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THE ROLE OF UNIVERSITIES ON THE PROBLEM OF HEALTH OF THE DEPRIVED SOCIETY

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Abstract

Higher education is vehicle for transforming society globally. Therefore, universities play crucial role in awareness of health problem of advanced and privileged segment of society. it is the disadvantage and deprive section of the society which have ample isolation from benefits of higher education. This is concern to be studies as to how universities can be vehicle fro and may have proper report with deprived isolated society so that the benefits of higher education may penetrate at the gross roots along with its intellectual and infrastructural capabilities. Present study deals with as to how universities play their role in coping with issues of health problems of socially, economically, geographically and ethnically deprived segment of society.

Keyword: Disadvantaged society, Economic backwardness, Health problem, University infrastructure

Introduction

Universities play pivotal role to stimulate progress and transform societies, some of which are inherent in the talents and resources they posses, and some in their capacity to build productive partnerships with other forces in society. They generate idea and spread new information & knowledge, develop new methodologies and technologies, and prepare future generations to apply them. In the field of health, not only health sciences, ethics and law, economics and business, engineering education, environmental sciences, agriculture, industry labour and employment all have contributions to make, and can be mobilized by universities for action and implementation.

At the turn of the thousand years, and spite of the general increase in the wealth of countries, one of the most preoccupying concerns of any society is the existence of large segments of the population who are denied adequate or any attention to their health. Those identified as “disadvantaged” are individuals or groups who for a variety of political, cultural, social, and economic reasons are consciously or unconsciously discriminated against and receive less attention than the majority of the population.

Driven by long –standing traditions of humanism, social justice and peace and development motives, universities can play a catalytic role in mobilizing energies to improve the cause of health of the disadvantaged. Their assets are generosity of youth, the wisdom of teachers, the methodic approaches of researchers, the prestige of academia, and the way these factors are interwoven in social fabric.

There are numerous programs of universities-particularly health sciences institutions-making efforts to identify to address priority health concerns of the people, orienting the education of health professors to respond to specific local needs, and developing a working relationship with the surrounding community. In addition the issue of inequities in health and health care has caught the attention of several institutions, group, and individuals involved in advocacy, policy formulation, knowledge base-building, and resource identification. However too often, action programs lack continuity and sustainability and achievements are fragile. The contributions of different groups and agencies toward the case of health of the disadvantaged are heterogeneous, and usually poorly coordinated. Energy spent has rarely led to an institutionalized programmed with guarantees of longevity of action and expansion of mission.

Universities, if properly organize their resources to do something and supported, can be in the best position to facilitate the convergence of interests by different contributors and create collations among key ones, such as local governments, health professions, and communities. The wide spectrum of responsibilities of universities in education, research , and service delivery, their capacity to get engaged in multidisciplinary interventions, and their ability to develop alliances with other constitutions give them the potential capacity to take the initiative and serve as mediators of a multidimensional action plan for improving the health of the disadvantaged.

In 1984, the World Health Organization (WHO) recognized the unique role that the universities could play in implementing the global goal of *health for all*. A resolution was adapted by the World Health Assembly indicating its awareness "of the prestige that universities carry and the influence they have in developing the minds of young people and in preparing them for their role in society as well as in forming public opinion" and inviting universities throughout the world to "offer to increase their collaboration with relevant ministries and other bodies for the preparation of policies and formulation, implementation and evaluation of strategies for health for all" (*WHO, 1984*)

In 1995, WHO again recognized the unique roles that universities could play in implementing the global strategy of health for all (*WHO, 1995*). Consistent with its mission, WHO continues to promote action in health care. It maintains a large network of research and academic institutions to assist in developing approaches to improve quality, cost effectiveness, and equity. The papers in this collection examine- in the wake of ideological uncertainties, unstable economics, threats to social security, and the widening gap between the well of and the disadvantaged, both between countries and within countries-how the social capital and the expertise of universities can reinvigorate the sense of solidarity across society in favor of the neediest groups and individuals.

II**. Definitions: WHO defined "advantaged" as:**

A. General: Groups of populations within a country who, compared with majority of the population, suffer from poorer health, fewer opportunities or reduced access to services may be called: Disadvantaged." Disadvantage may be the result of discrimination (race, gender, ethnicity), poverty, geography (rural residence), or other causes.

