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Health Justice Strategies to Combat the Pandemic: Eliminating Discrimination, Poverty, and Health Disparities During and After COVID-19

Emily A. Benfer, Seema Mohapatra, Lindsay F. Wiley & Ruqaiijah Yearby*

Abstract:

Experience with past epidemics made it predictable that people living in poverty, people of color, and other marginalized groups would bear the brunt of the coronavirus pandemic due to the social determinants of health (SDOH). The SDOH are subdivided into structural and intermediary determinants. Structural determinants include forms of subordination (discrimination and poverty) that influence intermediary determinants (health care, housing, and employment). The COVID-19 pandemic has magnified and accelerated the harms caused by these determinants, limiting health equity among historically marginalized groups and low-income populations. Black, Latino, and Indigenous populations have higher COVID-19 infection and mortality rates, higher rates of unemployment, less access to health care, and greater risk of eviction during the pandemic, among other significant inequities. Without robust and swift government interventions, the impacts of the pandemic will be wide and deep. This Article analyzes mechanisms of these determinants in the pandemic setting and provides solutions using the health justice framework. The health justice framework offers three principles: structural, supportive, and empowering. First, legal and policy responses must address the structural determinants of health. Second, interventions mandating

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healthy behaviors must be accompanied by material support and legal protections to enable compliance while minimizing harms. Third, historically marginalized communities must be engaged and empowered as leaders in the development and implementation of interventions and the attainment of health justice. To demonstrate the application of these principles, this Article focuses on two structural determinants of health (discrimination and poverty) and three intermediary determinants (health care, housing, and employment).

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INTRODUCTION

People with low socioeconomic status[1] and people of color[2] entered the COVID-19 pandemic more vulnerable to infection and mortality than their more privileged peers due in part to conditions linked to discrimination and poverty.[3] COVID-19 is more dangerous for, and has a higher mortality rate among, low-income people, people of color, and people with underlying chronic conditions, such as hypertension, diabetes, and lung disease.[4] These conditions disproportionately affect Black, Latino, and Indigenous communities, and people living in poverty.[5] Emerging data suggests that socioeconomic factors, such as poverty, were also significant predictors of infection and death rates.[6] In 2018, 38.1 million people, or 11.8% of the U.S. population, were living in poverty.[7] "The

1. *See* Michael G. Marmot, *Understanding Social Inequalities in Health*, 46 PERSP. IN BIOLOGY & MED. S9 (2003).

2. Merlin Chowkwanyun & Adolph L. Reed, Jr, *Racial Health Disparities and Covid-19—Caution and Context*, 383 NEW ENG. J. MED. 201 (2020); Ibram X. Kendi, *Stop Blaming Black People for Dying of the Coronavirus,* ATLANTIC (Apr. 14, 2020), https://www.theatlantic.com/ideas/archive/2020/04/race-and-blame/609946.

3. People with disabilities were also disproportionately vulnerable. *See* Gloria L. Krahn, Deborah Klein Walker & Rosaly Correa-De-Araujo, *Persons with Disabilities as an Unrecognized Health Disparity Population*, 105 AM. J. PUB. HEALTH, at S198 (2015).

4. Nancy Krieger, Pamela D. Waterman & Jarvis T. Chen, *COVID-19 and Overall Mortality Inequities in the Surge in Death Rates by Zip Code Characteristics: Massachusetts, January 1 to May 19, 2020*, 110 AM. J. PUB. HEALTH 1850 (2020).

5. *See, e.g.*, CTRS. FOR DISEASE CONTROL & PREVENTION, NATIONAL HEALTH INTERVIEW SURVEY: SUMMARY HEALTH STATISTICS tbls.A-1a, A-2a & A-4a (2018). Tables A-1a, A-2a, and A-4a respectively provide statistical information on the incidence of coronary heart disease and hypertension); asthma and chronic bronchitis; and diabetes.

6. *See* Samrachana Adhikari, Nicholas P. Pantaleo & Justin M. Feldman, *Assessment of Community-Level Disparities in Coronavirus Disease 2019 (COVID-19) Infections and Deaths in Large US Metropolitan Areas*, JAMA NETWORK OPEN (July 28, 2020); W. Holmes Finch & Maria E. Hernández Finch, *Poverty and Covid-19: Rates of Incidence and Deaths in the United States During the First 10 Weeks of the Pandemic*, 5 FRONTIERS SOC. (June 15, 2020); Gregorio A. Millett et al., *Assessing Differential Impacts of COVID-19 on Black Communities*, 47 ANNALS EPIDEMIOLOGY 37 (2020); Caitlin Brown & Martin Ravallion, *Poverty, Inequality, And COVID-19 In The US*, VOX EU (Aug. 10, 2020), https://voxeu.org/article/poverty-inequality-and-covid-19-us. *See also* Jonathan Jay et al., *Neighbourhood Income and Physical Distancing During the COVID-19 Pandemic in the United States*, NATUR HUMANE HUM. BEHAV (2020) (forthcoming) (reporting data suggesting that "people in lower-income neighborhoods have faced barriers to physical distancing"); 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 AM. J. PUB. HEALTH 132 (2012) (finding that "the absence of certain policies, such as paid sick leave," which disproportionately affects certain groups, led to increased cases of influenza-like illness during the 2009 H1N1 pandemic).

7. Jessica Semega et al., *Income and Poverty in the United States: 2018,* U.S. CENSUS BUREAU 12 (2019), https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-266.pdf.

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lower a person's socioeconomic status, the more limited their resources and ability to access essential goods and services, and the greater their chance of suffering from chronic disease, including conditions like heart disease, lung disease, and diabetes that may increase the mortality risk of COVID-19."[8] Past infectious disease epidemics in the United States and governmental responses to them made it highly predictable that people living in poverty and people of color would bear the brunt of the coronavirus pandemic[9] due to discrimination and other forms of subordination that limit equal access to resources in the realms of health care, housing, and employment.

Disparities in COVID-19 infection and death—and the chronic conditions that exacerbate them—stem from the social determinants of health. The social determinants of health "encompass[] the full set of social conditions in which people live and work."[10] The social determinants of health are subdivided into "structural determinants" and "intermediary determinants."[11] Structural determinants of health are "social and political mechanisms that generate, configure and maintain social hierarchies"[12] and organizations and institutions that

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

9. *See* Robert J. Blendon et al., *Public Response to Community Mitigation Measures for Pandemic Influenza,* 14 EMERGING INFECTIOUS DISEASES 778 (2008); Philip Blumenshine et al., *Pandemic Influenza Planning in the United States from a Health Disparities Perspective*, 14 EMERGING INFECTIOUS DISEASES 709 (2008); Monica Schoch-Spana et al., *Stigma, Health Disparities, and the 2009 H1N1 Influenza Pandemic: How to Protect Latino Farmworkers in Future Health Emergencies*, 8 BIOSECURITY & BIOTERRORISM: BIODEFENSE STRATEGY, PRAC. & SCI. 243 (2010); Sandra Crouse Quinn et al., *Racial Disparities in Exposure, Susceptibility, and Access to Health Care in the US H1N1 Influenza Pandemic*, 101 AM. J. PUB. HEALTH 285 (2011), https://ajph.aphapublications.org/doi/10.2105/AJPH.2009.188029.

10. COMM'N ON THE SOC. DETERMINANTS OF HEALTH, WORLD HEALTH ORG., A Conceptual Framework for Action on the Social Determinants of Health 9 (2010), https://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf.

11. *Id.* at 6. "The vocabulary of 'structural determinants' and 'intermediary determinants' underscores the causal priority of the structural factors." *Id.* Some initiatives in the United States tend to focus exclusively on the intermediary determinants when discussing the social determinants of health. For example, Healthy People 2020, a major initiative of the U.S. federal government, describes the social determinants of health as including five key areas: health and health care; neighborhood and built environment; economic stability; education; and social and community context. The impact of the social determinants of health is evidenced by health disparities due to unequal access to health care for prevention and disease management (health and health care); substandard housing and poor air quality (neighborhood and built environment), unequal wages (economic stability), and inequitable funding of primary and secondary education (education), among others. *Social Determinants of Health*, Healthy People 2020, U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health. Disregard for the structural determinants of health undermines the effectiveness of initiatives that focus on the intermediary determinants of health divorced from their root causes.

12. COMM'N ON THE SOC. DETERMINANTS OF HEALTH, *supra* note 10, at 5.

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can impact behavior.[13] Structural determinants (discrimination, poverty, and other forms of subordination, as well as the political and legal systems in which subordination is embedded), impact the intermediary determinants of health. The intermediary determinants include material and environmental circumstances, such as health care, housing, and employment conditions.[14]

The impacts of the pandemic on health disparities will be wide and deep. Unemployment and mass evictions are disproportionately occurring among people of color.[15] Disruptions to education and early childhood development are impacting those who were already living at or near the poverty line, in addition to Black, Latino, Indigenous, and other people of color.[16] Due to loss of income and employment and diminished financial resources caused by the pandemic, Black, Latino, Indigenous, and other people of color also face a higher chance of child welfare intervention and separation of children from their families, which have long-term consequences for health and well-being.[17] In the pandemic setting, policymakers must address a wide range of impacts, including decarceration and deinstitutionalization for people living in congregate settings, access to food and other necessities, and access to education, among other barriers to health.

While the United States waits for safe, effective, and widely distributed antiviral therapies and vaccines, health officials have deployed community mitigation measures to slow the spread of disease and flatten the curve of the epidemic. In the absence of mass testing, state and local governments have adopted a widely varying range of restrictions aimed at increasing physical distancing among the general population and shielding the most vulnerable from exposure. As we have previously observed, "[a]lthough widely discussed in terms of the steps *individuals* should take, [this] social distancing also demands commitment from federal, state, and local governments to financially support and protect marginalized populations, such as low-income communities and communities of

13. *See* Golden et al., *Upending the Social Ecological Model to Guide Health Promotion Efforts Toward Policy and Environmental Change*, 42 HEALTH EDUC. & BEHAV. 94 (2015); Kenneth R. McLeroy et al., *An Ecological Perspective Health Promotion Programs*, 15 HEALTH EDUC. Q. 351 (1988).

14. *Id*. at 6. COMM'N ON THE SOC. DETERMINANTS OF HEALTH, *supra* note 10, at 6.

15. Elise Gould & Valerie Wilson, *Black Workers Face Two of the Most Lethal Preexisting Conditions for Coronavirus—Racism* and *Economic Inequality*, ECON. POL'Y INST. (June 1, 2020), https://files.epi.org/pdf/193246.pdf; Emily Benfer et al., *The COVID-19 Eviction Crisis: An Estimated 30-40 Million People in America Are at Risk,* ASPEN INST. (Aug. 7, 2020), https://www.aspeninstitute.org/blog-posts/the-covid-19-eviction-crisis-an-estimated-30-40-million-people-in-america-are-at-risk.

16. Jack P. Shonkoff & David R. Williams, *Thinking About Racial Disparities in COVID-19 Impacts Through a Science-Informed, Early Childhood Lens*, CTR. ON THE DEVELOPING CHILD, HARV. UNIV. (Apr. 27, 2020) https://developingchild.harvard.edu/thinking-about-racial-disparities-in-covid-19-impacts-through-a-science-informed-early-childhood-lens.

17. *Id*.

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color."[18]

Federal coronavirus relief bills have provided some financial support and legal protections to enable compliance and minimize the secondary harms caused by restrictions.[19] However, many low-income individuals and people of color have not benefited from these programs, and where they have, the support is minimal. Moreover, infectious disease control and public health emergency laws rarely contemplate—let alone require—the provision of financial supports, protections, or mechanisms for addressing poverty and the long-standing practices of racial discrimination, which exacerbate the risk of infection. Additionally, because these measures are often stopgap in nature, they do not provide long-term protection for marginalized populations.

Health justice is an emerging framework for eradicating unjust health disparities, especially those caused by discrimination, poverty, and other forms of subordination.[20] The framework highlights the need to engage and empower

18. Benfer & Wiley, *supra* note 8.

19. *See, e.g.,* Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. No. 116-136, 134 Stat. 281 (2020); *see also* Lindsay F. Wiley & Samuel R. Bagenstos, *The Personal Responsibility Pandemic: Centering Solidarity in Public Health and Employment Law*, ARIZ. ST. L. J. (forthcoming 2021), *available at* https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3656789 (critiquing the federal government's pandemic response, especially for its focus on individual behavior and responsibility, which has "placed disproportionate burdens on those who are already disadvantaged").

20. *See, e.g.*, Lindsay F. Wiley, *Health Law as Social Justice*, 24 CORNELL J. L. & PUB. POL'Y 47, 47 (2014) ("[d]rawing on the experiences of the reproductive justice, environmental justice, and food justice movements, and on the writings of political philosophers and ethicists on health justice" to discuss health justice as a framework for the use of law to reduce health disparities); Emily A. Benfer, *Health Justice: A Framework (and Call to Action) for the Elimination of Health Inequity and Social Injustice*, 65 AM. U. L. REV. 275 (2015) (discussing health justice as a framework for eliminating health inequity and social injustice among low-income communities and communities of color); Lindsay F. Wiley, *From Patient Rights to Health Justice*, 37 CARDOZO L. REV. 833 (2016) (proposing the health justice model as an alternative to existing health law models for examining questions of health care quality and access); Lindsay F. Wiley, *Applying the Health Justice Framework to Diabetes as a Community-Managed Social Phenomenon*, 16 HOUS. J. HEALTH L. & POL'Y 191 (2016) (applying the health justice framework to diabetes disparities); Lindsay F. Wiley, *Tobacco Denormalization, Anti-Healthism, and Health Justice*, 18 MARQ. BENEFITS & SOC. WELFARE L. REV. 203 (2017) (applying the health justice framework to tobacco-related disparities); ELIZABETH TOBIN-TYLER & JOEL B. TEITELBAUM, ESSENTIALS OF HEALTH JUSTICE: A PRIMER 15 (2018) (noting that the authors "settled on *health justice* [for their title] because it tends to be relatively more recognized and understood by a greater number of people [than health equity]" and "[f]urthermore, 'justice' is often linked in people's minds to the legal system;" and defining health justice in terms of "laws, policies, systems, and behaviors that are evenhanded with regard to and display genuine respect for *everyone's* health and well-being"); Medha D. Makhlouf, *Health Justice for Immigrants*, 4 U. PA. J.L. & PUB. AFF. 235 (2019) (applying the health justice framework to assess public commitments to health care access for immigrants); Yael Cannon, *The Kids Are Not Alright: Leveraging Existing Health Law to Attack the Opioid Crisis Upstream*, 71 FLA. L. REV. 765 (2019) (applying the health justice framework to assess public commitments to meet the needs of people with adverse childhood experiences across the life-course); Emily A. Benfer et al., *Health Justice*

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marginalized populations in developing and implementing solutions and calls for policymakers to provide access to basic health-related rights, protections, and supports that eliminate health disparities. This Article suggests that policymakers not only apply the health justice framework to address discrimination and poverty, but also use it as a key strategy to protect and support marginalized populations, which include low-income communities and communities of color, both during and after the COVID-19 pandemic. Executive-branch officials should apply the health justice framework in the development and implementation of emergency and public health orders.[21] Judges should apply it in their adjudication of challenges to those orders. Legislatures should apply it in any reforms they adopt in response to the pandemic. Community organizations should also be guided by the health justice framework in their efforts to advocate for the needs of marginalized communities in pandemic response.

Part I provides an overview of discrimination and poverty, which create barriers to health in the pandemic setting. Part II describes the health justice framework and how it can be engaged in the pandemic setting. Parts III, IV, and V apply the health justice framework to three of the intermediary determinants of health (health care, housing, and employment) that support resilience and equip marginalized communities with the resources necessary to withstand the immediate impacts of the pandemic.[22] This application demonstrates how the health justice framework can be adopted across other structural and intermediary determinants of health to ensure the elimination of avoidable illness and death among marginalized people during and after the pandemic.

