INAUGURAL LETTER

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The Leprosy Campaign and General Health Care

Ladies and Gentlemen,

It gives me great pleasure to be here today for several reasons. The first of these is the topic of this conference itself: leprosy. For the average European, the word leprosy conjures up horrific pictures from a dim and distant past which has, fortunately, long since vanished from this continent. Unfortunately, however, Europe is not typical in this regard: it is estimated that there are still between 12 and 15 million leprosy sufferers living in the Third World. Even today, there is scarcely any place for them in the community. It is therefore particularly praiseworthy that you devote yourselves to helping our fellow men and that your words and actions, from Europe to the most remote part of the Third World, give true meaning to the campaign slogan "Leprosy can be cured!"

In the past, leprosy sufferers were isolated and shunned in Europe as they were for centuries in other parts of the world. The search for a decent life for sufferers is still no easy task. Fortunately, through the ages, there have been organizations and individuals that have taken to heart the fate of leprosy patients often for religious reasons. The names of only a few are still familiar to us. One is Father Damien who, in a life of self-sacrifice, contracted the disease himself and whose name lives on in a foundation devoted to combating leprosy and helping its victims. He was one of many in the past and the present whose dedicated work in rural areas and the slums of the great cities has often gone unnoticed. I should like to take this opportunity to pay tribute to them.

May I give you another example from the past: Norway, in the last century, at a time when leprosy was by no means a rare disease in Europe. Indeed, there were some areas in western Norway where one in 50 people suffered from it. It was there that Dr. Hansen conducted his pioneering research on leprosy, using a scientific method which made it possible to identify what was later called the Hansen bacillus, which causes leprosy. I have two reasons for referring to Dr. Hansen. First, his work may serve as an example of the high standard and the painstaking approach which are still characteristic of research on leprosy today. Recent examples are the new treatments which make a cure possible in a much shorter time than before. Secondly, Dr. Hansen's conclusions were largely based on what is now called epidemiology. As you are aware, the 20th century has seen a great increase in the use of epidemiology as a research method. The characteristic feature is that epidemiologists do not restrict their purview to biomedical factors, but take social and environmental factors into account in their studies of the incidence and distribution of diseases in populations. In addition to helping to explain the causes of disease, epidemiology has grown increasingly significant as an aid to solving problems and in determining the order in which problems should be tackled. In other words, epidemiology today is one of the principal tools in efforts to improve health in general.

After that excursion into the past, I should like now to turn to the present and the future. How do things stand? What are the most important problems facing us? What would be a realistic picture of the future of the leprosy campaign and health in the Third World in general?

I am afraid that the outlook for many countries is gloomy. Many of them are faced with serious financial difficulties, notably the poorest countries with the fewest reserves,

such as sub-Saharan Africa. Health care in these countries is being hit by spending cuts stemming from structural adjustment programs. Indeed, in some countries health care has reached a crisis. This situation has produced a difficult dilemma: the need for adjustment is clear, but the need to maintain the present level of health care is no less obvious. I take the view that it is vital for humanitarian reasons to ensure that the radical changes which adjustment programs may cause are accompanied by measures to preserve essential educational and health care provision. This is sometimes called "adjustment with a human face." Such issues should not be left to bilateral donors or nongovernmental organizations; rather, they should form part of the adjustment policy formulated in consultation between the government concerned and the World Bank. However, these are no more than emergency measures and for the long term we must seek more lasting ways of improving health care to a reasonable standard and of keeping it within reasonable financial limits. I believe that such ways exist. Changes will have to be made in the existing health services, however. In any event, the emphasis should shift from care in hospitals, which is very expensive, to basic health care. Much can be done to increase efficiency. One example might be that patients who can afford it share some of the costs of their treatment.

I am glad to say that the past ten years have seen many changes in thinking on the health services and in the form they take. I should like to say a few words on this point. Thanks to the work of epidemiologists, we now know more than we used to about the principal diseases affecting Third World countries and their causes, both medical and nonmedical. There can be no doubt that the picture is dominated by infectious diseases and not by such chronic degenerative disorders as cancer and cardiovascular diseases which afflict the rich countries.

