SECTION 8: Leadership for Health Equity

This guide was originally developed with a specific audience in mind: professionals within the Delaware Division of Public Health (DPH). However, the strategies needed for advancing health equity require partnerships across many different kinds of organizations and disciplines. Similarly, public health practitioners and advocates work in many different kinds of non-profit organizations, not solely within state agencies. For these reasons, the title, purpose, and contents were adapted accordingly, with the target audience broadly defined as public health practitioners and partners. These groups were identified, in part, because of their roles as leaders in advancing health equity.

Leadership can be defined in many different ways. For the purposes of this guide, "leadership is a process whereby an individual influences a group of individuals to achieve a common goal" (Northouse, 2007, p. 3). This definition is important as it draws attention to leadership as an action instead of a trait possessed by an individual. This means that leadership is about interactions between people and implies that leadership is available to everyone and is not restricted to people with innate or special characteristics (Northouse, 2007, pp. 3-4). Finally, this definition highlights the importance of influence since mobilizing others to reach a common goal is central to the concept of leadership.

> *"Leadership is a process whereby an individual influences a group of individuals to achieve a common goal" (Northouse, 2007, p3).*

With respect to this guide, the common goal is to promote health equity. More specifically, DPH's vision is for all Delawareans to achieve their full health potential. The various strategies and recommendations outlined in this guide are meant to move Delawareans closer to this common goal. However, as noted by Dr. Rattay in her foreword, these kinds of changes will not be easy. Achieving health equity is challenged, in part, by the fact that health inequities are caused by multiple factors such as access to resources, discrimination, and health-related behaviors operating on multiple levels (e.g. individual, neighborhood, state, etc.). There is not always agreement about who is responsible (e.g. individuals or societies/governments) or what should be done to addressthem. These characteristics suggest that health inequities may be defined

as a "wicked problem." A wicked problem is a social problem that is difficult[8] to solve for a number of reasons, including:

- Wicked problems are difficult to clearly define.
- Wicked problems have many interdependencies and are often multi-causal.
- Attempts to address wicked problems often lead to unforeseen consequences.
- Wicked problems are often not stable.
- Wicked problems usually have no clear solution.
- Wicked problems are socially complex.
- Wicked problems hardly ever sit conveniently within the responsibility of any one organization.
- Wicked problems involve changing behavior.
- Some wicked problems are characterized by chronic policy failure (Australian Public Service Commission, 2007, pp. 3-5).

Creating meaningful change to address the wicked problem of health inequities and advance health equity requires leadership of public health practitioners and partners alike. In particular, collaborative leadership will be required to achieve health equity. Among other things, collaborative leaders build broad-based support, engage with coalitions, empower and catalyze systems change, work across boundaries, and demonstrate a sustained commitment to a collective vision. Collaborative leaders build upon the theory of "collective impact," which is the synergy that can result from organizations working together towards common goals (Kania & Kramer, 2011).

No single organization can create large-scale, lasting social change alone. Therefore, addressing the multiple determinants of health requires working across sectors. Organizations working across sectors and at the community level to tackle multiple determinants of health will likely engage in various activities, all of which may occur simultaneously. For more information about wicked problems and collaborative leadership, see materials from the Australian Public Service Commission (2007) and Beinecke (2009).

[8] Wicked problems are often described as impossible to solve, but we, the authors of this guide, believe that health equity is attainable.

Section 8 briefly highlights some of the important leadership roles needed by different kinds of organizations working across Delaware. Many of the organizations highlighted earlier (and others that were not) are demonstrating collaborative leadership, but more is needed to achieve health equity in Delaware. This section concludes with a discussion of the role that individuals, especially individuals with privilege, can play as leaders to advance health equity in Delaware and beyond.

