

## THE EFFICIENCY OF INEFFICIENCY MEDICINE DISTRIBUTION IN SOUTH CAMEROON

SJAAK VAN DER GEEST

Anthropological-Sociological Centre, University of Amsterdam, Sarphatistraat 106A,  
1018 GV Amsterdam, The Netherlands

**Abstract**—An attempt is made to explain why public health services in South Cameroon function inefficiently. Special attention is given to the distribution of medicines. The root cause of inefficiency is believed to be 'corruption', the private use of public goods. It is suggested that some degree of commercialization may solve the present problems and replace the 'expensive free distribution' of medicines by a paid distribution of cheap medicines. The research for this article was carried out in 1980 in South Cameroon.

### INTRODUCTION

To avoid misunderstandings, the title of this paper has a cynical undertone. Efficiency? Yes for some! The main thrust is that the inefficiency of the present system of medicine distribution in Cameroon has attractive advantages for restricted groups of privileged people, but is harmful to the masses.

The second section contains a general, theoretical, discussion of the root cause of inefficiency: corruption. Then follows a description of the Division of Ntem, where most of the research was done, and of the system of medicine distribution. In the next section the inefficiency of this distribution is exposed, followed by a discussion of the question whether the apparent inefficiency does not hide an informal system which is quite efficient. The final section is devoted to the question on how the existing situation can be mended.

This paper is part of a much broader study of the distribution and use of Western medicines in Cameroon. The purpose of this study was to describe and understand the problems of medicine use in the widest possible context, including kinship, economics, politics, cognition and traditional medicine. The research dealt with medicines passing through official channels as well as through informal ones. The research ascended from medicine used by patients to the distributional organization at the level of ministry and importer. Research techniques consisted of participant observation, collection of case histories, and the study of health reports, files and financial accounts. A preliminary report of the research [1] has been distributed among a limited group of people.

### CORRUPTION

Reluctantly I use the term 'corruption' here. The term expresses moral disapproval and conjures up a state of decay, and yet, as Scott [2, p. x] warns us, 'corruption' does not refer to a deviant pathology but constitutes an integral part of most political systems. The main reason for using the term is its connection with a large body of theoretical and descriptive literature on 'corruption' (from now on used without inverted commas).

Scott [2, p. 4], in defining political corruption, cites Nye [3, p. 416]:

Behaviour which deviates from the formal duties of a public role (elective or appointive) because of private (personal, close family, private clique) wealth or status gains.

The discussion of corruption in this paper is based on this definition. The fact that the emphasis will be placed on the behaviour of low-ranking civil servants rather than on political leaders does not render the definition less useful. We are still dealing with private gains from public goods which are linked to a public role.

It should further be noted that 'private gain' must be understood in a wide sense. As is indicated in the definition, it may also refer to the interest of family members or other private relationships.

Scott shows that patterns of corruption should be understood in relation to, among other things, the character of the political system and the nature and rate of socio-economic change in a particular society. His comparisons embrace not only contemporary societies (Western and non-Western) but also societies that existed a long time ago.

There are a number of conditions, both cultural and structural, that promote corrupt practices. The most important ones mentioned by Scott and a few others [4-6] are:

(1) The continuation of traditional gift-giving practices. Relationships in traditional societies are sustained by a reciprocal system of gift-giving and granting services. The survival of this custom in a society with salaried civil servants constitutes a form of petty corruption.

(2) The prevalence of kinship ties and other traditional loyalties over modern bureaucratic obligations. Scott points out that in new nations values attached to the state bureaucracy tend to remain fairly formalistic and tenuous. These values have usually been imported from the West and have not been internalized. As Leys [5, p. 224] puts it, "the idea of the national interest is weak because the idea of a nation is new". Real security can only be found within the traditional structure. It is therefore understand-

able that people in government service let the interests of their family or traditional community prevail over those of the state. This leads to what in Western terminology is called 'corruption' and 'nepotism'.

