

Gaps in Worker Protections that Increase Essential Workers' Exposure to COVID-19

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SUMMARY. States and localities designated more than 55 million Americans as essential workers. Essential workers not only comprise those employed by the health care and food and agriculture industry, but also include teachers, grocery store workers, transit and airline workers, mail and delivery workers, energy sector and utility workers, and domestic workers (Petition for Emergency, 2020). Racial and ethnic minorities are disproportionately employed as essential workers, with Black Americans the most likely to be essential workers (Petition for Emergency, 2020). Essential workers have been left vulnerable to workplace COVID-19 infections and deaths in large part due to the federal and state government's failure to enforce health and safety laws (Yearby, 2020). Volume I discussed the need to issue airborne infectious disease specific laws and regulations to prevent workplace COVID-19 infections and deaths. This Chapter will examine how the lack of protective equipment, punitive attendance policies, and the failure to track workplace infections have left essential workers vulnerable to workplace COVID-19 infections and deaths.

Introduction

During the pandemic, health care workers have provided critical medical care to patients; grocery store workers, farm workers, and meat processing workers have continued to feed the country; mass transit, transport, and airline workers have delivered essential goods; while utility and communications workers have sustained access to fundamental human needs of water, electricity, and internet (*Amalgamated Transit Union v. Azar*, 2020). These workers have continued to work during state and local stay-at-home and lockdown orders, despite being left without protection from workplace COVID-19 exposure. Many of these workers are racial and ethnic minorities.

Data from the U.S. Bureau of Labor Statistics shows that 38% of Black workers were employed in jobs deemed essential compared with 27% of white workers (Petition for Emergency, 2020). More specifically, "43% of Black and Latino workers are employed in service or production jobs that for the most part cannot be done remotely," while approximately 25% of white workers held such jobs (Petition for Emergency, 2020). In the health care industry, "Black workers are about 50% more likely to work in the health care and social assistance industry and 40% more likely to work in hospitals, compared with white workers," while in the food and agricultural industry a majority of workers are racial and ethnic minorities (Petition for Emergency, 2020). Consequently, racial and ethnic minorities have disproportionately been exposed to COVID-19

in the workplace because of structural inequities. Specifically, the government has failed to enforce health and safety laws and permitted essential business to remain open in spite of being sites of COVID-19 outbreaks, prioritizing the needs of employers above those of essential workers, which has resulted in increased workplace exposure to COVID-19.

For more information on Protecting Workers that Provide Essential Services, please see Chapter 26 in *Assessing Legal Responses to COVID-19: Volume I*. This Chapter will examine how the lack of protective equipment (PPE), punitive attendance policies, and the failure to track workplace infections have left essential workers vulnerable to workplace COVID-19 infections and deaths.

Worker Safety during COVID-19

As discussed in Volume I, the Occupational Safety and Health Administration (OSHA) and 21 states with OSHA-approved plans have the authority to require private employers to provide employees with personal protective equipment and develop a respiratory protection standard to prevent occupational disease (Respiratory Protection, 2019). Moreover, under the OSH Act, employers have a "general duty" to provide employees with a place of employment free from recognized hazards that are causing or likely to cause death or serious harm. Nevertheless, OSHA and many states have not ensured that essential workers are provided with PPE or a workplace free from recognized hazards.

Lack of Protective Equipment

During the pandemic, OSHA and many states with OSHA-approved plans have not used their authority under 29 C.F.R. § 1910.134 to require employers to provide employees with PPEs. For example, in Tennessee, a state with an OSHA approved plan, a health and safety official OSHA said in early May 2020 that, “the only standard sanitation requirement Tennessee OSHA can govern is that employers provide soap and water for employees” because, “by TOSHA standards, face masks are not considered personal protective equipment, and the standard does not require an employer provide them” (Massey, 2020). The failure to require face masks is contrary to the OSH Act that requires employers to provide personal protective gear, including respirators at no cost to the employee, to address respiratory issues, which cannot be addressed simply by washing one’s hands (Respiratory Protection, 2019). Thus, it is not surprising that during this time, the COVID-19 infections in Tennessee went from 163 on May 1, 2020 to 566 on May 23, 2020 as a result of infections among essential workers (Massey, 2020). The federal government has also failed to use the Defense Production Act of 1950 (DPA) to obtain PPEs for essential workers.