A second feature of the modern era is the belief that every individual should be afforded an equal chance of a healthy life as far as possible. This principle—in a word, equity—and the idea that health care should be aimed at the most prevalent diseases—referred to as essential health care—are the main principles underlying the current strategy on primary health care. This year marks the tenth anniversary of the Alma Ata conference of UNICEF and the World Health Organization which initiated the worldwide implementation of this strategy. If equity and essential health care are to be put into practice, the existing health services must undergo far-reaching restructuring. In practice, equity implies both a considerable increase in the number of places where care is provided and the decentralization of the system. The introduction of equity is paralleled by the idea that care should be directed at the most prevalent diseases. After all, it is much more effective to combat infectious diseases from a large number of small-scale health care facilities than from a few large medical centers. These two principles likewise apply to the campaign against leprosy. Over the years you, too, have decentralized treatment to an increasing extent and thus brought care nearer to the patient.

"Health for All by the Year 2000," the worldwide strategy for improving health through an emphasis on primary health care, is, of course, familiar to you all. As I said earlier, two of the elements in this strategy, namely, equity and essential health care, are of great relevance to your work. The third principle also derives from an epidemiological study, in this case of the history of Europe and North America. This revealed that many diseases, including tuberculosis, cholera and leprosy, had virtually disappeared from the scene before a specific effective cure for them had been discovered. Obviously, the origins of disease in individuals and the standard of health of populations were and are significantly influenced by other than purely medical factors. The third element in the strategy therefore strongly emphasizes the promotion of an intersectoral approach to health care. In operational terms, this means coordination and cooperation with other sectors. This approach is reflected in Dutch development cooperation policy, which prefers health care activities to be incorporated in an integrated process of rural development. In other words, the idea is that health care should form part of a cohesive package of activities relating to ecology, nutrition, food production, the status of women, drinking water supplies, and population policy.

The last element in the strategy which I

would refer to here is public participation in and full public acceptance of health care. This, too, is closely connected with your work. Three groups are concerned with the acceptance of leprosy: the patients themselves, other people who are not suffering from the disease, and the medical professions. In the end, all three must become aware that leprosy patients, like other people, are entitled to live and work as normal members of society and to be treated in the normal way by the health services.

Health care should be accorded a very high priority in worldwide development cooperation, from the point of view of both the right to life and health and investment in human resources. We cannot shut our eyes to the fact that in developing countries at most one in two, and sometimes only one in three, of those who need help actually get it. This applies to people who need help for different reasons: those infected with leprosy, sufferers from tuberculosis, sickly infants, and women who experience complications in childbirth.

What can be done? Resources are limited. How can we make more efficient use of the resources available to the benefit of all? The first goal is to ensure that everyone who needs help can get help from the health services. The leprosy campaign has taken significant steps in this direction: dedication, a sound scientific infrastructure, and efficient organization and coordination have enabled you to achieve a great deal with limited resources. May I suggest that the Congress consider putting these achievements at the disposal of those who are suffering from diseases other than leprosy but who need help all the same. In other words, I should like to invite you to divide your efforts between combating leprosy on the one hand and on the other making an active contribution to the improvement of basic health care in general. This suggestion is motivated not only by humanitarian considerations but by my concern for health care that is both practicable and affordable. Closer cooperation and integration between the leprosy campaign and the organizations responsible for general health care could be of considerable benefit to both. I realize that carrying out this proposal would create problems and that you would, for example, have to weigh the advantages of integration against the maintenance of a distinctive identity and perhaps increased efficiency in your own organizations. However, I believe that the campaign against leprosy would ultimately benefit from being integrated in an improved system of general health care. After all, even if a leprosy vaccine were to be developed, and there is good hope that it will be, the disease could still only be eradicated if there was an effective system of general health care which could reach and vaccinate every child.

In conclusion, ladies and gentlemen, may I wish you a successful and productive Congress.

Thank you.