(3) Traditional political values often emphasize a proprietary view of public offices. This view is extended to the offices in the modern state. Public servants dispose of public goods as if they belong to them and in fact people expect them to do so.

(4) A weighty structural factor encouraging corruption is the relative importance of the state as a source of goods, services and employment. When the state is the main provider of such benefits, it is not surprising that corruption is a common practice. The tendency of supplying relatives and friends with public goods, or of selling them to others for private gain, is further reinforced by the fact that the person in charge is not the owner of the goods. Generous distribution of one's own property is after all less profitable. It is obvious that opportunity for misuse of public property increases with the growth of this public property. Myrdal's remark [7, p. 956] points in the same direction:

The relative integrity in politics and administration was achieved in Great Britain, Holland and Scandinavia during a period when state activity was reduced to a minimum...

(5) An underdeveloped economy is another structural factor leading to corruption. This factor overlaps to a great extent with the previous one, but views the problem from a different angle. A weakly developed economy constitutes a situation where, in Scott's words [2, p. 77] "power begets wealth more easily than wealth begets power". In other words, 'commercial success' is more likely to be achieved through a political career than by direct commercial enterprise.

(6) Processes of rapid social, economic or political change encourage corruption of a more strictly political nature. A sudden change often brings about a situation in which political power no longer reflects the existing socio-economic power relation. Corruptive practices, buying power with wealth, may help to redress the imbalance. This type of corruption is not the subject of this paper.

(7) A considerable gap in education and social status between civil servants and their clients is another factor which makes corruption easier. The two main reasons for this are:

First the administrator can make arbitrary decisions with impunity and can extort bribes and other special favours from his supine clientele. Second, the powerless client will more frequently offer a bribe in the hope of transforming the distant bureaucrat into a friendly patron and thus winning a favourable decision. If bureaucrats have particularly high status vis-à-vis their clients, then, and if there are no external power centres which could control the bureaucracy, corruption will normally thrive. [2, p. 15].

In summary one can roughly say that corruption is encouraged by two types of factors. One type derives from the traditional organization of social relationships: a pre-monetary system, characterized by multi-stranded social relationships [8], is carried over into a new social environment based on a market economy. The second type of factors refers to economic conditions. An examination of these factors suggests that corruption is most likely to appear in developing

countries, but it would be grossly incorrect to suggest that it is limited to these countries. Information on corruption in western countries is abundant as well. Moreover, it should be noted that theorizing about corruption has been predominantly based on research in developing countries. The conclusion that developing countries are more susceptible to corruption contains, therefore, a firm amount of circular reasoning.

A question on which the opinions are much more divided is: what are the effects of corruption? Obviously, this question cannot be answered in a general way. The effects of corruption depend largely on both the nature and rate of corruption and the characteristic of the society in which it occurs. An elaborate discussion of the 'toxic and tonic' attributes of corruption falls outside the scope of this paper. The question which interests us here is: what effect does corruption have on the distribution of medicines in South-Cameroon. This question will be taken up later on. Nevertheless, it may be useful to mention briefly three viewpoints which seem to be rather widely accepted:

(1) Corruption does not necessarily hamper economic development. Scott [2, pp. 79-86] contrasts two types of corruption, 'enlightened self-interest' and 'hand-over-fist' corruption. The latter is particularly detrimental to a country's economy (but is conversely also the product of a bad economy). There is no long-term perspective. Politicians and civil servants attempt to collect as many goods as possible before they are exhausted. The former type of corruption is based upon a sense of collective long-run interest and 'does not kill the goose that lays the golden eggs'. This type may promote economic growth.

(2) The costs of corruption may be bearable for rich countries but unbearable for poor ones. In other words, developing countries can afford less corruption than developed countries.

(3) Corruption tends to have a conservative impact on society. Inequalities, whether juridical, political or economic, can continue to exist because they can informally be circumvented or mitigated. Corruption is the peaceful alternative to violent change.