President Trump issued three executive orders to increase the adequate distribution of PPE to essential workers, alluding to the powers granted by the DPA, yet essential workers still lack adequate access to PPEs (Petition for Emergency, 2020). Executive Order (EO) 13909 authorized the Secretary of Health and Human Services (HHS) Azar in consultation with the secretary of commerce and the heads of other executive departments to prioritize and allocate PPE to respond to the spread of COVID-19. EO 13910 authorized Secretary Azar to designate PPEs as critical materials to prevent hoarding, while EO 13911 authorized Secretary Azar and the secretary of homeland security to expand production of PPEs using loans and loan guarantees as well as coordinating industry production through voluntary cooperation (Petition for Emergency, 2020).

Additionally, on April 2, 2020, President Trump issued a memorandum giving HHS Secretary Azar the authority to acquire, “from any subsidiary or affiliate of 3M Company, the number of N-95 respirators that the Administrator determines to be appropriate,” to respond to the spread of COVID-19. By April 7, 2020, the federal government had agreed to a deal with 3M to import more than 166 million N-95 respirators to the United States over a three-month period, while allowing 3M to still export respirators to Canada and Latin America. Nevertheless, many essential workers still remain without N-95 respirators or other personal protective gear, as illustrated by health care workers lack of access to PPEs.

Many health care workers who have requested access to PPE or spoken out about the lack of PPE have not only not received the PPE, but many have also been disciplined or fired. For example, a registered nurse and other colleagues filed multiple OSHA complaints regarding workplace safety violations at a Minnesota hospital. Although the hospital was eventually fined for failing to comply with the respiratory standard, the nurse was fired and the licensure board is investigating his conduct of wearing hospital supplied scrubs to protect himself from COVID-19 infection (Basen,

2020). An emergency physician in Washington state was also fired for publicly identifying the hospital’s failure to provide staff with adequate PPE and gaps in COVID-19 protections (Eldred, 2020). The retaliation and lack of PPE was so rampant in the health care industry that several medical societies, including the Council of Medical Specialty Societies that represents 800,000 physicians, issued statements urging the government to ensure that health care workers had adequate PPEs (Eldred, 2020).

Notwithstanding these actions, the EOs, and the memorandum, many essential workers still lack access to PPEs. Thus, on August 11, 2020, more than 30 leading labor unions and environmental groups representing more than 20 million workers and members, including the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO) and the Service Employees International Union (SEIU), submitted an Emergency Rulemaking Petition for access to PPEs “pursuant to the Administrative Procedure Act, 5 U.S.C. § 551, et seq. demanding” that the federal government, including HHS, invoke their delegated authorities under the DPA to manufacture and allocate PPE for the protection of essential workers (Petition for Emergency, 2020).

Essential workers access to PPEs did not improve after the petition was issued, and HHS did not use its powers to increase access to PPEs. Therefore, on October 8, 2020, the same 30 leading labor unions and environmental groups filed a complaint for declaratory and injunctive relief in the U.S. District Court for the District of Columbia challenging the federal government’s failure to use its powers to attain PPEs for essential workers (*Amalgamated Transit Union v. Azar*, 2020). Meanwhile, health care workers continue to be infected, which has severely harmed racial and ethnic minorities. For example, a National Nursing Union report from September 2020 showed that nurses of Filipino descent comprise 31.5% of nurse deaths from COVID-19, but only account for 4% of the nursing population.

