 366 (6464) SCIENCE 366, no. 6464421-22 (October 25, 2019): 421–22.). https://doi.org/10.1126/science.aaz3873.

African Americans and other minority populations are bearing the brunt of COVID-19. As such, they should have access to treatments and vaccines that will hopefully be developed for COVID-19 and policies that take into account should be developed in this regard. This will help rebuild trust and understanding. It may be important to focus on "local and state health departments, federally qualified health centers, and other health care providers …partner …with community-based organizations that serve at-risk populations."[98] This would help those without health care coverage, including undocumented immigrants, to seek care. Each of the suggestions noted above were made in some form by Quinn et. al. in 2011 during the H1N1 pandemic. We do not attempt an all-encompassing list here but we urge engagement with the past literature from pandemics and racial equity, many articles that are linked here. The COVID-19 pandemic is proving to be a more serious public health threat than H1NI, so it is time to adopt these changes to current public health plans.[99]

These are not easy solutions, but they are vital to prevent further unnecessary COVID-19 infection and deaths by racial and ethnic minorities. They require government investment and commitment. However, it is only through such support that we can end the cycle of racial and

[98] Supriya Kumar, et al, *The Impact of Workplace Policies and Other Social Factors on Self-Reported Influenza-Like Illness Incidence During the 2009 H1N1 Pandemic,* 102 (1) Am. J. Pub. Health (Jan. 2012): 132-140; Sandra Crouse Quinn et. al.,. *Racial Disparities in Exposure, Susceptibility, and Access to Health Care in the US H1N1 Influenza Pandemic*, American Journal of Public Health 101, no. 2 (February 2011), 285–93, available at: https://doi.org/10.2105/AJPH.2009.188029. Monica Schoch-Spana, et al., *Stigma, Health Disparities, and the 2009 H1N1 Influenza Pandemic: How to Protect Latino Farmworkers in Future Health Emergencies,* Biosecurity and Bioterrorism: Biodefense Strategy, Practice, and Science 8(3): 243-253 (2010).

[99] Legal scholars Emily Benfer and Lindsay Wiley have suggested a whole host of useful health justice strategies to "protect workers, freeze evictions and utility shut-offs, and prioritize programs that secure safe and healthy housing conditions and nutritional supports" to mitigate the harms for the particular harms of COVID-19 focusing on housing and workers. Emily Benfer & Lindsay Wiley, *Health Justice Strategies To Combat COVID-19: Protecting Vulnerable Communities During A Pandemic*, HEALTH AFFAIRS (Mar. 19, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200319.757883/full/
They note that "state and local leaders have an unprecedented opportunity to use a combination of routine and emergency powers to protect the health of low-income people who do not have the ability to shelter in place without severe consequences and who are exposed to unhealthy conditions in their homes at a much higher rate than higher income peers." *Id.*

ethnic inequity that this nation faces, not only during this pandemic, but in future disasters and pandemics. We have outlined some legal and policy measures that should be addressed. However, to achieve true health justice for all, interventions to address the root causes of inequity, including all community conditions through one's life course are necessary.