Pediatrician, preventive medicine and public health physician Aletha Maybank MD, MPH, has taken on the task of leading the AMA’s new Center for Health Equity, which the AMA House of Delegates directed the Association to create as part of sweeping policy on health equity adopted at the 2018 AMA Annual Meeting.

Dr. Maybank comes well-prepared for her new position. She was founding director of the New York City health department’s Center for Health Equity. In that role, she led changes in the culture and public health practice of the health department by building the capacity of staff to better understand how their work advances or exacerbates health equity.

She also oversaw the rebranding of local district public health offices as Neighborhood Health Action Centers, renewing the agency’s commitment to neighborhood-based work and enhancing coordination of these efforts. In addition, she oversaw one of the first place-based community health worker efforts in New York City public housing.

Dr. Maybank took some time to answer three big questions about her role—and the AMA’s—in the struggle to ensure that all Americans have access to high-quality, affordable health care.

**AMA:** What is the distinction between ending racial and ethnic health care disparities and the newer goal that gives its name to your position—achieving health equity?

**Dr. Maybank:** Health equity and social determinants of health have become very popular terms over the past five to 10 years. Thankfully, many folks now recognize the importance and urgency of addressing health equity and social determinants of health to ensure that all communities reach their full health potential.

The challenge is that these terms that have become quite jargony and are not always well understood. Within the health care space, the focus of health equity work is heavily focused on what are the health disparities—which are differences in health outcomes, often among groups—which is
important, and this data guides us. However, disparities data alone does not provide social or historical context in terms of power and fairness.

The AMA defines health equity as “optimal health for all” and recognizes the importance and urgency of advancing health equity to ensure that all people and communities reach their full health potential. The World Health Organization defines health equity as the “absence of unfair and avoidable or remediable differences in health among social groups.”

This definition clarifies that inequities and disparities do not have to exist, that inequities are produced—they do not just happen—that the people who are marginalized experiencing the injustice are not to blame, and there is something that we can actually do to close the gap.

The questions are: How do we fully operationalize equity? How do we embed equity in thoughts, actions and processes and into all of the work that we do especially as institutions? In order to do this, we have to better understand the systems and structures—the laws and policies—that create, perpetuate or exacerbate these differences and inequities and then hold ourselves accountable as institutions to monitoring and analyzing our efforts in evolved ways that reflect the integration of health equity.

We must be willing to name powerful structures and systems that leave people behind and do not value everyone fully. That includes racism, which lies at the intersection of compounding oppressions such as patriarchy, cissexism, heterosexism and classism.

AMA: In March, Cedars-Sinai named its first chief health equity officer and last year the Veterans Health Administration named an executive director for its health equity office. Is a consensus yet emerging on what defines the role of the chief health equity officer?

Dr. Maybank: I would imagine there is not consistency yet. From my view, it moves us beyond simply talking about diversity and inclusion. Don’t get me wrong—diversity and inclusion are critical to achieve equity, and they are values that help root us in vision. Diversity and inclusion deepen innovation.

Yet focusing solely on diversity and inclusion too often blames individuals for the poor health outcomes they experience. We must look internally at our own institutions’ power and privilege and how we are making decisions to address health equity and social determinants of health. This all affects how we advance health equity in our external facing efforts.
My role is to facilitate a process to embed health equity across the AMA so that health equity becomes part of the practice, process, action, innovation, and organizational performance and outcomes. This is critical for sustainability as well as shifting critical consciousness on what advances equity as well as what produces inequities.

Working with others across the AMA, we will build a Center for Health Equity that will be an organizational home designed to elevate the importance of—and to sustain—the AMA’s health equity efforts. The best measure of our long-term success, and our most desired outcome, is meaningful, relevant and impactful inclusion of health equity into the strategic and operational objectives of the AMA.

Although the AMA and physicians cannot control all factors that need to change to achieve health equity, the AMA views its role to identify their importance and to urge those who can have a direct role to act.

AMA: You earned your medical degree in 2000. The most recent “National Healthcare Quality and Disparities Report”, issued by the U.S. Agency for Healthcare Research and Quality, finds that between 2000 and 2015, 45% of quality measures for black patients didn’t improve and 40% of quality measures were worse for African Americans compared with whites.

Care disparities for Hispanics, Asian Americans, American Indians and Alaska Natives, Native Hawaiians and Pacific Islanders have also persisted to a large degree in the 19 years since you became a physician. What will it take for the next 20 years to tell a different story?

Dr. Maybank: There are a few key considerations to keep in mind when answering this kind of question.

First, health equity remains an emerging field. It was only in 1985 that the federal government, under the leadership of Health and Human Services Secretary Margaret Heckler, published a landmark study, “Report of the Secretary’s Task Force on Black and Minority Health.”

The Heckler Report marked the first convening of a group of health experts who conducted a comprehensive study of people of color and health by the federal government. This was the impetus for launching the national Office of Minority Health a year later.

It is important to credit the work of W.E.B. DuBois, the sociologist and first African American to receive a PhD from Harvard. When he was still a student, he published “The Philadelphia Negro” in 1899, then followed with “The Health and Physique of the Negro American” in 1906. DuBois was one of the first to quantitatively and qualitatively document disparities in health as well as comment on the influence of where people, specifically former slaves, were able to live, work, play, and pray on their
health—commonly referred to as the social determinants.

The second consideration is that the fundamental cause of why health inequities exist is rooted in systems of unequal distribution of power. There is plenty of evidence to support this. In this country, our legacy of racism—a powerful system experienced at internalized, interpersonal, institutional and structural levels—is a root cause of inequities and at the intersection of classism and gender oppression.

Laws, policies and practices created by a small subset of folks in our country over hundreds of years have structured how culture is created and evolves, how we see people—and don’t see people—and how we make decisions that influence all aspects of our lives.

Contextualizing this history helps to inform the future public health and healthcare policy and practice. There exist 13 generations of legalized slavery, four of legalized segregation, and only two generations have lived in this relatively new period of being legally free. The way we view the big social issues of our time, and thinking about who is deserving and not deserving, from housing and education, to employment and health, is very much determined through this lens of racism.

All of our systems—education, housing, wealth and health—are deeply entrenched in this reality. Therefore, achieving health equity will not happen in a few months, days or years. However, we can all be on the path of moving in the direction of advancing health equity through listening, learning and pushing us all to do better for the sake of excellence and to ensure we value all lives. Then we will not only tell different stories but also see and experience different stories.

I see an opportunity for the AMA to move even more upstream—to expand the use of our power and platform to advocate more directly for the conditions that we know support living healthier lives, such as food security, housing affordability, stability and quality, transportation equity, and economic justice.