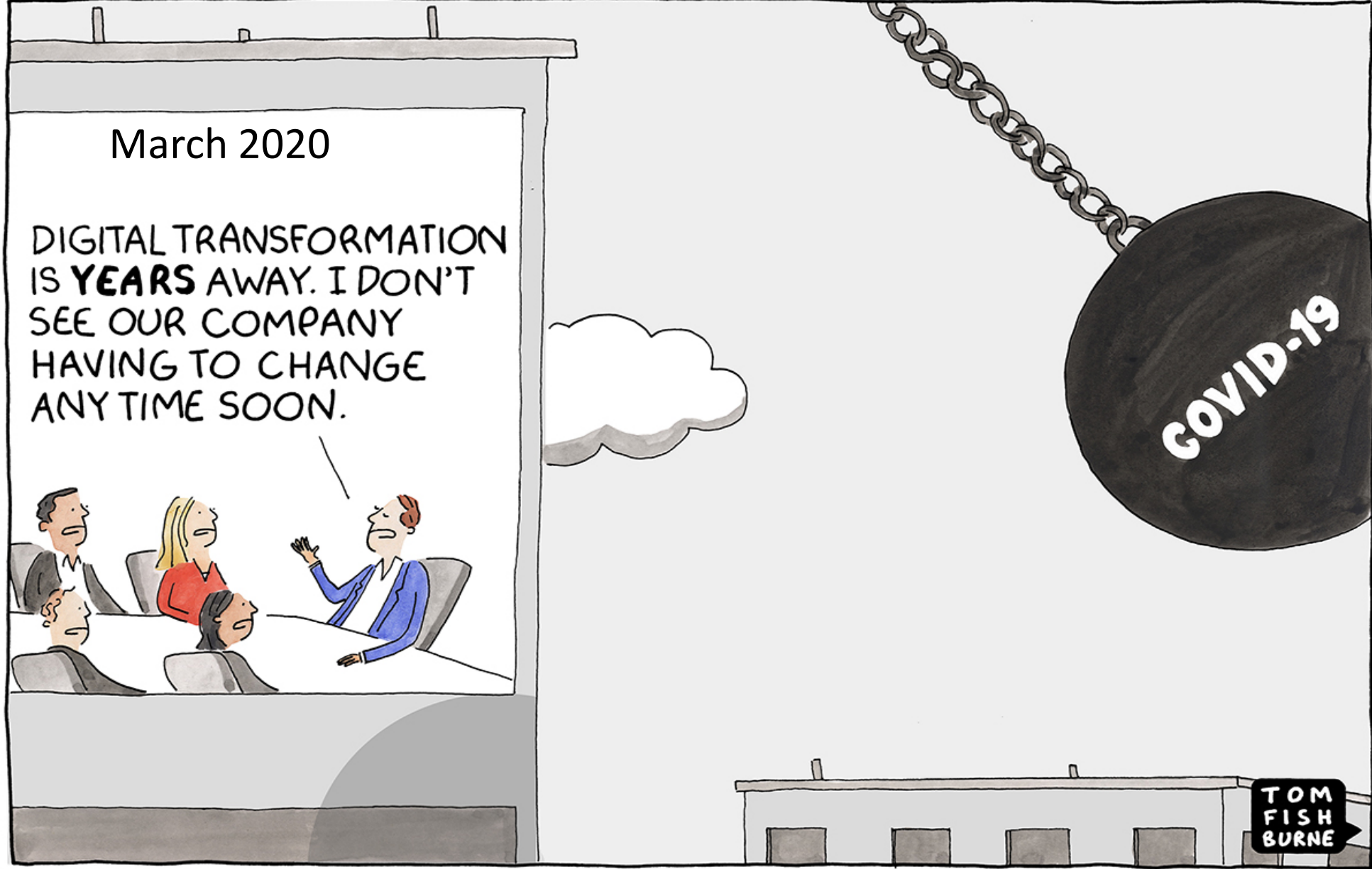




# Centering Equity

**Virtual 27th Princeton Conference Health Policy Innovation in an Era of Disruption**  
November 19, 2020

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**Chief Health Equity Officer, GVP**  
**American Medical Association**



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# Blacks, Latinx, and Native Americans are more likely to have and die from ‘underlying conditions’

Higher rates of

- Diabetes
- Obesity
- Hypertension
- Heart Disease

Not a sufficient explanation...



higher poverty  
higher household crowding  
higher racialized economic segregation

*“This pandemic is exacerbating deeply seated inequities rampant throughout our healthcare system and bearing witness to such, day in and day out, inflicts moral injury on healthcare workers every day.” – Asian Physician*