The question as to whether something should be done against corruption and what should be done, depends on the analysis of its causes and effects. Suggestions for the specific situation of medicine distribution in South Cameroon will be touched upon in the conclusion of this paper.

#### THE DISTRIBUTION OF MEDICINES IN SOUTH-CAMEROON

The Southern part of Cameroon is a tropical forest zone. The Division of Ntem, where most of the research was carried out, has a surface area of 16,000 km<sup>2</sup> (almost half the size of the Netherlands), and a population of about 140,000. The average population density is 9 per km<sup>2</sup>. A large majority of the rural population is engaged in agriculture; men occupy themselves with cocoa whereas women are almost exclusively engaged in the cultivation of food crops such as cassave, cocoayam, plantain and maize. The villages usually consists of two long-drawn-out rows of houses on both sides of the road. A narrow

strip, about 2 or 3 km deep, on both sides of the road is used for farming. Behind the strip is the forest.

The dominant ethnic group in Ntem are the Bulu but there are other groups, the Ntoumou, Mvae, Fong, Bane and Ewondo, who belong to the same language group. In Ebolowa, the divisional capital (20,000 inhabitants) and other towns such as Ambam, Ngoulamakong and Mengong one also finds emigrants from other parts of Cameroon, mostly Bami-leke, Basa, Hausa and Bamoun. These immigrants are involved in trading or are employed in public services.

Sanitary conditions, especially in the villages, leave much to be desired: bad quality of the water, absence or non-use of latrines, free movement of domestic animals such as pigs and goats, improper refuse disposal, and poor condition of the houses [9, pp. 342-356]. Malnutrition is an additional health hazard for children. As a result of the existing eating habits the best food is reserved for the adults, especially the men, and the children are thus deprived of necessary proteins. A recent survey [10] revealed that 20% of the children below 5 years in the forest zone are chronically undernourished and that 50% of them have anemia.

The most common diseases for which people consult modern health institutions are, in order of importance, malaria, intestinal worms, skin diseases, angina-cold-influenza, rheumatism, bronchitis and gonorrhea. Measles is the most frequently reported cause of death among infants and children, but it should be noted that the real cause of death is always a complication such as pneumonia, malaria or encephalitis. The infant mortality rate is 150 per 1000, the child mortality rate 86.

The distribution of modern medicines follows four major channels: (1) the public sector; (2) the private non-profit sector; (3) the legal private commercial sector, and (4) the illegal private commercial sector.

1. The *public sector* consists of all public hospitals and health centres. In these public institutions medicines are provided free of charge. The medicines are supplied by the Pharmacie Centrale d'Approvisionnement in Yaoundé. Health centres receive a fixed stock of medicines once a year. The nurses are supposed to plan their distribution in such a way that the stock lasts the whole year. The hospitals may order medicines according to their needs, as long as they remain within their budget.

2. The *private non-profit sector* consists of church health institutions. In Ntem these are the Presbyterian Church of Cameroon and the Roman Catholic Church. Patients coming to them have to buy the medicines which are prescribed by the doctor or nurse in charge. The health institutions order their medicines from a non-profit foundation which imports the medicines from abroad. The wholesale prices of these medicines are very low. The church-related health institutions are not allowed to sell medicines to non-patients.

3. By *legal private commercial sector* I mean the licensed pharmacies managed by qualified pharmacists. As pharmacists are primarily entrepreneurs [1, pp. 122-127], they reluctantly settle in rural areas. In the whole of Ntem there is only one pharmacy. Of

the 52 pharmacies in Cameroon in 1975 no less than 30 were found in the two largest towns, Douala and Yaoundé. Pharmacies have a wide assortment of medicines and have a relatively efficient supply system. They order their medicines from three commercial importers. The medicines are sold to the public in standard packings, they are not retailed in smaller quantities.