Public Health Practitioners and Organizations as Leaders

Public health organizations—whether they are community-based organizations, health care providers, or governmental agencies—have an important leadership role to play in advancing health equity. As the experts on health, causes of poor health, and interventions to improve health, public health professionals have "legitimate power" which can be used to influence others (Northouse, 2007). This is particularly important when working across sectors, as their health-related knowledge and expertise are considered the most credible. Public health professionals can use this legitimate power to inform policy and implement practices that are likely to positively impact health and health equity. Medical doctors, for example, are often seen as credible sources of health-related information and can use their legitimate power to lend support for equity-oriented initiatives, while encouraging others to do the same.

Health professionals can also lead by making changes within their own organizations. According to the National Collaborating Centre for Determinants of Health (2013), health equity-oriented changes can be applied to every aspect of how a public health organization operates. At the program level, a health equity lens can be applied to how needs are assessed and programs are planned, implemented, and evaluated (as discussed in Section 7). Practically, this includes reviewing whom the services are reaching and/or who is benefitting from the programs, and who is not being reached. This may include ensuring that individuals from communities that experience disadvantages are involved in the planning and evaluation of programs that affect them.

At the organizational level, a health equity lens can influence how priorities are set and how resources are allocated. State and local health departments can begin by undertaking an organizational self-assessment for addressing health inequities (Bay Area Regional Health Inequities Initiative, 2010; Bay Area Regional Health Inequities Initiative, 2014). Conducting such an assessment helps organizations identify internal areas for change. Examples of organizational level changes include things like changing hiring practices to recruit and retain more racial and ethnic minorities, incorporating more staff training on culturally competency, and adapting grant/contract funding mechanisms that require bidders to specifically address health inequities in their proposals. Additionally, hospitals can direct their community benefit

resources to communities most in need and other health-related organizations can incorporate an equity lens into their strategic planning processes.

Leadership from public health agencies is particularly important in relation to policy change and advocacy. (For examples of health equity-oriented policy changes across many sectors, visit Section 6.). While these examples are based upon scientific evidence linking environmental and social conditions to health, policy change is rarely a rational process driven by science. Even the existence of a strong evidence base is often insufficient to change policy; therefore, policy change requires advocacy.

Advocacy is simply defined as the process through which an individual or group tries to influence policy. The term advocacy often takes on a negative connotation, and many public and non-profit health professionals shy away from engaging in the political process. In some instances, professionals are legally prohibited from engaging in certain forms of advocacy, but there are often opportunities for health professionals to play a role tangent to advocacy. Health professionals can consider their role in interpreting and communicating what has been learned through public health research with the public and policymakers as a form of research translation. It is common for public health practitioners to encourage people to prevent obesity and related conditions by becoming more physically active and eating more nutritious diets, which are behavioral changes based upon scientific evidence. Advocacy of this nature can similarly be applied to the social determinants of health. As one expert noted:

> "We really have to re-explore what are the limits of our advocacy…what are we willing to take a stand on and say it is good for the public health, like prenatal care and WIC [Women, Infants, Children]… Can we expand that kind of health advocacy to include housing and poverty?" (Knight, 2014, p. 192).

Raising awareness about the social determinants of health (SDOH) is a form of education, but it can also be a form of advocacy. Being proactive about such advocacy, including having a well-developed communications strategy, can be particularly effective when partnering with others who can engage in stronger forms of advocacy, such as the newly formed Delaware Public Health Association (see http://de-pha.org/).

Authentic partnerships with community-based organizations and other state agencies are critical for advancing health equity. This truth holds in regard to advocacy, as well. Representatives from state agencies must support both internal and external partners to advance shared goals. Public health leaders should accept that it is not always necessary to make stakeholders aware of the health implications of a given proposal or policy action. For instance, ensuring ongoing support at the state level for affordable, quality early care and education could be viewed through the lens of health equity. However, public health advocates

can support early care and education initiatives without drawing attention to the health impacts. Sometimes raising awareness of the health impacts can broaden the base of support, but it can also unnecessarily complicate the debate. Unfortunately, there are no hard rules about when to raise health-related concerns and when to support partners' efforts from the sidelines. Involvement must be considered on a case-by-case basis.

