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Editorial

Physical health disparities and mental illness: the scandal of premature mortality†

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Summary

A 20-year mortality gap for men, and 15 years for women, is still experienced by people with mental illness in high-income countries. The combination of lifestyle risk factors, higher rates of unnatural deaths and poorer physical healthcare contribute to this scandal of premature mortality that contravenes international conventions for the 'right to health.'

Declaration of interest

None.

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It has been known for over two decades that the life expectancy of many groups of people with mental illness is at least 20% less than for the population as a whole in high-income countries.[1] Is this state of neglect improving? The remarkable paper by Wahlbeck and colleagues in this issue brings pessimistic news.[2] Even in three Scandinavian countries that provide among the best-quality and most equitably distributed healthcare in the world, this mortality gap has narrowed only by a modest extent over the past two decades and remains stubbornly wide. Why is this the case and what needs to be done?

These extraordinarily higher death rates reflect a combination of: (a) a higher occurrence of risk factors for many chronic diseases and some types of cancer; (b) the iatrogenic effects of some psychiatric medications; (c) higher rates of suicide, accidental and violent death; and (d) poorer access to physical healthcare than for the population as a whole.

Several lifestyle factors adversely affect the physical health of people with mental illness, for example relatively low rates of exercise along with higher rates of obesity. These combine with relatively high rates of smoking and worse diet[3] to contribute further to higher rates of hypertension, high plasma cholesterol and triglycerides, diabetes and obesity.[4] Yet the 'ecological fallacy' needs to be acknowledged, as the associations so clearly demonstrated in the paper by Wahlbeck and colleagues do not necessarily have aetiological importance, although they do generate clear hypotheses to be tested in future intervention studies (where the ecological fallacy means that the individual members of a group are incorrectly assumed to have the average characteristics of the group at large).

In addition, rates of 'unnatural deaths' are unnaturally high. Only 80% of people with schizophrenia die from natural causes, for example, compared with 97% of the general population. The higher rates of these deaths are largely attributable to accidents and suicide, which tends to occur more often in early than late adulthood, and the excess mortality rates identified among younger adults merit particular attention.[5,6]

People with mental illness are also less likely to receive effective screening for cancer and have higher case-fatality rates. This is partly due to the particular challenges when treating these patients including medical comorbidity, drug interactions, lack of capacity and difficulties in coping with the treatment as a result of psychiatric symptoms.[7] But more generally there is now strong evidence that people with mental illness receive worse treatment for physical disorders ('diagnostic overshadowing'). This takes place because general healthcare staff are poorly informed or mis-attribute physical symptoms to a mental disorder. For example, after adjusting for other risk factors, such as cardiovascular risk factors and socioeconomic status, depression in men was found to be associated with an increase in cardiovascular-related mortality.[8]

It seems clear, therefore, that medical staff, guided by negative stereotypes, tend to systematically treat the physical illnesses of people with mental illness less thoroughly and less effectively. For example, people with comorbid mental illness and diabetes who presented to an emergency department, were less likely to be admitted to hospital for diabetic complications than those with no mental illness.[9] It is clear that such consistent patterns of less access to effective physical healthcare can be considered as a form of structural discrimination.[10]

If such a disparity in mortality rates were to affect a large segment of the population with a less stigmatised characteristic, then we would witness an outcry against a socially unacceptable decimation of this group. The fact that life expectancy remains about 20 years less for men with mental illness, and 15 years less for women with mental illness denotes a cynical disregard for these lost lives, and shows, in stark terms, by just how much people with mental illness are categorically valued less than others in our society. This can justifiably be seen as a violation of the 'right to health' as set out in Article 12 'The right to the highest attainable standard of health' of the International Covenant on Economic, Social and Cultural Rights.[11] Further, in 2006, the United Nations General Assembly adopted the Convention on the Rights of Persons with Disabilities that explicitly applies to people with mental health problems as well as people with intellectual disabilities. The Convention on the Rights of Persons with Disabilities defines the protections and entitlements of the 650 million people with disabilities worldwide. In relation to the current violations of these legitimate expectations to equivalent years of life, Wahlbeck *et al* are correct to conclude that their results imply a 'failure of social policy and health promotion, illness prevention and care provision'.

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†See pp. 453–458, this issue.

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extra

Woodbridge Hospital – British psychiatry in Singapore

Ee Heok Kua

Woodbridge Hospital opened in 1928. At the time, the British Governor of Singapore stipulated that the medical superintendent should be an officer 'with some taste for gardening and farming who will help to make the patients interested in such pursuits. Must have attended lectures at the Mental Hospital, Denmark Hill. Must possess the Diploma of Psychological Medicine.' The decree of the Maudsley connection is heeded even to this day – every local medical superintendent or director has had training at the Maudsley and possesses the DPM or MRCPsych; but horticultural predilection is no longer a requirement.

The hospital was initially built as a 2500-bed asylum. It expanded to almost 3000 beds after 70 years. Woodbridge Hospital was one of the largest hospitals in Asia. In 2000 it was decided that it should be downsized and the governance restructured. Community psychiatry was emphasised and Professor Norman Sartorius from the World Health Organization suggested two services – the community addiction medicine programme and early psychosis intervention programme. The training and research units amalgamated to form the Institute of Mental Health.

For many years doctors from the hospital were sent to Britain for postgraduate education. Many were trained by eminent British psychiatrists such as Aubrey Lewis, Michael Rutter, David Goldberg, Eric Taylor, John Copeland, Paul Rogers and Robin Murray. However, after 1987, the National University of Singapore with the assistance of Professor Philip Seager from the Royal College of Psychiatrists (UK) started a local training programme for the Master of Medicine (Psychiatry). Research interest has grown gradually over the years and an outstanding project by the doctors was 'A 20-year follow-up study of schizophrenia in Singapore' which was initiated by Dr Tsoi Wing Foo.

Unfortunately, Woodbridge Hospital, like other asylums the world over, has sometimes been perceived by the public as a shameful place. A successful anti-stigma campaign led by Dr Lee Cheng took place in 2001 with a tagline 'winning hearts and minds'. It was important not just for the patients but also for the morale of staff.

The best of British psychiatry, with emphasis on 'soft skills' like meticulous history-taking, is still taught in the medical school. However, doctors know they do not have the luxury of time and cannot practice as in British hospitals. Lack of human resources, heavy workload and cultural differences mean that there should be a different approach in clinical practice, especially in the provision of psychological therapy. All these were discussed at a recent Teachers of Psychiatry meeting in Singapore, where some Asian leaders of psychiatry shared their experiences, work stress and favourite leisure activity, which fortuitously was gardening, a hobby decreed by His Majesty's Government in 1928.

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