Strategies to Eradicate Lead Poisoning: An Urgent Call to Action to Safeguard Future Generations, 19 YALE J. HEALTH POL'Y L. & ETHICS 146 (2020); Matthew B. Lawrence, *Against the "Safety Net*,*"* 72 FLA. L. REV. 49 (2020) (applying the health justice framework to critique the safety net metaphor for public benefits); Angela Harris & Aysha Pamukcu, *The Civil Rights of Health: A New Approach to Challenging Structural Inequality*, 67 UCLA L. REV. 758, 758 (2020) ("argu[ing] that a civil rights of health initiative built on a health justice framework can help educate policymakers and the public about the health effects of subordination, create new legal tools for challenging subordination, and ultimately reduce or eliminate unjust health disparities").

21. Lindsay F. Wiley, *Democratizing the Law of Social Distancing*, 19 YALE J. HEALTH POL'Y L. & ETHICS (2020).

22. Education is also a key pillar of the social determinants of health, *see supra* note 4, and has been severely impacted by the pandemic, but the impacts of disruptions to early childhood, K-12, and post-secondary education on health generally play out over a longer time period than the impacts of health care, housing, and employment disruption. In this project, our focus here is on immediate impacts, but we welcome collaborations between public health and education law and policy experts to address the intermediate and long-term impacts of education disruption on health disparities in future projects. A forthcoming piece by Seema Mohapatra is applying the health justice framework in various aspects of children's lives, including educational impacts. Seema Mohapatra, *Justice for Children During and After the Pandemic*, ANNALS HEALTH L. (forthcoming 2021) (on file with authors).

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I. DISCRIMINATION, POVERTY, AND BARRIERS TO HEALTH IN THE PANDEMIC SETTING

Discrimination and poverty are forms of subordination that prevent racial and ethnic minorities, people living in poverty, and other marginalized groups from equal access to material and environmental circumstances, such as health care, housing, and employment. Subordination is "a set of policies, practices, traditions, norms, definitions, cultural stories, and explanations that function to systematically hold down one social group to the benefit of another social group."[23] In this paper, the term discrimination is not limited to what courts recognize as a basis for legal remedies; it also includes actions described as discrimination, bias, and unfair treatment in public health and sociology literature, even though they may not be deemed legally actionable by US courts.[24] Discrimination—interpersonal, institutional, and structural—has exacerbated poor health outcomes among marginalized groups prior to the pandemic and continues to do so during it. [25] Interpersonal discrimination reinforces social norms of prejudice through individual interactions. Specifically, this occurs when an individual consciously and/or unconsciously restricts low-income individuals' or racial and ethnic minorities' equal access to material and environmental circumstances based on stereotypes and prejudice.[26] Institutional discrimination operates through "neutral" organizational practices and policies that limit equal access to services for individuals who are poor and racial and ethnic minorities.[27] Structural

23. ROBIN DIANGELO, WHAT DOES IT MEAN TO BE WHITE?: DEVELOPING WHITE RACIAL LITERACY 44 (2012).

24. *See* JOE R. FEAGIN, SYSTEMIC RACISM: A THEORY OF OPPRESSION (2006); Eduardo Bonilla-Silva, *Rethinking Racism: Toward A Structural Interpretation*, 62 AM. SOC. REV. 465 (1997); Chandra L. Ford & Collins O. Airhihenbuwa, *Critical Race Theory, Race Equity, and Public Health: Toward Antiracism Praxis*, 100 AM. J. PUB. HEALTH S30 (2010); Chandra L. Ford & Collins O. Airhihenbuwa, *The Public Health Critical Race Methodology: Praxis for Antiracism Research*, 71 SOC. SCI. & MED. 1390 (2010); David R. Williams et al., *Understanding How Discrimination Can Affect Health*, 54 HEALTH SERVS. RES. 1374 (2019).

25. Discrimination also includes internalized and superstructural forms. Internalized discrimination is when racial and ethnic minorities accept stereotypes about themselves and those who share the same racial identities, while believing that members of other racial groups are superior, which can be harmful to the psychological wellbeing and physical health of racial and ethnic minorities. Kira Hudson Banks & Jadah Stephens, *Reframing Internalized Racial Oppression and Charting a Way Forward*, 12 SOC. ISSUES & POL'Y Rev. 91, 92-94 (2018). Superstructural discrimination includes the value systems and arrangements that create enduring power differentials among different groups. Michael D. Sweat & Julie A. Denison, *Reducing HIV Incidence in Developing Countries with Structural* and *Environmental Interventions*, 9 *AIDS*, at S251. (1995). All forms of discirmination reinforce hierarchy and subordination.

26. Ruqaiijah Yearby, *Internalized Oppression: The Impact of Gender and Racial Bias in Employment on the Health Status of Women of Color,* 49 SETON HALL L. REV. 1037, 1046 (2019).

27. Leith Mullings & Amy J. Schulz, *Intersectionality and Health: An Introduction*, *in* GENDER, RACE, CLASS AND HEALTH 3 (Leith Mullings & Amy J. Schulz eds., 2005).

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discrimination operates at a societal level and refers to the way laws and policies are written or enforced, which advantages the majority and disadvantages minorities in their access to opportunity and resources.[28] When those disadvantaged are racial and ethnic minorities, it is deemed structural racism, which is often evidenced by "the embedding of socially and culturally enforced racial hierarchies in societal norms, institutional practices, and laws; it is often not explicitly identified as race-based and is perpetuated in the implicit assumptions that guide everyday institutional practices, such as clinical resource allocation and decision making in a segregated health care system."[29] Figure 1 shows how the different levels of discrimination interact with material and environmental circumstances, such as health care, housing, and employment.

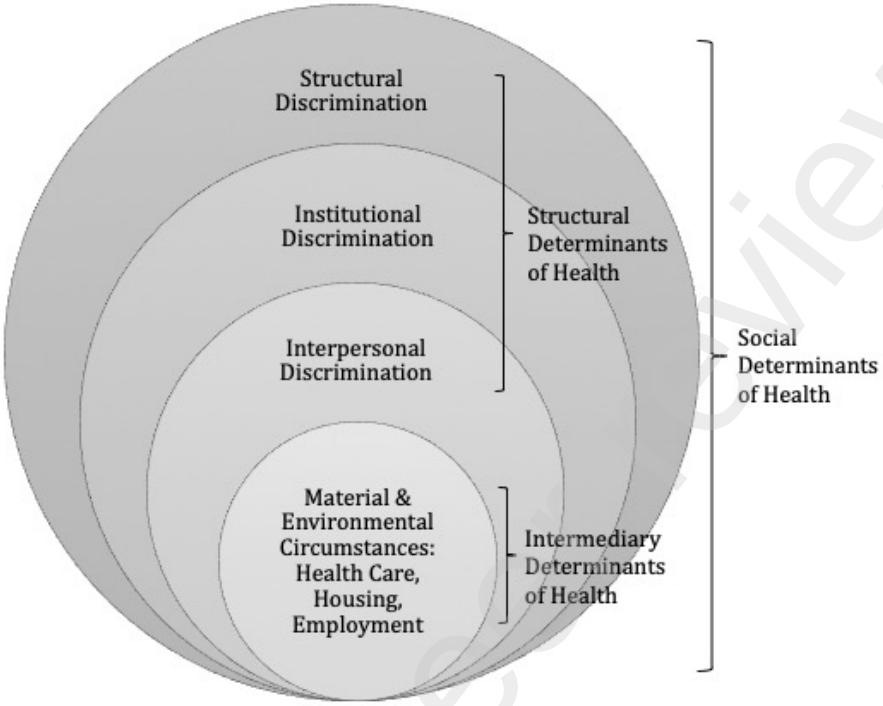
28 Ruqaiijah Yearby, *Structural Racism and Health Disparities: Reconfiguring the Social Determinants of Health to Include the Root Cause,* 48 J. L. MED. & ETHICS 518 (2020); Ruqaiijah Yearby & Seema Mohapatra, *Law, Structural Racism, and the COVID-19 Pandemic*, 7 J. L. & BIOSCIENCES 1 (2020).

29 Kristen Pallok, et al, *Structural Racism—A 60-Year-Old Black Woman with Breast Cancer*, 380 NEW ENG. J. MED. 1489, 1491 (2019).

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Figure 1. Discrimination and Material and Environmental Circumstances[30]



All three levels of discrimination interact with the political and legal determinants of health. Law is one of the tools used to structure society in a discriminatory way, while institutional and interpersonal discrimination reinforce the discriminatory structure of our society as illustrated in the examples discussed below.

The heavy use of command-and-control mandates by state and local governments as part of the community mitigation response to the coronavirus pandemic has exposed people of color, people experiencing homelessness, and other marginalized individuals to interpersonally discriminatory police surveillance and enforcement. For example, despite recommendations to adopt an education-first approach to policing, in which stay-at-home and face-covering orders are not enforced through arrests,[31] these policies were applied in a

30. Ruqaiijah Yearby, Lindsay F. Wiley, Emily A. Benfer & Seema Mohapatra, *Discrimination and Material and Environmental Circumstances* (2020). *See also* McLeroy et al., *supra* note 13; COMM'N ON THE SOC. DETERMINANTS OF HEALTH, *supra* note 10; Golden et al., *supra* note 13; Yearby et al., *Structural Racism and Health Disparities, supra* note 28, at 518.

31. Rosa Brooks & Christy Lopez, *Policing in a Time of Pandemic: Recommendations for Law Enforcement,* EDMOND J. SAFRA CTR. FOR ETHICS, HARV. UNIV. (Apr. 10, 2020),

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discriminatory way.[32] For example, in New York City, while police officers were handing out free masks and advising, but not requiring, people gathering outdoors in predominately White affluent neighborhoods to wear them, other officers were arresting and cracking down on Black and Latino people for gathering and not wearing masks.[33] These mandates are an example of interpersonal discrimination because individual officers treated affluent White people differently than they treated Black and Latino people.

Institutional discrimination also negatively impacts the health of low-income communities and communities of color, which makes them more vulnerable to the harms of COVID-19.[34] For example, the decision to prioritize funding hospital-based resources left low-income disabled individuals and elderly individuals in long-term care facilities that were understaffed by workers, creating fertile conditions for the virus to spread among vulnerable residents.[35] This "neutral" organizational decision left low-income disabled individuals and the elderly without equal access to quality health care services, resulting in unnecessary COVID-19 infections and deaths.[36]

As a result of racist, xenophobic, and ableist criminal and immigration enforcement policies and socioeconomic drivers of crime and migration, many people of color and those with low socioeconomic status are more likely to be confined in prisons, jails, and detention facilities. Mass incarceration is an example of structural discrimination, where policymakers' decisions resulted in laws, such as the "three strike" rule and the Anti-Drug Abuse Act of 1986 that punished people with rock cocaine more harshly than those with powder cocaine, that

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https://ethics.harvard.edu/files/center-for-ethics/files/7policingpandemic.pdf; Robert Gatter & Seema Mohapatra, *COVID-19 and the Conundrum of Mask Requirements*, 77 WASH. & LEE L. REV. ONLINE 17, 29-30 (2020).

32. Pascal Emmer et al., *Unmasked: The Impacts of Pandemic Policing*, COVID-19 POLICING PROJECT (October 2020), https://communityresourcehub.org/wp-content/uploads/2020/12/Unmasked.pdf.

33. Ashley Southall, *Scrutiny of Social-Distance Policing as 35 of 40 Arrested Are Black*, N.Y. TIMES (May 29, 2020), https://www.nytimes.com/2020/05/07/nyregion/nypd-social-distancing-race-coronavirus.html.

34. Benfer & Wiley, *supra* note 8; Yearby & Mohapatra, *supra* note 28 (*citing* 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, 1035 (2005) ("Hospital closures set into motion a chain of events that threaten minority communities' immediate and long-term access to primary care, emergency and nonemergency hospital care. . . .")).

35. Joanne Kenen, Rachel Roubein & Susannah Luthi, *How Public Health Failed Nursing Homes*, POLITICO (April 6, 2020), https://www.politico.com/news/2020/04/06/public-health-failed-nursing-homes-167372.

36. Nina A. Kohn, *The Pandemic Exposed a Painful Truth: America Doesn't Care About Old People,* WASH. POST (May 8, 2020), https://www.washingtonpost.com/outlook/nursing-home-coronavirus-discrimination-elderly-deaths/2020/05/07/751fc464-8fb7-11ea-9e23-6914ee410a5f_story.html.

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disproportionately harmed low-income and racial and ethnic minorities.[37] As a result, people of color make up the majority of the prison population and are subject to overcrowded congregate settings, increased risk of contracting COVID-19, and limited access to health care.[38]

Poverty is also a major barrier to health because it decreases material and environmental circumstances, such as health care and housing, among others.[39] In 2018, 8% of Whites were in poverty, compared to 21% of Blacks and 18% of Latinos.[40] Working age women (18-64) had a poverty rate of 12.3%, while working age men (18-64) had a poverty rate of 9%.[41] Reports from the Bureau of Labor Statistics show that in 2017, 6.9 million working adults were poor, with women (4.5%) more likely to be among the working poor compared to men (3.5%).[42] Moreover, Blacks (7.9%) and Latinos (7.9%) were twice as likely to be among the working poor compared to Whites (3.9%) and Asians (2.6%).[43] Working women of color, such as Black women (10.0%) and Latino women (9.1%), were more likely to be in poverty compared to White women (4.5%) and men (3.5%).[44]

As a result of structural determinants of health (discrimination and poverty), racial and ethnic minorities, people living in poverty, and other marginalized groups lack equal access to the intermediary determinants of health, such as health care, housing, and employment, among others. Figure 2 illustrates the connection between subordination and social hierarchies; political and legal systems; material and environmental circumstances, and the health system as social determinants of health, which cause disparities in health outcomes: COVID-19 infection, illness, potentially long-term disability, and death. This Figure is not intended to be a comprehensive description of the structural and intermediary determinants of health that make up the social determinants of health, but rather a frame that can be adapted to address other contexts.

37. Jelani Jefferson Exum, *Forget Sentencing Equality: Moving From the "Cracked" Cocaine Debate Toward Particular Purpose Sentencing*, 18 LEWIS & CLARK L. REV. 95, 99, 101-02 (2014).

38. *A State-by-State Look at Coronavirus in Prisons*, MARSHALL PROJECT (Nov. 20, 2020), https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons.

39. Ruqaiijah Yearby, *Breaking the Cycle of "Unequal Treatment" with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias,* 44 U. CONN. L. REV. 1281, 1308-09 (2012).

40. Semega et al., *supra* note 7, at 13 fig.8, 15, 50 tbl.B-1, https://www.census.gov/library/publications/2019/demo/p60-266.html.

41. *Id.* at 15 & fig.10.

42. *A Profile of the Working Poor, 2017*, U.S. BUREAU OF LAB. STAT. 1, 4 (Apr. 2019), https://www.bls.gov/opub/reports/working-poor/2017/pdf/home.pdf.

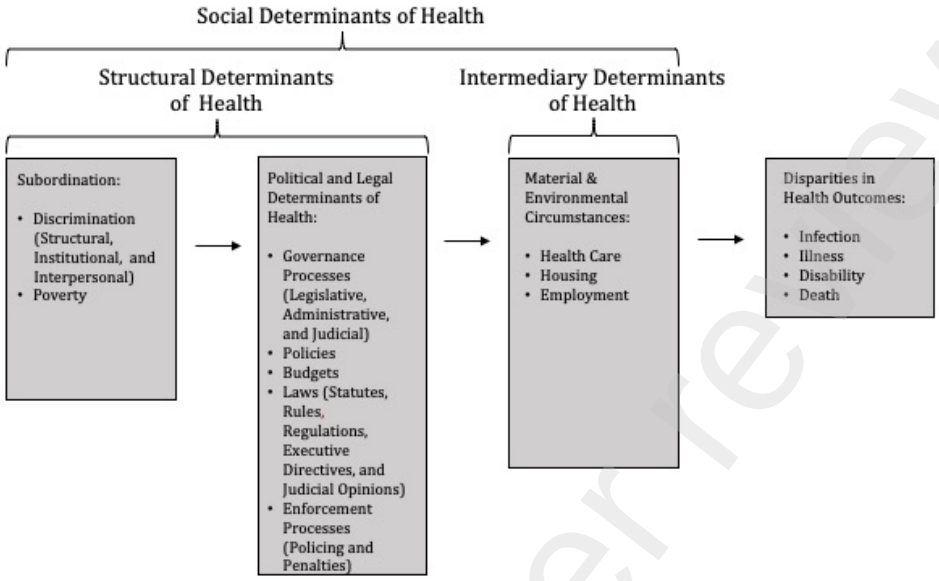
43. *Id.* at 3.

