Social Justice Is Not the COVID-19 Vaccine Alone: It Is Addressing Structural Racism Through Social Policies That Shape Health

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The first author (V. M. M.) was being interviewed by a reporter, who asked, "Is getting the vaccine social justice?" Perhaps in some measure equitable access to a vaccine can be construed as indicative of social justice. But social justice as a concept is a much more complicated construct.[1] Social justice includes several key principles: fairness in how individuals and society interact, equitable access to public goods and institutions, equitable access to opportunities to improve well-being, and trust that these principles will be followed equitably. A social justice lens brings into sharp focus how structural racism contributes even now to early mortality for many racial and ethnic minorities. Police encounters that are more likely to result directly in violent death for Black men are but one risk.[2] Trauma from actual or anticipated encounters in which such violence is possible is yet another corrosive factor for health. And, of course, there is the disparity in morbidity and mortality risk from COVID-19.[3,4] History underscores the lack of social justice in the United States when it comes to the impact of infectious disease on racial/ethnic minorities.[5] The COVID-19 pandemic is no exception.

COVID-19 IMPACT ON MINORITY COMMUNITIES

Common methods of reducing COVID-19 infection risk that emphasize working from home, using personal protective equipment, social distancing, and isolating potentially infected individuals in separate spaces are more difficult to achieve by racial/ethnic minorities, who are more likely to live in higher density households and communities, work at jobs that require their onsite presence, and lack adequate personal protective equipment.[5,6] During the pandemic, job losses have been disproportionately steeper in racial/ethnic communities and more likely to affect those with fewer financial reserves to carry them through.[7] Food insecurity has severely affected many racial/ethnic minority families.[8] Finally, preexisting and well-documented health disparities affecting racial/ethnic minority communities have also increased the risk of severe illness or death.[4] The losses this pandemic has engendered have not been borne equally.

In this special issue on mortality, *AJPH* touches on some of the ways that a lack of social justice percolates through the landscape of society and permeates our public health infrastructure responsible for recording COVID-19 deaths. It is timely that we do so—more than 600 000 individuals in the United States have died from COVID-19, with American Indians/Alaska Natives, Blacks, and Latinxs 1.9 to 2.4 times more likely on a national age-adjusted basis to have died than non-Hispanic Whites.[9] This racial/ethnic disparity is hard evidence of the toll that structural racism exerts on the lives of some Americans. Yet, many of those who have died from COVID-19 are invisible to the nation. They are often the everyday workers who keep all of us fed or cared for when infirm—essential needs when a pandemic hits. Many of the deceased belonged to families who may include COVID-19 survivors as well. It is important to state that many of the deaths among Blacks, Latinxs, American Indians, and Pacific Islanders are not owing to what they did willingly but to what they could not do despite public health messages.

During this pandemic, essential workers often did not have the option to social distance or mask up. Those who

were not licensed health care providers working in hospital settings often did not have access to vaccines in the first distribution wave despite their occupational risks. And even when eligible for vaccines, for some the path toward getting those shots sometimes involved mechanisms (e.g., interface with computer systems) that they were less likely to have access to or familiarity with or requirements (e.g., car access only, take a day off from work) that were insurmountable. Public health authorities also have had more trouble keeping track of vaccination rates among racial/ethnic minorities.[10]

So, yes, getting shots in arms is good; it is leading to the end of this pandemic. But shots in arms alone is not social justice. Social justice is recognizing the differential vulnerabilities unmasked by the COVID-19 pandemic and working to eliminate them. Social justice calls for developing policies that will serve to protect all going forward and enforcing existing policies that aim for equity but have been allowed to lapse. Racial and ethnic minorities, low-income individuals, and tribal members died unnecessarily while public health approaches emphasized feasible risk-reduction strategies for those of greater privilege but lacked the vision to create approaches to infection control that would protect equitably. For example, as Feldman[11] notes, the possibility that workplaces were major contributors to the COVID-19 pandemic has been downplayed, perhaps to minimize business disruptions. But studies have documented that a primary contributor to the racial inequalities seen in COVID-19–related infection transmission is workplace exposure among in-person essential workers.[12,13]