Understandably, health equity-related work may require that the public health workforce develop new skills, knowledge, and competencies. In addition to this guide's many resources, several online training programs support public health organizations and individual practitioners in this regard, including:

- The Roots of Health Inequity: A web-based course for the public health workforce, (NACCHO, 2011) retrieved from http://www.rootsofhealthinequity.org/.
- PH101 Dialogue Series from the Alameda County Public Health Department (2009) retrieved from http://www.acphd.org/social-and-health-equity/organizational-transformation/trainings-and-dialogues/ph101.aspx.
- Addressing Health Equity: A Public Health Essential from the Empire State Public Health Training Center (2012) retrieved from http://www.phtc-online.org/learning/pages/catalog/equity/default.cfm.

Other Kinds of Organizations as Leaders

Leadership for health equity can reside within organizations not explicitly focused on health. This is largely due to health equity being about fairness and justice and indistinguishable from equity in general (Knight, 2014, p. 191). Therefore, the common goal or vision may be expanded to encompass social justice broadly. The need for collaborative leadership speaks to the value of having many kinds of community-oriented efforts working towards social justice. Furthermore, organizations that recognize the value of collective impact (described in Section 4) and help to facilitate collaborative, community-based efforts, can be leaders in advancing health equity. For more information about how to bring an equity lens to collective impact, see Williams & Marxer, 2014.

It is also important to recognize that not all changes need to be part of a large, coordinated strategy. Creating the kinds of social and cultural shifts that are necessary for health equity requires changes on all levels. Small changes matter, many different groups can play a part, and leadership comes in different shapes and sizes. Another way to view this is that effective leadership can be task-specific. For example, individuals working in organizations can consider ways to promote health equity as tasks or decisions arise. The University of Delaware (UD) educates many students who will secure jobs and remain in Delaware after graduation.

Whether they work in a health-related organization or discipline or not, their understanding of SDOH and awareness of the magnitude and nature of health inequities in Delaware is important to advance health equity. For this reason, the *Introduction to Public Health* class at UD, which is open to the entire student body, incorporates a strong focus on these issues. This was a conscious decision on the part of the instructor (who is also the lead author of this guide). Other examples include when individual business owners choose to pay their employees a living wage, or when faith-based organizations partner with each other to promote understanding and tolerance. Each of these decisions and actions can contribute to broader social and cultural changes, ultimately moving the state closer to the vision of health equity.

Individuals as Leaders

Leadership is generally ascribed to individuals or groups of individuals. Power is also a concept closely tied to leadership since it is related to the process of influencing others (Northouse, 2007). Because leadership is a process open to everyone, each person has the potential power to make change.

The idea that individuals possess power to influence change is important because the root causes of health inequities are often tied to differences in power and privilege among different groups of people. As mentioned in Section 2 (page 37), the complicated and uncomfortable discussion about class and power that underlie social inequities and injustices is purposely omitted from this guide in favor of more tangible steps. The kinds of social and political changes needed to address issues such as institutional racism and other forms of structural discrimination do not lend themselves to a "how to" guide. However, it is important not to lose sight of the various systems of oppression that are deeply embedded in our culture. For example, our culture tends to value males over females, Whites over Blacks, heterosexual individuals over homosexual or bisexual individuals, young over old, and able-bodied individuals over those with disabilities. Unfortunately, "built into the very fabric of our society are cultural values and habits which support the oppression of some persons and groups of people by other persons and groups. These systems take on many forms but they all have essentially the same structure" and are root causes of health inequity (Just Conflict, n.d.).

Although part of the broader, wicked problem of social injustice and inequity, there are practical daily steps that individuals can take to contribute to positive social change. Individuals can work toward social justice and promote health equity by being an "ally." Social justice allies are "members of dominant social groups (e.g., men, Whites, heterosexuals) who are working to end the system of oppression that gives them greater privilege and power based on their social-group membership" (Broido, 2000, p. 3). Allies work *with* those from the oppressed group in collaboration and partnership to end the system of oppression (Edwards, 2006, p. 51). Frances

Kendall, an author and consultant for organizational change specializing in issues of diversity and white privilege (see www.franceskendall.com), explains this more simply:

> "Those of us who have been granted privileges based purely on who we are born (as white, as male, as straight, and so forth) often feel that either we want to give our privileges back, which we can't really do, or we want to use them to improve the experience of those who don't have our access to power and resources. One of the most effective ways to use our privilege is to become the ally of those on the other side of the privilege seesaw. This type of alliance requires a great deal of self-examination on our part as well as the willingness to go against the people who share our privilege status and with whom we are expected to group ourselves" (Kendall, 2003).