44. *Id.* at 9 & tbl.2.

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Figure 2. Subordination and Law as Social Determinants of Health[45]



In this Article, we focus on the influence of poverty and the three levels of discrimination on health care, housing, and employment, which result in disparities in COVID-19 infections and deaths for people in low-income communities and communities of color. In the health care context, poverty limits access to health care and the prejudice of some health care providers limits racial and ethnic minorities' and indigenous people's access to care, which is evidence of interpersonal discrimination. Institutional discrimination is also present in the health care context when health care institutions close hospitals in low-income communities and communities of color to relocate in well-off communities as a result of "neutral" policies that disproportionately harm low-income communities and communities of color. [46] Hence, these populations are more likely to suffer

45. Ruqaiijah Yearby, Lindsay F. Wiley, Emily A. Benfer & Seema Mohapatra, *Subordination and Law as Social Determinants of Health* (2020). *See also*, Yearby et al. *Discrimination and Material & Environmental Circumstances* (2020), *supra* Figure 1, and Harris & Pamukcu, *supra* note 20, at 758.

46. Alan Sager & Deborah Socolar, *Closing Hospitals in New York State Won't Save Money But Will Harm Access to Care*, B.U. SCH. OF PUB. HEALTH 27-31 (Nov. 20, 2006), http://www.bu.edu/sph/files/2015/05/Sager-Hospital-Closings-Short-Report-20Nov06.pdf. Michelle Ko et al., *Residential Segregation and the Survival of U.S. Urban Public Hospitals,* 7 MED. CARE RES. & REV. 243 (2014); Renee Y. 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 ANNALS EMERGENCY MED. 358 (2012); Renee Yuen-Jan Hsia & Yu-

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from diseases that increase the risk of COVID-19, more likely to die from COVID-19, and more likely to have a friend or family member who has died from COVID-19 than non-Latino White people.[47] Access to safe and decent housing is tied to economic status in the United States, and thus, poverty prevents equal access to housing. Furthermore, structural discrimination in housing, such as neutral decisions not to enact laws mandating safe housing or preventing utility shut-off, restricts people with low socioeconomic status and people of color from accessing safe and healthy housing and clean water. Consequently, people with low socioeconomic status and people of color live in housing where they cannot wash their hands, the best way to prevent the spread of COVID-19. As a result of structural discrimination in employment, laws prevent people with low socioeconomic status and racial and ethnic minorities from acquiring paid sick leave or a living wage, leaving these workers in poverty. Therefore, these individuals cannot stay at home even when they are sick, and thus, they are more likely to contract COVID-19 than their more privileged peers.

Discrimination, poverty, and other forms of subordination are structural determinants of health inequities that prevent equal access to the intermediary determinants of health.[48] Applying the health justice framework will not only address poverty and discrimination in health care, housing, and employment, which cause disparities in COVID-19 infections; it will also serve as a way to protect and support low-income communities and communities of color during and after the pandemic across multiple social determinants of health.

II. THE HEALTH JUSTICE FRAMEWORK FOR PANDEMIC RESPONSE

The health justice framework, which aims to eliminate health disparities caused by discrimination and poverty and empower historically marginalized communities, is a powerful instrument for policymakers charged with protecting public health of all people during and in the aftermath of the COVID-19 pandemic. We have written elsewhere about the key commitments of the health justice framework.[49] In this Article we discuss the interplay of discrimination, law, poverty, and other structural determinants of health that have caused health

Chu Shen, *Rising Closures of Hospital Trauma Centers Disproportionately Burden Vulnerable Populations,* 30 HEALTH AFF. 1912 (2011); 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).

47. Shikha Garg et al., *Hospitalization Rates and Characteristics of Patients Hospitalized with Laboratory-Confirmed Coronavirus Disease 2019—COVID-NET, 14 States, March 1-30, 2020*, 69 MORBIDITY & MORTALITY WKLY. REP. 458, 459 (2020); *Health Equity Considerations and Racial and Ethnic Minority Groups*, CTRS. FOR DISEASE CONTROL & PREVENTION (Jul. 24, 2020), https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html.

48. COMM'N ON THE SOC. DETERMINANTS OF HEALTH, *supra* note 10.

49. *See supra* note 20 and accompanying text.

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disparities during the pandemic and that can be addressed by adopting a health justice framework for pandemic response. Ultimately, "[a]ny solution to racial health inequalities must be rooted in the material conditions in which those inequalities thrive. Therefore, we must insist that for the health of the [B]lack community and, in turn, the health of the nation, we address the social, economic, political, legal, educational, and health care systems that maintain structural racism. Because as the COVID-19 pandemic so expeditiously illustrated, all policy is health policy."[50]

The health justice framework provides a mechanism for systems-level transformation of governmental responses to health disparities to achieve health equity, in which "every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or any other socially determined circumstance."[51] It offers three overarching principles to prevent and eliminate health disparities during and after the COVID-19 pandemic. The health justice framework is structural, supportive, and empowering. We use these three adjectives as shorthand for the three principles we examine below.

First, legal and policy interventions must address the structural determinants of health inequities.[52] The structural determinants of health are "social and political mechanisms that generate, configure and maintain social hierarchies," a phrase from the World Health Organization (WHO) Commission on the Social Determinants of Health[53] that we interpret to include discrimination, colonization, ableism, poverty, and other forms of subordination.[54] Subordination is embodied in the political and legal systems that also act as structural determinants of health

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

51. Health Equity, CTRS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/chronicdisease/healthequity/index.htm (last visited Nov. 8, 2020) (internal quotation marks omitted).

52. Harris & Pamukcu, *supra* note 20, at 806 ("[H]ealth justice . . . places subordination at the center of the problem of health disparities . . . ."); Wiley, *Health Law as Social Justice*, *supra* note 20, at 87 ("Health justice naturally expands the focus beyond access to health care to address the community conditions that play such an important role in determining health disparities."); *id.* at 85 ("[Achieving health justice] will take organizing from the ground up; social change that transforms the current systems of neglect, bias, and privilege into systems—policies, practices, institutions—that truly support health[y] communities for all.") (quoting a now-inactive website developed by The Praxis Project).

53. COMM'N ON THE SOC. DETERMINANTS OF HEALTH, *supra* note 10, at 25.

54. The WHO Commission's framework describes offers "the labor market, the educational system, and political institutions including the welfare state" as examples of the structural determinants of health. *Id.* We agree that these examples qualify as structural determinants, but in the health justice framework, it is important to name and center racism, poverty, and other forms of subordination.

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in their own right.[55] Because emergencies typically exacerbate long-standing and interconnected crises in marginalized communities, legal and policy responses must address root causes in addition to immediate needs through structural redress and remediation. Subordination and the laws, policies, and institutions in which it is embedded impact the intermediary determinants of health, including health care access, housing security, and employment income.[56] Together, these determinants contribute to the disproportionate burden of public health emergencies on low-income communities, communities of color, and other marginalized groups.

Second, interventions mandating healthy behaviors must be accompanied by supports and protections that address inequities in the intermediary determinants of health.[57] Intermediary determinants include the material and environmental circumstances in which people live and work and their access to and treatment within the health system.[58] Financial supports and legal protections are critical to enable compliance and minimize harms; without them, interventions will be ineffective and unjust. Governmental efforts to influence individual behaviors have been a cornerstone of the response to COVID-19. Public health and emergency orders have mandated that individuals minimize close contacts outside the home, seek testing and self-isolate if infectious, and cooperate with contact tracers and self-quarantine if exposed. Eventually, they may mandate compulsory vaccination for some types of workers. But unless these behaviors are supported by legal protections, financial supports, and accommodations to increase access to both, the benefits and burdens of behavioral mandates will be unjustly distributed. The ability to comply—and therefore the distribution of the benefits of public health intervention—varies sharply depending on poverty, employment, housing status, and access to health care at both the individual and community levels. Health justice also requires that the burdens of public health interventions, including the closure of businesses, health care facilities, and schools, be minimized and mitigated for marginalized communities.

Third, low-income communities and communities of color must be engaged and empowered as leaders in the development and implementation of laws, policies, or other interventions aimed at protecting or promoting health.[59]

55. *Id.*

56. The intermediary determinants of health include "material circumstances; psychosocial circumstances; behavioral and/or biological factors; and the health system itself." *Id.* at 6. Our focus here is on material circumstances (particularly with respect to employment and housing) and the health system (health care access).

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

58. *Id*.

59. Harris & Pamukcu, *supra* note 20, at 765 (describing "the emergent health justice

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Interventions adopted under the banner of public health—including interventions expressly aimed at eliminating disparities—are often tainted by racism, classism, and other forms of subordination. "[P]robing inquiry into the effects of social and cultural bias on the design and implementation of measures to reduce health disparities" is a key commitment of health justice.[60] These efforts cannot be led by communities who have benefited from the very forms of subordination that must be dismantled if health justice is to be achieved. Empowerment of affected communities in decision-making processes helps ensure that the design and implementation of interventions intended to benefit them are actually tailored to their needs.[61]

Figure 3 illustrates how each prong of the health justice framework addresses structural and intermediary determinants of health in order to prevent disparities in health outcomes modeled in Figure 2.

movement [as] a framework that places the empowerment of marginalized populations at the center of action"); Wiley, *Health Law as Social Justice*, *supra* note 20, at 101 ("[T]he health justice framework [should] root ongoing efforts to ensure access to health care and healthy living conditions more firmly in community engagement and participatory parity.").

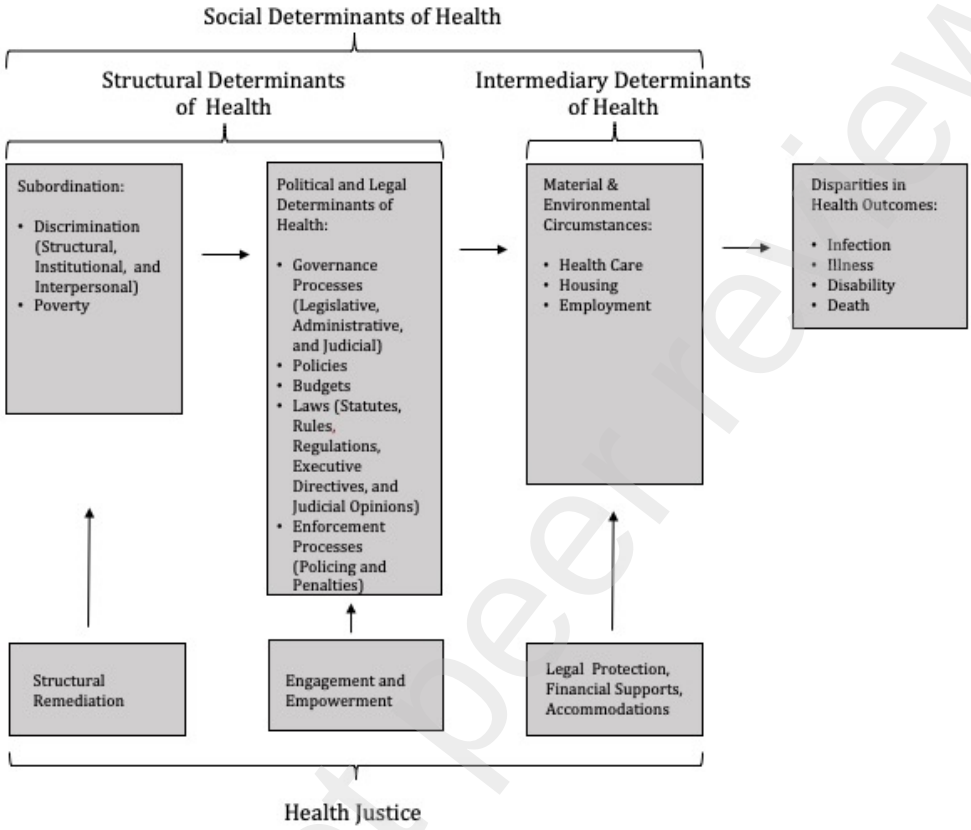
60. Wiley, *Health Law as Social Justice*, *supra* note 20, at 53.

61. Harris & Pamukcu, *supra* note 20, at 806 ("[H]ealth justice . . . calls for subordinated communities to speak and advocate for themselves. Embracing social movements as equal partners . . . acknowledges the internal limitations of public health and law. Moreover, allowing marginalized groups an equal voice empowers them against the possibility of abusive alliances of public health and law.").

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Figure 3. The Health Justice Framework and the Social Determinants of Health[62]



A structurally supportive and empowering pandemic response grounded in health justice will ensure that historically subordinated communities are equipped to protect themselves from harm by mitigating the effects of—and ultimately dismantling—long-standing discrimination and poverty. To demonstrate the application of the health justice framework and principles, as well as provide an example of how the health justice framework can be used to address health disparities, we focus on two forms of subordination as structural determinants of health (discrimination and poverty) and how they relate to three intermediary

62. Ruqaiijah Yearby, Lindsay F. Wiley, Emily A. Benfer & Seema Mohapatra, *The Health Justice Framework and the Social Determinants of Health* (2020). In this Figure, we apply the health justice framework from Wiley, *Health Law as Social Justice*, *supra* note 20, and Benfer, *Health Justice: A Framework*, *supra* note 20, to *supra* Figure 2.

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determinants of health (health care, housing, and employment), which are pillars that support resilience and equip marginalized communities with the resources to withstand the immediate impacts of the pandemic.

III. HEALTH JUSTICE IN HEALTH CARE

A. Health Care Is a Social Determinant of Health

Health care has long been recognized as a social determinant of health. Over two decades of research has shown that equal access to quality health care is limited by discrimination, which restricts low-income individuals' and people of color's access to quality care.[63] Specifically, low-income and Black, Latino, Indigenous, and other people of color have faced barriers to quality health care for decades, limiting their access to health care facilities and high-quality health care providers.[64] Thus, health care discrimination, institutional and interpersonal, is itself a social determinant of health.

Institutional discrimination, which operates through "neutral" organizational practices and policies, has limited racial and ethnic minorities' equal access to health care. Research studies show that health care institutions have closed hospitals in low-income communities and communities of color to relocate in more affluent communities as a result of "neutral" policies that disproportionately harmed low-income communities and communities of color. [65] Due to the dearth of hospitals and physician offices in many low-income and racially segregated communities, those who live in such communities face difficulties in accessing health care.[66] A domino effect has occurred. As hospitals have closed in low-income communities and communities of color, health care providers who used to work at the shuttered hospitals have left. The remaining hospitals in these areas are overburdened, which results in poorer care than in other areas.[67] "Neutral" decisions to close hospitals in low-income communities and communities of color often failed to consider the need for the equal distribution of health care facilities among all communities, leaving these marginalized communities without access to health care and provider services.[68]

63. Yearby, *Breaking the Cycle of "Unequal Treatment" with Health Care Reform*, *supra* note 39.

64. *Id*.

65. *See* Sager & Socolar, *supra* note 46.

66. Yearby & Mohapatra, *supra* note 28; David Barton Smith, *Healthcare Divided: Race and Healing a Nation* 200 (1999); and David G. Whiteis, *Hospital and Community Characteristics in Closures of Urban Hospitals*, *1980-87*, 107 PUB. HEALTH REP. 409 (1992).

67. As hospitals closed in predominantly Black neighborhoods, physicians connected to the hospitals left the area and the remaining hospitals' resources were strained, causing the care provided to gradually deteriorate. Clark, *supra* note 34, at 1033-35.

68. Many of these "neutral" decisions were tied to more to the race of the community residents

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This lack of access to care has led to Black people having "higher rates of untreated respiratory disease and cardiovascular disease, which are risk factors for COVID-19."[69] In her book *Just Medicine: A Cure for Racial Inequality in American Health Care*, Dayna Bowen Matthew notes that health care disparities are the cause of over 83,000 minority patient deaths, and that disparities persist even after controlling for income and insurance status.[70] This suggests that people of color face interpersonal discrimination unrelated to their income and insurance status.

