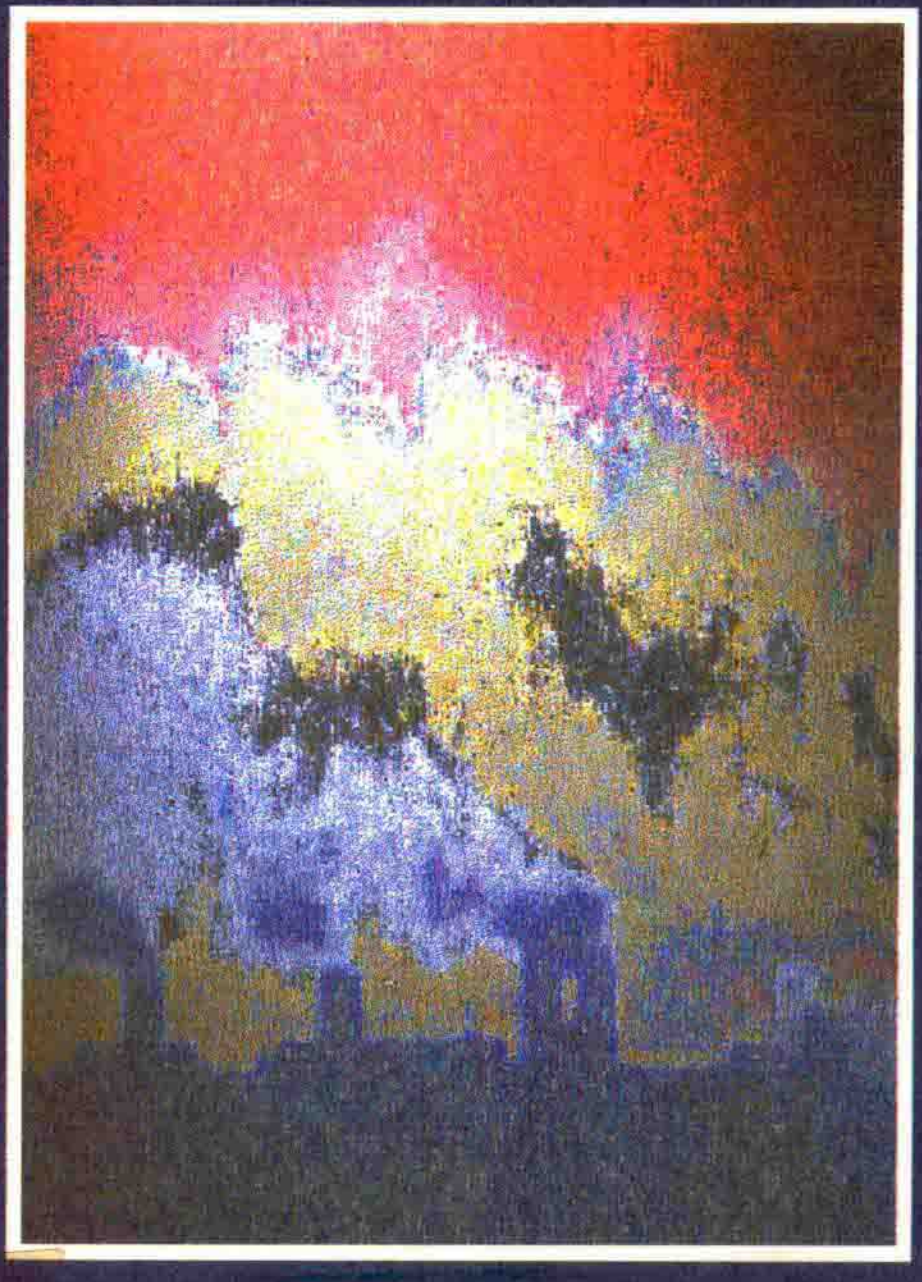
The urban health crisis

Strategies for health for all in the face of rapid urbanization



World Health Organization
Geneva

THE URBAN HEALTH CRISIS

Strategies for health for all in the face of rapid urbanization

Report of the Technical Discussions at the Forty-fourth World Health Assembly

World Health Organization
Geneva 1993

WHO Library Cataloguing in Publication Data

The Urban health crisis : strategies for health for all in the face of rapid urbanization : report of the Technical Discussions at the Forty-fourth World Health Assembly.

