Nearly forgotten: The mental health needs of an urbanised planet

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Introduction

It is an amazinig fact that goverments of the world, faced with rampant urbanisation, have not developed a strategy for the provision of health care in cities. In some 30 years four-fifths of the world population in developed and developing countries, will be living in urban areas. This represents a steady growth for industrialised countries and a revolutionary change for most of the others. It is easy to predict that this change will bring new health problems or magnify those currently facing health care in an unprecedented manner: it is also probable that a well formulated plan of action to counter these problems might make it easier to deal with them.

These predictions have to be considered against the background of three arrays of facts. The first concerns the size of future cities: it is very unlikely that cities will cease to grow when they reach the size of today's largest towns: judging from tendencies already visible in sorne developing countries the cities of the future will grow to unprecedented sizes –to agglomerations of dwellings of 20 or 30 million people. Megalopolises are not only cities grown big: they are likely to be different creatures– in the same vein as adults are not big children although they continue to belong to the same biological species when they are children and when they grow up. This change –a revolution in Hegelian sense– means that most of the knowledge and administrative skills developed to manage cities will be only partially applicable to deal with life of a megalopolis; that health care organisation as well as other social services will have to examine systematically the applicability of their current strategies and ways of functioning if they are to be useful. This change of size also means that cities will no longer have a decorative town hall and a ceremonial mayor: a future megalopolis the size of a country or even a group of countries, will have the political processes and powers of a country the size of Ukraine, or of all of the Nordic European countries taken together.

The second array of facts concerns the locus of fastest growth. Urban growth is already much faster in the developing than in the industrialised countries. Life in Third World towns, with all its dangers and shortcomings, is still better than life in rural areas. Towns act as an irresistible magnet for the populations in the rural areas. Villagers in many countries become exhausted by their battle against corrupt administration, failing crops, the harsh environment and consequences of disasters rendered ever more costly in human life because of growing population density. Their vital forces get sapped up feeding guerrilla wars, by economic difficulties reflecting speculations at faraway stock exchanges, by expenses of pharaonic buildings, and by the continuing presence of (often preventable) communicable diseases. The apparent easy availability of all things in cities also exerts its influence, as do stories of successes and easy lives that some of the first migrants to cities have been able to lead.

Villagers do not migrate to towns any longer in small numbers and slowly: their move to cities is massive. They bring with them their culture and their habits, their manner of life often incompatible with functioning of large aggregations of humans sharing a restricted area. They are at first amazed by all that can be obtained, then despondent because all this wealth cannot be theirs; their search for a better life then takes different paths, from work for minimal wages (and without protection) to crime, violence, and prostitution. Health care for newcomers to towns is neither that appropriate for the villages from which they came nor that of towns in which they now live.

Third world cities are not only growing faster than their counterparts in industrialised countries: they also differ from them in many other ways. The population density in Cairo in 1995 was 375 inhabitants per hectare and in Calcutta 220: in comparison London had 40, New York 44, and Frankfurt 26 inhabitants per hectare. The number of children and adolescents in the developing country cities is much higher than in the developed countries, reflecting the difference in demographic structure between those two types of countries in general. There are other differences, often neglected, that matter a great deal in organising health care; the number of abandoned children and adolescents without family, for example, in some developing countries (e.g. in Latin America) is much higher than in the developed countries and continues to grow at a fast rate.

The third set of facts concerns the dramatic changes of the demographic composition and function of rural areas, the main donors of population to cities in many countries. Young and able-bodied people are often the

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first to leave home, with the resulting increase in proportion of the disabled, elderly and those too young to leave the rural areas. In some instances those who fail to succeed in towns or become disabled because of working conditions return to villages, further decreasing the capacity of the rural areas to function independently.

Villages near towns become dependent on them and on demands that towns make. Modern agricultural production reduces employment opportunities in rural areas, greatly increasing the numbers of the rural proletariat and of seasonal migrant agricultural populations now reaching vast numbers, for example in the Americas. The change of production style in rural areas further contributes to the reasons for leaving villages and migrating to towns, without any hope or wish to return to the rural area.

Mental disorders in towns

The prevalence of mental disorders in cities differs from that in rural areas. In China, for example, schizophrenia seems to be more prevalent in cities and learning disability in villaiges (Cooper & Sartorius, 1997); in the UK, a 1995 survey showed that depressive disorders, generalised anxiety and phobias are higher in urban areas than in rural areas (Meltzer, Gill, Petticrew, & Hinds, 1995). There are more lonely chronic mentally ill people in cities than in villages. The homeless mentally ill in urban areas of industrialised countries are comparable to vagrant psychotics described in developing countries. It is uncertain, however, whether the mortality of these two groups is similar. It is also probable that mental disorders linked to early brain damage should be more prevalent in areas –urban slums or remote villages– in which access to health care and appropriate nutrition is difficult: unfortunately, these are also areas in which statistics (or results of studies) about morbidity from mental illness and mental impairment are less reliable, if available at all.