Indeed, racial and ethnic minorities have long been subject to poor treatment by health care providers because of interpersonal discrimination.[71] In one study, almost 70% of medical students surveyed "exhibited implicit preferences for [W]hite people" and "other studies have found that physicians tend to rate [Black] patients more negatively than [W]hite [patients] on a number of registers, including intelligence, compliance, and propensity to engage in high-risk health behaviors."[72] Black people often sense this interpersonal discrimination against them, which results in delays seeking care, an interruption in continuity of care, non-adherence, mistrust, reduced health status, and avoidance of the health care system.[73] Additionally, Black people are much less likely to encounter a physician who is also Black than White Americans or Asian Americans are to encounter physicians who look like them. One study showed that increasing the workforce of Black doctors could protect Black men from dying of heart-related ailments and reduce the Black-White gap in cardiovascular mortality among men by 19%.[74] Lack of access to health care has a significant impact on poor health outcomes for low-income individuals and people of color, which has been exacerbated by the COVID-19 pandemic.

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than economic reasons. *See* Yearby, *Breaking the Cycle of "Unequal Treatment" with Health Care Reform supra* note 39, at 1301-06.

69. Yearby & Mohapatra, *supra* note 28.

70. Rachel Sachs et al., *Structural Racism and COVID-19*, WRITTEN DESCRIPTION (June 11, 2020), https://writtendescription.blogspot.com/2020/06/structural-racism-and-covid-19.html (citing Dayna Bowen Matthew, *Just Medicine: A Cure for Racial Inequality in American Health Care* 1 (2015)).

71. Janice A. Sabin et al., *Physicians' Implicit and Explicit Attitudes About Race by MD Race, Ethnicity, and Gender*, 20 J. HEALTH CARE POOR & UNDERSERVED 896, 907 (2009).

72. Kimani Paul-Emile, *Patients' Racial Preferences and the Medical Culture of Accommodation*, 60 UCLA L. REV. 462, 492 (2012).

73. *Id*. at 493.

74. Marcella Alsan, Owen Garrick & Grant C. Graziani, *Does Diversity Matter for Health? Experimental Evidence from Oakland*, 109 AM. ECON. REV. 4071, 4071 (2019). *See also* Emily Cleveland Manchanda et al., *Inequity in Crisis Standards of Care*, 383 NEW ENG. J. MED. e16 (2020); Pallok et al., *supra* note 29.

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B. Health Care Discrimination as a Barrier to Health Justice During the COVID-19 Pandemic

Low-income individuals and people of color, who are bearing the brunt of COVID-19 infections and deaths because of poverty and discrimination, lack access to adequate health care services and facilities. The full extent of these disparities is not known because many states, counties, cities, and health care facilities took a "colorblind" approach to the novel coronavirus and did not report racial or ethnicity statistics.[75] However, even with incomplete data, stark disparities have emerged. "[C]ounties that are majority-[B]lack have three times the rate of infections and almost six times the rate of deaths as counties where [W]hite residents are in the majority."[76] These disparities are in part due to poverty and discrimination.[77] Access to health care in the United States is driven by ability to pay and health insurance, whether it is public insurance, such as Medicare or Medicaid, or private insurance, which is often provided as a perk of employment. Insurance coverage differs greatly by race with Black, Latino, and Indigenous people often uninsured or underinsured.[78] Ninety-one percent of disproportionately Black counties are in the South, where many states have not expanded Medicaid under the Affordable Care Act, leaving many low-income adults without health insurance.[79] These racially segregated counties have much higher rates of COVID-19 infection and death than majority White counties.[80]

Additionally, although COVID-19 testing sites were chosen using "neutral" policies, in the early days of the COVID-19 pandemic, people in low-income communities and communities of color were less likely to have access to coronavirus testing due to the lack of hospitals and physicians' offices in these areas. Although the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) provides Medicaid coverage for COVID-19 testing and treatment, it has not addressed racial and ethnic disparities in access to health care.[81] For example, lack

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75. Cleveland Manchanda et al., *supra* note 74.

76. Reis Thebault, Andrew Ba Tran & Vanessa Williams, *The coronavirus Is Infecting and Killing Black Americans at an Alarmingly High Rate*, WASH. POST (Apr. 7, 2020), https://www.washingtonpost.com/nation/2020/04/07/coronavirus-is-infecting-killing-black-americans-an-alarmingly-high-rate-post-analysis-shows.

77. Yearby, *Structural Racism and Health Disparities*, *supra* note 28.

78. Heeju Sohn, *Racial and Ethnic Disparities in Health Insurance Coverage: Dynamics of Gaining and Losing Coverage over the Life-Course*, 36 POPUL. RES. & POL'Y REV. 181 (2017).

79. Millett et al., *supra* note 6, at 39.

80. Erin Schumaker, *Majority White Counties Have Significantly Fewer COVID-19 Cases: Study*, ABC NEWS (August 12, 2020), https://abcnews.go.com/Health/majority-white-counties-significantly-fewer-covid-19-cases/story?id=72328054 (citing Gregorio A. Millett et al., *White Counties Stand Apart: The Primacy of Residential Segregation in COVID-19 and HIV Diagnoses*, 34 AIDS PATIENT CARE & STDS 417 (2020)).

81. Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. No. 116-136, § 3211(b), 134 Stat. 281, 368 (2020). The act did not provide coverage for undocumented immigrants,

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of access to health care services is having a deadly impact on Black people in St. Louis. In April 2020, all but three deaths from COVID-19 in St. Louis afflicted Black people, however, Black communities did not get public testing sites until after the data was released.[82] More specifically, the "[p]redominately Black north St. Louis got its first testing site April 2, three weeks after the first sites went up in the suburbs," and the "information campaign targeting [B]lack residents did not start until a week after that."[83] By that time, everyone person who had died from COVID-19 in St. Louis was Black. According to Dr. Will Ross, the chairman of the St. Louis health advisory board making decisions about the COVID-19 response, Black lives were unnecessarily lost because "race neutral" decisions by the government regarding the placement of testing sites ignored the fact that Black communities most impacted by COVID-19 lacked access to public testing sites.[84]

During the pandemic, especially when COVID-19 tests were scarce, lack of access to a primary health care provider and racially prejudicial decisions to dismiss the symptoms of racial and ethnic minorities has exacerbated the harm in these communities. Interpersonal discriminatory practices in health care delivery also delayed care for COVID-19 symptoms. Black people may have been more likely to be turned away by health care providers than their non-Black peers, even when they reported similar symptoms and risk factors. Examples abound.[85] In one case, Black teacher Rana Zoe Mungin was twice denied a COVID-19 test and her symptoms were dismissed by an EMT as a panic attack.[86] She later passed away from COVID-19 at Brooklyn's Brookdale Hospital. There have also been numerous such reports of Black people seeking testing and treatment for COVID-19, who have been turned away.[87] Unfortunately, just like Rana Zoe Mungin, many of those turned away have since died.[88]

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and it "permitted states to create an option to cover COVID-19–related testing for those who are uninsured individuals with a federal match, but it did not require this support." Yearby & Mohapatra, *supra* note 28.

82. Paulina Cachero, *All but 3 People Who Died from COVID-19 in St. Louis, Missouri, were Black* (Apr. 12, 2020), https://www.businessinsider.com/all-but-three-people-who-died-from-covid-19-in-st-louis-were-black-2020-4.

83. Robert Samuels et al., *This is What Happens to Us: How U.S. Cities Lost Precious Time to Protect Black Residents from the Coronavirus,* THE WASH. POST (June 3, 2020), https://www.washingtonpost.com/graphics/2020/politics/coronavirus-race-african-americans/.

84. *Id.*

85. Jasmin Barmore, *5-Year-Old with Rare Complication Becomes First Michigan Child to Die of COVID-19*, DETROIT NEWS (Apr. 20, 2020), https://www.detroitnews.com/story/news/local/detroit-city/2020/04/19/5-year-old-first-michigan-child-dies-coronavirus/5163094002.

86. Arielle Mitropoulos & Mariya Moseley, *Beloved Brooklyn Teacher, 30, Dies of Coronavirus After She Was Twice Denied a COVID-19 Test,* ABC NEWS (April 28, 2020), https://abcnews.go.com/Health/beloved-brooklyn-teacher-30-dies-coronavirus-denied-covid/story?id=70376445.

87. *Id*.

88. Shamar Walters & David K. Li, *New York City Teacher Dies from COVID-19 After She*

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Furthermore, Black people, though disparately harmed by COVID-19, have been erased in certain discussions of progression of the disease. For example, when physicians started noting the symptoms of novel coronavirus that can be observed, such as "pink and white" COVID toes, any similar symptoms in dark skin were not noted.[89] In this way, the default descriptions applied to only White patients. Moreover, when low-income people and people of color become severely ill, they may be less likely to receive scarce resources such as antiviral drugs or ventilator support, due to biased protocols for allocation. For example, researchers point out that though many allocation guidelines consider "social value" in allocating resources, they favor those patients with better health.[90] This harms groups that suffer from disproportionate health ills, including racial minorities and people with disabilities, which could further exacerbate existing health inequities.[91] Moreover, even the fairest guidelines can only limit the influence of conscious considerations among people applying them, leaving room for unconscious biases to affect decision making.[92]

Many state and institutional resource allocation protocols do not even allow race and social factors to be considered. Although these "neutral" policies may seem "colorblind," and therefore equitable, they are actually unfair to communities of color and disadvantaged communities.[93] Research has shown that:

> The conditions in which people are born, grow, live, work, and age are responsible for most of the unjust, preventable, and systemic differences in outcomes among groups, including differential rates of chronic and life-shortening conditions such as hypertension, diabetes, chronic kidney disease, and chronic obstructive pulmonary disease. Some 70 to 80% of the difference

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Was Denied Tests, Family Says, NBC NEWS, (April 29, 2020) https://www.nbcnews.com/news/us-news/new-york-city-teacher-dies-covid-19-after-she-was-n1195516; *Detroit Man with Virus Symptoms Dies After 3 ERs Turn Him Away, Family Says: "He Was Begging for His Life*," CBS NEWS (April 22, 2020), https://www.cbsnews.com/news/coronavirus-detroit-man-dead-turned-away-from-er.

89. Michele K. Evans et al., *Diagnosing and Treating Systemic Racism*, 383 NEW ENG. J. MED. 274, 274 (2020).

90. Somnath Saha & Mary Catherine Beach, *A Model for Avoiding Unequal Treatment During the COVID-19 Pandemic,* Health AFF. Blog (May 14, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200511.691265/full.

91. *Id.* One model policy out of the University of Pittsburgh attempts to address this issue by using a weighted system to even the playing field for those from a disadvantaged area or essential workers. Douglas B. White et al., *Model Hospital Policy for Fair Allocation of Scarce Medications to Treat COVID-19*, UNIV. OF PITTSBURGH SCH. OF MED. 1 (May 28, 2020), https://ccm.pitt.edu/sites/default/files/2020-05-28b%20Model%20hospital%20policy%20for%20allocating%20scarce%20COVID%20meds.pdf.

92. *Id.* Cleveland Manchanda et al., *supra* note 74.

93. *Id*.

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> in life expectancy between Blacks and Whites can be explained by socioeconomic factors.[94]

Thus, "neutral" protocols that look at life expectancy or prognosis as guides for allocating ventilators and other potentially scarce supplies discriminate against Black people, even when they do not consider race.

C. Applying the Health Justice Framework to Achieve Health Care Equity

The COVID-19 pandemic demonstrates the inequities of the health care system in the United States. It also presents an opportunity to effect health justice by addressing discrimination and poverty. First, the legal and policy response must address the social and structural determinants of health, in this case, access to health care. These responses must directly target discrimination and poverty using a variety of suggested interventions. These interventions include providing supports, which is the second prong of the health justice framework.

First, Medicaid and other health care coverage should be expanded so that COVID-19 treatment is covered for more people, including undocumented immigrants. The health insurance system in the United States "enables a tiered and sometimes racially segregated health care delivery structure to provide different quality of care to different patient populations."[95] It is worth seriously considering whether such tiered systems of Medicare, Medicaid, private insurance, and self-pay should be replaced with some form of universal single-payer health care. This will help ensure more equitable care and ultimately achieve health justice by addressing the underlying discrimination that thwarts access to health, increasing the risk of COVID-19 infection and death for low-income individuals and people of color. Additionally, inequalities in access to health care coverage must be addressed when making treatment and resource allocation decisions.

To further tackle discrimination, public health professionals and health care providers in charge of educating low-income communities and communities of color about healthy behaviors must be trained to address their own prejudice. Specifically, they need to receive education about interpersonal discrimination during their professional programs and at least yearly once they enter practice. Also, underrepresented minority physicians must be added to the physician workforce in all specialties; financial support for training, recruiting, and retaining such physicians is needed to improve the lives of minority communities and ensure culturally sensitive care. In light of the dearth of high-quality health care services in low-income communities and communities of color, equal access to health care facilities must be realized. Using cancer care as an example, in Chicago, only two

94. *Id*.
95. Hardeman, Medina & Boyd, *supra* note 50, at 198.

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of the twelve Chicago hospitals designated as quality cancer care centers are in the predominantly Black South Side of Chicago,[96] despite higher rates of exposure to carcinogens.[97] "Black women in Chicago were almost 40% less likely than [W]hite women to receive breast care at a breast imaging center of excellence."[98] In these areas, the lack of specialists and adequate equipment in hospitals results in inferior care.[99] Marginalized communities should also have access to free coronavirus testing via mobile sites. Like many of the former suggestions, this also maps onto the second prong of the health justice framework requiring that interventions mandating healthy behaviors be accompanied by supports.

Finally, the third prong of health justice requires engaging marginalized communities as leaders in the development of any interventions and the attainment of health justice. We encourage robust community involvement in developing these solutions because these marginalized communities will otherwise continue to be denied access to quality health care. For example, without involving the community in decisions regarding testing, many of the initial testing facilities and resources were not available to predominately Black and low-income communities, such as St. Louis, MO, Nashville, TN, Shreveport, LA, Jackson County, MO, and Merrillville, IN.[100] Additionally, priorities in health care access should be determined by the communities impacted by the lack of health care access. Community leaders and organizations should be empowered to help drive health policy decisions for their communities.

Access to health care is a necessary component of health justice. We suggest a variety of legal and policy measures and supports to achieve access to health care, including robust insurance coverage, access to health care facilities and testing, and culturally competent care. We also advocate for leadership from within Black, Latino, Indigenous, and other marginalized communities to drive these efforts to increase access.

IV. HEALTH JUSTICE IN HOUSING

A. Housing Is a Social Determinant of Health

There is strong evidence that housing is a social determinant of health.

96. Pallok, *supra* note 29, at 1489-90.

97. *Cancer Facts & Figures for African Americans 2019-2021*, AM. CANCER SOC'Y 20 (2019), https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/cancer-facts-and-figures-for-african-americans/cancer-facts-and-figures-for-african-americans-2019-2021.pdf.

98. Pallok, *supra* note 29, at 1490.

99. *Id*.

100. Samuels et al., *supra* note 83; Blake Farmer, *Long-Standing Racial and Income Disparities Seen Creeping Into COVID-19 Care*, NPR – NASHVILLE PUBLIC RADIO AND KAISER HEALTH NETWORK (Apr. 16, 2020), https://khn.org/news/covid-19-treatment-racial-income-health-disparities.