Punitive Attendance Policies

Punitive attendance policies have also increased essential workers workplace exposure to COVID-19. Before the COVID-19 pandemic, some industries attendance policies were punitive. For example, meat and poultry processing companies’ issued points for workers that missed work. Workers that accumulated too many points were fired (Schlitz, 2020). These policies have persisted throughout the COVID-19 pandemic as some of the biggest meat and poultry processing companies (JBS, Smithfield, and Tyson) actively penalize workers for taking time off, even if it is for illness (Schlitz, 2020). Meat and poultry processing workers at Tyson and JBS note that they are required to go to work even if they are experiencing symptoms of COVID-19 or awaiting test results (Schlitz, 2020).

In fact, one Tyson plant does not approve prearranged absences for things such as testing, unless it does not affect the production needs of the plant. Furthermore, excused absences for COVID-19 are only given if a worker has physician documentation of a positive COVID-19 test, otherwise the worker is assessed points, which can be used to fire them (Brown, 2020). This was confirmed by JBS spokesperson Nikki Richardson, who noted that “points were not

assessed against team members for absences due to *documented illness*" (Brown, 2020).

For instance, at the JBS plant in Greeley, CO, where six workers died and 290 were infected with COVID-19 in July and 32 workers tested positive for with COVID-19 in November, 2020, the attendance policy allowed for six points for absences before firing, which was less than the seven and a half points allowed before the pandemic (Schlitz, 2020). Workers could only recoup points by getting physician documentation of a positive COVID-19 test and calling an English-only attendance hotline. This policy disproportionately harmed some racial and ethnic minorities, who do not speak English or have a physician to write the note (Schlitz, 2020). To address this problem, JBS promised to provide workers with free COVID-19 tests after COVID-19 outbreaks at the plant. However, instead, JBS offered the low-wage and uninsured workers COVID-19 tests at its plant if they paid \$100, which workers declined (Brown, 2020).

Punitive attendance policies are associated with increased rates of infection because many workers either cannot obtain physician documentation of a COVID-19 infection or fear being assessed points, and thus, they continue to go to work sick. Moreover, these punitive attendance policies seemingly contradict the OSH Act "general duty" standard. The policies encourage employees with COVID-19 symptoms to come to work, increasing workplace COVID-19 exposure, which is a recognized hazard causing or likely to cause death or serious harm, for healthy employees. It is hard to determine the full impact of these attendance policies on COVID-19 infections and deaths because OSHA and many states are not actively and accurately tracking workplace infections.

Failure to Track Workplace Infections

OSHA and many states have either not required employers to record and report employee's COVID-19 infections and deaths, or refused to release the information, which is necessary for contact tracing and surveillance. (Michaels, 2020; Pattani et al., 2020; Pfannenstiel, 2020). For example, nursing home residents account for 8% of all COVID-19 cases and more than 40% of all COVID-19 deaths in the United States, but there is no data regarding how many nursing home workers have been infected or died, because OSHA has let nursing homes decide whether to report the infections and deaths (Pattani et al., 2020).

Research shows that between 6% to 8% of all the COVID-19 cases and 3% to 4% of all COVID-19 deaths in the United States are tied to meat and poultry processing plants (Taylor et al., 2020). When the Centers for Disease Control and Prevention (CDC) issued a report in May 2020, there were 16,233 confirmed cases of COVID-19 infections for meat and poultry processing workers and 86 COVID-19 related deaths in 239 plants (Waltenburg, et al, 2020). Of the 9,919 (61%) cases with racial and ethnic data, 56% of COVID-19 cases occurred in Latinos, 19% occurred in non-Latino Black people, 13% in non-Latino whites, and 12% in Asians. Yet, even the CDC acknowledged that the actual numbers of COVID-19 infections and deaths for meat and poultry processing workers were probably higher because only 23 states submitted data and "only plants

with at least one laboratory-confirmed case of COVID-19 among workers were included" (Waltenburg, et al, 2020). Notwithstanding this report, the federal government is not regularly tracking these deaths and many states that have experienced COVID-19 outbreaks are not releasing the information as shown by Iowa, a state with an OSHA approved plan.