Drug and alcohol dependence have been described as urban mental health problems: there are, however, many areas in the Third World in which rural areas are just as strongly hit by drug dependence problems as the populations of towns (e.g. Pakistan, Thailand), and there is little doubt about the ravages that alcohol abuse and dependence creates in rural areas in many countries.

Studies of schizophrenia showed differences in course and outcome of mental disorders between developing and developed countries. Systematic comparisons of course and outcome of schizophrenia and other mental disorders in urban and rural areas of developing and developed countries are however lacking and it is unlikely that such data will become available in the immediate future. What is true for major mental disorders such as schizophrenia may also be true for other mental disorders and for neurological disorders. Differences in the prevalence of mental disorders in urban and rural areas have also been described: there is however little agreement about the reasons for this differences which may well, at least in part, be the result of variations in course and outcome of diseases.

While there is some information about differences in the prevalence of mental disorders in urban and rural areas data about the differences in the severity of the psychosocial problems of cities are by and large lacking. Loneliness, anomia, stress-related disorders (e.g. hypertension) as well as various forms of antisocial behaviour (e.g. violence) are seen as being typical of cities: it is difficult to know whether the situations that have been described in cities of industrialised countries also exist in developing countries and to what extent they are qualitatively different from them. Violence has been epidemically and then endemically present in certain countries, in both rural and urban areas (e.g. Mexico, Colombia) and it is difficult to declare violence in those countries as a typically urban problem.

It may be that in the future the differences in prevalence rates of mental and physical disorders in towns and villages will diminish. In developing countries today, for example, people suffering from a chronic disease will move to towns where help for their condition is available and then stay there, thus increasing the prevalence of certain chronic diseases. The increased density of families that contained a person suffering from a mental disorder around hospitals has been demonstrated in the past in the USA: similar phenomena are even more visible in the newly created settlements at the doorsteps of mental hospitals, for example in front of the Aro Mental Hospital in Abeokuta, Nigeria. With the development of communications, i.e. roads and cheaper transport between towns and surrounding areas, this type of migration of selected groups of population might decrease, thus diminishing differences between towns and rural areas.

A recent report (Harvard Working Group on New and Resurgent Diseases, 1995) provides a gloomy forecast of diseases of the future by pointing out that infectious diseases remain the leading cause of death in the world and that numerous diseases that were considered to be under control have made their way back to the top of the killing charts. Diphtheria has emerged as a major killer of adults in the countries of the Community of Independent States (in Russia alone the number of cases doubled between 1985 and 1992). Malaria and tuberculosis are creating major problems in many countries. Plague has made its way back in India and cholera has emerged in Latin America. Dengue fever, haemorrhagic fever, yellow fever as well as some diseases about which little was known (e.g. Lyme disease, hanta virus syndrome, toxic shock syndrome, AIDS and Ehrlichiosis) have appeared on the lists of priorities for public health authorities. Changes of ecosystems, water management, major development programmes, pollution, and over-harvesting of certain species (e.g. fish) as well as other excesses of socio-economic development combined with an increasing vulnerability of the human organism seem to make it certain that communicable diseases will continue to grow and create public health problems –the major difference probably being that they will no longer be restricted only to rural or only to urban areas but will hit both areas, and in them particularly the poor, with similar power.

Opportunities for health care interventions in cities

At present urban areas offer opportunities for health care interventions that would be difficult to find in villages. The population is easier to reach in health campaigns. Health care personnel are concentrated in towns and are likely to stay there. Slum dwellers, particularly in the developing countries are resourceful and can be motivated to participate in health care activities. Funding for health care is easier to find. In-service training for personnel of health and other social services is easier to organise. Quality assurance of health care facilities is less complex. Supplies of health care materials are easier to organise. Laboratories can function more efficiently. Politicians and other individuals of high public visibility can be shown health services in difficulty and be involved in improving them. Gaps between academia and practice can be diminished and training of different categories of health care personnel can be carried out in health facilities serving the majority of the population.

Many of these opportunities for improving or providing health care in towns are not utilised; it is however important to remember them in defining health strategies for cities and in calculating investments that might be necessary to put urban health care into operation.

