Leadership and Prenatal Health Disparities: It Takes a Village

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Abstract

Despite improvements in and access to prenatal care, race-based infant mortality disparities persist. Not only are non-Hispanic blacks more than two times likely than other racial/ethnic groups to experience early fetal mortality, black babies are more than two times likely to die within the first year of life. The reasons for these disparities prove complex, with many concomitant factors at work—poverty, poor access to medical care, environmental hazards, stress, and racism (among others). This paper focuses on the role of leadership at the community, family, and individual levels, and how leaders can address factors that contribute to disparities. We explore how several leaders are working to address African American infant mortality within their community, and suggest that interdisciplinary collaborations are uniquely positioned to develop and implement innovative solutions.

Introduction

During the run up to the 2004 Presidential elections, President Bush remarked that the United States has the best healthcare system in the world. The United States certainly ranks number one for a number of measures, such as innovation, technology, and higher education; but for many health indicators the United States falls well below other industrialized nations. One explanation for the low rankings is the excess morbidity and mortality, and differential access and quality of care for African Americans and other racial/ethnic minorities and citizens with lower socio-economic status. Despite considerable investment to reverse these trends, a racially linked gap remains in nearly all areas of health. Improving access to healthcare remains a popular strategy to address the problem, despite showing mixed results; therefore, new strategies to increase synergies between traditional disciplines are required. Broad-based interdisciplinary research teams have the potential to offer new, integrated, and more effective approaches to addressing the problem.

An area frequently neglected in the interdisciplinary literature on healthcare is leadership. Although we have the commitment of multiple stakeholders to close the healthcare disparity gap,

there is very little understanding of how leaders should effectively organize to achieve these goals. Moreover, the literature has failed to identify what type of leadership is effective and who is responsible for leading. This is not surprising since a limited dialogue exists between healthcare disparity researchers and sub-disciplines that study leadership, such as organizational behavior, psychology, public policy, and social work.

This paper proposes a more in-depth understanding of leadership and suggests looking at the area of leadership to provide a different viewpoint for alleviating health disparities. The viewpoint this study presents challenges researchers and practitioners to go beyond studying healthcare leaders and policymakers. Solutions to health disparities may be found by exploring the role of community leaders, family leaders, and individual leadership through patient empowerment. We focus on prenatal care as a backdrop to understand the role of leadership in alleviating health disparities. We begin the manuscript by defining leadership, and explore the role of leadership policy as it relates to prenatal healthcare access. We then conceptualize a holistic, multi-level perspective of health disparity leadership in the context of prenatal care. We conclude the paper by suggesting an interdisciplinary research agenda that provides direction for a future focus in addressing this important public health issue.

What Is Leadership?

Leadership is an important aspect of society that has defined civilization values and goals through time (Young, 2004). In many instances, it serves as the focal point and guiding force of a group's behavior by inducing compliance, discharging influence, personifying norms, and mobilizing efforts toward goal achievement (Bass, 1997; Stogdill, 1950). Accomplishing these leadership tasks demands the capability to inspire people and mobilize resources. In the context of health disparities, this definition suggests a leadership skill set that understands and can maneuver social, political, and economic institutions through decision making and the implementation of policies (Bryson & Crosby, 1992). It also assumes that successful leaders understand the needs and perspectives of the constituents they serve and can create a network of individuals to meet these needs whose boundaries extend beyond the focal organization (Denis, Lamothe, & Langley, 2001).

Based on these contemporary definitions, leadership is a complex phenomenon, especially when coupled with the challenge of alleviating prenatal health disparities between Whites and African Americans. The causes of health disparities are multiple and include poverty, educational level, access to healthcare, societal discrimination, and lack of understanding for how to treat diseases affecting minority populations (Hogan, 2004). This makes it difficult for leaders to craft a viable strategy and define effective mechanisms for alleviating this problem. Although some organizations and groups have attempted, the successes are few, and the infant mortality and pre-term delivery statistics still indicate a significant racially linked disparity.