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Housing stability, quality, safety, and affordability all affect health outcomes, as do environmental and social characteristics of neighborhoods.[101] At the same time, foreclosure, housing instability, and homelessness are all pathways to poor health.[102] In fact, the mere threat of eviction can increase stress levels, anxiety, and depression.[103] Eviction leads to overcrowding, homelessness, doubling up and couch surfing, which could place renters at greater risk of contracting COVID-19.[104] Evictions are associated with several interrelated conditions, including all-cause mortality,[105] emergency department utilization,[106] sexually transmitted infections,[107] HIV-related treatment outcomes,[108] needle sharing,[109] exposure to violence,[110] mental health hospitalization,[111] and suicide,[112] among other poor health outcomes.[113] In addition, residential crowding, a potential outcome of eviction, is associated with respiratory disease,[114] which is a risk factor for COVID-19 complications and mortality. For women, eviction is associated

101. Ana V. Diez Roux, *Investigating Neighborhood and Area Effects on Health*. 91 AM. J. PUB. HEALTH 1783 (2001).

102. Brief for Am. Med. Ass'n et al. as Amici Curiae Supporting Respondents at 15-26, Brown v. Azar, No. 20-cv-03702 (N.D. Ga. Oct. 9, 2020) [hereinafter Public Health Brief]; Lauren Taylor, *Housing and Health: An Overview of the Literature*, HEALTH AFF. (June 7, 2018), https://www.healthaffairs.org/do/10.1377/hpb20180313.396577/full/HPB_2018_RWJF_01_W.pdf.

103. Matthew Desmond & Rachel Tolbert Kimbro, *Eviction's Fallout: Housing, Hardship, and Health*, 94 SOC. FORCES 295, 317 (2015); Hugo Vásquez Vera et al., *The Threat of Home Eviction and its Effects on Health Through the Equity Lens: A Systematic Review,* 175 SOC. SCI. & MED. 199, 202 (2017). Allison K. Groves et al. *Housing Instability and HIV Risk: Expanding our Understanding of the Impact of Eviction and Other Landlord-rElated forced moves,* AIDS & Behavior (2021) https://link.springer.com/article/10.1007/s10461-020-03121-8.

104. Public Health Brief, *supra* note 102, at 15-26.

105. Yerko Rojas, *Evictions and Short-Term All-Cause Mortality: A 3-Year Follow-Up Study of a Middle-Aged Swedish Population*, 62 INT'L J. PUB. HEALTH 343, 346 (2016).

106. ROBERT COLLINS & DAVID REED, *The Effects of Evictions in Low-Income Households*, N.Y.U. WAGNER SCH. OF PUB. SERV. 3 (Dec. 2018).

107. Linda M. Niccolai et al., *Eviction from Renter-Occupied Households and Rates of Sexually Transmitted Infections: A County-Level Ecological Analysis*, 46 SEXUALLY TRANSMITTED DISEASES 63, 65 (2019).

108. Mary Clare Kennedy et al., *Residential Eviction and Risk of Detectable Plasma HIV-1 RNA Viral Load Among HIV-Positive People Who Use Drugs*, 21 AIDS & BEHAVIOR 678, 681 (2017).

109. Andreas Pilarinos et al., *The Association Between Residential Eviction and Syringe Sharing Among a Prospective Cohort of Street-Involved Youth*, 14 HARM REDUCTION J. at 3 (2017).

110. Mary Clare Kennedy et al., *Residential Eviction and Exposure to Violence Among People Who Inject Drugs in Vancouver, Canada*, 41 INT'L J. DRUG POL'Y 59, 61 (2017).

111. COLLINS & REED, *supra* note 106, at 3.

112. Yerko Rojas & Sten-Åke Stenberg, *Evictions and Suicide: A Follow-Up Study of Almost 22,000 Swedish Households in the Wake of the Global Financial Crisis*, 70 J. EPIDEMIOLOGY & COMMUNITY HEALTH 409 (2016).

113. For a comprehensive overview of co-morbidities associated with eviction, *see* Public Health Brief, *supra* note 102, at 15-26.

114. P. Braverman et al., *How Does Housing Affect Health?*, ROBERT WOOD JOHNSON FOUND. (May 1, 2011), https://www.rwjf.org/en/library/research/2011/05/housing-and-health.html.

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with physical and sexual assault,[115] drug use and related harms,[116] mental illness,[117] and repeated episodes of housing precarity in the future.[118]

Lack of stable and safe housing disrupts employment, social networks, education, and the receipt of social services benefits.[119] It sets children back emotionally[120] and academically,[121] results in lead poisoning[122] and food insecurity,[123] and, as a condition correlated with adverse childhood experiences,[124] has negative long-term health impacts. For children whose mothers are evicted during pregnancy, eviction results in adverse birth outcomes, including pre-term pregnancies and low birth weights.[125] Eviction almost always leads to a downward move,[126] into poorer quality housing, residential instability, homelessness, and

115. Nihaya Daoud et al., *Pathways and Trajectories Linking Housing Instability and Poor Health Among Low-Income Women Experiencing Intimate Partner Violence (IPV): Toward a Conceptual Framework*, 56 WOMEN & HEALTH 208 (2016).

116. Alexandra B. Collins et al., *Surviving the Housing Crisis: Social Violence and the Production of Evictions Among Women Who Use Drugs in Vancouver, Canada*, 51 HEALTH & PLACE 174, 179 (2018).

117. Patty R. Wilson & Kathryn Laughon, *House to House, Shelter to Shelter: Experiences of Black Women Seeking Housing After Leaving Abusive Relationships*, 11 J. FORENSIC NURSING 77 (2015); Allison Bovell-Ammo & Megan Sandel, *The Hidden Health Crisis of Eviction,* B.U. SCH. OF PUB. HEALTH (Oct. 5, 2018), https://www.bu.edu/sph/2018/10/05/the-hidden-health-crisis-of-eviction/.

118. Craig Evan Pollak et al., *When Storms Collide: Evictions, COVID-19, and Health Equity*, HEALTH AFF. BLOG (Aug. 4, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200730.190964/full.

119. Diana Hernandez & Shakira Suglia, *Housing as a Social Determinant of Health*, ROBERT WOOD JOHNSON FOUND. (2016), https://healthequity.globalpolicysolutions.org/wp-content/uploads/2016/12/Housing2.pdf.

120. Diana Becker Cutts, et al, *US Housing Insecurity and the Health of Very Young Children*, 101 AM. J. PUB. HEALTH 1508 (2011).

121. Kathleen M. Ziol-Guest & Claire C. McKenna, *Early Childhood Housing Instability and School Readiness*, 85 CHILD DEV. 103 (2014).

122. Gabriel L. Schwartz et al., Is Eviction Poisonous?: A Survival Analysis of Eviction and Lead Poisoning in a National Urban Birth Cohort, *in* Cycles of Disadvantage: Eviction and Children's Health in the United States 5 (Apr. 2020) (unpublished Ph.D. dissertation, Harvard University), https://dash.harvard.edu/bitstream/handle/1/37365869/SCHWARTZ-DISSERTATION-2020.pdf?sequence=1.

123. Kathryn M. Leifheit, et al., *Eviction in Early Childhood and Neighborhood Poverty, Food Security, and Obesity in Later Childhood and Adolescence: Evidence from a Longitudinal Birth Cohort*. 11 SSM – POPUL. HEALTH (Apr. 4, 2020).

124. Amber Bellazaire, *Preventing and Mitigating the Effects of Adverse Childhood Experiences*, NAT'L Conference of State Legislatures 2 (Aug. 2018), https://www.ncsl.org/Portals/1/HTML_LargeReports/ACEs_2018_32691.pdf.

125. Kathryn M. Leifheit et al., *Severe Housing Insecurity During Pregnancy: Association with Adverse Birth and Infant Outcomes*, 17 INT'L J. ENVTL. RES. & PUB. HEALTH 1 (Nov. 21, 2020).

126. *Why Eviction Matters*, EVICTION LAB, PRINCETON UNIV. (2018), https://evictionlab.org/why-eviction-matters/.

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negative health consequences for adults[127] and children.[128] The health conditions and high health care expenditures associated with eviction also increase vulnerability to future eviction.[129] In this way, eviction is a cause of poverty and perpetuates longstanding patterns of housing instability.[130]

B. Housing Discrimination as a Barrier to Health Justice During COVID-19

People of color entered the pandemic at extreme risk of housing instability, due to structural factors that include the United States' sordid history of racially discriminatory housing laws, higher rates of eviction among people of color, and the growing inequities in a person's ability to afford a home based on race. Leading up to the pandemic, the United States was in the midst of a severe affordable housing crisis that affected Black and Latino populations at higher rates than White populations. According to Harvard's Joint Center for Housing Studies, prior to the pandemic, 20.5 million families struggled to pay rent[131] and only one in four eligible renter households received financial assistance.[132] The risk of housing displacement is especially heightened among renters of color.[133] After controlling for education, Black households are more than twice as likely as White households to be evicted.[134] In another study of multiple cities, approximately 80% of people facing eviction were non-White.[135] Black women are evicted at higher rates than other groups,[136] with 1 in 5 Black female renters reporting that they have

127. Desmond & Kimbro, *supra* note 103.

128. Megan Sandel et al., *Unstable Housing and Caregiver and Child Health in Renter Families*, 141 PEDIATRICS (Feb. 2018); Pollak et al., *supra* note 118.

129. Heidi L. Allen et al., *Can Medicaid Expansion Prevent Housing Evictions?,* 38 HEALTH AFF. 1451 (2019).

130. Pollak et al., *supra* note 118.

131. Sean Veal & Jonathan Spader, *Nearly a Third of American Households Were Cost-Burdened Last Year*, JOINT CTR. FOR HOUSING STUD. OF HARV. U. (Dec. 7, 2018) https://www.jchs.harvard.edu/blog/more-than-a-third-of-american-households-were-cost-burdened-last-year/.

132. JOINT CENTER FOR HOUSING STUD. OF HARV. U., *The State of the Nation's Housing 2018* 5 (2018), https://www.jchs.harvard.edu/sites/default/files/Harvard_JCHS_State_of_the_Nations_Housing_2018.pdf.

133. Tim Robustelli et al., *Displaced in America: Mapping Housing Loss Across the United States,* NEW AMERICA (2020), https://www.newamerica.org/future-property-rights/reports/displaced-america/.

134. Katherine Lucas McKay, Zach Neumann & Sam Gilman, *20 Million Renters Are at Risk of Eviction; Policymakers Must Act Now to Mitigate Widespread Hardship*. ASPEN INST. (June 19, 2020) https://www.aspeninstitute.org/blog-posts/20-million-renters-are-at-risk-of-eviction/.

135. Cities studied included New York, Chicago, Baltimore, Philadelphia, Los Angeles, and Oakland. *See* Chester Hartman & David Robinson, *Evictions: The Hidden Housing Problem*, 14 HOUSING POL'Y DEBATE 461, 467 (2003).

136. Matthew Desmond, *Eviction and the Reproduction of Urban Poverty*, 118 AM. J. SOC. 88, 91 (2012).

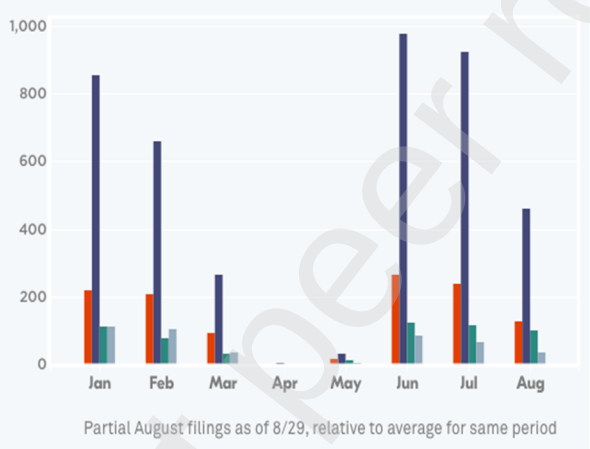
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experienced eviction compared with 1 in 12 Latino women and 1 in 15 White women.[137] Black female renters are at high risk, with filings for eviction double the rate of White renters in 17 out of 36 states studied.[138] Black women with children have the highest risk.[139] The pandemic has only increased these disparities.

The Eviction Tracker System, developed by the Eviction Lab at Princeton University, tracks eviction filing rates in numerous cities and states and found that census tracks with high Black populations had much higher rates of eviction than other areas during the pandemic in multiple cities. (See Figures 4, 5, and 6.)

Figures 4, 5, and 6. Eviction Filing Rate by Race in Milwaukee, Wisconsin; Cleveland, Ohio; and Richmond, Virginia[140]



137. Rachel Dovey, *What 80 Million Eviction Records Can Tell City Leaders*, NEXT CITY (Apr. 9, 2018), https://nextcity.org/daily/entry/what-80-million-eviction-records-can-tell-city-leaders.

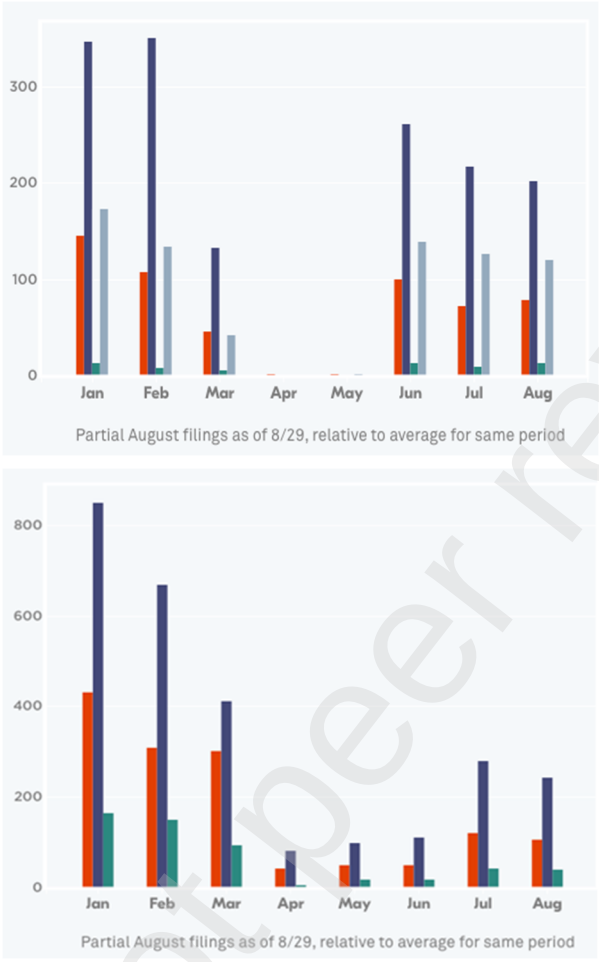
138. Sophie Beiers et al., *Clearing the Record: How Eviction Sealing Laws Can Advance Housing Access for Women of Color*, ACLU (Jan. 10, 2020), https://www.aclu.org/news/racial-justice/clearing-the-record-how-eviction-sealing-laws-can-advance-housing-access-for-women-of-color/.

139. Matthew Desmond & Rachel Tolbert Kimbro, *Eviction's Fallout: Housing, Hardship, and Health,* 94 SOC. FORCES 295, 298 (2015).

140. *Eviction Tracking System*, Eviction Lab (2020), https://evictionlab.org/eviction-tracking/ (filing rates were lower during the months of April and May due to state and local eviction moratoriums).

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The eviction trends are, in part, explained by the disproportionate rates of job and wage loss among people of color that decreased ability to pay rent. In April, 44% of Blacks and 61% of Latinos said that they or someone in their household had experienced a job or wage loss due to the coronavirus outbreak, compared with only 38% of White adults.[141] As of July 7, 2020, the U.S. Census reported that half of U.S. adults live in households that have suffered COVID-19 related job loss, but among Black and Latino groups, that rate is 57% and 62% respectively.[142] In

141. Kim Parker, Juliana Menasce Horowitz & Anna Brown, *About Half of Lower-Income Americans Report Household Job or Wage Loss Due to COVID-19*, PEW RES. CTR. (Apr. 21, 2020), https://www.pewsocialtrends.org/2020/04/21/about-half-of-lower-income-americans-report-household-job-or-wage-loss-due-to-covid-19/.

142. *Week 10 Household Pulse Survey: July 2 - July 7*, U.S. CENSUS BUREAU (July 15, 2020), https://www.census.gov/data/tables/2020/demo/hhp/hhp10.html.