Possible areas of action

A prerequisite for the formulation of a useful and usable strategy is agreement on the meaning of terms and concepts used in its formulation. In the instance of a strategy for health care in cities, the meaning of many of the concepts that have to be used changed in the past few years. There is no commonly accepted definition of a city, or of a village, township or town. Villages previously inhabited by farmers toiling the land nearby have become inhabited by middle class and richer people from towns who establish secondary residences in those villages now being described as romantic, charming, quaint and culturally traditional. Townships have forever lost their previous meaning and now remain synonymous with the aggregations of prefabricated and concentration camp like structures established during apartheid in Zimbabwe and South Africa. Cities in the developing world have grown rapidly and often have the appearance of a huge camp of migrants or refugees situated around a dilapidated nucleus of a previously established small or medium sized town housing the administrative centre of a province or a country, built over the past 100 years or so. The periphery of the settlement may contain the newest migrants to town; but there are vast differences in the manner in which these towns have grown and in which the population groups that make up the town have distributed the space occupied by the city. In some instances the original tribes or villages re-establish themselves in the new settlement; in other instances the social class structure prevails and the rich live with the rich, the poor with the poor. Developed country towns have also become different from what has been described by writers, sociologists and demographers in the past six or eight decades, during which much of the writing on the subject was done. Inner city slums have been turned into expensive property and house the chic and rich; and the huge buildings or groups of buildings housing several thousand people have not infrequently turned into citadels, better depicted by artists in films or novels, than by scientists who seem to write little about the structure and functioning of such conglomerates. Currently growing gaps between scientific disciplines do not help to learn more about these matters: geographers who produced excellent descriptions of new urban arrangements rarely write in a manner that is attractive to doctors; and even if they did, it is unlikely that public health decision makers or psychiatrists would be following this literature.

Even the concepts of a street or a park have different meanings from one setting to another. The streets in which house numbers go up to 10,000 or more represent different concepts from the street in most European towns which never had more than a couple of hundred house numbers and in which it was highly probable that everybody knew everybody else. Towns that came into existence at different points of time bear characteristics of that time that distinguish them architecturally and functionally from one another, to a degree that makes it necessary that they organise the lives of their citizens and their health care in radically different ways. While basic medical skills required to work in towns may be similar, demographic features of a town —e.g. the preponderance of elderly persons, or of children— and various other characteristics of the city will require special or more skills in one area than in another.

Terms used to describe towns are not the only which have changed their meaning: the same is true for other frequently used notions and concepts, for example that of the community. A community was earlier defined as a population subgroup occupying a defined geographic area and having links of mutual support: nowadays, the criterion of living in the same area is only rarely useful. Links of mutual support are still important but do not, any longer, exist primarily among neighbours. People inhabiting the same geographical area in modern towns often do not know each other and have little in common with the exception of their address; links of support are defined differently, by family ties, by the enterprise emploving the breadwinner, by minority or language grouping. Administrative authorities still do not recognise this change of definition of community and establish community health centres, for example, that serve only a small subgroup of the population.

Nor is there agreement on the way in which the functioning of a town or the success of a health care intervention will be assessed. Indicators of change differ from one setting to another and their definition is often slightly but significantly different so that comparison across services, across towns or across time are flawed.

It would be too ambitious at present to seek acceptance of indicators of progress, on the definition of criteria, on methods of definition of areas of intervention (e.g. of 'communities'), or criteria for the assessment of levels of priority, although this would be highly desirable. An immediate objective at present should be to work

on the definition of terms in a manner that will allow their clear comprehension and a rational interpretation of the results of studies or of monitoring service interventions.

Next, it will be necessary to admit that towns have their personalities and that there is no such thing as a strict doctrine that will be applied in each case. The best that can be expected is agreement on certain principles that can serve as the frame for health care activities. These principles will have to be formulated, proclaimed and then used in developing plans, in educating the general public and in creating new generations of health workers. The essence of most of these principles can already be stated: the challenge is to formulate them sufficiently clearly for all to understand and use.

One such principle is that health care in cities can not and should not be planned or executed by the health care sector alone. This principle of multisectoral involvement has also been put forward in the Alma Ata Declaration: over time, it has been implemented in a number of settings, often with reluctance and usually with reservations. Successful services developed already, and described in the chapters that follow, show how health and social services can collaborate; how the voluntary sector can be included in mental health services; and how users themselves can contribute to the overall service. The political backing for multisectoral collaboration should not be sought as an afterthought: rather it will be of importance to assert that no significant improvement of health in cities can be expected until and unless the political authorities and leaders make that their own priority and force the administrative authorities to find structures and manners of function that will ensure collaborative action that will result in better quality of life of citizens. Those that can demonstrate that their efforts can make a significant contribution to that goal can then be given an opportunity to do so.

It is also clear that long-term planning in conditions of rapid social change and amid economic upheavals can not be realistic. While general principles of health care –such as equity in distributing benefits of health care and parity in service provision for mental and physical disorders– must be stated and used as a framework for short-term specific plans, 'rolling horizon' planning and programming, are imperative: in order to make them possible and realistic, resources of health care services will have to be structured in a manner that will allow changes in the direction of care or a major re-orientation of activity in a short time.

