





Building Healthy Communities Requires Trustworthiness

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On my first day as a public health civil servant in the Bronx, New York, the assistant commissioner gave me a tour and brief history of our district office, which had just opened two years earlier. The building was certainly older than that, so I asked what had previously occupied the space. She said it had always had a health focus and, although nonprofit organizations were the immediate past tenants (and some remained), there had been another public health office located in it some 20 years ago. “We’re still trying to get past that,” she noted. I asked what she meant. “We left. We set up, built relationships, provided services, and then an administration changed, budgets tightened, and we left. They don’t trust us.”

I was therefore unsurprised when, more than 15 years later, the first of the 10 principles in the AAMC Center for Health Justice’s “Principles of Trustworthiness” announced: “The community is already educated; that’s why it doesn’t trust you.”¹ That resource, co-created by the center and 40 community members and researchers from across the country, was born at the outset of the COVID-19 pandemic when we heard a lot about what “the community” needed from medical, public health and political voices — but not from any community ones.² The narrative those voices presented (at a time when vaccines were being developed and many people were rightfully focused on clinical trial diversity) went something like, “If only the community were educated. If only we had the perfect pamphlet, with the right pictures and the right local jargon, they’d see that we’re not ‘like that’ anymore — like Tuskegee, like the Havasupai genetic study, like the Guatemala

syphilis experiments.”

My colleagues and I found that narrative patronizing, unhelpful and incorrect. Instead of “educating” the community, perhaps medical, public health and government institutions could try “partnering” with them, because the necessary education flows both ways. There is much the community knows that our organizations and agencies have either overlooked, ignored, never learned or forgotten. For example: The community knows when we have left them.

The time had come to flip the script and place the onus where it belonged: Not on communities to “get over” their valid distrust and mistrust of medicine, science and public health, but for organizations with power and privilege to demonstrate they are worthy of their community’s trust by showing humility, transparency, authentic commitment and by taking responsibility. Trustworthiness is core to building healthy

communities because it brings together the diverse, multisector partnerships needed to build effective movements for change.

TRUSTWORTHINESS AND COMMUNITY ENGAGEMENT

The Association of American Medical Colleges recently added “community collaborations” as its fourth mission area alongside medical education, clinical care and research.³ This addition reflects and strengthens the work of medical schools, hospitals and health systems to deepen their own community engagement through community health needs assessments, mobile clinics, community- and patient-partnered science, service-learning programs, community advisory or action boards, and more. However, this engagement is often perfunctory, after the fact and may entail convening that advisory board a few times a year to present your own team’s ideas, extract some feedback and get the community’s thumbs up. That is not the kind of authentic community engagement that improves population health and achieves health equity.

The National Academy of Medicine recently formed an organizing committee on Assessing Meaningful Community Engagement in Health and Health Care Programs and Policies, comprised of more than 30 diverse community leaders, researchers and policy advisors. In 2022, the committee published a conceptual model that identifies outcomes associated with authentic engagement that can form the basis for evaluating

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and improving our partnerships and processes.⁴ The framework names the core principles of meaningful community engagement: coequal, shared governance, equitably funded, cocreated, bidirectional, ongoing, multiknowledge, inclu-

sive, culturally-centered and trust. For me, trust is the most crucial of these principles since none of the others are achievable without it.

The model states that when partnerships walk this talk, our alliances are strengthened, everyone learns and grows, and our programs and policies are better and more likely to be implemented and sustained in ways that transform our systems for health to create thriving communities and health equity. A community advisory board is often an important feature of an authentic community engagement process. However, as the fifth Principle of Trustworthiness asserts, “It doesn’t start or end with a community advisory board.”⁵ Community engagement is not something you do quarterly, on the weekend or at a special event. It is an iterative, ongoing, context- and community-dependent process that requires and builds trust, and all of us in health care, public health and other sectors are responsible for it.

CREATING MULTISECTOR COLLABORATIONS THAT VALUE ALL PARTNERS’ GOALS

With whom we partner is as crucial as how we partner. Health equity — all people and communities having a fair and just opportunity to attain their highest level of health — is not the responsibility of health care alone. In fact, social science tells us that only 20% or so of a person’s or community’s health results from medical care.⁶ While genetics and lifestyle also play roles, the largest contribution to health is made by the presence or absence of the vital conditions for health and well-being in our communities.⁷ Vital conditions are the basic building blocks of real, authentic health opportunity: humane housing; reliable transportation; basic needs for health and safety, including nutritious food, clean and safe potable water, access to high-quality health care and freedom from violence; and lifelong learning, among many others. Without these vital conditions, no community can thrive.