1.Urban health 2.Urbanization 3.Health policy

ISBN 92 4 156159 9 (NLM Classification: WA 380)

TYPESET IN INDIA
PRINTED IN ENGLAND

93/9628–Macmillan/Clays–7000

Contents

Introduction

The selection of urban health as the subject of the Technical Discussions at the Forty-fourth World Health Assembly was a highly significant turning-point. It marked the explicit recognition by the World Health Organization of the impending health crisis in urban areas, and indicated a distinct shift of emphasis in public health thinking. Previously, there had been an almost exclusive preoccupation with the problems of health in rural areas; however, it was becoming clear that, although there were some issues that were specific to either the rural or the urban situation, the core issues of the balance between population and resources, the movement of people, and the process of rapid urbanization had implications for health and well-being in both rural and urban areas. The resulting problems of both rural and urban areas are interrelated and indivisible.

The recent emergence of concern about urban health can be easily explained from a review of the growth and distribution of the world population. The number of people living in towns and cities throughout the world is growing rapidly, and by the end of the century the number of urban dwellers will exceed the number of rural dwellers for the first time in human history. The large-scale movement of people to the towns, which began in Europe with industrialization, has become a global phenomenon. The urbanization process may be seen as one that begins with movement from country villages to small and medium-sized towns, which rapidly become big cities, and that progresses to intercountry migration and the movement of people from the poorer to the richer parts of the world.

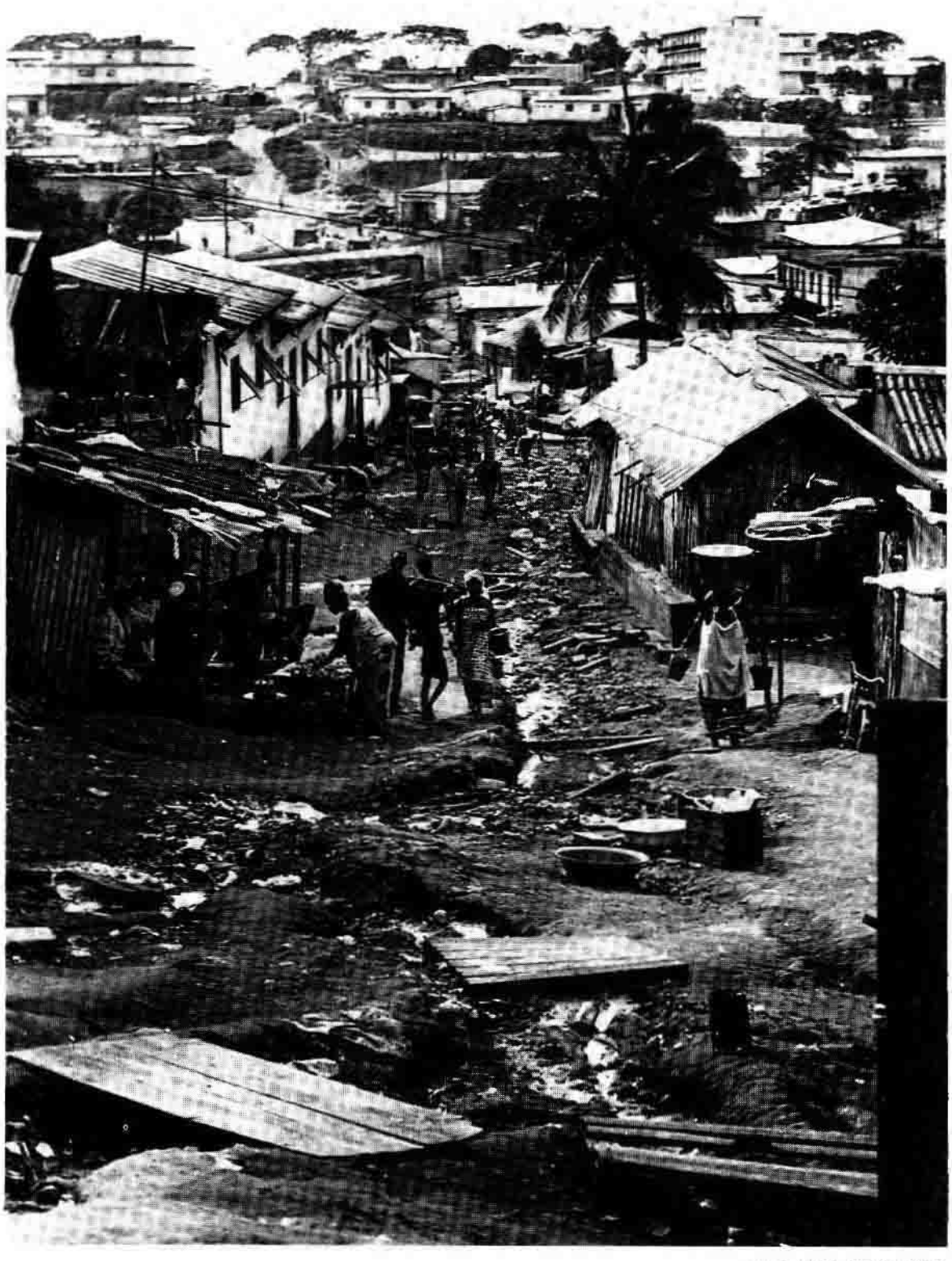
Rapid urbanization is now most marked in developing countries, where urban growth rates of 3% or more each year are not uncommon. Such growth rates, which lead to a doubling of population every twenty years, are so high that the local authorities are unable to keep pace with the demand for basic services such as housing, water, and sanitation.

