Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

The Pandemic Challenge: End Separate and Unequal Healthcare

INTRODUCTION

Viruses do not care about income, wealth, insurance status, or color lines. Universal healthcare protects everyone by assuring that no one is blocked from getting care because of unaffordable out of pocket costs. As the only developed nation that has failed to provide such protection and where a growing population of 27.9 million are uninsured and roughly an equal number have inadequate coverage that still makes essential care unaffordable, we face greater risks.[1] Fifty-one percent of the uninsured population are either African American or Hispanic. The uninsured are more likely to delay testing and treatment. Amid the COVID-19 pandemic, this exposes everyone- insured, uninsured, rich, poor, and all racial and ethnic categories to greater risks. Proposals to address this vulnerability have been dead on arrival since before the last deadly pandemic swept across this country in 1918. The reason for the deaths of these proposals is so embedded into the structure of our existing health system that it tends to be overlooked. It is a way of thinking about the organization and financing of healthcare that evolved in the wake of the *Plessy v. Ferguson* Supreme Court "separate but equal" decision in 1896 that justified segregating services by race and privilege.[2,3,4] Jim Crow laws in the South, residential segregation laws in the North and patterns of medical practice that evolved adapting to these conditions shaped the development of our modern health system.[5,6] While the 1954 *Brown v. Board of Education* Supreme Court decision rejected the "separate but equal" argument, an accumulation of even less plausible euphemisms as strategies for preserving the segregated status quo left the health system largely unchanged.

Special interests stalled 5 major universal care initiatives over the past century invoking racially coded messages to gain broader public support. I summarize some of the details related to these efforts in a Table 1 and will focus here on how thinly veiled racially discriminatory excuses proved so effective in blocking all these efforts to achieve universal healthcare.

WE TAKE CARE OF OUR OWN (1896-1934)

In the shadow of *Plessy*, lodges and fraternal orders tried to take care of those who shared common racial and ethnic identities. The American Association of Labor Legislation during World War I sponsored state legislation to provide healthcare to industrial workers supported by matching funds from the state, the employers and the employees that had the muted support of organized medicine's national leadership.[7] Lodges had already begun providing such protection for their members and objected. They contracted with physicians to provide care for their members for a fixed amount per year. Despite the opposition of local medical societies, this approach to assuring access to care grew rapidly and many assumed it was the way most care would be financed in the future.[8] They saw no reason to undermine their influence in recruiting new members by substituting "compulsory governmental paternalism for private voluntary fraternalism." It was also easy to appeal to the broader aversion to racial and ethnic mixing that state legislation implied.

THE VOLUNTARY WAY IS THE AMERICAN WAY (1934-1954)

"Volunteerism," is the 19th century notion that charity could better be handled by private philanthropic efforts than government. The interests of hospitals and medical societies were protected by producer cooperative "voluntary" prepayment arrangements (Blue Cross and Blue Shield plans). These arrangements also helped end what organized medicine regarded as the "evils" of lodge medicine. While it could never cover those most in need of protection, it still offered as an illusory alternative to what was portrayed as the unpalatable "compulsory-government sponsored-socialistic" Social Security proposals of the Roosevelt and Truman Administration.[9] It also helped perpetuate segregation by delegating the care of those not eligible for employer-based insurance to the local indigent care system. The Roosevelt-Truman proposals never had a chance.

PEOPLE SHOULD BE FREE TO CHOOSE (1954-1973)

The Brown decision and the efforts of the civil rights movement, however, helped propel the passage of the Medicare and Medicaid legislation in 1965.[10] Hospital accommodations were desegregated using the leverage of this new federal funding to overcome the "freedom of choice" defense of the segregationists. If hospitals remained segregated, they argued, it was because people should always have the "freedom of choice." Federal officials rejected this argument and insisted on full integration of accommodations. However, that insistence generated a backlash that stalled expansion of this coverage to the rest of the population and partially re-segregated care.

COSTS MUST BE MANAGED (1973-1994)

Attention shifted, partly as an excuse for not expanding coverage to controlling rising costs. Payment methods changed to "control" those costs (e.g., Diagnostic Related Group hospital payments and Health Maintenance Organization (HMO) capitated payments to group practices). While neither succeeded in stemming cost

TABLE 1. How Jim Crow stalled universal healthcare initiatives.

	1896-1834	1934-1954	1954-1973	1973-1994	1994-Present
Strategies for preserving Jim Crow and blocking Universal Healthcare (UHC)	Self-Help Solidarity- The "We take care of our own" consumer adaptation to Jim Crow.	Volunteerism- "The Voluntary way is the American way" provider adaptation to Jim Crow.	Freedom of Choice No Government imposed integration-people should be "free to choose."	Cost Control- "Management is the solution" Segregation in the guise of cost control (e.g., HMOs and DRGs).	Privatization "Government is the problem"-Free market circumvention of integration and civil rights law.
Key special interest opponents of UHC	Lodges and Trade Unions	AHA and AMA	AMA and Southern Segregationists	Private Insurance Coalitions	Emerging private sector insurers, suppliers and providers.
UHC proposals and their outcomes	Model state legislation providing for shared financing by worker, employer and state of industrial workers- Failed (American Association of Labor Legislation)	National Universal Health Insurance funded by Social Security- Failed (Roosevelt and Truman)	Medicare- Social Security Act of 1965 - Coverage for those over 65- Passed but expansion to the rest of the population stalled. (Johnson)	The Health Security Bill- Expanded coverage through managed care networks- Failed (Clinton)	Affordable Care Act of 2010- Expanded Medicaid and private coverage, individually mandated coverage and preexisting condition protection. - Passed but future uncertain. (Obama)

increases, they did succeed in partially re-segregating care. State Medicaid programs became dominated by Medicaid only HMO plans and Diagnostic Related Group shifted much of the care that had been provided in acute hospitals back into more segregated communities.[11] The Clinton Health Security Act of 1994, relying heavily on HMO contracting in the face of rising opposition to such arrangements from those with private insurance never had a chance.[12]

GOVERNMENT IS THE PROBLEM AND PRIVATIZATION THE SOLUTION (1994-PRESENT)

Steps in expanding coverage subsequently followed the lead of conservative think tanks, expanding coverage but privatizing it. This did little to control costs but the more fragmented "free market" approach helped insulate the health system from civil rights challenges. The Affordable Care Act followed the privatization blueprint and succeeded in expanding coverage. However, since the Democrats and our first black president served as sponsors of the legislation it was now racially coded as "Obama Care" and has faced unrelenting political and legal challenges from the right.[13] It did nothing to alter the existing fragmented insurance system and its future survival is uncertain.

CONCLUSIONS

We are, in the face of the current pandemic, all in it together. No one disputes that the health of any individual depends on the heath of everyone. Perhaps this can lead organized medicine, a century long laggard in promoting universal care, to finally question the hollow rhetoric that has supported the status quo of Jim Crow healthcare. Something as simple as just a uniform payment structure would not just cut costs but help end the tiered segregated system of care that persists. Perhaps we can finally put an end to Jim Crow.

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