Racial/ethnic minorities are more likely than are non-Hispanic Whites to be employed as essential workers in industries in which there have been higher infection rates (e.g., health care, agricultural work, food processing, warehouse work, customer-facing food supply work). As one example, in California, there was a 30% increase in deaths in 10 essential industries over the period of the first 10 months of COVID-19.[12] The highest statewide increase in deaths compared with the previous year was in warehouse and food chain workers. In a second example,[14] evidence from a large grocery store in Boston, Massachusetts, revealed that employees with customer interaction jobs were five times more likely to test positive for COVID-19 antibodies than were those who worked in noncustomer contact positions.

SAFETY NET POLICIES CREATE INEQUITY

One significant policy intervention that could have made a difference in protecting workers and their families equitably during the COVID-19 pandemic is a robust, universal paid sick leave policy at the start of the pandemic. Without paid sick leave, workers in low-wage jobs with little savings—disproportionately Black and Latinx workers—faced considerable barriers to following public health guidelines to social distance and quarantine if exposed. In April 2020, Congress enacted emergency paid sick leave, which temporarily provided 10 paid sick days to workers affected by COVID-19. However, companies with more than 500 employees were exempt from the mandate, leaving more than 68 million Americans—including the more than 2 million essential workers employed by large grocery store chains—without protections.[15] Even for workers covered by the law, the protections expired at the end of the year, just as COVID-19's second wave was beginning.

Paid sick leave's benefits to public health are extensive, are well documented, and shape whether individuals can prevent and receive treatment for diseases with substantial morbidity and mortality. Access to sick leave, for example, reduces the spread of influenza, which, according to the Centers for Disease Control and Prevention, is responsible for between 12 000 and 61 000 deaths in a typical year[16]; amid the pandemic, the provision of emergency paid sick days—even with its gaps in coverage—prevented approximately one case of COVID-19 per day for every 1300 workers who newly had access to leave.[17] And both during and independent of the pandemic, individuals who have access to leave are more likely to be able to go to clinics to receive immunizations, more likely to be able to see physicians for preventive care, and less likely to go to work when they are sick and, hence, inadvertently spread communicable diseases.

Yet the US failure to adopt permanent, paid sick leave at the national level has created significant racial, ethnic, and socioeconomic disparities in coverage, making these benefits more accessible to some workers than others. With no national policy, the United States has largely left the provision of paid sick days up to employers. As a direct consequence, racial/ethnic minority and low-wage workers are disproportionately left out. As just one example, 54% of Latinx workers lack paid sick leave, compared with 37% of non-Hispanic White workers. This gap leaves Latinx workers at higher risk for exposure to COVID-19 and many other illnesses and far less able to receive care early, which has been

reflected in much higher case and hospitalization numbers.[18]

Meanwhile, another piece of the safety net has had important gaps. The 1993 Family and Medical Leave Act (Pub L No. 103–3) was designed to exclude workers in small firms, part-time workers, and workers who recently changed jobs from unpaid medical leave. The purpose of these limitations was to reduce burdens on small business, but the consequence was to create exclusions that left millions of Americans without adequate coverage—another opportunity missed for true social justice in public policies. For example, just 29% of Latinx workers, compared with 41% of non-Hispanic White workers, are both eligible and can afford to take unpaid medical leave under the Family and Medical Leave Act.[19]

These structural inequalities in access to sick and medical leave have profound health and economic consequences that go far beyond the current pandemic and exacerbate other health disparities. Workers without paid sick leave are three times more likely to forgo personal health care.[20] Parents without sick leave are also more likely to send their children to school or childcare when the children are ill and less likely to be able to provide care to elderly family members who are sick.[21] Workers without sick leave are also more likely to lose their jobs because of their own illness or medical condition.[22,23] One of the authors (J. H.) first documented marked racial and class disparities in access to sick leave 25 years ago.[24] The question is not whether the lack of sick leave is a clear contributor to health and economic inequality in the United States; nor is it whether the passage of national paid sick leave would benefit all Americans. Both have now been repeatedly documented. The question is whether the United States will finally close the egregious gaps in who is able to care for their own health and that of their family.