4. The *illegal private commercial sector* includes the shops and kiosks that sell certain medicines next to other items such as food, clothes, toilet-articles and cigarettes. It also includes petty-traders who trek from village to village to sell these commodities. Particularly in the cocoa season, when the villagers have cash money, one meets these traders in large numbers, either on foot or on bicycle. Although the sale of medicines by ordinary traders is against the law, it is practised openly and is socially accepted. The traders obtain their medicines mainly from three sources. Most of the medicines have been smuggled into Cameroon from Nigeria and are sold to the traders by intermediaries. Other medicines are bought in licensed pharmacies and retailed to the public. Finally some medicines are taken from stocks in hospitals and health centres by personnel and sold to the petty traders.

#### THE INEFFICIENCY OF MEDICINE DISTRIBUTION

The distribution of medicines in the public sector is clearly inefficient. Public health centres are popularly known to be almost continuously short of medicines and public hospitals are hardly better. Let us first look at the causes and then at the consequences of this situation.

First the Pharmacie Centrale d'Approvisionnement (PCA) in Yaoundé works inefficiently. This inefficiency exists at various levels, some of which are:

- ordering of and paying for medicines abroad;
- record keeping;
- storage of medicines;
- transport of medicines.

Medicines arrive at the PCA on the average about 2 years after they have been ordered. Defective record keeping causes further delays both in ordering medicines and in supplying health institutions with medicines. As a result of the bad storage facilities medicines are stored in places where they are not protected against climatological factors which may affect them. Often old medicines remain in the warehouses till they expire while new supplies are sent on to the health services.

I have calculated that due to the PCA's inefficiency the elementary health centres received on the average about 65% of the medicines they should have received. If we further take into account that the total stock of medicines which they should have received would not have been sufficient to last a year anyway, it becomes clear that these health centres have to contend with serious medicine shortages. The more developed health centres receive a larger proportion of the allotted supply and the hospitals still more. Ironically, the central hospitals in Yaoundé and Douala receive even more than 100% of their budget!

A second level of inefficiency is found in the health

institutions themselves. Many of the medicines which finally arrive (about 65% of the planned amount) and which should be distributed freely among patients are taken by health personnel for private use or distribution among friends and relatives. Medicines are also sold to petty traders or directly to patients visiting health workers in their private homes. A medical doctor gave as his opinion that nearly everybody working in a public health institution practises at least some private medicine at home. This applies to doctors and nurses as well as to untrained workers. The case below is an example.

*Case 1. The public health nurse with a private practice*

Nicolette's daughter has stepped on a broken bottle and cut her foot. I take her to the mission hospital. Because we arrive there at five minutes past five we have to pay 2000 CFA extra (about £4). The total bill for this simple treatment is around 5000 CFA (£10), which is about half a month's salary for those with minimum wages. She is told to come back six times for additional antibiotic injections but she never returns. Not far from her house lives a nurse who works in the state hospital in town. The nurse delivers private medical services in her house to people of the neighbourhood for very reasonable prices. Nicolette takes her daughter to this nurse for the other six injections. She brings the medicines along, because she had bought them all at the same time at the mission hospital. Nicolette tells me that the nurse treats people also with medicines which she brings along from her work. A penicillin injection is only 100 CFA, which is really cheap. In the town pharmacy it costs 245 CFA. The people in the vicinity are very content with this 'private service'.

It is extremely difficult to calculate the amount of medicine which is withdrawn from the public medical service in this way. A very rough estimate, based upon interviews and observations in a limited number of health institutions arrives at about 30% for health centres and about 40% for one of the hospitals. Altogether it means that in the elementary health centres less than half of the allotted medicines are in fact distributed among patients (70% of 65% makes 45%), while it should be taken into account that the allotted stock was already insufficient. In the more developed health centres and hospitals the proportion of medicines given to patients seems slightly more than 50% of the total allotted stock.

The most conspicuous consequence of this chronic lack of medicines is the underutilization of health services. Health centres which are known to be without medicines are no longer visited and people seek alternative solutions for treating their ailments: private institutions, the pharmacy in town, illegal medicine vendors who often function as practitioners as well and, of course, traditional medicine. Meanwhile the state continues to pay for the—non-functioning—infrastructure of health centres. The following example illustrates this point.