B. Developed countries**:** Virtually every country has groups that are disadvantaged relative to the population as a whole: Examples are:

Geography: virtually all countries have a deficiency of physicians and other health professionals in rural areas as compared to urban and suburban areas. In developed countries, the imbalances are generally not as dramatic as in the less developed countries, but many areas exhibit deficiencies of health professionals. In the United States, 1,970 of the country's 3, 141 rural counties (62.7%) are designated. Health professionals Shortage areas meaning that they have less than one full-time equivalent primary care physician per 3,500 populations (not including nurse practitioners, physician assistant, or federal physicians assigned to relieve the shortage). (*USDHHS, 1998*)

Poverty: The relationship between poverty and ill health has long been recognized. (*Black D, 1980*) The poor have higher morbidity (*Hemingway, J. et al. 1997*) and mortality rates (*Fiscella, K. and Franks, P. 1997*) and are more likely to suffer from conditions ranging from cancer (*Parham, GP. and Hicks. M L. 1995*) to mental illness (*Hopton, JL. and Hunt, SM. 1996*). The association between poverty and ill health remains after controlling for potential confounders such as nutrition an access to health services

Race/ethnicity: the life expectancy of blank Americans is about five to seven years less than for white Americans (*USDHHS, 1998*) for Australian Aborigines, as compared to white Australians, the gap is about 20 years, (*Gracey, M. 1985*) with respect to opportunity, although African Americans constitute about 12% of the US population, they represent only about 3% of US physicians, (*USDHHS, 1992 and Libby, DL. et al. 1997*) in the united kingdom, applicants from ethnic minority groups (as indicated by surname) are less likely to be admitted to medical school than similarly-qualified applicants of European extraction (*McManus. IC. et al. 1995*). The impact of disparities in opportunity is left at the point of service: ethnic minority physicians are more likely to care for members of their own ethnic group (as well as poor and sicker patients; the relatively low numbers of such physicians reduces service to ethnic minorities (*Moy, E. and Martman, BA. 1995*). Moreover, member of racial/ethnic minority groups are less likely than members of majority population to receive appropriate diagnostic and treatments services. (*Duran. TE. et al. 1996 and Bahl, V. 1996*)

Other groups with special needs: A number of groups or sub populations in developed countries are disadvantaged by virtue of special needs that may not be met. For instance, well over 100,000 refugees from Africa, Asia, and Eastern Europe enter the countries of North America and Western Europe each year. They have a high prevalence of infectious disease, malnutrition, and physiological stress syndromes (*Ackerman, LK. 1997*).

C. Developing countries: Virtually the entire population of the poor countries is disadvantaged by comparison with the wealthy countries. For instance, the economically developed countries account for almost 90% of total world expenditures on health with in an annual average of about $ 1500 per person (over $ 3500 per person in the United States). In contrast, developing countries spend an average of $ 41 per person annually, with the poorest countries spending as little as $ 5 per person (*WHO, 1992*). Within developing countries, however, there are identifiable groups whose health, opportunity, and access to services are reduced compare to the majority of the population. Examples are:

Geography: Rural physician: population ratio in the least developed countries may be as low as 0.2/1000 population (example: Mali, 0.2/1000: Malawi, 0.3; Niger, 0.4; Nepal, 0.6; Papua New Guinea, 0.6; Central African Republic, 0.9). In countries such as these, the physician: population ratio in urban areas may be 50-100times that of rural areas (*Blumenthal, DS. 1994*).

Poverty: One fifth of the world's population lives in absolute poverty (*World Bank, 1997*).The vast majority lives in developing countries. These people lack adequate food, clothing, housing social services, and the opportunity of work. In addition to absolute poverty, relative poverty within nations is associated with both diminished access to health care and diminished health status.

Race: In Brazil, life expectancy for blacks is about seven years less than for whites (*Wood, CH. and Lovell, PA. 1992*).

Other groups with special needs: As in developed countries, a number of groups of subpopulations in developed countries are disadvantaged by virtue of special needs that may not be met. For instance:

Refugees: The world now has an estimated 18 million refugees and over 25 million displaced persons (*Giger, HJ. and Deegan, RM. 1993*). Most are not fortunate enough to find their way to a wealthy country. Those who flee from one developing country to another way overwhelm even the capacity of international relief organizations to respond. For instance, in the first month after 500,000-800,000 Rwandan refugees entered the North Kivu region of Zaire in July 1994, almost 50,000 died, an average crude mortality rate of 20-35 per 10,000 per day (*Goma Epidemiology Group, 1995*).