This rapid urban growth is a result of two factors: the movement of rural populations into towns on the one hand, and the natural increase resulting from a surplus of births over deaths in urban populations, on the other. In general, as countries reach higher levels of urbanization, the impact of migration becomes less important and that of natural increase more important, especially among low-income groups.

The problems observed in cities 150 years ago are all to be found today, on a much bigger scale and with much worse consequences. However, some things are different; science has provided some remarkably effective tools, such as immunization and family planning methods which, if made available to populations and properly used, can help prevent a vast amount of human misery, ill health, and loss of life. Many cities have well-developed public services and health systems which, if properly managed, can make a significant contribution to this process. Unfortunately, these services and systems are frequently bureaucratic, compartmentalized, and ineffective. They fail to connect with other organizations that have a contribution to make, and alienate the people they are supposed to serve. Sometimes it may seem that public organizations are run more for the benefit of the employees than for the public.

In many countries, urban populations are now so large that they have outgrown the capacity of the surrounding agricultural areas to provide the food and raw materials needed to sustain them, and they overload the natural water systems with human and industrial waste. As a result there is a vicious circle of environmental deterioration, reduced agricultural production, "natural disasters", and increased pauperization and landlessness. In addition, the idea that the cities offer a better life than the depressed countryside is encouraging migration to the cities just when decreased agricultural production is reducing the availability of food and increasing its price.

As a result there is poverty and ill health in both rural and urban populations, together with severe ecological pressures on the environment. About half the inhabitants of cities in the developing world are likely to be living in conditions of extreme poverty and, until this basic problem is tackled, the total number of premature deaths in developing cities will continue to increase. One difficulty in taking effective action to deal with the situation is the lack of even basic information on birth and death rates, the incidence of disease, and environmental conditions. When such information is available it is usually found that, in urban areas, the health of the poor is much worse than that of the better-off and that, contrary to popular belief, it is no better and may be much worse than that of people living in rural areas.



WHO/UN/B. Wolff (20952)

Crowded, makeshift housing and inadequate water and sanitation are associated with increased mortality and morbidity due to communicable diseases, especially gastrointestinal and respiratory diseases.

Nor are the problems of the urban poor confined to the developing countries. In the industrialized parts of the world, cities are to be found at many different stages of development. In some places, new cities are still being established, and old ones continue to grow and to be remodelled. In others, once-great cities are undergoing a rapid decline, with increasing pollution, deteriorating physical infrastructure, and inner-city decay, as well as the loss of young and skilled people to economically more rewarding areas. The populations left behind tend to have a high proportion of old and sick people, with more social stress and weaker networks of social support. All of this is made worse by the limited access to health and social services that is the usual lot of the poor.

