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**UNIVERSITIES AND THE HEALTH OF THE DISADVANTAGED:
BUILDING COALITIONS WITH THE HEALTH PROFESSIONS, LOCAL
GOVERNMENTS, AND THEIR COMMUNITIES ****
(Tucson, Arizona)

One of the characteristics of a good society surely must be the manner in which it looks after the well-being of all of its members, but giving particular attention to the less fortunate. There are many ways in which societies, over the years, have organized this function, and there is usually some degree of direct involvement of some state apparatus in organizing such attention. The welfare state will determine the allocation of the resources to ensure that there is more or less equitable access to such measures that will ensure a certain level of well-being. Other forms of social organization have seen less attention paid by the state to ensuring such an equitable access, and many of the resources necessary for well-being are parts of one or other rewards system. But my perception is that there will always be a tendency for good government to be involved in the well-being of its citizens, and the actors in such government are now increasing in number. The days are now past in which all the functions previously reserved for the state are executed by the formal public sector as characterized usually by a representative government and its attendant bureaucracy.

This does not in any way deny that the fundamental roles of the state—even the minimalist one- must include the provision of some basic social services and protecting the most vulnerable of society. One of the questions is the extent to which actors other than the public sector will be involved in facilitating the discharge of some of these functions.

I had been attracted to the idea that universities may be part of those institutions now defined as pertaining to civil society that will seek to address some of the functions previously thought of as belonging uniquely to the state. There are two possible views of civil society. One that is to my mind unduly narrow sees civil society associations as being restricted to those that are civic or related to the essential functions of being a good citizen and are predominantly political. The other view sees civil society more broadly and takes it to include all the institutions and associations that provide a wide range of services that may range from the cultural to the commercial.

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If we apply some of the criteria that are usually applied to civil associations such as autonomy and independence from the state, then only some universities would qualify. Perhaps universities may be in the nature of hybrid institutions, participating in some of the kinds of activities usually associated with the associations of civil society and in some ways as part of the state institutional apparatus that is needed for facilitating the discharge of some of the social functions normally ascribed to the government.

The idea that universities might have some social function is relatively new. The original universities that were companies of masters and scholars and grew out of the European Renaissance and the great revival of learning were concerned uniquely with the creation of knowledge that was in many instances beautiful in its own right and not necessarily of any immediate practical or relevant use. This changed slowly over the centuries until we now see the university adopting a posture of an institution that must be useful to society.

Perhaps the movement that forever sealed the function of the university as a social instrument was the foundation of the land grant colleges in this country in the last century. There would be few universities, if any, which will now not accept that service is as much a part of their remit as their pristine functions of teaching and research.

This concern for service and seeing the university as an instrument for social change has perhaps been helped along because of the increasing emphasis on egalitarianism, at least, of opportunity that has marked the last half of this century. I cite the example of my own university that is only 50 years old. When I entered the University of the West Indies almost at its inception, there was very much the concept of forming a selected elite group of citizens that would be the leaven for our society, as it rose to some situation that approximated what was to be found in the industrialized countries. Over the years one has seen the welcome change to expanding Caribbean university education to incorporate large numbers of students and diverse disciplines. This is accompanied by the growth of numerous tertiary level institutions dedicated to broad-based enhancement of human capital.

The university is unique in other ways. There are many fine non-university institutions dedicated to research, some exclusively to teaching and obviously many more to service. But it is in the university that one finds the mixture of all three to create an institution that is fundamental to the growth of nations. We must, of course, be aware of the constant and perhaps healthy conflict that involves many universities as they balance their role as social engineers with their cherished independence.

If the university is to be effective in addressing the social and, more particularly, health needs of the vulnerable and the disadvantaged in the societies in which they function, then there must be more clarity about the sources of this vulnerability or disadvantage. For example, there may be differences or vulnerability on the basis of ethnicity or sex. There is every indication that there are significant differences in health status and access to health services that are ethnically determined. Some of these differences may be amplified when ethnicity is combined with other factors that make for social disadvantage.