# Key Insights of Marginalized/Minoritized Physicians

- Generally a different experience for Black physicians compared to other physicians
  - Black physicians least likely work in practice settings with enough PPE for all frontline health care workers.
  - Black physicians report seeing more COVID-19 patients proportionately but report less access to PPE, COVID-19 testing and treatment than other physicians.
  - Black physicians more likely to report burnout since onset of COVID-19.
  - Black physicians more likely to report patients' lack of ability, knowledge or resources to receive care via telehealth as a barrier.
- Black and Latinx physicians more likely to report their ability to test for and treat COVID-19 is hampered by a lack of resources within their practice.
- Latinx, Asian and Black physicians more likely to report knowing other physicians that passed from COVID-19.
- Black and Asian physicians most likely to agree that the COVID-19 pandemic has highlighted the existing health inequities
- Mental health outcomes related to depression, anxiety and suicidal ideation associated with COVID-19 have increased dramatically for LGBTQ+ physicians

*Taken from AMA Research Study 5/2020 – 6/2020*

# Critical questions to center equity: How do we ensure our efforts and innovation do not discriminate, exacerbate inequities, or deny care?



What's the data? What does the data tell us? What data are missing?  

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How have communities (physicians, patients, etc.) been engaged?

Are there opportunities to expand engagement?  

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Who benefits from or will be burdened by your proposal?

What are your strategies for advancing equity or mitigating unintended consequences?  

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Who holds the decision-making power and privilege?

Are there opportunities to share/shift power?  

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How will you ensure accountability to communicate, and evaluate results?

*Adapted from the Racial Equity Toolkit: An Opportunity to Operationalize Equity – Gov't Alliance on Race and Equity*

# COVID-19 Health Equity Resource Center

## NYT Op-ed



## Oprah COVID -19 Series

**Dr. Aletha Maybank** @DrAlethaMaybank · Apr 14  
Thank for gift & opportunity @Oprah to elevate racism in health. Thank you for shining light to make injustice visible. #COVID19

**Oprah Winfrey** @Oprah · Apr 14  
@DrAlethaMaybank founded the first center for health equity for the @AmerMedicalAssn. She seeks to provide underserved populations across the country with resources & access to quality healthcare. Thank you for your work #OprahTalks #COVID19



## JAMA Article

**VIEWPOINT**

### Responding to the COVID-19 Pandemic: The Need for a Structurally Competent Health Care System

**Jonathan M. Merrill, MD, PhD**  
Departments of Medicine, Health, and Society, Vanderbilt University, Nashville, Tennessee

**Aletha Maybank, MD, MPH**  
Chief Health Equity Officer, American Medical Association, Chicago, Illinois

**Fernando de Melo, PhD**  
Center for Health Equity, American Medical Association, Chicago, Illinois, and Department of Sociology, DePaul University, Chicago, Illinois

The coronavirus disease 2019 (COVID-19) pandemic has exposed the consequences of inequality in the US. Even though all US residents are likely equally susceptible to infection with SARS-CoV-2 (severe acute respiratory syndrome coronavirus 2), the virus that causes COVID-19 disease, the resulting illness and the distribution of death/infections systems of discriminatory housing, education, employment, earnings, health care, and criminal justice.<sup>1-3</sup> The patterns of COVID-19 illuminate centuries of support systems that the US did not build and investments it did not make.

Each stage of the pandemic, from containment, to mitigation, to reopening, highlights the extent to which certain populations were rendered vulnerable long before the virus arrived. As a result, marginalized, racialized, and communities of low wealth have been at highest risk, with disproportionate death rates among African Americans, Latinos, and Native American populations across the US.<sup>1,4</sup>

Sociodemographic differences in COVID-19 morbidity and mortality highlight an unavoidable reality facing the US health care system as it strives to fulfill its mission to promote health and well-being, and to treat disease. At its core, the practice of medicine is based on individual-level interactions among clinicians, patients, and families. Yet the pandemic highlights the extent to which illness for many people results from larger structures, systems, and economies.<sup>5,6</sup>

harmful social conditions that fundamentally shape pandemic patterns.<sup>7</sup>

Over the coming months and years, the US health care system will struggle to adapt to new, post-pandemic norms. In the moment of crisis, however, the US health care system has a generational imperative to begin to address the inequities made even more apparent by the COVID-19 crisis. The opportunity exists to reimagine and redesign the health care delivery and education systems through a lens of health equity and racial justice. By so doing, during a pandemic that highlights the extent to which no one is safe until everyone is safe, health outcomes can be improved more broadly.