Leadership Policy and Access to Prenatal Healthcare

Many previous leadership attempts to alleviate health disparities focused on access to healthcare and health education (Green, Lewis, & Bediako, 2005). For example, in 1965 Medicaid was created as a vehicle to improve access to healthcare for the poor. Initially Medicaid prenatal

coverage was limited to very poor unmarried women, but the program's expansion of coverage in the l980s and early 1990s greatly increased eligibility. The legislation associated with Medicaid expansion was one of the most prominent governmental leadership initiatives regarding health policy to improve access to care and birth outcomes for uninsured women. However, in most states Medicaid expansion has made only a small impact on improving birth outcomes for the targeted populations (Currie & Gruber, 1996; Coulam, Cole, & Irvin, 1995).

Whereas the Medicaid expansions were intended to have a positive impact on birth outcomes through better access, other decisions by federal government leaders actually have decreased access, such as the Balanced Budget Amendment (BBA) that was implemented in 1997. The goal of this act was to control federal deficits through limiting expenditures to such programs as Medicare (the entitlement program serving the elderly). BBA reduced Medicare expenditures by over $300 billion and had far-reaching consequences for healthcare access, particularly in areas with a high penetration of low-income citizens, such as the city of Detroit where 82% of the population is African American. Moreover, BBA added to the reduction of "Food Stamp and Medicaid program enrollments, a rise in the uninsured population [and inadequate enrollment in the State Child Health Insurance Plan" (Pati, Omero, & Chavkin, 2002, p. 1441), further compromising some communities' ability to address the needs of its citizens.

Within three years of the introduction of the BBA, four Detroit hospitals closed, resulting in the elimination of 1,220 beds and 4,468 full-time jobs. Detroit was left with only six hospitals to care for a population of slightly under one million citizens (Report of the Detroit Health Care Stabilization Workgroup, 2003). The policy decisions that led to the hospital closures also contributed to the city's largest healthcare provider, the Detroit Medical Center, losing over $350 million in six years. In fact, the four major hospital systems surrounding Detroit (the Detroit Medical Center, Henry Ford Health System, St. John, and Oakwood) showed collective financial losses of $261 million in 2002. Although many hospitals have the ability to cost shift better-paying patients' profits to the poorly insureds' losses, this was hardly possible in 2002 given that 59% of Detroit's population had an income below 200% of the federal poverty level and only 35% of Detroit's residents had commercial insurance.

In Detroit's case, the effect of these federal policies on the predominantly low-income population has had an unintended and disproportionate impact on healthcare access overall. This may provide the best example of what Schulz, Williams, Israel, & Lempert (2002) described as "race-based residential segregation as a spatial manifestation of macro-level social processes and racial ideologies that keeps many African Americans from resources necessary to maintain health" (p. 680). In Detroit today, zero private practice obstetricians remain to care for pregnant mothers in the entire city. Though a few clinics exist in hospital-owned facilities, the conditions have caused a flight of physicians, further limiting choice and healthcare access to the city's African American population.

Given the limited success of Medicaid and the demise of many urban healthcare facilities, we propose that leadership and the policies they implement should adopt a more holistic approach. This suggests that leadership expand its cognitive map not only to focus on traditional prenatal care systems as the primary method for reducing infant mortality disparities, but also to explore interventions that encompass the interpersonal, economic, psychological, and socio-cultural

attributes of the populations experiencing health disparities. Our proposition is aligned with the social ecological model of healthcare that contends health behaviors are influenced by a variety of factors and constrained by environmental and economic resources (Stokols, 1992). Furthermore, given the complexity and interactive nature of these factors it requires a non-traditional view of leadership and the coordination of leaders from different types of organizations. In the next sections we present examples of this type of leadership.