Just as the United States is long overdue to ensure that sick leave is available to all regardless of race and class, the United States also urgently needs to fulfill its duty to eliminate structural racism in other social policies. Unemployment insurance gaps are an important example that the pandemic has provided. In addition to workers who lost jobs during COVID-19 because of illness, many became unemployed because of the shutdowns imposed to control the pandemic's spread. As with sick leave, structural inequalities have shaped both the accessibility and the adequacy of unemployment benefits that these newly unemployed persons have had access to. Because of higher barriers to eligibility in states with larger Black populations, White workers were nearly twice as likely to receive unemployment benefits as Black workers when the first wave of pandemic layoffs hit, placing the health and well-being of Black workers and their families at far greater risk.[25] Moreover, the cumulative evidence suggests that this racial variation in benefit accessibility is not by chance: states with larger Black populations also provide lower levels of cash assistance ("welfare"),[26] have been less likely to expand access to Medicaid,[27] and impose higher barriers to the right to vote.[28]

ENACTING EQUITABLE SAFETY NET POLICIES

Solutions are within our reach. In the case of paid sick leave, 181 countries around the world have a national guarantee[29]; the United States is 1 of only 11 countries that does not. Moreover, the enactment of modest paid sick leave policies at the state and local levels, although no substitute for national action, has demonstrated the feasibility and impacts of adopting permanent sick days in the United States. When New York City passed five days a year of paid sick leave, workers who had Medicaid for health insurance—a population with higher proportions of Black and Latinx Americans—began to receive better preventive care for chronic diseases.[30] Likewise, with regard to unemployment insurance, there is no reason that the United States cannot replace and modernize the current patchwork of state policies with national standards that would eliminate racial inequalities in benefit access embedded in the current system. Numerous countries—including others with federal systems of governance—also have nationally funded and administered systems of unemployment insurance.

At its core, building a national safety net that is equally accessible regardless of race, ethnicity, or social class is critical to advancing the fundamental ideal of equal rights that the United States has never fully realized but must do all in its power to rapidly fulfill. Providing sick leave and unemployment insurance are but two examples of many possible remedies that would put us on the road to achieving social justice. A commitment to social justice also demands that we address the panoply of health and social policies—including those related to health insurance, economic support, US Food and Drug Administration rules for shipping harm-reduction supplies, immigration enforcement, and mass incarceration—that have created an outsized burden of the pandemic on racial/ethnic minority communities. US reliance on immigration detention, for example, put thousands of children and adults at high risk for COVID-19 infection because of the infeasibility of social

distancing in confinement; the experience of numerous countries elsewhere shows that effective alternatives did exist.[31] Likewise, rates of COVID-19 infections in jails and prisons—which disproportionately house Black and Latinx men because of systemic racism in criminalization, policing, and sentencing—have been more than five times greater than those of the general population.[32] As with the US failure to guarantee sick leave, this institutionalized neglect of the health of marginalized populations both violates basic human rights and threatens the health of everyone. In rural counties with large correctional facilities, for instance, COVID-19 cases spiked as a result of community spread.[33]

The COVID-19 pandemic, like all pandemics before it, has exploited the opportunities we created by allowing structural racism to pervade our approaches to protecting public health. We must use evidence-based approaches to determine the lattice of social and health policies that will create social justice in health for all.[34] It is also critical to investigate data quality standards that will contribute to equitable benefits from public health surveillance. A commitment to social justice demands renewing our efforts to advance equitable policies, approaches, and procedures in how we seek to ensure health for all. AJPH

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CONFLICTS OF INTEREST

All authors report no conflicts of interest.

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