Switching from “addressing social determinants” to “creating vital conditions” facilitates



health equity and community health work in various ways. First, the goal of creating vital conditions is clearer and more accurate. It is more accurate because social determinants are not “determinant,” as they do not automatically confer negative outcomes for those born into communities made marginalized. Additionally, this goal is clearer because of the ambiguity of “addressing” upstream factors. For example, health care often claims to address social determinants through efforts to screen patients for individual-level health-related social needs and to then refer them to local community services.

Does a referral truly “address”? Does helping an individual patient secure safe, stable housing make a dent in the more upstream issue of a community’s lack of humane, affordable housing? Conversely, ensuring all communities have breathable air or safe outdoor spaces are unambiguous goals, even if the path there is not uniform. In fact, that lack of a one-size-fits-all approach to the vital conditions is another strength: While the goal is inclusive and universal, achieving it is hyperlocal and allows for the kind of collaborative, multisector, context-dependent solutions that authentic community engagement seeks to produce.

Taking an intentional multisector approach is foundational to creating practices, policies and programs that resonate across all necessary partners for health. That is why one of the first actions the AAMC Center for Health Justice took was to convene its Multisector Partner Group, a group of 10 paid local and national experts representing the vital conditions for health, including the arts, civil rights, housing and public health. In our work to ease the path for health equity action, we aim to demonstrate how health equity broadly benefits our communities and specifically benefits each individual sector. Ensuring metrics that matter to all partners are embedded in process and outcome evaluations achieves two goals: It demonstrates trustworthiness by explicitly acknowledging and valuing all partners’ desired outcomes, and it provides diverse evidence of success that enhances advocacy efforts at all levels — organizational, local, state and federal.

ADVOCATING FOR SUSTAINABLE HEALTH OPPORTUNITY

Population health and health equity are not achieved one patient at a time in a doctor’s office. Furthermore, they are not achieved by medicalizing population health and placing all our health (and health advocacy) eggs into health care’s basket. While advocating for policies that

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increase insurance coverage and easy access to high-quality, affordable health care services is a crucial component of population health advocacy, contributing to a health justice movement requires that health care organizations — given their immense and respected voices at policymakers’ tables — advocate for “health,” not just health care. This means partnering across sectors to help develop an advocacy agenda that reflects the vital conditions and makes an evidence-based case for policies that create sustainable opportunities for health with the stroke of a policy pen.

Even the best-intentioned, multisector advocacy efforts will fall short if we are not mindful of how policies can be implemented or enforced in ways that exacerbate, rather than narrow, health inequities. In the mid-1990s, scientists proposed that social conditions like classism, racism, sexism, xenophobia, etc. act as so-called fundamental causes of disease.⁸ These fundamental causes operate through many pathways to affect an array of health outcomes, and they do so by controlling and embodying access to resources like power, voice, information, beneficial social connections and prestige. In short, fundamental causes dictate which groups have authentic opportunities for health, and they often operate through our policy decisions.

It is not a stretch to see how the fundamental cause of homophobia, for example, is baked into state “Don’t Say Gay” laws, which intentionally limit health- and well-being-related opportunities for members of the LGBTQ+ community. Similarly, one can argue that classism informs

policies that propose work requirements to access the social safety net, or that racism undergirds laws restricting voter enfranchisement. Other examples abound. Our policy decisions — what health care and public health leader Daniel Dawes calls the “political determinants of health”⁹ — when grounded in the -isms and -phobias of fundamental causes, inequitably and unjustly distribute the vital conditions for health across geographic and sociodemographic communities. This results in the seemingly intransigent health and health care inequities that our nation continues to grapple with.

Thus, being trustworthy partners in our communities and advocacy demands health care take a clear antiracist, antidiscriminatory and intersectional approach to the research questions we ask, the practices we interrogate and the policies we propose. What are the unintended consequences? Are we falling into a trap of -isms and -phobias? Whose voice is being heard in these discussions? Whose outcomes matter? Who has the power to decide?

This process of grounding one foot in community wisdom and multisector partnerships and the other in an “evidence-to-policy imperative” is at the core of how our center operationalizes health justice. We firmly believe that the process is as important as the product. If health equity is the goal, health justice is the path, and trustworthiness is its non-negotiable foundation.

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NOTES

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5. “The Principles of Trustworthiness,” AAMC Center for Health Justice.

6. “County Health Rankings Model,” County Health Rankings & Roadmaps, <https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model>. A copy of this model can be found on page 8 of this issue.

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