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one study of eviction during the pandemic, the majority of tenants facing eviction (50% of whom were Black) reported unemployment or a decrease in income related to COVID-19 hardship as the reason for rental shortfall.[143] Underscoring the pandemic's immense toll, researchers at the UC Berkeley Terner Center for Housing Innovation estimate that 50 million renters live in households that suffered COVID-19-related job or income loss,[144] with almost 40% occurring in low-income households.[145] The demand for financial assistance is further evidence of rent hardship, with a 92% increase in daily rental assistance requests[146] and food pantry requests increasing by as much as 2,000 percent in some states.[147] Similarly, during the pandemic, renters took on financial risk by paying for rent on credit cards at an increased rate.[148] This will only widen the wealth gap and collapse any remaining safety net.

Communities of color are more susceptible to COVID-19-related job and wage loss and the housing displacement it causes because of structural discrimination that has led to lack of wealth accumulation, access to credit or emergency funds to cover expenses, and poverty. The disproportionate impact on racial and ethnic minorities is in part due to decades of laws and policies that perpetuated housing discrimination repeatedly infringed on the rights of low-income communities and communities of color, and continues today.[149] The federal government created the Federal Housing Administration (FHA) in 1934, which subsidized housing builders as long as none of the homes were sold to Black

143. Ninette Sosa, *A Closer Look: Arkansas Evictions During COVID-19; Tenant Stories*, KNWA FOX24 (Aug. 3, 2020), https://www.nwahomepage.com/news/a-closer-look/a-closer-look-arkansas-evictions-during-covid-19-tenant-stories/.

144. Elizabeth Kneebone, *Estimating COVID-19's Near-Term Impact on Renters*, TURNER CTR. FOR HOUSING INNOVATION U.C. BERKELEY (Apr. 24, 2020), https://ternercenter.berkeley.edu/blog/estimating-covid-19-impact-renters.

145. Board of Governors of the Federal Reserve System, *Report on the Economic Well-Being of U.S. Households in 2019, Featuring Supplemental Data from April 2020* 53 (May 2020), https://www.federalreserve.gov/publications/files/2019-report-economic-well-being-us-households-202005.pdf.

146. Rachel Garg et al., *Rent Requests Higher in States with Few Protections for Renters*, WASHINGTON U. (Apr. 30, 2020), https://hcrl.wustl.edu/items/rent-requests-higher-in-states-with-few-protections-for-renters/.

147. Balaji Golla et al., *Food Pantries – Updated*, WASHINGTON U. (Mar. 26, 2020), https://hcrl.wustl.edu/items/food-pantries-updated/.

148. Will Parker, *Out-of-Work Apartment Tenants Putting Monthly Rent on Plastic*, WALL STREET J. (Apr. 15, 2020), https://www.wsj.com/articles/out-of-work-apartment-tenants-putting-monthly-rent-on-plastic-11586966251.

149. Dale Van Ollefen, *Civil Rights Leaders Respond to Trump Administration's Latest Attack on Fair Housing, Legacy of Martin Luther King, Jr*, NAT'L FAIR HOUSING (Jan. 16, 2020) https://nationalfairhousing.org/2020/01/16/civil-rights-leaders-respond-to-trump-administrations-latest-attack-on-fair-housing-legacy-of-martin-luther-king-jr/; *see also* The Leadership Conference on Civil & Human Rights, *Trump Administration Civil and Human Rights Rollbacks*, C.R. (2020), https://civilrights.org/trump-rollbacks/.

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people, a practice that was called "redlining."[150] The FHA also published an underwriting manual that stated housing loans to Black people would not be insured by the federal government.[151] The FHA policies, examples of structural discrimination, advantaged White people seeking to buy homes, thereby increasing wealth accumulation, while relegating Black people to racially segregated neighborhoods and substandard housing. The effects are apparent today in entrenched segregation, lack of wealth accumulation, and urban disinvestment.[152] Because one way Americans attain wealth is homeownership, it is not surprising that the median wealth of a White family is nearly twelve times that of a Black family.[153] Making matters worse, Black families lost all homeownership gains made over the last fifty years due to predatory lending practices in the early 2000s and the foreclosure crisis that followed.[154]

Due to structural discrimination, communities of color are at heightened risk of peril as millions of adults and children face eviction and homelessness in the midst of a pandemic. As a result of the extreme socioeconomic divide, over 70% of Black and Latino adults entered the pandemic lacking the emergency funds to cover three months of expenses, compared to under half of White adults.[155] Without a safety net, when crisis strikes, the downward fall is immediate and precipitous, and recovery may be impossible. This is especially true in a pandemic setting and in light of mounting rental debt and sustained unemployment among people of color.

Eviction leads to homelessness, overcrowding, and transiency, which increase contact with others and make compliance with pandemic health guidelines difficult or impossible and increase the transmission rate of infectious disease.[156] Recent

150. Richard Rothstein, *The Color of Law*: *A Forgotten History of How Our Government Segregated America*, ECON. POL'Y INST. (2017), https://www.epi.org/publication/the-color-of-law-a-forgotten-history-of-how-our-government-segregated-america/.

151. *Id*.

152. Benfer & Wiley, *supra* note 8.

153. Janelle Jones, *The Racial Wealth Gap: How African-Americans Have Been Shortchanged out of the Materials to Build Wealth*, WORKING ECONS. BLOG (Feb. 13, 2017), https://www.epi.org/blog/the-racial-wealth-gap-how-african-americans-have-been-shortchanged-out-of-the-materials-to-build-wealth/.

154. Ruqaiijah Yearby, *Racial Disparities in Health Status and Access to Health Care: The Continuation of Inequality in the United States Due to Structural Racism,* 77 AM. J. ECONS. AND SOC. 1113 (2018).

155. Mark Hugo Lopez et al., *Financial and Health Impacts of COVID-19 Vary Widely by Race and Ethnicity*, PEW RES. CTR. (May 5, 2020), https://www.pewresearch.org/fact-tank/2020/05/05/financial-and-health-impacts-of-covid-19-vary-widely-by-race-and-ethnicity/.

155. Jamie Smith Hopkins, *The Invisible Hazard Afflicting Thousands of Schools.* CTR. FOR PUB. INTEGRITY (Feb. 17, 2017), https://publicintegrity.org/environment/the-invisible-hazard-afflicting-thousands-of-schools/.

156. Emily Benfer et al., *Health Consequences of Eviction During the COVID-19 Pandemic* (2020) (unpublished manuscript) (on file with author).

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studies demonstrate that evictions may increase the spread of COVID-19 and that the absence or lifting of eviction moratoriums are associated with an increased rate of COVID-19 infection and death.[157] By driving families to poorer neighborhoods, eviction and housing displacement may also lead to less frequent COVID-19 testing and medical attention.[158] Eviction is also associated with decreased access to primary and specialty medical care, regardless of an individual's housing status post-eviction. [159] Even when infected individuals present with COVID-19 symptoms, eviction decreases the likelihood that they will seek timely medical attention that could stem community transmission.[160] In addition, those facing eviction have difficulty prioritizing their health needs while struggling to maintain housing.[161] From this baseline, eviction itself amplifies individual risk of COVID-19 complications and mortality.

In addition to inequalities in wealth and COVID-19 risk, communities of color are plagued by crumbling infrastructure, environmental injustice,[162] and poverty.[163] This is often the result of the lack of investment in communities of color resulting from "neutral" policies that are examples of institutional discrimination. Racially segregated neighborhoods that are predominately Black have less economic investment and fewer resources, such as places to exercise or for children to play, which is associated with higher rates of cardiovascular disease risk among Black women.[164] These neighborhoods also have more pollution, noise, environmental hazards and an overcrowded housing stock that is associated with asthma, obesity, and cardiovascular disease,[165] which increase the susceptibility of contracting

157. Justin Sheen et al., *The Effect of Eviction Moratoriums on the Transmission of SARS-CoV-2*, GITHUB (Sept. 8, 2020), https://github.com/alsnhll/COVID19EvictionSimulations/blob/master/The_effect_of_eviction_moratoriums_on_the_transmission_of_SARS-CoV-2.pdf .

157. Kathryn M. Leifheit et al., *Expiring Eviction Moratoriums and COVID-19 Incidence and Mortality* (Oct. 2020) (unpublished manuscript), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3739576.

158. Stephanie Schmitt-Grohé, Ken Teoh & Martín Uribe, *Covid-19: Testing Inequality in New York City, 8* CEPR PRESS 41 (2020).

159. Mary Clare Kennedy et al., *Residential Eviction and Risk of Detectable Plasma HIV-1 RNA Viral Load Among HIV-Positive People Who Use Drugs*, 21(3). AIDS BEHAV. 678 (2017).

160. Robert Collinson & Davin Reed, The Effects of Evictions on Low-Income Households (2018) (unpublished manuscript), https://bit.ly/3lrYftK.

161. Danya E. Keene, Monica Guo & Sascha Murillo, *"That Wasn't Really a Place to Worry About Diabetes": Housing Access and Diabetes Self-Management Among Low-income Adults*, 197 SOC. SCI. MED. 71 (2018).

162. Jamie Smith Hopkins, *The Invisible Hazard Afflicting Thousands of Schools.* CTR. FOR PUB. INTEGRITY (Feb. 17, 2017), https://publicintegrity.org/environment/the-invisible-hazard-afflicting-thousands-of-schools.

163. Benfer & Wiley, *supra* note 8.

164. Lee Mobley et al., *Environment, Obesity, and Cardiovascular Disease Risk in Low-Income Women,* 30 AM J. PREVENTATIVE MED. 327, 327 (2006).

165. Ingrid Ellen et al., *Neighborhood Effects on Health: Exploring the Links and Assessing the Evidence*, 23 J. OF URBAN AFF. 391, 393 (2001); Nicole Larson et al., *Neighborhood Environments:*

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COVID-19.[166]

People at the highest risk of eviction are more likely to live in substandard housing conditions that threaten their health,[167] such as poor ventilation, pest infestations, and mold—all closely associated with the development of respiratory conditions and general poor health.[168] Similarly, evictions force renters into living conditions that increase exposure to social determinants of poor health. Communities of color are affected by substandard conditions at a higher rate than predominately White communities. Thirty-five million, or 40% of, homes in U.S. metropolitan areas have one or more health and safety hazards, and rental properties in these areas have a greater prevalence of health-harming conditions than owner-occupied units.[169] Substandard homes are concentrated in low-income communities and communities of color.[170] Two million people in the United States live in severely inadequate homes that lack heat, hot water, electricity, or maintenance of structural defects, and also have other severe problems, which have all been linked to negative health outcomes.[171] Tenants in rental housing disproportionately suffer the negative health effects—including asthma, respiratory distress, carbon monoxide poisoning, high blood pressure, heart disease, lead poisoning, mental health impairment, and cancer, among others—that result from environmental hazards in substandard housing. It is widely recognized that one's zip code is more indicative of health than genetic code.[172] In the pandemic setting, zip code also predisposes low-income communities and historically marginalized groups to COVID-19 contraction and mortality.

Disparities in Access to Healthy Foods in the U.S., 36 AM. J. OF PREVENTATIVE MED. 74, 74 (2009); LaVonna Lewis et al., *African Americans Access to Healthy Food Options in South Los Angeles Restaurants*, 95 AM. J. OF PUB. HEALTH 668, 672 (2005); Roux, *supra* note 101, at 1786; Renee Walker et al., *Disparities and Access to Healthy Food in the United States: A Review of Food Deserts Literature,* 16 HEALTH & PLACE 876, 881 (2010).

166. Blumenshine et al., *supra* note 9.

167. Wilhelmine D. Miller, Craig E. Pollack & David R. Williams, *Healthy Homes and Communities: Putting the Pieces Together*, 40 AM. J. PREVENTATIVE MED., at S48 (2011).

168. Emily A. Benfer & Allyson E. Gold, *There's No Place Like Home: Reshaping Community Interventions and Policies to Eliminate Environmental Hazards and Improve Population Health for Low-Income and Minority Communities*, 11 HARV. L. & POL'Y REV. S1 (2017).

169. *See State of Healthy Housing*, NAT'L CTR. FOR HEALTHY HOUSING (2013), http://nchharchive.org/Policy/2013StateofHealthyHousing.aspx.

170. Benfer & Wiley, *supra* note 8.

171. Office of the Surgeon General, *The Surgeon General's Call to Action to Promote Healthy Homes*, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, vii (2009).

172. *See* Douglas S. Massey & Nancy A. Denton, AMERICAN APARTHEID: SEGREGATION AND THE MAKING OF THE UNDERCLASS (1993); Douglas S. Massey, *American Apartheid: Segregation and the Making of the Underclass*, 96 AM. J. OF SOC. 329 (1990); Douglas S. Massey & Nancy A. Denton, *Hypersegregation in U.S. Metropolitan Areas: Black and Latino Segregation Along Five Dimensions*, 26 DEMOGRAPHY 373 (1989);Douglas S. Massey & Mary J. Fischer, *How Segregation Concentrates Poverty*, 23 ETHNIC AND RACIAL STUD. 670 (2000); Douglass S. Massey & Jonathan Tannen, *A Research Note on Trends in Black Hypersegregation*, 52 DEMOGRAPHY 1025 (2015).

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All of these housing inequalities are rooted in structural and institutional discrimination and increase the likelihood that people of color will be hardest hit by the pandemic. For example, policies that allowed industry and freeway development in low-income communities and communities of color benefited the well-off by granting them access to the city from the suburbs, while destroying low-income communities and communities of color, an example of structural discrimination.[173] Institutional discrimination is also present in housing decisions that seem "neutral" but disproportionately harm low-income individuals and people of color. For example, many states have yet to provide housing supports for the homeless, toll utility shut-offs, or guarantee access to safe, decent and health housing. As a result of these "neutral" decisions many low-income individuals and racial and ethnic minorities are left without a way to social distance, making them more vulnerable to COVID-19 infection.[174] Without intervention, we can expect disparities to deepen, especially in the housing context, as COVID-19 mortality[175] and job loss[176] and the lack of income to pay the rent affect communities of color at higher rates than other groups.[177]

C. Applying the Health Justice Framework to Achieve Housing Equity

Especially in a pandemic setting, the achievement of health justice requires equity in housing, which means access to safe, decent, and affordable housing. First, the legal and policy response must address the structural and intermediary determinants of health. This requires the prevention of eviction and homelessness, social supports to enable individuals to maintain stable housing and safely shelter in place, and long-term investment in affordable housing and areas of opportunity to redress longstanding housing disparities.

To direct resources to homelessness response and prevention, states and cities can include homeless shelters as "essential services" that receive access to emergency supplies during an outbreak and divert emergency funds to reduce exposure to the virus for individuals experiencing or at high risk of homelessness. To support individuals facing homelessness, localities can provide temporary housing in hotels or motels, or permanent supportive housing to reduce exposure

173. Deborah N. Archer, *White Men's Roads Through Black Men's Homes: Advancing Racial Equity Through Highway Reconstruction,* 73 VAND. L. REV. 1259 (2020).

174. Yearby, *Structural Racism and Health Disparities*, *supra* note 28.

175. *COVID-19 Racial Disparities in U.S. Counties*, AMFAR (2020), https://ehe.amfar.org/inequity?_ga=2.51214761.1618924293.1588715818-1730120696.1588715818.

176. Mark Hugo Lopez, et al., *Financial and Health Impacts of COVID-19 Vary Widely by Race and Ethnicity*, PEW RES. CTR. (May 5, 2020), https://www.pewresearch.org/fact-tank/2020/05/05/financial-and-health-impacts-of-covid-19-vary-widely-by-race-and-ethnicity.

177. Emily A. Benfer et al., *Eviction, Health Inequity, and the Spread of COVID-19: Housing Policy as a Primary Pandemic Mitigation Strategy,* J. URBAN HEALTH (2021).