It is often said that the concept of vulnerability should extend to women. I hold firmly that we must not confuse biological with social vulnerability. Women are not particularly

vulnerable simply because of their sex: they are vulnerable because of the social constructs that surround their sex. The vulnerability is gender-based in the sense that there are societal arrangements disadvantageous to women, and I will refer later to this in relation to health.

Economic status and geographic location may contribute to vulnerability. The rural populations are disadvantaged in many ways, and the most obvious is in the burden posed by distance that prevents them accessing essential services. Poverty is a barrier to almost every measure needed for human well-being.

I wish to focus more specifically on health of some groups that are among the most disadvantaged — the poor, women, and the elderly. The poor have poorer health than the rich. The situation was put graphically in the introduction to the 1995 World Health Report of the World Health Organization.

The world's most ruthless killer and the greatest cause of suffering on earth is listed in the latest edition of WHO's International Classification of Diseases, an A to Z of all ailments known to medical science, under the code Z59.5. It stands for extreme poverty.

Poverty is the main reason why babies are not vaccinated, clean water and sanitation not provided, and curative drugs and other treatments are unavailable and why mothers die in childbirth.

Poverty is the main cause of reduced life expectancy, of handicap and disability, and of starvation. Poverty is a major contributor to mental illness, stress, suicide, family disintegration, and substance abuse.

Poverty wields its destructive influence at every stage of human life from the moment of conception to the grave.

I cannot put it better. There are several data from our Region of the Americas that put a finer point to the above. When we divide our countries into five groups according to income, there is a 12-fold difference in infant mortality rates between the richest and the poorest group. Infant mortality rates are 74 per 1,000 live births in Haiti and 5.6 in Canada. Whereas 8.7% of infants in the rich countries have birth weights less than 2,500 grams, the figure is 13.2% for the poor countries. Maternal mortality varies from a figure of 8 per 100,000 live births in one of the richest countries to 450 per 100,000 live births in one of the poorest.

The list of differences goes on and on, and there are excellent data to show that the average life expectancy on a country basis increases as income rise. In a recent lecture, Professor Amartya Sen referred to data that analyze this relation between wealth and health and showed that this correlation between wealth as measured by GNP per caput and life expectancy as a measure of health works mainly through the effect of GNP on the incomes of the poor and the public expenditure on health care.

In addition to poverty per se, there is also an effect of income inequality on health. The more unequal the society is in terms of wealth, then the poorer the health status as indicated by such measures as life expectancy and child mortality rate. The use of concentration indices similar to those used by the economists to calculate income inequality has been applied to

various measures of health status and health outcomes and provide a very useful tool for making the differentials objective and correlating them with other measures of inequality. The relative weights of the inequalities in the various determinants of health in influencing health status is still to be unraveled, but I would suspect that we will find that personal health care services are less important in this context.

I include the elderly not only because this is the international year of the older persons, but the reality is that the demographic transition is very evident in our Region, and the number of older persons is increasing at a rate that perhaps is faster than we realize. They will present many diseases and infirmities that do not affect the young, and the obvious ones are the chronic diseases. The problem is usually that at the very time that they need more attention, there are fewer resources available to attend to them, except provisions are made individually or at the level of the state to protect them. In the majority of the countries of our Region the coverage by the social security systems is not such as to guarantee access by the elderly in their moments of greatest need. The situation is compounded by the fact that because of the differential in life expectancy, large numbers of these older adults will be female living alone with minimal social support.

Women outlive men, and there is still much discussion as to whether this difference is due to biological factors or the social and physical environment, but some of this difference is narrowing in those places where more women are adopting some of the unhealthy practices such as smoking that contribute to male mortality. The excess female mortality in children is a clear signal of gender discrimination, and in almost every age group one can find gender-related increases in female deaths. One of the problems in determining the total burden of illness that is gender-based lies in the fact that gender discrimination is very subtle, and it takes insight and persistence to determine, for example, the extent to which our health services discriminate against women in their non-reproductive roles.