Women: Because of the strong preference for male children in many parts of the world, females receive inferior nutrition and health care from birth. (*Craft, N. 1997 and Mudur, G. 1996*) of the all health statistics monitored by the WHO, maternal mortality is the one with the largest discrepancy between developed and developing countries. For example, while infant mortality is almost seven times higher in the developing world, maternal mortality is 18 times higher. Up to third of all deaths of women of reproductive age in many developing countries are the result of complications of pregnancy or child birth (*KIrwin S, 1998*).

III. Extent of the problem:

A. Developed Countries: Despite the wealth of countries such as those in North America and Western Europe, the disadvantaged constitute a substantial portion of the population. Examples are:

Race/ethnicity: Cultural or language minority groups comprise between 1.4% (Italy) and 8.2% (Germany) of the population of the western European countries, 14% of the population of Canada, and over 20% of the population of Australia. The population of the US is about 12% black and 6% Hispanic.

Poverty: Poverty rates in developed countries range from 3% in countries such as Sweden and the Netherlands to rates of 20% in the US, 17% in Canada, and 11% in Ireland (*Duncan, DJ. et al. 1993*).

Geography: In most developed countries, 20-30% of the population lives in rural areas (Canada 23.8%, France 26.2%, Norway 25.4%, and United States 26.0%. However, only 3.2% of the population of Belgium is rural: in Austria and Finland over 40% of the population is rural (*World Bank, 1997*).

B. Developing countries: Poverty in these countries often results from a combination of factors such as instability, lack of important investment in education, scarcity of economic opportunities, and poor infrastructure development. The most vulnerable groups are associated with:

Race/ethnicity: Nearly every county has racial and/or ethnic minority populations and in some countries, tensions between different ethnic groups have resulted in significant conflict.

Poverty: With poverty define as an income of less than $1 per capita per day, about 30% of the world's population is poor. The number of people living on less than $1 a day rose by about 85 million to 1.2 million between 1987 and 1993 (*WHO, 1997*).

Geography: 80% or more of the population of most of the least countries lives in rural areas (example: Afghanistan 82.3%, Burkina Faso 91.5%, Myanmar 83.0%, Nepal 95.6%). Among other developing countries, the percentage of the population living in rural areas is generally in the range of 30-80% (example: China 53.4%, India 73.2, Morocco 53.3%, and Peru 31.2%) (Wood, CH. and Lovell, PA. 1992).

IV. Bases for action:

Universities are places of higher education learning, research, and community service. They are generally respected by community people, politicians, and governments. The universities, therefore, is in a strategic position to act on behalf of and work in partnership with disadvantaged communities in promotion equity, justice, and accountability in building a new health care models. Many universities are situated in close proximity to disadvantaged communities; equity requires that the university serve these neighboring communities if they are also to serve wealthier, more distant communities.

In 1995, the 48th World Health Assembly approved resolution WHA 48.8, which point out the "special contribution of medical practitioners and medical schools in attaining health for all", and calls action that would promote the greater involvement of universities in addressing the health problems of the disadvantaged (*WHO, 1995*).

In 1998, UNESCO called a world conference on higher education and reaffirmed in a "World Declaration on higher education for the Twenty-first Century" that special attention should be paid to the community service functions of higher education institutions through activities aiming at eliminating poverty, violence, illiteracy, hunger and disease and to activities aiming at the development of a culture of peace (*UNESCO, 1998*).

V. The role of the universities and intend course of action:

A. General

1. Relationships between universities and disadvantaged communities have traditionally favored the university. People from these communities have served as "teaching material" for university students who will ultimately peruse their carriers in well-off areas. Communities' members have served as research subjects, often without adequate informed consent. These practices should cease.

2. Member of disadvantaged communities should be included in the planning and oversight the programs that will affect the communities. They should participate on relevant standing committees of the universities, such as the admission committees and the committee that reviews proposed research ("Institutional Review Board").

3. All health problems have multiple causes an all call for interventions from multiple disciplines and from multiple sectors of development (*Boelen, C. 1991*). The biomedical sciences, the behavioral sciences, political science, engineering, education, agriculture, and other fields all have a role to play in addressing the health problems of disadvantaged. The separation of the university into colleges, schools. And department that have little interaction must be overcome if the university is to achieve its potential.