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to COVID-19 among marginally housed seniors, people with underlying health conditions, and individuals experiencing homelessness, and living in communal shelters. During the pandemic, California Governor Newsom launched "Project Roomkey," an initiative to secure hotel and motel rooms to protect homeless individuals from COVID-19 with the goal of securing 15,000 rooms.[178] However, exemplifying "NIMBYism" and discrimination, cities filed for an injunction, arguing that the measure put their communities at higher risk of COVID-19 spread.[179] The U.S. District Judge David O. Carter dismissed the NIMBY-rooted argument and upheld the plan. He determined that "under state law, the county can use city property to address the public health crisis, consistent with Newsom's declaration of emergency."[180] The provision of safe and decent housing or apartment style shelter is necessary to both protect people who are homeless from contracting COVID-19 and requiring significant medical interventions, as well as to address the underlying roots of disparity in exposure. The federal CARES Act included $4 billion for Emergency Solutions Grants (ESG) to help reduce the number of people living in homeless encampments and congregate shelters, but more is needed to prevent an increase in homelessness and to increase access to assistance,[181] such as stimulus checks.[182] The National Alliance to End Homelessness recommends a four-phase pandemic framework including immediate and long-term actions that ultimately move people experiencing homelessness into greater housing stability, including permanent supportive housing.[183]

To address the structural and intermediary determinants of health related to eviction during the pandemic, state governors, policymakers and courts should

178. Office of Governor Gavin Newsom, *At Newly Converted Motel, Governor Newsom Launches Project Roomkey: A First-in-the-Nation Initiative to Secure Hotel & Motel Rooms to Protect Homeless Individuals from COVID-19*, STATE OF CALIFORNIA (Apr. 3, 2020), https://www.gov.ca.gov/2020/04/03/at-newly-converted-motel-governor-newsom-launches-project-roomkey-a-first-in-the-nation-initiative-to-secure-hotel-motel-rooms-to-protect-homeless-individuals-from-covid-19.

179. City News Service, *Judge: Governor's Orders Override Cities' Objections to Homeless Hotel Housing.* L.A. DAILY NEWS (Apr. 27, 2020), https://www.dailynews.com/2020/04/23/judge-governors-orders-override-cities-objections-to-homeless-hotel-housing.

180. *Id*.

181. Senator Debbie Stabenow & Senator Chuck Schumer, *Racial Disparities on Full Display: COVID-19 is Disproportionately Affecting Communities of Color*, DEMOCRATIC POL'Y & COMM. COMMITTEE 1, 5 (Apr. 30, 2020), https://www.stabenow.senate.gov/imo/media/doc/DPCC%20Report%20on%20Racial%20Disparities.pdf.

182. Letter from Members of Congress, to Steven T. Mnuchin, U.S. Department of Treasury, and Charles Retting, Internal Revenue Service (Apr. 22, 2020), https://bluntrochester.house.gov/uploadedfiles/irs_and_stimulus_checks_for_homeless_population.pdf.

183. The National Alliance to End Homelessness et al., *The Framework for an Equitable COVID-19 Homelessness Response Version*, 4 HOUSING EQUITY FRAMEWORK 3 (Oct. 19, 2020), https://endhomelessness.org/wp-content/uploads/2020/04/COVID-Framework-4.29.2020-1.pdf.

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adopt eviction and foreclosure moratoriums and financial support to preserve housing. Moratoriums should apply to all evictions and all renters and suspend every stage of the eviction process, including initiation (notice and filing), court process (hearing and issuance of writ of possession), and enforcement of an order of eviction.[184] They should include tenant education and be applied uniformly and enforced. They should extend beyond the state of emergency and be coupled with supportive measures, such as a prohibition on late fees and rent raises and a guaranteed right to counsel, and housing stabilization measures, including rental assistance and a grace period to pay rent. During the pandemic, U.S. state and local policymakers instituted a patchwork of emergency orders and legislation that effectuated eviction moratoriums. However, the moratoriums varied in length and application and few suspended all stages in the eviction process or provide supportive measures.[185] The majority of moratoriums were lifted in May 2020, before COVID-19 was contained and before financial assistance was distributed, which resulted in an eviction crisis estimated to affect 30 to 40 million adults and children.[186] The federal CARES Act established a temporary 120-day moratorium on the nonpayment of rent evictions in federally assisted housing and federally backed mortgages.[187] The Act required landlords to provide 30 days' notice of eviction once the moratorium expired on July 24, 2020. In addition, the Federal Housing Finance Agency issued and extended foreclosure and eviction moratorium on single-family homes. However, it was unclear whether a unit is covered under the CARES Act, and only a few state courts required certification that a property is exempt from the federal moratorium.[188] On September 4, 2020, the Centers for Disease Control and Prevention issued a nationwide moratorium on eviction for non-payment of rent, provided tenants deliver a declaration of eligibility to their landlords. However, at the time of this Article, the order was eroded by the agency's Frequently Asked Questions notice, was inconsistently implemented and interpreted across states, and was not coupled with tenant education, rental assistance, or enforcement mechanisms. Without improvements, it cannot fully address the social and structural determinants of eviction because many eligible renters were not protected and, for those who did exercise their

184. Emily A. Benfer, et al., *What an Effective Eviction Moratorium Must Include*, SHELTER FORCE (Mar. 24, 2020), https://shelterforce.org/2020/03/24/what-an-effective-eviction-moratorium-must-include/.

185. Emily A. Benfer, *COVID-19 Eviction Moratoria: Federal (CDC), State, Commonwealth, and Territory*, GOOGLE (2020), http://bit.ly/COVID19EvictionFreezeUS; *COVID-19 Housing Policy Scorecard*, EVICTION LAB (2020), https://evictionlab.org/covid-policy-scorecard/.

186. Benfer et al., *Health Consequences of Eviction During the COVID-19 Pandemic*, *supra* note 156; Benfer et al., *The COVID-19 Eviction Crisis*, *supra* note 15.

187. Coronavirus Aid, Relief, and Economic Security Act of 2020, Pub. L. No. 116-136, § 4022, 134 Stat. 281 (2020).

188. Benfer et al., *supra* note 156.

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rights, the mounting rent will still be due when it expires, and renters will likely face eviction at that time. Ultimately, to prevent the immediate eviction crisis, the United States must adopt a nationwide eviction moratorium, rental assistance to cover rental debt and rent burden, and the civil right to counsel for those facing eviction to ensure equal access to justice in the process.

Because the pandemic has exacerbated long-standing and interconnected crises in housing in low-income communities and communities of color, the first prong also requires that legal and policy responses must address root problems in addition to immediate needs. To redress housing precarity among communities of color, the United States should invest in low-income communities and communities of color by providing rental subsidies and engaging in new construction and rehabilitation that will increase long-term affordable housing. Federal, state, and local policymakers must reform the housing market in a way that provides equal access to housing, thriving communities, and areas of opportunity to ensure that a person's livelihood is no longer determined by zip code. The Federal Housing Administration must redress racially discriminatory policies that locked Black families out of asset accumulation and resulted in the long-term disinvestment in communities of color. The Enterprises must address the persistence of mortgage lending discrimination and the inattention to affordable housing. Ultimately, the United States should create the right to safe and decent housing. The 1949 Housing Act set the national housing goal: "the realization as soon as feasible of the goal of a decent home and a suitable living environment for every American family."[189] COVID-19 underscores the urgency of achieving this goal, especially for historically marginalized communities.

Second, interventions mandating healthy behaviors must be accompanied by legal protection, financial supports, and accommodations to enable compliance while minimizing harms. This means that, in addition to preserving the tenancy, renters must have access to water and electricity if they are to comply with social distancing mandates. States must prevent utility shut offs and restore any disconnected service in order to allow residents to safely shelter in place. The COVID-19 pandemic and social distancing requirements create a situation in which utility shut off would result in a life-threatening emergency. Clean water and electric, gas, and steam utilities are crucial to one's ability to follow recommended hygiene practices, cook and preserve foods, and heat and cool a home. Most states have already adopted medical exceptions to utility shut off, including if the termination of service would affect an elderly individual and where a serious illness, life threatening emergency, low-income hardship, or extreme weather is documented.[190] However, these measures may not apply to people who

189. 42 U.S.C. § 1441a (1949).
190. Benfer & Wiley, *supra* note 8.

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are sheltering in place before contracting the coronavirus. Despite the necessity of water and electricity to maintain health and heed shelter in place orders, not every state has a utility disconnection moratorium,[191] in part due to the governance of utilities by state and the inability of governors to require service. State policymakers and governors in over half the states ordered the suspension of utility disconnections.[192] In some states, these orders are limited to certain populations, such as low-income or senior customers, and those experiencing hardship or illness due to COVID-19. [193] Where the state has not ordered disconnection suspension, investor-owned utility companies and state utility boards have suspended disconnections and, in some areas, late fees.[194]

To prevent debt and support long-term stability, utility companies should forgive—and federal, state, and local governments should help carry—any consumer debt incurred while combating COVID-19 and waive late fees. The federal stimulus packages included funding for heating and cooling bills through the Low-Income Home Energy Assistance Program (LIHEAP) and $300 million to bring high-speed internet to rural communities and ensure health care providers can perform telehealth services.[195] To protect residents—and the public's—health, local and state governments can issue and enforce protections against utility shut-off, at a minimum while social distancing recommendations are in effect, and ideally for 120 days after the pandemic is contained, to enable people to recover from the economic crisis it has created.

Further applying the second prong of health justice, when a key component of the public health response is urging people to stay home, securing safe and sanitary conditions in low-income housing must remain a priority. Every jurisdiction has municipal public health and building codes that are designed to protect health and safety by setting minimum requirements. For example, the majority of states have adopted a warranty of habitability standard, the Uniform Residential Landlord Tenant Act, the International Building Code and the International Residential Code, which, taken together, prohibit environmental hazards in the home.[196]

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191. Energy Justice. *LIVE: Utilities That Have and Have Not Suspended Disconnects Amid COVID-19*, CLEAN ENERG. (Aug. 7, 2020), https://cleanenergy.org/blog/live-utilities-that-have-and-have-not-suspended-disconnects-amid-covid-19/.

192. David Pomerantz, *LIVE: Utilities That Have and Have Not Suspended Disconnects Amid COVID-19*, ENERGY AND POL'Y INST. (Aug. 28, 2020), https://www.energyandpolicy.org/utilities-disconnect-coronavirus/; Office of Governor Gretchen Whitmer, *Exec. Order No. 2020-28 (COVID-19)*, STATE OF MICHIGAN (2020), https://www.michigan.gov/whitmer/0,9309,7-387-90499_90705-523414--,00.html.

193. *State Response Tracker*, NAT'L ASS'N OF REG. UTIL. COMMISSIONERS (2020), https://www.naruc.org/compilation-of-covid-19-news-resources/state-response-tracker/.

194. *Id.*

195. Coronavirus Aid, Relief, and Economic Security Act of 2020, Pub. L. No. 116-136, § 4022, 134 Stat. 281 (2020).

196. Adopted by the Uniform Law Commission in 1972, the URLTA set standards to govern

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Robust enforcement is essential to protect the health and wellbeing of low-income people and must be increased to prevent deleterious health harms to low-income people forced to shelter in place in substandard housing. As of 2016, 23% percent of local health departments were engaged in activities to promote safe and healthy housing and 31% of departments conducted housing inspections.[197] During the COVID-19 pandemic, housing and public health inspectors must be deployed to low-income communities to support remediation efforts. After the pandemic, inspections should continue to identify and resolve conditions that are hazardous to health.

Finally, the third prong of health justice requires engaging marginalized communities as leaders in the development of any interventions and the attainment of health justice. People at risk of housing displacement must be included in decision-making bodies and provided resources necessary to participate. They must be consulted as interventions are developed and given autonomy over decision-making that will affect their lives. COVID-19 Task Forces must include affected populations and the conveners must provide resources, such as compensation, training, childcare, and transportation, to enable participation. The formation of tenant unions across the country during the eviction crisis demonstrates a way for tenants to increase bargaining power and ensure greater control over their home environment and community. The model of equity between parties can be adopted across all systems that have a nexus with housing.

The pandemic magnified and accelerated inequities in housing and presented an opportunity to prevent the devastating harms of eviction and housing instability in a targeted and comprehensive way. Ultimately, applying the health justice framework to the housing crisis in order to eliminate health disparities caused by discrimination and poverty can increase housing security, long-term wellbeing, and access to opportunity for millions of adults and children well into the future.

V. HEALTH JUSTICE IN EMPLOYMENT

A. Employment as a Social Determinant of Health

Employment is inextricably tied to health disparities. For example, the social determinants framework states "21% of African Americans work in jobs that put them at high risk for injury or illness compared to only 13% of white people."[198] It

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the landlord and tenant relationship. Twenty-one states adopted the URLTA, with more influenced by particular sections. John Ahlen & Lynn Foster, *Uniform Residential Landlord Tenant Law: Changes on the Way*, 28 PROB. & PROP. MAG. 21 (2014).

197. NATIONAL ASSOCIATION OF COUNTY & CITY HEALTH OFFICIALS, 2016 NAT'L PROFILE OF LOC. HEALTH DEP'T 77, 128 (2016), https://www.naccho.org/uploads/downloadable-resources/ProfileReport_Aug2017_final.pdf.

198. *Social Determinants of Health: Interventions and Resources — Employment*, Healthy

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is also way most Americans obtain health insurance and the income necessary to pay for health care.[199]

Women of color remain disproportionately employed in low-wage occupations, such as "jobs that involve cooking, cleaning, and caregiving."[200] Based on a Center for American Progress 2007 report, "nearly half—43 percent—of the 29.6 million employed women in the United States were clustered in just 20 occupational categories, of which the average annual median earnings were $27,383."[201] Specifically, 62% of Latino women, 57% of Black women, and 53% of White women are clustered into low-wage service and sales and office occupations.[202] This is in comparison to 26% of Latino women, 35% of Black women, and 43% of White women, who are employed in higher-wage management, professional, and related jobs.[203] Many of these low-wage workers who are considered the working poor have been designated as essential workers. In fact, almost a quarter of essential workers are considered low-income workers.[204]

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."[205] The Centers for Disease Control and Prevention (CDC) found that African Americans account

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People 2020, U.S. DEP'T OF HEALTH & HUM. SERVS. (2020), https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources/employment.

199. *Id*.

200. TERESA AMOTT & JULIE MATTHAEI, RACE, GENDER, AND WORK: A MULTICULTURAL ECONOMIC HISTORY OF WOMEN IN THE U.S. (1996); JACQUELINE JONES, LABOR OF LOVE, LABOR OF SORROW: BLACK WOMEN, WORK, AND THE FAMILY FROM SLAVERY TO THE PRESENT (1885); Nina Banks, *Black Women's Labor Market History Reveals Deep-Seated Race and Gender Discrimination*, ECON. POL'Y INST. (Feb. 19, 2019), https://www.epi.org/blog/black-womens-labor-market-history-reveals-deep-seated-race-and-gender-discrimination/.

201. Alexandra Cawthorne Gaines, *The Straight Facts on Women in Poverty,* CTR. FOR AM. PROGRESS (Oct. 8, 2008), https://www.americanprogress.org/issues/women/reports/2008/10/08/5103/the-straight-facts-on-women-in-poverty. U.S. Bureau of Labor Statistics, *Labor Force Statistics from the Current Population Survey*, U.S. DEP'T OF LAB. (Nov. 22, 2019), https://www.bls.gov/cps/earnings.htm.

202. Milia Fisher, *Women of Color and the Gender Wage Gap*; CTR. FOR AM. PROGRESS (Apr. 14, 2015), https://www.americanprogress.org/issues/women/reports/2015/04/14/110962/women-of-color-and-the-gender-wage-gap.

203. *Id*.

204. Hye Jin Rho, Hayley Brown & Shawn Fremstad, *A Basic Demographic Profile of Workers in Frontline Industries*, CTR. FOR ECON. AND POL'Y RES. 8 (Apr. 2020), https://cepr.net/wp-content/uploads/2020/04/2020-04-Frontline-Workers.pdf.

205. Campbell Robertson & Robert Gebeloff, *How Millions of Women Became the Most Essential Workers in America*, N.Y. TIMES (Apr. 18, 2020), https://www.nytimes.com/2020/04/18/us/coronavirus-women-essential-workers.html.

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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.[206] Additionally, essential workers who are poor or people of color are more likely to work in crowded and unsanitary conditions such as nursing homes and meat processing plants and distribution warehouses, without adequate protective gear.[207] Emerging research demonstrates that individuals who are poor or people of color have higher rates of exposure to COVID-19 due to employment conditions such as lack of paid sick leave, low-wages, and lack of health insurance, among other risk factors.[208] These inequalities in employment are due to structural discrimination.