Collective Leadership

Often effective strategic healthcare leadership requires organizations to coordinate efforts across organizational boundaries (Denis, Lamothe, & Langley, 2001). This is because healthcare is the classic example of an industry with pluralistic domains involving the divergent objectives of multiple stakeholders (Shortell, Gillies, Anderson, Erickson, & Mitchell, 1996). Hence, for many healthcare initiatives a collective approach to leadership would enable different individuals and organizations to pool their talents and resources. In addition, collective leadership across organizational boundaries exposes individual stakeholders to a less parochial view of environmental opportunities and external demands for change. Collective leadership mobilizes support and manages relationships. For collective leadership to work it also depends on members acting in complement with one another, in other words working together equally and pooling different areas of expertise.

The Friendly Access Infant Mortality Initiative (FAIMI) in Flint, Michigan, is an example of a collective leadership strategy created to alleviate prenatal health disparities. In response to the infant mortality crisis in Flint, a unique partnership of leaders from healthcare, business, government, social service agencies, community & faith-based organizations, and members of the community itself joined together to develop and implement a strategy to close the infant mortality chasm. Under the leadership of the Greater Flint Health Coalition (a nonprofit organization whose mission is to improve the health status, cost effectiveness, and quality of the healthcare system in Genesee County, Michigan), the FAIMI workgroup has outlined five core goals: Coordinate and integrate existing services and resources in the pre-conceptual and perinatal care system; encourage early, continuous, and adequate prenatal care; promote planned pregnancies among African American women; reduce barriers for African American women to obtain health insurance coverage; and promote maternal and infant health within the larger community.

Although other communities have set similar goals, FAIMI offers an important opportunity for real change because of four important factors. First, the group has explicit support from an array of leaders throughout the community, such as the CEOs from the county's healthcare organizations, executive director of the county medical society, superintendent of the intermediate school district, health officer of the county health department, faith-based leaders, business executives, organized labor leaders, the city's mayor, and a state senator. Second, community members have been given real power to determine the direction of the initiative. For example, only community members have voting authority for decisions affecting the African American Family Resource Information Center and Network (the organization serving as a resource clearinghouse for both community members and healthcare professionals). Third, the group openly acknowledges, discusses, and struggles with the topic of racism—often a subject

considered taboo, even for those addressing racially linked health disparities. In fact, FAIMI's work plan explicitly states that, "Any initiative directed to change health outcomes also must address the immediate and long-term impact of racism on healthcare delivery for women and their infants" (FAIMI, 2005). Fourth, the group acknowledges that the antecedents of infant mortality stem from a complex web of socioeconomic, psychosocial, behavioral, historical, cultural, political, and biological factors. Thus, FAIMI perceives its mission is to address the social origin of health disparities and develop a broad-based intervention to reverse this societal problem. In summary, FAIMI, through its distinctive mix of leaders from a range of sectors across the community, are strategically positioned to make an impact on the gap in infant mortality unlike traditional groups that have tackled this problem.

Kinship Leadership in African American Communities

Historically, kinship networks consisting of a web of immediate and extended family, friends, neighbors, and church members have been sources of informal support for African Americans. Such kinship networks are employed for the exchange of support, goods, services, and knowledge and are similar to the clans of ancient society (Ouchi, 1980). Because of these reciprocal relationships, kinship networks have been significantly associated with the subjective well being of African Americans and serve as a surrogate for or complement to traditional healthcare channels (Taylor, Chatters, Hardison, & Riley, 2001; Carlton-LeNey, Hamilton, Ruiz, & Alexander, 2001; Hamilton & Sandelowski, 2003). Historically, this alternative to traditional health channels was in response to racism, limited access to quality healthcare, and a lack of material resources (Hamilton & Sandelowski, 2003), resulting in African Americans relying more on informal social networks for disease management than other ethnic groups (Ford, Tilley, & McDonald, 1998). Leaders emerge from the kinship networks, and through group interactions collective responsibility is created for each member's well being. Sources of the leadership power can stem from expertise, age, or social influence. In other kinship networks, religious figures are dominant leaders since the church is an important social institution in the African American community.