Prior to major COVID-19 outbreaks at meat and poultry processing plants, Iowa's policy was to publicly confirm cases. However, by May this changed when officials would only confirm outbreaks at businesses if 10% of a company's employees tested positive and reporters asked about the outbreaks (Pfannenstiel, 2020). This hampered reporting of cases and local officials' efforts to control infections as the state even limited information given to local officials, including Perry city officials, where it was later learned that 58% of employees tested positive at a Tyson plant in Perry city (Pfannenstiel, 2020).

In Missouri, when efforts to use private firms to track state employees infected with COVID-19 failed, the state health department issued a statement saying that many local health departments would no longer conduct contact tracing of positive tests. Instead, the state recommended that those who tested positive should contact close contacts on their own. However, this ignores the fact that state employees interact with numerous members of the public during work, and do not have the ability to contact these people.

The government's failure to use its authority under the DPA and health and safety laws to ensure that essential workers have access to PPEs, can stay at home when they are sick, and are contacted about workplace infections has left essential workers vulnerable to workplace exposure to COVID-19. As a result of the government's inaction, workers have continued to be unnecessarily infected and die from COVID-19. These structural inequities have disproportionately harmed racial and ethnic minorities, who make up a majority of essential workers, resulting in racial inequities in COVID-19 infections and deaths. To address these inequities, the government must not only increase enforcement, but also empower essential workers to participate in addressing workplace COVID-19 infections. 🌞

Recommendations for Action

These recommendations are based in part on state and local government examples. Virginia, California, and New Mexico “have issued emergency regulations to require employers to report COVID-19 cases, regardless of whether the infection results in hospitalization, so a rapid investigation can be made” (Michaels, 2020). California and Michigan require employers to provide employees with clean PPE, while the Los Angeles County supervisors unanimously approved a program “in which workers from certain sectors will form public health councils to help ensure that employers follow coronavirus safety guidelines” (Miller, 2020; Ball, 2020; Personal Protective Equipment, 2020). These laws and programs should be used as a model for changes in the governmental response. The Biden administration has already issued an executive order and a COVID-19 plan with recommendations to address these issues, but the recommendations are not mandatory. Below are some suggestions for mandatory laws and policies.

Federal government

President and Congress

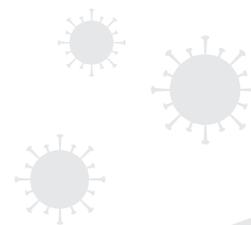
- Enact a national workplace safety law that includes an airborne infectious disease rule, which prohibits punitive attendance policies and requires employers to report COVID-19 infections and deaths to the CDC and state and local health departments.
- Create employee safety boards that advise the White House, Congress, OSHA, and the USDA in the creation, implementation, tracking, and evaluation of a national COVID-19 worker protection plan and agenda.
- Develop a national COVID-19 worker protection plan, which requires all employers to develop and implement infection control plans, and provides protection for workers who raise safety concerns.
- In COVID-19 economic relief bills, require states to use part of the money to invest directly in racial and ethnic minority communities severely and disproportionately impacted by COVID-19, including money for culturally appropriate and multilingual mental health services for those tested positive and their family members and friends.
- Make this testing data, which does not include individually identifiable information, publicly available and disaggregate by race, ethnicity, job duty, and occupation to determine businesses that are hotspots for COVID-19. This data should be readily accessible to the workers, state and local officials, and the media.

OSHA and States with OSHA Approved Plans

- Mandate testing of workers employed at essential businesses that are hotspots for COVID-19, including, but not limited to hospitals, long-term care facilities, meat and poultry processing facilities, farms, and food processing facilities.

State governments

- Enact a statewide workplace safety law that includes an airborne infectious disease rule, which prohibits punitive attendance policies and requires employers to report COVID-19 infections and deaths to the health department.
- Create employee safety boards that advise state, county, and local governments in the creation, implementation, tracking, and evaluation of a national COVID-19 worker protection plan.



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