*Case 2. The health centre at N*

The public health centre at N is run by seven people. One is a highly qualified nurse, one is an 'aid-soignante' (two years training) and five are 'agents de l'état' (no school training). Two months before the centre will receive its annual stock of medicines it has virtually run out of medicines. The centre receives hardly any patients. The few who do come usually bring their own medicines along. These medicines have not been prescribed by anyone. The

patients often make their own diagnosis and decide what medicines to buy for their treatment.

They buy them from itinerant petty traders, local shopkeepers, health-personnel or in the established pharmacy in a town about 30 km away.

Some people come to the centre to let themselves be treated with their own medicines, usually injections. Most sick people without medicines do not even trouble themselves to come to the centre because they know they come for nothing. In one week we checked the number of patients treated at the centre; we counted nine.

The relationship between the head-nurse and the others is tense. According to some the head has hidden a large amount of medicines for his own use. He wants the others to stay at the centre where they have nothing to do because of the drug shortage. Thus it happens that on an ordinary day one finds the door of the centre locked. In the morning one can see the employees of the centre leave to work on their fields, just like the other farmers of the place. The head-nurse himself is absent nine out of ten days.

When two months later the new stock of medicines finally arrived an inhabitant of N made the following observations for me.

"The keys of the centre's pharmacy room are kept by the head-nurse, who is absent most of the time because he is busy driving around in his new car. So, when he is not there it is almost impossible to treat patients".

"It should be noted that certain privileged people are entitled to receive medicines when a new stock arrives. They put these medicines in their pharmacy box at home. I heard the wife of the mayor, who works at the centre, instruct someone to prepare an order of medicines for her home 'as usual'. The other day D, who is a teacher, showed me two vials of Totapen and two vials of distilled water which, he said, the head-nurse had given to him. He was taking the medicines to one of the nurses who was to use them for treating his sick mother. He told me that the head-nurse had given him a large amount of antibiotics in case he caught a venereal disease.

If an ordinary teacher gets that much one can imagine what the mayor will receive!"

A few days later my informant actually heard from the mayor's wife that her husband had at least 30 vials of Totapen and many vials with vitamins to treat diseases in his family.

Two days after the arrival of the new medicines my informant wrote the following observation in his diary: "One Saturday evening I was with B at the bar when I saw the head-nurse with a bag enter a car for Ebolowa. B, who works at the health centre, pointed at him and said, 'I bet there are medicines in the bag and that he is going to get rid of them in Ebolowa'".

In the morning, he said, his wife had left with a bag which must also have contained medicines.

The trouble with this kind of accusations is that they can not be checked, and without doubt, some may be without ground. The above information does, however, make two things abundantly clear: the health centre functioned extremely badly because of medicine shortages and there is a general consensus that medicines are taken out of the centre for private use. The head-nurse accuses his subordinates and the latter accuse the head. My informant is convinced that both parties are right.

In public hospitals doctors write out prescriptions when medicines are no longer available. Patients use them to buy the medicines in the—sometimes nearby, sometimes distant—pharmacy. That this practice is highly inefficient need not to be argued. One author [11, p. 303] reports:

The perennial chronic shortage of essential drugs in our public hospitals has reached scandalous dimensions. Daily

we give a bed-ridden patient a prescription to go out to the chemist to buy drugs with which to be treated. The same patient often-times is made to buy dressing and intravenous fluids (glucose and normal saline) for operations. It not only makes a mockery of in-patient care, it is also inhuman! It would be more humane to provide these requirements in the hospitals and let the patient pay for them.

Case 3 below shows one of the many ways in which medicines which are meant for patients at the hospital may end up in other places.