Interestingly, most programs focusing on prenatal healthcare disparities ignore the leadership strength of these kinship networks, but this is not the case for the Centering Pregnancy Program developed by Certified Nurse Midwife Sharon Schindler Rising. This program recreates a kinship network by bringing women out of the exam room into groups for augmented prenatal care (Centering Pregnancy, 2005). The women have their initial intake in a traditional obstetric care setting, and then join groups of 8-12 with similar due dates. The groups meet generally until six weeks postpartum. The focus is on the group interaction and discussion, although each woman has individual time to talk over concerns with health practitioners. Since the Centering Pregnancy Program begins early in pregnancy, women become invested in the well being of group members, and a network or "community" is built. Research indicates such community building leads to increased support, decreased feelings of isolation, and higher birth weights, especially for infants delivered preterm (Ickovics et al., 2003).

The African Methodist Episcopal churches of South Carolina provide another example of leading through kinship networks to alleviate prenatal health disparity of African Americans (March of Dimes, 2005). This faith-based program raises awareness of infant mortality in the African

American population, teaching about the value of folic acid and the signs and symptoms of preterm labor. The program also aims to reduce SIDS risk among its 609 congregations (200,000 members) in South Carolina. Program leaders believe they have successfully raised awareness about pre-conceptual health (Speed & Miles, 2003). Because of the significance of elders in African American communities, they also have worked to target a diversity of age ranges to clarify myths about pregnancy.

Leadership through Patient Empowerment

The previous two sections of the paper advocate utilizing collective leadership and kinship leadership for narrowing the prenatal health gap, but we also contend that healthcare providers use empowerment leadership to help women take control of their prenatal care. Self-leadership occurs when patients develop a stronger sense of self-consciousness and obtain the resources needed to ensure optimal healthcare experiences. In this approach, the healthcare provider acts as an advocate by supporting development and becoming part of the patient's resource network (Manning, Cornelius, & Okundaye, 2004). In other words, the healthcare provider is a servant leader who partners with the woman to help her develop her own comprehensive health plan.

The idea of patient empowerment assumes that positive health behaviors are both strengthened and learned as the result of a participatory experience and sense of control over health encounters with medical professionals (Ouschan, Sweeney, & Johnson, 2000). Patient empowerment is the discovery and development of an inherent capacity to be responsible for one's health and well being (Anderson et al., 1991). Therefore, patients become empowered when they have the knowledge, skills, resources, and self-awareness to improve the quality of their health.

The Washtenaw County Health Department in Michigan is an example of leaders adopting a patient empowerment model of prenatal healthcare. Its prenatal care program empowers patients by providing individualized attention and mentoring through the health systems. It strives to remove barriers, such as insurance eligibility and transportation to medical appointments. Similar to the Washtenaw County Health Department, the New Jersey Department of Health and Senior Services – Division of Family Health Services has integrated patient empowerment into its overall strategy. Its patient empowerment efforts focus on awareness, education, and programs. Using education as a starting point for patient empowerment, leaders of these organizations have aggressively used the media in their Black Infants – Better Survival campaign (New Jersey Department of Health and Senior Services, 2005). This health promotion campaign presents the infant mortality statistics for African Americans, signs of preterm delivery and emphasizes the importance of prenatal care. The State also funds a specific project, Black Infant Mortality Reduction Resource Center, to provide healthcare professionals, community programs, and other audiences with information regarding intervention strategies and cultural competency.

Conclusions

Throughout this article, the authors have expanded on the African proverb "It takes a village to raise a child" by also proposing it takes a village to alleviate the White-African American infant mortality gap. We assert that non-traditional models of leadership, such as those described here, can complement existing federal policies and programs. An approach is needed that requires

public policy, healthcare executives, and community leaders to go beyond simplistic solutions to address this complex problem. Furthermore, a comprehensive strategy for addressing infant mortality disparities should involve multiple stakeholders and incorporate a diversity of intervention programs to prevent preterm deliveries and infant mortality, such as culturally competent prenatal care, kinship networks, and patient empowerment. Many of the recommended leadership initiatives are cost effective and draw upon a range of resources to reduce the infant mortality gap. If the investment is not made, however, there is a potential for this health disparity crisis to continue to escalate, having a profound impact not only on African Americans but on the greater society.

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