The health consequences of poverty in the cities of the developed world include a high incidence of heart disease and stroke, cancer, drug and alcohol abuse, accidents, violence, and sexually transmitted diseases, including HIV infection and AIDS. In the cities of the developing world, a high incidence of these conditions exists alongside traditional health problems such as high maternal, perinatal, infant, and child death rates and infections and parasitic diseases that have thrived under squalid urban conditions.

The trends of growth and decay in cities have been accompanied by dramatic changes in traditional social structures—the decline of the three-generation family and the changing expectations of women and of marriage, together with many changes in personal and social expectations and goals. Accompanying these changes have been increasingly mixed societies with multiracial and multicultural communities becoming commonplace.

The widespread breakdown of family structures and networks of social support has been an important factor in such escalating threats to world health as AIDS and drug abuse and the high incidence of mental illness. The dramatic increases in population are in many parts of the world accompanied by considerable increases in the proportion of people who live to an old age; this in itself is creating a crisis of social and medical care throughout the world in both rural and urban areas.

All these aspects of the urban condition have combined to throw the spotlight on the urban health crisis and to challenge governments, nongovernmental organizations, local health systems, and ordinary citizens to do something now before the situation is completely out of control.

Chapter 1

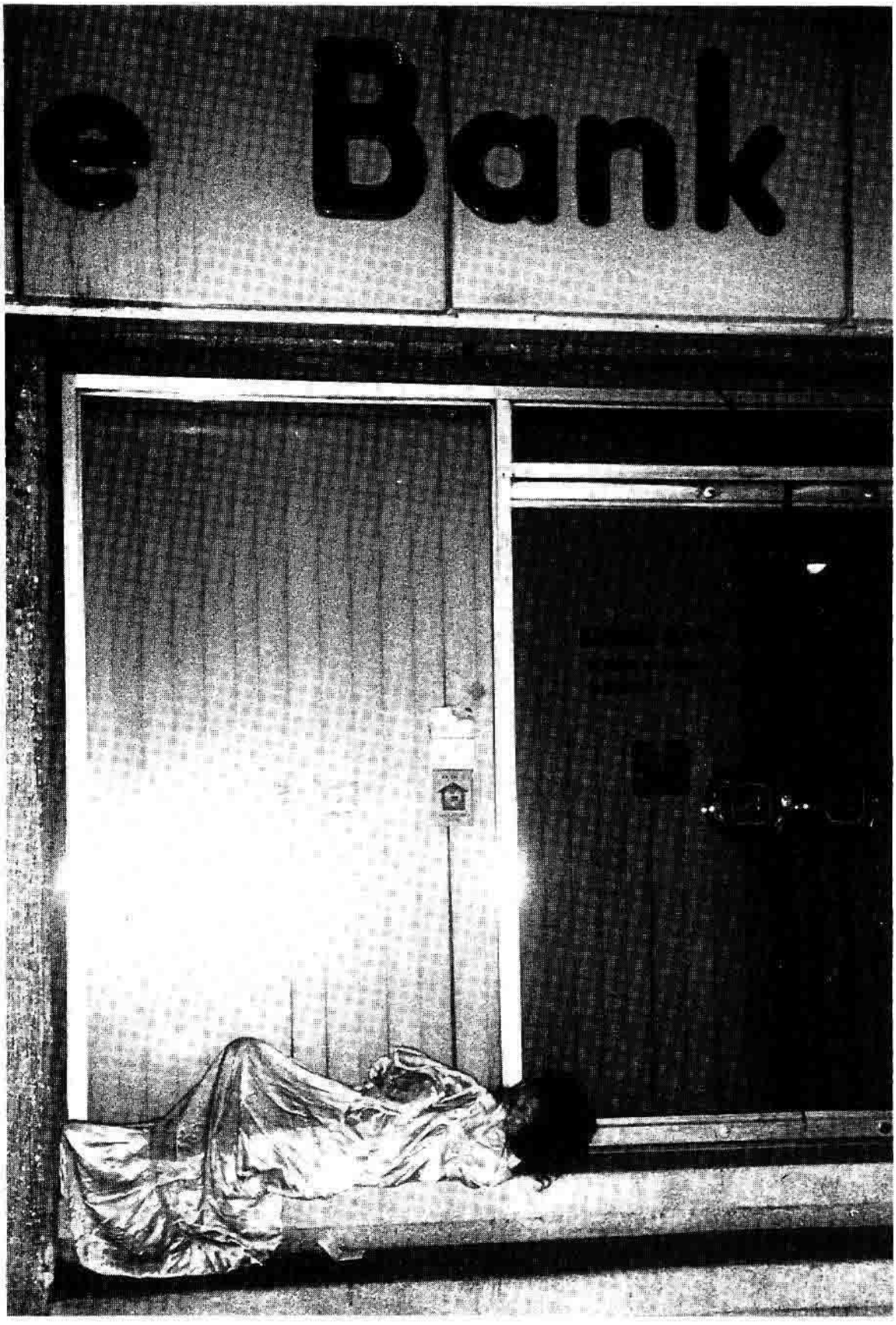
Health and the cities: a global overview