#### Case 3. 'Bons de congé'

Social relationships must be greased with favours and gifts, in the first place family relationships. Illness histories which I collected usually mention a moment when free medicines are supplied by a relative or friend working in some kind of health institution. But also at work gifts are necessary to make relations run smoothly. An interesting example of medicine-gifts which I came across in a hospital, is the custom of 'bons de congé', literally translated as 'vacation tickets'. Members of the personnel who go on vacation usually go to stay for one month in their home village. Because their village may be situated at some distance from effective medical services, they judge it wise to take some medicines along. From this has originated the practice that someone going on holidays makes a list of medicines which he needs in the village in case he or someone of the family falls ill. The list has to be signed by the hospital director. According to the director, the practice has over-shot its mark widely nowadays. People present huge lists with the clear intention of getting hold of as many medicines as possible. They will distribute them among relatives and co-villagers to boost their position in the village and perhaps sell some of them to traders or patients whom they treat privately. The director says he does not like the practice but he is not able to stop it. All he can do is to cancel some items on the list or reduce their quantities before endorsing the list.

The 'bon' is then sent to the hospital pharmacist who gives the person the medicines.

Once, the director tells me, someone presented an extremely big list which he did not want to sign. Some influential people from the town came 'to see' him and threatened him in an indirect way that it would be wiser to sign that 'bon'. He did, because, as he says, without 'good relationships' it is impossible to work fruitfully.

Not only the employees of the hospital send 'bons'. Local authorities and other influential people do as well. Since they are the appointed defenders of law and order in society there is a vague feeling that the practice is legal and normal. The fact that all the 'bons' are officially kept in a box in the pharmacy confirms this impression. We were even allowed by the director to look at the 'bons' personally. The following one had been written by an important notable. It is addressed to the director.

Dear Felix, I have not troubled you for 4 months, but I am ruined by that bunch of children of mine. Could I have:

Alcool iodé	250 cc	Nivaquine syrup	1 vial
Mercurochrome	250 cc	Aspirine	50 tablets
Ether	250 cc	Phérgan	30 tablets
Sparadrap	$\frac{1}{2}$ roll	Théralène syrup	1 vial
Coton-hydro	$\frac{1}{2}$ kg	Pipérazine	72 tablets
Compress	1 packet	Pipérazine syrup	1 vial
Bande en gaze	5	Gardénal 100 mg	20 tablets
Bande en coton	5		

A third consequences of this inefficiency is that the rural population is clearly at a disadvantage compared to the urban population. The scarcity of essen-

tial medicines is felt most by them; a fact which further contributes to the unequal development of urban and rural areas.

Up till now we have only spoken about inefficiency in the public sector. It is indeed true that medicine distribution in private church institutions and pharmacies functions comparatively well. Even the illegal sector functions somehow effectively in the sense that the few medicines which are traded tend to be constantly available. An explanation for this contrast between public and private services does not seem difficult to find. The commercial impulse urges the private institutions to provide the best possible services, whereas a similar commercial impulse encourages people in public health institutions to provide very defective services. The reason is that it is more expedient to them to withdraw medicines, materials and time from the public service for private use than to perform the best possible service. In the latter case they only receive their—low—salary, in the former they will be able to earn an additional income. Whether the public health services function properly or not does not affect their salaries. Similar observations have been made in Bangladesh [12, p. 58] and Ivory Coast [13].

A second observation with regard to the private distributors of medicines is that their efficient functioning is closely linked to the inefficiency of the public sector. Patients come to private institutions *because* their problems are not solved in public health services (cf. Case 2).

#### THE 'EFFICIENCY' OF INEFFICIENCY

The conclusion of the previous section is that the public system of free medicine distribution does not work and one of the main reasons for this failure is that the medicines disappear before they reach the patients. One can, however, also look at the disappearance of medicine from another point of view. Many—I suspect the majority—of the medicines which disappear from the health institutions are given to relatives and friends of health workers. In other words, they are, in fact, *freely distributed*, although differently than was planned. One could perhaps say that, after all, the problem of medicine distribution does not really exist.

