private markets may not restrain costs in health care as they do in other sectors. Patients frequently rely on professionals to decide what services are needed, and costs may not be a consideration for either patients or professionals. As the Covid-19 pandemic painfully reveals, in health care, markets can fail to allocate resources to meet health needs, preserve the quality of care, and achieve desired levels of access and equity.

In most high-income countries, governments fill the gaps where markets fail. For example, the United States provides insurance to elderly and disabled people (through Medicare) and poor people (through Medicaid) who could not afford it otherwise. But rather than operate facilities (as the government does for military veterans), the U.S. federal and state governments generally use purchasing and information-transparency strategies to try to foster competitive health care markets. Governments may also serve as a backstop, providing the dollars that keep private hospitals and professionals in operation during disasters (such as hurricanes or pandemics) or covering extreme costs for very sick patients through reinsurance to keep premiums from skyrocketing.

An audio interview with Dr. Schneider is available at NEJM.org

Americans are increasingly concerned about health care. Polls show that they are especially dissatisfied with the costs they face personally. Many Americans have begun to view high-quality health care as an opportunity available only to some people, a financial burden for many, and an unsafe and financially ruinous ordeal for others. But a health care system is not immutable. It can be changed through policies. In future articles in this series, experts will further describe the problems with quality, equity, and cost; explore solutions; and reflect on the policy levers that can help bring about reforms.

The Covid-19 pandemic reminds us that the dedicated health professionals delivering care every day are the indispensable part of any health system. Without their motivation and dedication, access to high-quality, equitable care would not be an option. But sound health policies are also indispensable. They shape the delivery system, strongly influencing whether someone like the elderly woman with chronic health problems and new and worrisome symptoms decides to suffer at home, delaying until it is too late, or seeks care when it can be most effective. And health policies set the terms under which health professionals can provide high-quality care that achieves her health goals at a price that she and society can afford.

Disclosure forms provided by the author are available at NEJM.org.

From the Commonwealth Fund, New York.

1. Churchill W. The Russian enigma. October 1, 1939 (http://www.churchill-society-london.org.uk/RusnEnig.html).
2. GBD 2015 Disease and Injury Incidence and Prevalence Collaborators. Global, regional, and national incidence, prevalence, and years lived with disability for 310 diseases and injuries, 1990-2015: a systematic analysis for the Global Burden of Disease Study 2015. Lancet 2016;388:1545-602.
3. Tikkanen RS, Schneider EC. Social spending to improve population health — does the United States spend as wisely as other countries? N Engl J Med 2020;382:885-7.
4. National healthcare quality and disparities reports. Rockville, MD: Agency for Healthcare Research and Quality.
5. Anderson GF, Hussey P, Petrosyan V. It's still the prices, stupid: why the US spends so much on health care, and a tribute to Uwe Reinhardt. Health Aff (Millwood) 2019;38:87-95.

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Covid's Color Line — Infectious Disease, Inequity, and Racial Justice

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The disproportionate effects of the Covid-19 pandemic on African Americans, Latinx Americans, and Native Americans is not unforeseen. Inequities in health, health care access, and quality of care are ingrained in the U.S. health care system. These inequities are not a sign of a broken system: in fact, in this sense, the system is operating just as it was built to operate. It promulgates poor health outcomes for Black and Brown people as an ineffable legacy of slavery. In New York City and other major metropolitan areas, Black and Latinx people have substantially higher Covid-19

incidence and age-adjusted death rates than Whites. American Indians and Alaska Natives have the highest age-adjusted hospitalization rates, followed by African Americans and Latinx people. Black people and other minorities who live in poverty, in dense conditions, on the street, or on reservations or who perform "essential" jobs are at unusual risk for infection.

The disparate burden and risk assumed by Black Americans in infectious-disease disasters began at the nation's birth. During the 1793 Philadelphia yellow fever epidemic, Benjamin Rush, physician and signer of the Declaration of Independence, believed on the basis of anecdotes that Africans had innate immunity. He reported that belief as fact, urging free Africans to perform nursing and other essential municipal duties.[1] Prominent Black ministers Absalom Jones and Richard Allen led the effort to care for the sick and bury the dead, using members of the Free African Society as essential workers. As it turned out, Africans died at rates similar to those for Whites. Nevertheless, Rush proclaimed that Africans had "lighter disease," which influenced the roles they were expected to play in later yellow fever epidemics.

When the 1918 influenza pandemic hit, Black Americans suffered from major health disparities. Legalized segregation and racism precluded equitable health care access for Black patients in White medical institutions. Black nurses struggled to provide care in Black hospitals but were also pressed into service at White hospitals. Segregation impaired collection of public health data, resulting in inaccurate reporting of the incidence and mortality for Black populations. Black Americans appeared to have lower incidence and mortality rates, which incorrectly and without evidence reinforced the notion that they had greater immunity. The incidence may have appeared lower in Black communities because of exposure to a milder initial wave of infection in the spring. Later reports document, however, that when they were infected, Black Americans had higher mortality than Whites owing to coexisting conditions.[2]

A century later, the Covid-19 pandemic finds African Americans still grappling with vestiges of slavery that endeavor to brand them as a permanent underclass. The pandemic is a stunning reminder of inequities in American life driven by structural racism. Many members of marginalized minority and immigrant communities are poor, have two or more coexisting conditions, and reside in conditions that impede social distancing. Many fill frontline jobs that cannot be done remotely. These jobs — in transportation, emergency response, health care, and agriculture — are essential for a functional society but pay near the minimum wage and do not compensate workers for the risks they incur.