Trends in urbanization

Urban growth is fuelled by poverty, the search for work, insecurity of land tenure, changes in farming and in industrial processes, and the growth of service industries. Policies for economic development that tend to lead to concentration of opportunities for work and of pools of skilled labour in towns and cities are accompanied by a widespread view that cities offer a better life than the increasingly depressed rural areas. Despite prophecies that the cities are doomed, they remain in the front line of innovation and change and, for many, offer dreams of an urban Utopia; millions of young people around the world still flock into cities.

Slum conditions are to be found in all the cities of developing countries. However, the extent of these conditions and of actual homelessness varies from city to city. In some cities, such as Calcutta and Bombay, a majority of the population lives in slums. However, in addition to the large numbers of slum-dwellers there are also many people who are completely homeless and who live on the streets. This is a particular problem in, for example, Calcutta, Manila, and even in Los Angeles, where as many as 50 000 people may be homeless.

Meanwhile urbanization contributes to changes in local ecosystems and the biosphere that affect the health and living conditions of both urban and rural populations. These changes have produced a burden of ill health and disability that is of crisis proportions in some Third World cities, especially in countries that have stagnant economies and heavy burdens of external debt to banks and institutions in the developed world. This crisis is deepened when health service resources are used inequitably or are misused on low-priority or inappropriate programmes.



WHO/Zafar (20917)

The bank houses the wealth of the few; its entrance offers a place to sleep for one of the many "street children".

- Urban populations have greatly increased in the past 40 years.
- The greatest increase has been in developing countries.
- Urban populations will increase even more rapidly in the next 35 years with an explosive growth of cities in developing countries.
- Although the number of rural dwellers will increase, their share of the total population will not: people living in cities will become a majority of the world population, and the proportion of people in developing countries living in cities will approach that of the developed world.

Factors that have an impact on health include:

- Rapid and massive urban population growth, both in an increasing number of "megacities" and in smaller cities.
- Large populations in squatter settlements and shanty towns often occupying urban land subject to landslides, floods, and other natural hazards.
- Increased population density, overcrowding, congestion, and traffic, and the spread of unsuitable residential patterns.
- Ever-growing numbers of people living in extreme poverty, many of them—especially women and children—at high social risk.
- Increasing biological, chemical, and physical pollution of air, water, and land from industrialization, transportation, energy production, and commercial and domestic wastes.
- Financial and administrative inability to provide a sanitary infrastructure, promote adequate employment and housing, manage wastes, and ensure security, environmental controls, and health and social services.

Quality of life

Productivity and poverty are two indicators that are useful in assessing the quality of life of urban dwellers. Productivity is a measure of the efficiency of large cities as engines of economic

development and producers of amenities. A minority of the population of developing countries living in cities produces the majority of the gross domestic product (GDP). The extreme cases include Bangkok, where 10% of the national population produces 80% of Thailand's GDP, and Dhaka, which contains 4% of Bangladesh's population and 60% of its manufacturing establishments. Among the reasons for urban productivity are the economies of scale and the benefits that come from a variety of productive facilities being close to each other and to a large market for their products, and the tendency of cities to attract the better educated, the skilled, and those with disposable income. These factors make it feasible to provide an efficient infrastructure and services, including medical care services. However, the possibility of doing so may be reduced because of a lack of investment, wasted resources, poor management, and inadequate political and social organization.