Being an ally is a unique form of collaborative leadership. Kendall offers a number of recommendations and examples for how to be an ally. These are reproduced as Figure 31, with permission from Kendall. Note that the examples provided focus largely on the oppression of Black individuals and are geared towards individuals with the privilege of having white skin. However, the recommendations are applicable to many forms of social and economic privilege and systems of oppression.

Figure 31: How to be an Ally

1. **Allies** work continuously to develop an understanding of the personal and institutional experiences of the person or people with whom they are aligning themselves. If the ally is a member of a privileged group, it is essential that she or he also strives for clarity about the impact of privileges on her or his life. What this might look like:
   - Consistently asking myself what it means to be white in this situation. How would I experience this if I were of color? Would I be listened to? Would I be getting the support I am getting now? How would my life be different if I were not white/ male/ heterosexual/ tenured/ a manager?
   - Closely observing the experiences of people of color in the organization: how they are listened to, talked about, promoted, and expected to do additional jobs.
2. **Allies** choose to align themselves publicly and privately with members of target groups and respond to their needs. This may mean breaking assumed allegiances with those who have the same privileges as you. It is important not to underestimate the consequences of breaking these agreements and to break them in ways that will be most useful to the person or group with whom you are aligning yourself. What this might look like:
   - Speaking out about a situation in which you don't appear to have any vested interest: "Jean, there are no women of color in this pool of candidates. How can we begin to get a broader perspective in our department if we continue to hire people who have similar backgrounds to ours or who look like us?"
   - Interrupting a comment or joke that is insensitive or stereotypic toward a target group, whether or not a member of that group is present. "Lu, that joke is anti-Semitic. I don't care if a Jewish person told it to you; it doesn't contribute to the kind of environment I want to work in."
3. **Allies** believe that it is in their interest to be allies and are able to talk about why this is the case. Talking clearly about having the privilege to be able to step in is an important educational tool for others with the same privileges. What this might look like:

- Regularly prefacing what I am about to say with, "As a white person, I [think/ feel/ understand/ am not able to understand...]" By identifying one of my primary lenses on the world I let others know that I am clear that being white has an impact on how I perceive everything.