B. In education

1. The university students should be recruited from disadvantaged communities. Such students are more likely to in India, as per constitution of the country, other back ward class (OBC), scheduled cast (SC) and scheduled tribe (ST) are given reservations in university admission, *i.e.* 27%, 15.5% and 7.5% respectively who are playing crucial role in social awareness, economic uplift and are sharing democratic expressions for the cause of disadvantaged, return to disadvantaged communities to pursue their careers, are more likely to remain there, and are more likely to understand and respond to the unique problems of such communities. It is the responsibility of the university not only to provide information about opportunities in higher education to secondary school and pre-professional students in disadvantaged communities, but also to provide medical and enrichment programs to assist such students to qualify for university admission and retention.

2. The curriculum should prepare students for careers in disadvantaged communities. Attention should be given to:

- Relevant cultural factors, such as language, modes of communication, and health-related beliefs and practices.
- The environment, since disadvantaged communities often suffer from in adequate housing and sanitation and are often located in the least desirable areas, where they may be exposed to pollutants.
- Substantial practical experience in such communities as are required component of the curriculum.

C. In research

1. Priority should be given to research on the special health problems of disadvantaged communities, on understanding the underlying determinants of poverty and inequality, and on approaches to reducing the disparity in health status between disadvantaged and well-off communities.

2. Exploitation of disadvantaged communities and disadvantaged patients for research purposes should specifically be avoided. Attention should be given to obtaining informed consent from both individuals and communities. Members of disadvantaged groups should be included on university committees with research oversight.

D. In service

1. Universities are among the institutions that have an obligation to serve as the ethical leaders in societies. Indian constitution also recommends the reservation of Govt. jobs for scheduled cast (SC) and scheduled tribe (ST) *i.e.* 27%, 15.5% and 7.5% respectively. It is consistent with this obligation that they provide health services for the disadvantaged. The duty to provide such service is strengthened by the fact that most health profession schools, even private schools, receive a significant public subsidy in some form. The service commitment is independent of the need of the school for patients that provide learning opportunities for its students.

2. The innovators, universities should explore and develop new models of providing care for disadvantaged communities. This role is closely connected to the university's role in both teaching and research. Universities are in need of new, community-based service sites at which teaching can take place; and the evaluation of new modal of care is an important aspect of health service research.

3. Universities must accept a certain degree of accountability of society's health and well-being if they wish to continue to be force for social progress and consequently to merit taxpayer support. To fully respond to societal needs, universities must accept responsibility for their deeds. The social accountability of universities can be defined as the obligation to direct their education, research, and service activities towards addressing priority health concerns of the community, region, and/or nation they have a mandate to serve (*Boelen, C. and Heck, J. 1995*).

E. In policy development

1. Beyond their own walls, universities play an important role in policy development at the local, regional, and national level. Increased attention to the health and health care needs of the disadvantaged by universities will be reflected in other venue as well. There is reservation for member of parliament in both upper and lower house for scheduled cast (SC) and scheduled tribe (ST) i.e. 15.5% and 7.5% respectively who play pivotal role in national policy discussion for disadvantaged sincerely, in *Panchayti Raj* system there is reservation for other back ward class (OBC), scheduled cast (SC) and scheduled tribe (ST) i.e. 27%, 15.5% and 7.5% respectively who are crucial in country side in policy discussions. Besides that several universities have been established in geographically isolated areas.

2. The health of the disadvantaged will be improved less by health care than by initiatives affecting economics, employment, education, and social issues. University leadership in policy development that has an impact on these determinants is of particulars importance.

VI. Summary and conclusion:

This paper has illustrated the potentiality of higher education institution and there course of action and the course of action and background for university involvement in improving the health of the disadvantaged. The gap between "have" and "not have" in both developed and developing societies have been noted. While the degree of disadvantage may vary, disadvantaged persons and groups may be found in all societies. The fundamental causes are to be found in such social determinants as race/ethnicity, poverty, and geography. Traditionally, minority populations living in poverty and located in rural areas are the most disadvantaged with regards to health status and otherwise.

Given their role in society and multidisciplinary aspects, the universities are particularly well-equipped to address the problems of the disadvantaged. Indeed, they have been called to do so at many levels, including resolution by the World Health Assembly in 1984 and 1995. To be effective, however, universities must enter into partnerships with disadvantaged people and communities rather than relating to them from the position of superiority. The must see the interrelationship of service, education and research and develop new models for addressing the problems of the disadvantaged. This will be done by policy development and application of universities' multidisciplinary expertise. Concern for the health of the disadvantaged will only be part of this process.

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