Both developed and developing countries have examples of places where poorly managed urban development, together with economic stagnation, has led to reduced production, higher prices

WHO/ILO/D. Bregnard (20951)

Job-seekers in urban areas are increasing faster than municipal economies. Is this employment? Repairmen offering their services by the roadside, Mexico City.

and unemployment levels, cuts in public expenditure for social services, higher borrowing rates, and a decline in infrastructure investment. Urbanization may either help or hinder rural development. The rural economy may be supported through increased demand for products and through people who have moved to the towns sending cash to their families. On the other hand, urban consumption may place excessive demands on the hinterland's resources, as well as causing damage through the disposal of waste. Although comprehensive statistics on urban poverty are lacking and the ways in which it is measured differ, it is likely that about a quarter of the world's population—1 100 million people—are living in poverty, most of them in developing countries, and that about one-third of urban dwellers in developing countries live in substandard housing or are homeless.

Health risks are increased by poverty because basic needs go unmet and the poor are exposed to additional hazards. In most industrialized countries the urban poor are a small but growing minority. They suffer the effects of deprivation and are increasingly afflicted by the evils associated with industrialization: toxic pollution, congestion, noise, heart disease, mental illness, drug abuse, crime, and violence. In developing countries, poor and near-poor populations are much larger, economic conditions worse, infrastructures undeveloped, personal safety more threatened, goods scarcer, and illiteracy more widespread. Most social development policies have tried to counter the effects of poverty but the interventions have usually helped relatively few people. Rarely do policies attack the root causes of poverty—the need for land reform, low pay and inequitable wage structures, insecure housing tenure, poor protection for workers, social isolation, and poor health. Meanwhile, the potential contribution to improved well-being of those working in the informal economy has seldom been fully realized, although they make major contributions to house-building, the recycling of waste, and the production of cheap goods and services essential to urban enterprise and to consumers.

Urban growth and community organization

Newcomers to growing towns and cities have always been likely to find themselves living in the most adverse surroundings. Some 140 years ago, 300 000 refugees from the Irish potato famine landed in Liverpool, England. Between 60 000 and 80 000 of them settled in the city at a time when the resident population was 120 000, living predominantly in the poorest parts of the city, where they recreated

as best they could a village and parish structure within the town. The inevitable result of this influx of desperately poor and starving people, forced to live in crowded and insanitary slum conditions, was a massive outbreak of typhus, accompanied by epidemics of smallpox, measles, scarlet fever, tuberculosis and, in 1849, cholera.

This type of experience is being echoed today around the world, often on a much greater scale than in Liverpool in 1848. Not only are there countless disadvantaged high-risk groups living in unhealthy conditions, but the situation is further grossly compounded by serious socioeconomic problems and the crisis of international debt, which diverts financial resources from being used to further social justice among the urban poor. The groups that are most at risk in these circumstances are the illiterate, the unemployed, the homeless, the sick, and people who are stigmatized because of their lifestyles or alienated because they are refugees. Their unfavourable situation is compounded by their limited access to good primary health care.

Squatting in shanty dwellings in the least desirable areas, often on the edge of town, perhaps in an area of swamp or stagnant water, without sanitary infrastructure, vulnerable to natural disaster, flood, and infection, millions of people struggle to survive. Often the efforts made by communities to organize and house themselves, or to provide themselves with services, are actively opposed by government authorities or professional groups who feel their own position to be in some way threatened. Shanty towns may be cleared and people compulsorily removed from areas where they have invested their limited funds and their labour in trying to create the beginnings of a community, while their contributions to greater well-being through the informal economy often go unrecognized. Poor city-dwellers often have to pay high amounts to private vendors for limited water supplies, while the public services that are provided are often imposed in a paternalistic and patronizing manner which fails to recognize the knowledge and skills of the local people. Public services throughout the world usually have a centralized and compartmentalized character, which removes them from the people they are supposed to serve, at the same time failing to capitalize on the advantages of providing services in a horizontal and integrated, rather than in a vertical and specialized, manner.