A further argument to support this view is that nearly everybody will have some relative or acquaintance working somewhere in a health institution. In other words, nearly everybody will have access to free medicines through this particular contact person. Can it thus be argued that the so-called inefficiency of the public health service is only the outside of an efficiently functioning informal system of medicine distribution? It is indeed tempting to thus bagatelize the existing problems, but this view does not take into account some of the detrimental consequences of the present practices.

(1) Particularly at rural health centres patients who *urgently* need a certain medicine may not find this because it has already disappeared (i.e. it has been taken for a future, *not an urgent*, disease). Obviously, the medical consequences of such a situation can be very serious.

(2) As a result of the repeated medicine shortages

health institutions are under-utilized. Patients no longer visit health centres where they cannot be treated. Funds and manpower in public health institutions are wasted.

(3) Patients who do not find medical assistance in health services are forced to travel long distances for treatment elsewhere. Particularly in villages transport is scarce, people may have to wait a whole day and even longer for it. Such delays can also have negative medical consequences. Moreover, transport is expensive, which may deter them from travelling altogether. It therefore becomes attractive to consult medical 'practitioners' who, although they are often less capable, are situated in the vicinity. These include traditional experts and co-villagers who claim to have medical skills. Consulting these practitioners may, however, involve considerable risks.

(4) The medicines which disappear will perhaps never be used but will decay in a cupboard of a private home, because the inhabitants never needed them. Or the medicines may be used incorrectly by someone who does not know their exact function and dose. These medicines could have been used more effectively under the supervision of a doctor or nurse to treat more serious cases.

(5) The very limited stock of medicines in health centres, which is partly due to private taking of medicines, may induce nurses to treating patients with too small doses of medicines. This phenomenon has been observed in the Northern Province [14]. The consequences are that patients are not cured and may even develop resistencies. It means that these few medicines which are given to patients are wasted as well.

There is still another argument which might be used to defend the inefficiency and corruption in the present system. By allowing health workers to earn some extra income from the (illegal) sale of medicines or to spend less on purchasing medicines which are demanded by relatives, the government is able to economize on salaries of health workers. This argument is of course untenable. By allowing health workers such a large scale private use of medicines the government is undermining the very *raison d'être* of these health workers. Why should a state pay for an infrastructure of health services if these do not serve a purpose? When economizing in the health services leads to a severe deterioration of those services then the result is the opposite of economizing. It would be more economical then to abolish the entire health system. The toleration of the existing practices is all the more irrational when we consider that only 12% of the health budget is spent on medicines—as opposed to 78% on personnel expenses. In most developing countries about 25% of the health budget is spent on medicines. The disproportion of personnel expenses *vis-à-vis* medicines has continuously increased during the last 5 years [15]. The fact that a substantial part of the medicines budget—and this budget is already too small—is used to supplement the salaries of the health workers is unacceptable.

We may thus conclude that, in spite of the fact that some medicines are distributed freely in the informal (illegal) sector, the negative consequences of this system of distribution are too numerous and too serious to warrant its continued existence.

The only real efficiency is probably that the present

system enables state-employed health workers to practise private medicine at home next to their work in a public institution. This constitutes an important, though informal form of health care. Health workers thus bring about a decentralisation of health care (cf. Case 1). Health care at the official medical institutions, which may be quite remote both in geographical and social terms, is brought onto the people's doorsteps. Moreover, *public* health workers are often felt to be negligent and careless, whereas the same people as *private* health workers are believed to pay real attention to patients' complaints. This consideration does, however, not necessarily imply that the present practice should be continued. The advantages of this type of 'private health care' can probably be retained in a way which is less costly to the state. Moreover, it should be taken into account that not all people working in public institutions prove to be valuable health workers. Some of them may not have any medical qualification.

Another 'efficiency' of the present system is that its bad functioning is advantageous for some specific groups or categories of people. Those who profit most of its inadequacy are health workers, ministerial and local civil servants, licensed pharmacists and unlicensed drug vendors.