Infectious outbreaks like Covid-19 are dynamic processes that accentuate weaknesses in our societal structure and social policies. While the most cited coexisting conditions associated with Covid-19 are hypertension, diabetes mellitus, and obesity — all highly prevalent among African Americans — we frequently fail to highlight the significant disparities in immune-system disease affecting African American and other minority communities. The prevalence of immune-disease disparities increases Covid-19 risk by layering one infectious disease vulnerability on another.

Minorities are generally affected by infectious diseases at disproportionately higher rates than the rest of the population.[3] Medical mistrust, limited health care access, and other factors lead to late diagnosis and suboptimal management of infectious diseases among vulnerable minority populations. Morbidity and mortality rates from HIV/AIDS in the United States are highest among African Americans, Latinx people, Native Hawaiians, and Pacific Islanders. In 2018, Black people accounted for 13% of the U.S. population but 42% of new HIV/AIDS diagnoses.[4] Our failure to provide high-quality care for HIV/AIDS among Black and other minority populations increases their risk not only for contracting Covid-19 but also for poor outcomes.

To extinguish the outbreak, we must confront and accept our individual and societal responsibility to respect and care for one another. It should be embarrassing to us that the excess burden of Covid-19 among Native Americans is so severe that Doctors without Borders, an international medical aid organization, has deployed to the Navajo Nation. We have neglected the medical needs of this Indigenous population. We often obfuscate issues of health inequity, health care inequality, or health disparities by blaming behavioral, educational, cultural, and psychological factors. But we need to disambiguate these factors and address root causes.

We must recognize and begin to dismantle the normalization and legitimization of race-based

actions that have advantaged White people and produced pervasive adverse outcomes for minorities. Now is the time to begin to build pathways to health equity as a long-term goal, since the United States ranks last on measures of health equity among industrialized nations in part because of racial injustice.[5]

In the short term, we need to expand free minority-neighborhood–based Covid-19 testing, reduce the time for reporting test results, increase tracking and tracing of contacts, and provide cost-free temporary housing to isolate non–critically ill and asymptomatic people with Covid living in densely crowded conditions where spread is likely. The National Institutes of Health has kickstarted this effort through its NIH Rapid Acceleration of Diagnostics Underrepresented Populations (RADx-UP) Initiative (www.nih.gov/research-training/medical-research-initiatives/radx/).

At the same time, biomedical researchers must include representative populations in Covid-19 studies. The disproportionate burden of Covid-19 on African American, Latinx, and Native American populations makes it ethically untenable to conduct or publish studies that do not clarify whether the variables being studied affect minorities differently. In addition, in anticipation of a Covid-19 vaccine, we must immediately address current racial and ethnic disparities in adult vaccination for preventable infectious diseases, including hepatitis B, influenza, and pneumococcal disease.[3]

In the time of Covid-19, health care delivery has been dramatically transformed by the implementation of telemedicine. The digital divide may exacerbate disparities in health care access and quality. Practitioners need to traverse this divide during their patient interactions, recognizing the barriers that may be present in minority populations.

Health care providers, health care organizations, and academic medical centers should consider how their attitudes, actions, management, and ignorance of the realities that shape the lives of minority populations contribute to health disparities. Many universities and medical centers held momentary campus gatherings showing solidarity with the racial justice protesters. Now is the time to use that protest as a springboard to develop policies to redress actions that have contributed to the dearth of minority physicians and the failure to develop and promote African American and other minority faculty, as well as a failure to support career development and higher pay for lower-level minority workers.

Health care organizations need to recognize and appreciate that African Americans, through their enslavement, built this country. Native Americans, the Indigenous people of this country, despite being driven from their lands and having their languages and cultures suppressed, have made extraordinary contributions to our freedom. The Latinx, the fastest-growing population group in the United States, are a vital workforce in every aspect of our economy. Congresswoman Shirley Chisholm once noted, "Most Americans have never seen the ignorance, degradation, hunger, sickness, and futility in which many other Americans live. . . . They won't become involved in economic or political change until something brings the seriousness of the situation home to them." We have now seen it, and we must act.

Disclosure forms provided by the author are available at NEJM.org.

From the National Institute on Aging, Baltimore.

1. Espinosa M. The question of racial immunity to yellow fever in history and historiography. Soc Sci Hist 2014;38:437-53.
2. Northington Gamble V. "There wasn't a lot of comforts in those days:" African Americans, public health, and the 1918 influenza epidemic. Public Health Rep 2010;125:Suppl 3:114-22.
3. Grief SN, Miller JP. Infectious disease issues in underserved populations. Prim Care 2017;44:67-85.
4. Centers for Disease Control and Prevention. Diagnoses of HIV infection in the United States and dependent areas, 2018 (preliminary). November 2019 (https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2018-preliminary-vol-30.pdf).
5. Davis K, Stremikis K, Squires D, Schoen C. Mirror, mirror on the wall, 2014 update: how the U.S. health care system compares internationally. New York: Commonwealth Fund, June 16, 2014 (https://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror-wall-2014-update-how-us-health-care-system).

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