Does the university have any role in addressing these problems of those who are disadvantaged by reason of their vulnerability? The modern university has or has taken unto itself several roles, some of which may not be related to improving the lives of the disadvantaged. Perhaps one of the oldest roles of the universities to which they have held steadfastly over the years is that of the articulation, legitimizing, and transmitting some of the important societal values. The respect for honest enquiry and the search for truths in various areas have always been vital to university life. The support for intellectual excellence is another one of these values of which every university is proud.

Every university maintains the function to generate information that its masters transform into the knowledge for which they are valued so lightly. In this quest for creation of new knowledge, universities have been the place for the kinds of research that question assumptions that are the standard dogmas of their time. Organization of this knowledge-creating function has changed dramatically over the years, and much of this has been due to change in funding which is now a veritable Joseph's coat with many pieces of varying sizes and colors. Although this is to me one of the most important functions of the university, it is not exclusive to universities, because there are now many prestigious non-university institutions that are performing this function. But the peculiar feature of the university is the combination of masters and scholars

and the opportunity for the creation of knowledge and transmission of information to those who will carry on the tradition is, if not unique to the university, at least very characteristic of it as an institution.

Of course, the universities must be transmitters of not only information but also of the method of acquiring such information and transmuted it to knowledge. This teaching role was clear from the beginning. Even though the changes in the means of transmitting information are making that commodity available to all who wish it, I still have faith that there will always be place for the physical and social interaction that makes for more ready inculcation of knowledge such as is found in a university.

I continue to believe that these functions of producing information, the creation of knowledge and the quest for excellence that are so much a part of scholarship, themselves contribute to the leveling of inequalities. The claim of universities to be meritocracies is sustained in part by the ability to judge the information produced and the knowledge generated.

The fields of teaching grow constantly, and now there is almost no area of learning that will not be found at some university. Universities are also called upon to play the role of giving seals of approval to ensure that those who study and learn have reached a certain level of competence. Many years ago, I read a proposal that suggested that it was unfortunate that this function was acquiring such prominence in detriment to the more important one of mental development and equipping the young to learn. It is probably now in the realm of fantasy to believe that the function of training will be so much a part of the world of work that persons will be able to enter directly into training in a particular field without having experienced what has been termed the "rite of passage" through acquiring university qualifications.

How can these functions I have described contribute to building coalitions with the health professions, local governments, and their communities such that the health of the disadvantaged is improved? My approach is to examine how the university can improve the health of the disadvantaged and the extent to which it can influence the diverse groups of institutions mentioned above in terms of partnerships or through their own direct execution of programs and projects.

The most obvious first approach must be through the university's research function and the transmission of the information gained in such a way that policies are affected. Some of the areas to be researched may not be considered appropriate for serious enquiry and, therefore, have not attracted significant funding. It is, therefore, heartening to see the field of welfare economics gaining in prestige and health economics flourishing. There is much work to be done with regard to the factors that determine the health of the poor and, of equal importance, whether improving the health of the poor will be a significant instrument for lifting them out of poverty. There are now robust data to show that investment in health will lead to national economic growth, but there is still a great void of knowledge as to the best ways of investing in health. The question as to whether a reduction in health inequality will serve to reduce inequality in income is still unanswered.

I mentioned the increased prevalence of the chronic diseases, and it is now clear that the approach to this epidemic on the sole basis of changing individual behavior will not work. There has to be community involvement as well, and there is a clear role for the university in the research into the methods of creating community cohesion and action that favor behavioral change such that the incidence of these diseases decrease. The problem is compounded in that poor communities do not necessarily respond to the same approaches of health promotion as do rich ones.

There are gaps in university research on the problems of the disadvantaged in communities, but there are even fewer examples of universities assuming responsibility for the health care of communities. Perhaps one of the oldest and most famous examples comes from the University Faculty of Health Sciences at the Ben Gurion University of Negev in Beersheba, Israel, which began in 1974. This university is responsible for merging the whole health care system under a simple authority and has as one of its goals: "To assume responsibility for the health care of the population of the Negev by delivering medical services of the highest standards both in the hospital and the community."