Increasing numbers of US medical students and physicians are already acclimated to understanding the importance of confronting inequities because many have been trained to understand the social determinants of health and its clinical adaptation, structural competency. Structural competency calls on methods from sociology, economics, urban planning, and other disciplines to systematically train health care professionals and others to "recognize ways that institutions, neighborhood conditions, market forces, public policies, and health care delivery systems shape symptoms and diseases."<sup>8</sup> Structural competency is also relevant for identifying the often-invisible networks that support health, ranging from supply chains, to food delivery networks, to transit systems.

**Prioritizing Equity:**

**The Experience of Physicians of Color and COVID-19**

Thursday, April 2, 2020  
7 pm ET

Guests:

Aletha Maybank, MD, MPH  
Chief Health Equity Officer  
American Medical Assoc.  
Moderator

Oliver Brooks, MD  
President  
National Medical Assoc.

Patricia Harris, MD, MA  
President  
American Medical Assoc.

Elena Ross, MD, MSPH  
President & CEO  
National Hispanic Medical Assoc.

Sackhar Wiscott, MD, MPH  
Assoc. of American Indian  
Physicians representative  
American Medical Assoc.

Winston Wong, MD, MS, FAAP  
Chairman  
National Council on  
Asian Pacific Islander Physicians

**Prioritizing Equity:**

**COVID-19 & the Experiences of Medical Students**

Thursday, May 7, 2020 | 6:00 p.m. CT

Alec Calac  
UC San Diego Chapter President  
Assoc. of Under American Medical Students  
UC San Diego School of Medicine  
@AMMSD1919

Alex Lindqvist  
CSJ National Chair  
Assoc. of American Medical Colleges  
Dartmouth School of Medicine  
@AMACtoday

Osone Olosh, MPH  
President  
Student National Medical Association  
MSU College of Human Medicine  
@SNMA

Sarah Mae Smith  
Board of Trustees  
American Medical Association  
UC Irvine School of Medicine  
@AmaMedicalAssn

Yinyi Wu  
National President  
Asian Pacific American Medical Student  
Medical College of Wisconsin  
@APAMSA

#AMAHealthEquity

# AMA Equity-Focused Advocacy Efforts

- Requested relief provisions on the **COVID-19 relief bill on inequities** affecting racial, ethnic and marginalized communities
- Called on the administration and Congress to **promote health equity by collecting and releasing demographic data** to help address any potential race/ethnicity, gender, and age disparities during the pandemic
- Submitted a written statement to Congress on the disproportionate impact of COVID-19 on people of color
- Testified at a hearing titled “Health and Wealth Inequality in America: How COVID-19 Makes Clear the Need for Change” Reducing regulatory impediments
- Urged **broad telehealth expansion** and improved payments (and parity) at the federal and state levels to increase access to care
- Urged U.S. Immigration and Customs Enforcement (ICE) to **release all children together with their parents and caregivers from ICE-run family residential centers**
- Urged the administration to consider J-1 and H-1B **International Medical Graduates (IMGs)** and their families’ entry into the U.S. to be in the national interest of the country
- Ensure **fair and equitable allocation of vaccines**; and appropriate prioritization of vaccines to high-risk groups, including physicians



# Earlier this week...AMA House of Medicine

Passed and Adopted Policies on:

- Name and act on **Racism as a Public Health Threat**
- Rid our healthcare system of **Racial Essentialism**; recognize race as a social, not a biological, construct
- Support the elimination of **Race as a Proxy for Ancestry, Genetics, & Biology in MedEd, Research, & Clinical Practice**

WE, THE BOARD OF TRUSTEES, STATE THAT:

The AMA recognizes that racism in its systemic, structural, institutional, and interpersonal forms is an urgent threat to public health, the advancement of health equity, and a barrier to excellence in the delivery of medical care.

The AMA opposes all forms of racism.

The AMA denounces police brutality and all forms of racially motivated violence.

The AMA will actively work to dismantle racist and discriminatory policies and practices across all of health care.



# Policies need to have an anti-racist, structural justice lens

- Health is a human right (“anti-racism is its right bearer”)
- Universal health care
- Diversify the health-care workforce; training inclusive of awareness of racism
- Establish of systems that collect and look at health outcome data by race and ethnicity as well as how racism may be operating (eg, discrimination)
- Implement medical training and competency that includes not only an awareness of racism but also how to address it
- Establish performance standards related to structural racism and equity for health-care systems
- Advocate for equitable innovation in design and workforce
- Advocate for patients unjustly impacted by health inequities, police brutality and for affordable housing, no-cost education, jobs, paid leave

Crear-Perry J, Maybank A. Moving towards anti-racist praxis in medicine. *Lancet*. 2020 15-21 August; 396(10249): 451–453.



**Physicians' powerful ally in patient care**