4. **Allies** are committed to the never-ending personal growth required to be genuinely supportive. If both people are without privilege it means coming to grips with the ways that internalized oppression affects you. If you are privileged, uprooting long-held beliefs about the way that the world works will probably be necessary. What this might look like:
    - Facing in an on-going way the difficult reality of the intentionality of white people's treatment of people of color, both historically and currently. In order to be an ally, I must hold in my consciousness what my racial group has done to keep us in positions of power and authority. This is not about blaming myself or feeling guilty. In fact, I think guilt is often self-serving; if I feel terribly guilty about something, I can get mired in those feelings and not take action to change the situation. Staying conscious of our behavior as a group moves me to take responsibility for making changes. It also gives me greater insight into the experiences of those with whom I align myself.
5. **Allies** are able to articulate how various patterns of oppression have served to keep them in privileged positions or to withhold opportunities they might otherwise have. For many of us, this means exploring and owning our dual roles as oppressor and oppressed, as uncomfortable as that might be. What this might look like:
    - Seeing how my whiteness opened doors to institutions that most probably would not have opened so easily otherwise. Understanding that as white women we are given access to power and resources because of racial similarities and our relationships with white men, often at the expense of men and women of color. While we certainly experience systemic discrimination as women, our skin color makes us less threatening to the group which holds systemic power.
6. **Allies** expect to make some mistakes but do not use that as an excuse for inaction. As a person with privilege, it is important to study and to talk about how your privilege acts as both a shield and blinders for you. Of necessity, those without privileges in a certain area know more about the specific examples of privilege than those who are privileged. What this might look like:
    - Knowing that each of us, no matter how careful or conscious we are or how long we have been working on issues of social justice, is going to say or do something dumb or insensitive. It isn't possible not to hurt or offend someone at some point. Our best bet is to acknowledge to others our mistakes and learn from them.
    - Keeping a filter in your mind through which you run your thoughts or comments. Remarks such as, "If I were you..." or "I know just how you feel..." are never very helpful in opening up communication, but, in conversations in which there is an imbalance of privilege, they take on an air of arrogance. People with privilege can never really know what it is like to be a member of the target group. While I can sympathize with those who are of color, it is not possible for me truly to understand the experience of a person of color because I am never going to be treated as they are. The goal is to show someone you are listening, you care, and you understand that being white causes you to be treated differently.
7. **Allies** know that those on each side of an alliance hold responsibility for their own change, whether or not persons on the other side choose to respond or to thank them. They are also clear that they are doing this work for themselves, not to "take care of" another. What this might look like:
    - Examining continually the institutional and personal benefits of hearing a wide diversity of perspectives, articulating those benefits, and building different points of view into the work we do.
    - Interrupting less-than-helpful comments and pushing for an inclusive environment. We do it because we, as well as others, will benefit. We do not step forward because we think we should or because the people without our privileges can't speak for themselves or because we want to look good. We are allies because we know that it is in our interest.
8. **Allies** know that, in the most empowered and genuine ally relationships, the persons with privilege initiate the

change toward personal, institutional, and societal justice and equality. What this might look like:

- Assessing who is at least risk to step into a situation and initiate change, conferring with others who are at greater risk about the best strategies, and moving forward. Our moves should be carefully designed to have the greatest impact.
- Understanding that this is not another opportunity to take charge. Ally relationships are just that: relationships. Together with the people who aren't privileged, we choreograph who makes which moves and when they will be made.

9. **Allies** promote a sense of inclusiveness and justice, helping create an environment hospitable for all. What this might look like:
   - Recognizing the expectation that people of color will address racism, women will take care of sexism, and gay men and lesbians will "fix" heterosexism in the organization and, in their stead, becoming the point person for organizational change on these issues. Clues that this assumption is operating include: the Diversity Committee is composed predominantly of people of color and white women, while those with greater decision-making power are on the "important" committees; or the majority of people pushing for domestic partner benefits are gay or lesbian.
10. **Allies** with privilege are responsible for sharing the lead with people of color in changing the organization and hold greater responsibility for seeing changes through to their conclusion. *Sharing* the lead is very different form *taking* the lead. What this might look like:
    - Working to build a strategic diversity plan for the organization, tying it to the organization's business plan, and assuring that the plan is implemented.
    - Assessing current policies and procedures and changing them so that they don't differentially impact groups of people.
11. **Allies** are able to laugh at themselves as they make mistakes and at the real, but absurd, systems of supremacy in which we all live. As many oppressed people know, humor is a method of survival. Those with privilege must be very careful not to assume that we can join in the humor of those in a target group with whom we are in alliance. What this might look like:
    - Appreciating that there are times when laughing together is the only thing we can do.
    - Paying attention to the boundaries of who-can-say-what-to-whom: While it may be OK for a person of color to call me his "white sister," it would be presumptuous for me to call him my "Latino brother."
12. **Allies** understand that emotional safety is not a realistic expectation if we take our alliance seriously. For those with privilege, the goal is to "become comfortable with the uncomfortable and uncomfortable with the too-comfortable" and to act to alter the too-comfortable. What this might look like:
    - Being alert to our desire to create a "safe" environment for an interracial conversation. My experience is that when white people ask for safety they mean they don't want to be held accountable for what they say, they want to be able to make mistakes and not have people of color take them personally, and they don't want to be yelled at by people of color. Those of us who are white are almost always safer, freer from institutional retribution, than people of color. That knowledge should help us remain in uncomfortable situations as we work for change.
13. **Allies** know the consequences of not being clear about the Other's experience, including lack of trust and lack of authentic relationships. For allies with privilege, the consequences of being unclear are even greater. Because our behaviors are rooted in privilege, those who are in our group give greater credence to our actions than they might if we were members of groups without privilege. Part of our task is to be models and educators for those like us. What this might look like:
    - Understanding that because we don't see a colleague of color being mistreated doesn't mean that daily race-related experiences aren't occurring. I often hear white people make comments such as, "Well, my friend is Black but he's beyond all this race stuff. He is never treated poorly." Comments such as these alert a person of color to the fact that we don't have those experiences, we can't imagine other people