It is responsible for the care of approximately 400,000 residents of the Negev desert and has been hailed as a magnificent example of a medical school being the guardian of the health of an entire community and carrying out its teaching and research functions in the community.

The Rural Health Office of the University of Arizona College of Medicine is not as old as the Ben Gurion University, but I trust that in time it will become equally famous. The Office, which is a PAHO/WHO Collaborating Center, is involved in a number of research and demonstration projects as well as paying attention to development and training in the rural setting. One of the projects that is particularly pertinent there is the Border Health Outreach, which aims "to develop effective community-based health outreach models that will increase access to health care for border populations". I hope that these models, when tested and found to be appropriate, will indeed be applied not only here but also elsewhere.

I am particularly interested in this project because of the involvement of my Organization in health along the United States/Mexico Border. We have compiled recently an analysis of the mortality profiles of sister cities along the border that gives data that allow us to detect the commonalities and differences between the two sides. But of equal importance is that it allows us to see the differences in mortality of this area as a whole from what pertains in the two countries. The 14 pairs of sister communities that were examined represent about 90% of the population along the border.

These examples of Arizona and Beersheba show how it is possible to build coalitions. In Israel, apparently once the coalition had been established and the authority created, there was no need for a coalition with the health profession. In other cases, this will be different, and the challenge for the university will be how to make it attractive to other health professionals to be involved. One of the most obvious is the cachet of university affiliation, but from my experience universities have been super jealous in guarding their titles and maintaining that mythical seal of quality by exclusion rather than inclusion. But because health professionals almost all have university backgrounds, it is still relatively easy to build relationships, if not coalitions, with

them, and there are several good examples of university personnel playing active roles in their professional associations and taking pride in the extent to which they are regarded for their leadership by their colleagues who do not have formal university affiliation.

I have noted much more difficulty in building coalitions with communities, and the standard approach that is adopted by schools of public health or departments of community medicine is to regard the community in the same way personal care physicians regard patients. The extent and success of these efforts are measured by the degree to which population health improves. This is highly laudable, and we should see more of it, but there are other aspects to be considered.

In the technical discussions in the World Health Assembly in 1982 on the role of the universities in the strategies of health for all, the aspect of community involvement was put thus:

Participation in the analysis of the community's needs differs sharply from the previous levels of intervention because it calls for a different concept of the university's role. It presupposes community acceptance of the university's capacity to conduct research and suggest solutions without being bound by prior options of the community. These actions also have an impact on the university: participation in the analysis of problems and in the definition of demand presupposes that the university is prepared to make adjustments in its own structures, research agenda, teaching methods, and so on.

This may not be enough if there is to be sustainability of the efforts for community building. This involves utilizing the whole panoply of university resources to restructure the various systems of community government and organization. Since an important aspect is increasing the capacity of the poor in the community, the references I have made to health in terms of improving economic performance are very relevant. As one authority says: "The activities range from the conceptualization of the issues and strategies through the daily operations of the initiatives to the evaluation of completed projects."

The Reports of your Rural Health Office in its capacity as a Collaborating Center shows that you are contemplating this approach.

Mr. Chairman, my own background has convinced me of the importance of universities as institutions that are critical for the growth and prosperity of nations. I have come to appreciate that their remit is widening to promote academic internationalism, a role that is being facilitated by the rapid diffusion of the information technology. Your University and its Rural Health Office as a Collaborating Center must of necessity look towards some international projection as this is one of the possible roles of collaborating centers—a role that is doubly important when collaborating centers are in universities. Thirty-eight percent of the collaborating centers in the Americas are in universities.

I take this Conference as one expression of that international projection, and I wish you well in disseminating the results of your work to other areas of the world, especially where there are border communities that are as important as this one. The Pan American Health Organization supports this effort, and we look forward to assisting you as one of our collaborators.

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