B. Employment Discrimination as a Barrier to Health Justice During COVID-19

Inequalities in employment, which have caused disparities in COVID-19 infections for individuals who are poor and people of color, are due in large part to structural discrimination. For example, many laws that expanded collective bargaining rights in the 1930s and 1950s either explicitly excluded racial and ethnic minorities or allowed unions to discriminate against racial and ethnic minorities.[209] These employment laws benefited White people by providing them with access to unions that bargained for paid sick leave. However, they 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. To this day, many racial and ethnic minorities still do not have paid sick leave[210] and other employment laws still limit racial and ethnic minorities' access to equal pay, which causes disparities in exposure to COVID-19. The plight of agricultural workers and home health care workers is illustrative of this point.

Twenty-one percent of workers deemed essential during the COVID-19 pandemic work in the food and agricultural industry,[211] which have been hotspots

206. *COVID-19 in Racial and Ethnic Minority Groups*, CTRS. FOR DISEASE CONTROL & PREVENTION (July 24, 2020), https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html.

207. Marmot, *supra* note 1; Rho, Brown & Fremstad, *supra* note 204; Kristi L. Kirschner, Lisa I. Iezzoni & Tanya Shah, *The Invisible COVID Workforce: Direct Care Workers for Those with Disabilities* (July 27, 2020), https://www.commonwealthfund.org/blog/2020/invisible-covid-workforce-direct-care-workers-those-disabilities.

208. Shonkoff & Williams, *supra* note 16.

209. Danyelle Solomon et al., *Systematic Inequality and Economic Opportunity*, CTR. FOR AM. PROGRESS (Aug. 7, 2019), https://www.americanprogress.org/issues/race/reports/2019/08/07/472910/systematic-inequality-economic-opportunity/.

210. Kumar et al., *supra* note 6, at 134-40.

211. Celine McNicholas & Margaret Poydock, *Who Are Essential Workers? A Comprehensive Look at Their Wages, Demographics, and Unionization Rates*, ECON. POL'Y INST. (May 19, 2020),

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for COVID-19 infections. In mid-April, there were already signs of outbreaks tied to agriculture businesses as evidenced by the 100 COVID-19 cases linked to a produce-processing plant in Rhode Island. By June over 2,076 agricultural workers in New York, 1,948 in California, and over 1,000 in Illinois, Texas, Iowa, Washington, and Minnesota were infected with COVID-19.[212] As of September 10, 2020, more than 60,000 food and agricultural workers have tested positive for COVID-19 and 258 have died.[213] More specifically, 6,999 farmworkers have tested positive and 15 farmworkers have died. A majority of agricultural workers are racial and ethnic minorities who live in poverty and do not have paid sick time. For example, 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.[214] 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).[215]

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.[216] In 1966, the minimum wage requirements were applied to *most* agricultural workers, yet these workers still do not receive overtime and are paid fifty cents less than the minimum wage.[217] Also, instead of the minimum wage, some workers are still paid based on each piece of food they pick.[218] The failure to provide agricultural workers with higher wages and overtime pay is due to structural discrimination. 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 racial and ethnic minority workers that cannot afford to miss work even when they are sick. Therefore, these

https://www.epi.org/blog/who-are-essential-workers-a-comprehensive-look-at-their-wages-demographics-and-unionization-rates.

212. Amy Sowder, *COVID-19 Cases Mount as Summer Harvesting Heats Up*, PACKER (June 18, 2020), https://www.thepacker.com/article/covid-19-cases-mount-summer-harvesting-heats.

213. Leah Douglas, *Mapping Covid-19 Outbreaks in the Food System*, FOOD & ENV'T REPORTING NETWORK, (Sept. 10, 2020) https://thefern.org/2020/04/mapping-covid-19-in-meat-and-food-processing-plants.

214. Monica Schoch-Spana et al., *supra* note 9, at 243-53.

215. The Fair Labor Standards Act of 1938, 29 U.S.C. §§ 201-19 (2018).

216. Peggie R. Smith, *Aging and Caring in the Home: Regulating Paid Domesticity in the Twenty-First Century*, 92 IOWA L. REV. 1835, 1857 (2007); Solomon et al., *supra* note 209.

217. Autumn Canny, *Lost in a Loophole: The Fair Labor Standards Act's Exemption of Agricultural Workers from Overtime Compensation Protections*, 10 DRAKE J. AGRIC. L. 355 (2005).

218. *Fact Sheet #12: Agricultural Employers Under the Fair Labor Standards ACT (FLSA)*, U.S. DEP'T OF LAB., (Jan. 2020), https://www.dol.gov/agencies/whd/fact-sheets/12-flsa-agriculture.

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racial and ethnic minority workers are forced to work even when they are sick, increasing the risk of exposure to viruses for all agricultural workers because they work in close quarters.

Health care workers have also been disproportionately infected with COVID-19. Thirty percent of all essential workers work in the health care industry.[219] As of September 10, 2020, more than 157,298 health care personnel have tested positive for COVID-19 and 697 have died.[220] Unfortunately, these numbers are not disaggregated by job, but many of the most vulnerable health care workers during the COVID-19 pandemic are home health care workers, who work in close contact with patients vulnerable to COVID-19.[221] Home health care workers, who are considered domestic workers, are also left unprotected. Two-thirds of home health care workers are women of color.[222] Although the Medicaid program[223] 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.[224] 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,[225] 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.[226] 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 discrimination. The initial failure to cover these

219. Celine McNicholas & Margaret Poydock, *supra* note 211.

220. *COVID-19 Data Tracker: Cases & Deaths Among Healthcare Personnel*, CTRS. FOR DISEASE CONTROL & PREVENTION (Sept. 10, 2020), https://covid.cdc.gov/covid-data-tracker/?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcases-updates%2Fcases-in-us.html#health-care-personnel.

221. Yearby & Mohapatra, *supra* note 28.

222. *Id*.

223. 42 U.S.C. §§ 1396, 1396a(a)(1)–(2), (5) (2006 & West Supp. 2018).

224. *U.S. Home Care Workers: Key Facts*, PHI, 5-6 (2018).

225. 80 C.F.R. §§ 55029-30 (2015).

226. Memorandum from Bryan Jarrett, Acting Administrator, to Regional Administrators (July 13, 2018), https://www.dol.gov/agencies/whd/field-assistance-bulletins/2018-4; Labor and Employment Group, *Labor Classification in the Home Health Care Industry: A Sign of What's to Come?*, BALLARD SPAHR LLP (July 16, 2018), https://ballardspahr.com/alertspublications/legalalerts/2018-07-16-labor-classification-in-the-home-health-care-industry-a-sign-of-whats-to-come.

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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 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[227] have been deemed as "essential" including agricultural workers[228] and home care workers, yet they do not have adequate wages or personal protective gear.[229] 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.[230] Additionally, unlike health care workers providing care in institutional settings, home care workers have not been provided with masks. In fact, one worker said, "her colleagues had been making protective masks out of paper towels" and another worker had been making "hand sanitizers out of supplies she bought herself."[231]

The CARES Act[232] 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-19, increased unemployment benefits, and paid sick leave.[233] But the CARES Act does not cover

227. Beatrice Jin & Andrew McGill, *Who Is Most at Risk in the Coronavirus Crisis: 24 Million of the Lowest-Income Workers*, POLITICO (March 21, 2020), https://politico.com/interactives/2020/coronavirus-impact-on-low-income-jobs-by-occupation-chart.

228. Alejandra Borunda, *Farm Workers Risk Coronavirus Infection to Keep the U.S. Fed,* NAT'L GEOGRAPHIC (Apr. 10, 2020), https://www.nationalgeographic.com/science/2020/04/farmworkers-risk-coronavirus-infection-keep-us-fed.

229. Christopher Ingraham, *Why Many 'Essential' Workers Get Paid So Little According to Experts,* SEATTLE TIMES (Apr. 6, 2020), https://www.seattletimes.com/business/why-do-so-many-essential-workers-get-paid-so-little-heres-what-economists-have-to-say.

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

231. Andrew Donlan, '*I Deserve to Be Respected:' Home Care Workers Make Emotional Plea for Better Treatment*, HOME HEALTH CARE NEWS (Apr. 15, 2020), https://homehealthcarenews.com/2020/04/i-deserve-to-be-respected-home-care-workers-make-emotional-plea-for-better-treatment/.

232. Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020, Pub. L. No. 116-136, Tit. III, 134 Stat. 146, 147 (2020).

233. Erica Warner et al., *Senate Approves $2.2 Trillion Corona Virus Bill Aimed at Slowing*

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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.[234] 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 they were included.[235] Thus, the CARES Act is an example of structural discrimination because it primarily advantages White workers, while disadvantaging racial and ethnic minorities who do not receive the protections of the CARES Act, leaving them unprotected and in poverty.

C. Applying the Health Justice Framework to Achieve Employment Equity

As briefly discussed in Section III, due to the economic impacts of the pandemic, Latino and Black people have experienced higher rates of job loss and financial hardship. "Nearly three-quarters of Black (73%) and Hispanic adults (70%) said they did not have emergency funds to cover three months of expenses; around half of White adults (47%) said the same," and **"**Black (48%) and Hispanic adults (44%) were more likely than white adults (26%) to say they 'cannot pay some bills or can only make partial payments on some of them this month.'" [236] Thus, the impact of employment inequalities before and during the COVID-19 pandemic has disproportionately harmed the poor and racial and ethnic minorities, which is not addressed by current relief bills. Thus, policymakers need to adopt the health justice framework to not only address the impact of discrimination, but also the impact of poverty.

The patchwork of federal and state COVID-19 laws does not address these structural inequalities.[237] Thus, federal and state policymakers must use the health justice framework to address these problems. First, the legal and policy response must address the social and structural determinants of health by providing workers with a living wage and health insurance to address employment inequalities. For instance, governments must provide paid sick leave to all workers, even if they are independent contractors, "because it reduces costly spending on emergency health care, reduces the rate of influenza contagion, and saves the U.S. economy $214

Economic Free Fall, WASH. POST, (Mar. 25, 2020), https://www.washingtonpost.com/business/2020/03/25/trump-senate-coronavirus-economic-stimulus-2-trillion.

234. Borunda, *supra* note 228.

235. Donlan, *supra* note 231.

236. Mark Hugo Lopez, Lee Rainie & Abby Budiman, *Financial and Health Impacts of COVID-19 Vary Widely by Race and Ethnicity*, PEW RES. CTR. (May 5, 2020), https://www.pewresearch.org/fact-tank/2020/05/05/financial-and-health-impacts-of-covid-19-vary-widely-by-race-and-ethnicity.

237. Yearby & Mohapatra, *supra* note 28.

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billion annually in increased productivity and reduced turnover."[238]

Second, the interventions mandating health behaviors, such as staying at home from work when sick, must be accompanied by supports to enable compliance and minimize harms, such as paid sick leave and a guaranteed basic income. Thirty-four million workers, including 54% of Latino and 38% of Black workers, have no paid sick leave.[239] Without sick leave, working people are 1.5 times more likely to go to work with a contagious disease and three times more likely to go without medical care compared to those with paid sick days.[240] The National Governor's Association and the Association of State and Territorial Health Officials pointed to these risk factors as the reason for stark disparities, particularly in low-income communities, for the higher rate of COVID-19 infection and mortality.[241] Some governors have tried to address these issues. For example, the Arkansas governor received approval from CMS to use some CARES Act funding to provide payments to direct care workers.[242] Eligible workers, all direct care workers except those working in nursing homes and hospitals,[243] 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).[244] 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 to 39 hours and $500 a week for those working 40 hours or more."[245] The payments will be retroactive to April 5 and will continue until at least May 30.[246]

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

238. Benfer & Wiley, *supra* note 7.

239. *Id*.

240. *Id.*

241. Hemi Tewarson et al., *Roadmap to Recovery: A Public Health Guide for Governors*, NGA (Apr. 21, 2020), https://www.nga.org/wp-content/uploads/2020/04/NGA-Report.pdf.

242. Elisha Morrison, *CMS Approves Some Healthcare Worker Bonuses,* SALINE COURIER (Apr. 16, 2020), https://www.bentoncourier.com/covid-19/cms-approves-some-healthcare-worker-bonuses/article_3946adc8-800c-11ea-944a-1b151690787e.html.

243. KATV, *Governor Announces Bonus Pay for Some Health Workers: COVID-19 Death Toll Rises to 34* ABC7 (Apr. 15, 2020), 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.").

244. Morrison, *supra* note 242.

245. *Id.*

246. The governor will extend the payments an additional 30 days if COVID-19 cases on May 30th exceed 1,000. *Id.*

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residential facilities with weekly $300 payments for working during the COVID-19 pandemic until the end of June.[247] 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,[248] 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 universal solutions.

Members of low-income communities and communities of color are already relegated to working in low-paying jobs. Due to the record high unemployment rates and grim realities for low-income communities and communities of color, this is the optimal time for policymakers to adopt legal and policy responses that address the root problem of employment inequities: poverty and discrimination. A guaranteed basic minimum income and health insurance for workers from these communities would minimize the economic harms of not going to work, enabling them to comply with social distancing measures.[249] 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.[250] Thus, for almost 20 years, Alaska has provided guaranteed support for residents, helping to address poverty, with no change in full-time employment.

Third, many employment policies aimed at putting an end to poverty are ill-informed and ineffective. Thus, policymakers must engage low-income communities and historically marginalized groups in the development of any interventions to end poverty and attain health justice. For example, most recently policymakers have tried to condition the receipt of Medicaid on work requirements, ignoring the data that most individuals are already working. This is best illustrated by home health care workers, paid by the federal government, who are still so poor that they remain in poverty and eligible for Medicaid. Moreover,

247. Mia Summerson, *NH Moves to Boost Pay for Long-term Care Workers,* SENTINELSOURCE (Apr. 14, 2020), https://www.sentinelsource.com/news/local/nh-moves-to-boost-pay-for-long-term-care-workers/article_78db684f-a0a6-5eaf-bf0d-29caae8811b4.html.

248. The states include Arizona, California, Colorado, the District of Columbia, Illinois, Indiana, Maine, Minnesota, Montana, New York, Pennsylvania, Rhode Island, and Washington. *See* Ruqaiijah Yearby et al., *State Wage Pass Through Laws for Direct Care Workers* (Aug. 31, 2020), (unpublished manuscript) (tracking state laws that increase wages for direct care workers providing care to elderly Medicaid patients as of August 31, 2020).

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

250. Michael J. Coren, *When You Give Alaskans a Universal Basic Income, They Still Keep Working,* QUARTZ (Feb. 13, 2018), https://qz.com/1205591/a-universal-basic-income-experiment-in-alaska-shows-employment-didnt-drop.

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COVID-19 relief must apply to all essential workers regardless of immigration status or independent contractor designation.

During the COVID-19 pandemic, many racial and ethnic minorities, people living in poverty, and other marginalized groups have been unable to stay at home or socially distance because they work in positions deemed to be essential. Although these workers have been labeled as essential, they have not been provided with the economic support necessary to keep them safe, such as paid sick leave and health insurance, as a result of structural discrimination. This problem is illustrated by the disproportionate COVID-19 infections and deaths of agriculture and home health care workers who lack paid sick leave, because they were explicitly excluded from the CARES Act and other laws providing this benefit. To address this problem, policymakers should use the health justice framework to include low-income communities and historically marginalized groups in the development of legal and policy responses to address employ inequalities, such as providing a living wage, health insurance, paid sick leave, and a guaranteed basic income.

CONCLUSION

The COVID-19 pandemic magnified and accelerated the impact of longstanding discrimination, poverty, and health inequities among low-income communities and historically marginalized groups. Health justice is an effective framework for eradicating unjust health disparities, especially those caused by discrimination and poverty.[251] The achievement of health justice requires addressing the roots of and preventing new forms of discrimination and poverty both during and after the COVID-19 pandemic. The application of the health justice framework to the supportive pillars of health care, housing, and employment demonstrates how the framework can be adopted across numerous social determinants of health and structures to ensure the elimination of discrimination, poverty, and poor health among marginalized people during and after the pandemic.

251. Benfer & Wiley, *supra* note 7.

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