Parallel to the principle of flexibility must be the principle of accountability and transparency of expenditure and investment. If the population is to be a willing partner to health care authorities it must be given respect and opportunities to see what is going on and what its own contribution to health care might be. In the first instance this will involve a major investment in a different type of health education –education on how to plan, execute and evaluate health care programmes. Health education of the type that was promoted previously –for example on the reproductive cycle of disease vectors– will have to continue but should not be seen as sufficient for health care purposes.

The acceptance of the population as an equal partner in the planning and execution of health care requires a significant change of the definition of the health professions and their life course: this is however the price to pay if a new paradigm of health care is to be introduced. A corollary of these principles is that investments have also to be made in activities that will promote health and mental health on the scale of values of individuals and communities. Once the population values health highly it will be willing to participate in efforts to prevent diseases or make arrangements for their treatment (Sartorius, 1998).

Another principle that might be useful for the improvement of mental health care in cities is that progress should be achieved by learning from others –in the same country or elsewhere– and by sharing one's experience with them. This commonality in progress will involve the creation of networks of information exchange and the development of an attitude of humility about one's own achievements or country. This volume is an important step in that direction.

Coda and invitation

Thirty years ago, the World Health Assembly that brings together Ministers of Health or their envoys from the member countries of the World Health Organization expressed appreciation and unanimously adopted the various measures that were necessary to put the Alma Ata Declaration on primary health care into operation. The Declaration and the documents that accompanied it defined a new strategy of health care for the world. It introduced principles and guidelines that directed health systems into a new manner of operation. It underlined the need for delegation of most of health care tasks to relatively simply trained personnel, the imperative necessity to rationalise health care expenditures, the unavoidable assignation of priorities to health problems, the need for new alliances between health and other social sectors in all health care action and the usefulness of monitoring progress and achievements. Primary health care was a strategy (Sartorius, 1997) expressing the manner in which health care should reflect ethical principles governing societies at the end of the 20th century. It harnessed energy, knowledge and good will of many into a common framework of health care for the next three decades.

Useful as it might have been at the time of its formulation, the Primary Health Care strategy was deficient in that its prescription was primarily applicable to developing countries and in them, to care in rural areas. It did not anticipate changes in the trends of urban development nor foresee a viable mechanism for its own evaluation and revision in time. It was clearly overawed by the magnitude of health problems of the 1970s and captured in the political tensions that prevailed at the time of its formulation.

The consequences of these shortcomings are emerging in a variety of ways. Primary health care as a single strategy and as the only locus of investment in the health care system has lost its appeal in many countries and for most of the public health and other decision

makers. Faced with urban health problems and changes in the rural areas ministries of health and social welfare employ a variety of strategies that are often in part or in their totality contradictory to one another although concocted in the same country or even in the same city at two points of time. Health plans are based on obsolete public health notions and lack foresight. Investments into health care are spasmodic and often governed by the need to deal with yet another crisis. Data on which public health action should be based are not collected regularly, or are losing credibility for a variety of (usually political and managerial) reasons. Economic imperatives are invoked to justify decisions whose ethical features are often at the very limit of acceptability. The complex mental health systems, involving many agencies and bringing together expertise from different sources that are described in the pages that follow are examples of the sort of systems that will need to be developed. They go well beyond a simple reliance on primary care services as the remedy for all problems.

Mental health problems of cities of today and even more of tomorrow are many and severe. They complement and aggravate other health problems that endanger existence and quality of life of citizens of urban and rural areas. They must be faced and overcome if the majority of mankind is to have a future worth living.

The formulation of a strategy to overcome mental and other health problems of the cities of the future will have to proceed in an inductive manner, basing its formulation on examples of successes often achieved under conditions of tremendous scarcity and deprivation of resources of all types. It will have to draw its strength from the motivation and creative power that was demonstrated in towns that have developed mental health and other health services. It will have to use the experience gained in developing health care and in many other areas of humanitarian effort.

Developing strategies and services that can provide appropriate health care for the cities of tomorrow is a venture of survival in an unknown territory replete with problems but also with promises of progress in a material and moral sense. In this game success will depend more than ever before on the collaboration of many, on the creation of a productive alliance between the population at large, patients and users of health services, scientists, health professionals, decision makers in the fields of health, mental health and other industry, nationally and internationally.

The principles for action proposed above are a personal choice. Their enumeration will have achieved its purpose if the list will stimulate the formulation of a list of tenets for urban development —including the development of urban health and mental health care. Reaching agreement on these tenets, the creation of a strategy formulated jointly by all concerned and then used by them, is an essential task for all of us at the point of entry into a new millennium in which people should not only end up by being in cities but should share a determination of making cities a liveable place, in which they can grow together and continue to improve the quality of life for themselves and for all those who will follow them in time.

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