> having them, and therefore put little credence in the stories that people of color share. If we are to be genuine allies to people of color, we must constantly observe the subtleties and nuances of other white people's comments and behaviors just as we observe our own. And we must take the risk of asking, "What if I am wrong about how I think people of color are being treated in my institution? What can I do to seek out the reality of their experiences? How will I feel if I discover that people I know, love, and trust are among the worst offenders? And what will I do?"

Source: Kendall, 2003.

Conclusion

Leadership on multiple levels, across many different kinds of organizations and sectors, and even among interpersonal relationships, is necessary for the kinds of changes needed for achieving health equity. Armed with the knowledge and resources presented in this guide, public health practitioners and partners should:

1. Embrace a broad definition of health and the determinants of health and encourage others to do the same.
2. Make available continuous training and professional development opportunities around health equity.
3. Ensure a culturally competent and linguistically diverse workforce.
4. Make equity a priority by regularly identifying opportunities to incorporate health equity strategies into their work.
5. Move efforts upstream, when appropriate, for the greatest impact, but recognize the value of the full continuum of strategies needed to achieve health equity.
6. Incorporate health equity strategies into grant applications and set aside funding specifically for health equity work.
7. Invite non-traditional partners to advance their health equity goals and support partners' efforts in-kind.
8. Build and maintain authentic partnerships with communities throughout all steps of a health equity effort.
9. Incorporate measures of health equity and the social determinants of health into their existing and future work and analyze data accordingly.

> *"Above all, it should be stressed that solving problems of inequity cannot be achieved by one level of organization or one sector but has to take place at all levels and involve everyone as partners in health to meet the challenges of the future." (Whitehead, 1991, pp. 217-228).*

10. Evaluate their work and remain accountable for advancing health equity; hold others accountable, in turn.
11. Be willing to commit for the long term and find support among colleagues to maintain the effort; celebrate success along the way.
12. Be a collective leader and ally; participate in a network of support to advance equity.

Many different kinds of changes on many different levels are required to advance health equity in Delaware. This guide presents a number of promising practices and resources to facilitate such changes. There is positive momentum at the national level, in communities across the country, and in Delaware specifically. Given the moral and ethical imperative that Dr. Rattay referenced in her foreword, each Delawarean has a responsibility to use our power and privilege to move towards this common goal. Over time and through our collective efforts, we will realize the vision that all Delawareans will achieve their full health potential.

Glossary – Section 8

Advocacy: The process through which an individual or group tries to influence policy and decision making.

Ally: A member of a dominant social group (e.g., men, whites, heterosexuals) who is working to end the system of oppression that gives him or her greater privilege and power based on membership in that social group

Collaborative leadership: A form of leadership that builds broad-based support, engages coalitions, empowers and catalyzes systems change, works across boundaries, and demonstrates a sustained commitment to a collective vision.

Collective impact: Collaboration across disciplines and sectors to solve complex social problems. It is grounded in the premise that no single organization can create large-scale, lasting social change alone.

Leadership: A process whereby an individual influences a group of individuals to achieve a common goal or vision.

Wicked problem: A social problem that is particularly difficult to solve because of its complexity, dynamic and contradictory nature, and interconnected relations with other problems.

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