The impact of urbanization on health

Physical, economic, social, and cultural aspects of city life all have an important influence on health. They exert their effect

through such processes as population movement, industrialization, and changes in the architectural and physical environment and in social organization. Health is also affected in particular cities by climate, terrain, population density, housing stock, the nature of economic activity, income distribution, transport systems, and opportunities for leisure and recreation. The impact on health is not the simple total of all these factors, but the effect of their synergistic action, the whole being greater than the sum of the parts.

In Europe and North America, three overlapping phases of public health can be identified from the mid-nineteenth to the late twentieth century. The first phase began in the industrialized cities in response to the appalling toll of death and disease among the urban poor living in abject squalor. The displacement of large numbers of people from the land by their landlords, who wished to take advantage of the increased productivity obtained by applying scientific agricultural procedures, enhanced the attraction of the growing cities which appeared to offer country people opportunities for self-improvement. The results were massive population movements, disruption of the prevailing pattern of rural life, and the rapid creation of large slum areas.

The organized response of local and national governments included the introduction of legislation and the use of specially trained medical and environmental health officers to address the predominantly environmental threats to health with considerable effect. The focus of this movement was on improving standards of housing and sanitation and providing bacteriologically safe water and food. This initial public health movement with its emphasis on environmental change was, in time, eclipsed by one based rather on personal preventive action, made possible by advances in bacteriology, immunology, and the promotion of mechanical methods of birth control. This preventive phase was in turn superseded by the therapeutic era, starting in the 1930s with the advent of insulin and the sulfonamide drugs, to be followed later by antibiotics and a great number of scientifically based treatments. The beginning of this period coincided with the apparent conquest of the infectious diseases in developed countries, on the one hand, and an increased involvement of governments in direct patient care through insurance-based and public health care systems, on the other. Historically it marked the weakening of public health departments, and of the role of general medical practitioners and a shift of power and resources to hospital-based services that lasted until well into the 1970s.

Since the early 1970s a comprehensive approach to health development has emerged, combining environmental change with appropriate preventive and therapeutic interventions, especially for high-risk groups such as children, mothers, the elderly, and the disabled. The origins of this so-called "new public health" can be traced to a growing awareness of the limitations of therapy and a greater understanding of the reasons for health improvements in the past. Ideas about health have been changing: the traditional "sanitary" view, focusing on the environment, and the more recent mechanical, biomedical view, focusing on the human body, have been superseded by more holistic concepts which recognize that health is fundamentally an ecological matter and must deal with the linked phenomena of population growth, urbanization, consumption, environmental degradation, premature death and disability, and poor services. There is a growing awareness of the need to take a horizontal rather than a vertical view of public health as "the science and art of preventing disease, prolonging life and promoting health through the organized efforts of society" (*1*).

Unless such an integrative view is taken, health service interventions can have only a limited impact on the health of populations. Children whose lives are saved by immunization may nevertheless die from malnutrition, while sanitary improvements alone will have little or no effect on many infectious diseases. Public water systems may be constructed, but the effective delivery of safe water to slum populations needs well-organized and well-managed water companies and the ability to maintain plant and equipment. The reduction of respiratory disease that is due in part to air pollution depends on controlling traffic and exhaust emissions, the location of industrial premises, the nature of industrial processes, and the types of facility used for domestic heating and cooking—in short, it needs an intersectoral approach.

In theory, a city's compactness and high productivity can support the promotion and protection of health, but, while such threats to health as air pollution may affect all social groups, it is the growing numbers of urban poor in all countries who are exposed to the most health-threatening elements in the urban environment. Health needs are greatest in Third World cities whose health problems include both the infectious diseases and malnutrition traditionally associated with developing countries and the non-infectious diseases associated with development (heart disease, stroke, cancer, accidents, suicide, alcohol dependence, other drug-related problems, and mental disorders). In addition, the new scourge of AIDS, which appears to be a particularly acute urban problem, is a significant threat to public health in both the develop-