That health workers in public institutions benefit from the inefficiency of their services needs little argumentation. As we have seen the system allows them a fair share of medicines to augment their income. But there is also a second factor which tends to be to their advantage. The subsequent medicine shortage often leads to a virtual closure of some health centres, at least for some time of the year. This fact makes it possible for health workers to devote their time to other activities, and thus earn a double income. In many places it is quite normal for health workers to close the centre and go to their farms.

The benefits for civil servants are variform. Decision-makers and lower civil servants at the Ministry have ample opportunity for personal gain in the present system. These opportunities exist both in the phase of ordering medicines and in the phase of supplying the health institutions. A dated example of fraud in the Pharmacie Centrale has been published [16]. Less tangible corruption is of course the acceptance of 'cadeaux'. The WHO has proposed a list of about 200 essential drugs as a model for countries which want to bring their purchase of medicines in accordance with their needs and means [17, 18]. The advantages of such a selection of a limited number of essential medicines for developing countries (and not only for them!) are obvious. It is therefore a matter for surprise that so few countries have as yet followed the WHO suggestions. Lall and Bibile [9] have described the potential advantages of the WHO list for Sri Lanka and analysed the opposition to its introduction. Among the local opponents they mentioned the members of the medical establishment and the consumers who belong to the elite. Although concrete evidence is lacking, it seems probable that in Cameroon the delay in the adoption of the WHO guidelines is also due to the fact that influential political decision-makers will loose attractive privileges when foreign pharmaceutical firms are forced to deliver medicines under conditions which are commercially

less interesting. Moreover, the fact that rural health institutions receive only part of the medicines which have been allotted to them also suggests that things go wrong right from the top. The relationships between policy-making and the self-interest of the policy-makers can perhaps be best explained with an example from another sector of public life: housing.

#### *Case 4. The accommodation of civil servants*

A medical doctor explains to me in an interview that there are mainly two ways in which people at the top enrich themselves, a rough way and a gentle way. The rough way is that they cause a lot of disorder in their files, so that no one can exactly check how much was ordered, how much was paid, etc. The next step then is large scale appropriation of public goods. The gentle way is that they themselves create the technical conditions in which they can—sometimes even legally—gain private profit from their position.

Such opportunities abound in the sphere of pharmaceutical business. (An example in Kenya is given by Yudkin [21] who quotes two newspapers which report that two Ministry of Health officials had been bribed to purchase sufficient quantities of two medicines made by one company to last the nation for more than ten years whereas at least one of the medicines would expire in two to three years). The doctor I interviewed made his point clear by giving the example of accommodation for civil servants

"I live in a house for which the state pays the rent. That rent is twice my salary. I wish the state paid me all that money and left it to me to look for a house and pay its rent, but that is not possible. The explanation is very simple. The people who make the law that civil servants must freely live in houses which are paid for by the state are often the same people as those who own the houses and are thus able to present excessive bills to the state". Of course not all landlords are politicians, but the fact that many are, and that many others have common interests with them, explains how such an expensive practice could come into being and—more importantly—how it could continue to exist after it had proved to be outright wasteful for the state.

Local authorities not directly involved in public health care also benefit from the present system. Their position of political authority enables them to claim various privileges from the public health institutions, including the supply of medicines for private use (cf. Cases 2 and 3).

The pharmacists are conspicuous beneficiaries of the inefficiency in public services. It is clear that there would be hardly any room for pharmacists if the public system were to work ideally. Patients would be given their medicines freely in hospitals and health centres and would not need to buy them in pharmacies. In reality, however, the commercial sector of medicine distribution, disposes of more medicines than the public sector [1, p. 140]. Pharmacists make huge profits *because* the public system does not work. Finally illegal drug vendors, most of whom are only petty traders, can eke out an existence thanks to the failure of the public health system.

It should be noted, in conclusion, that the main profiteers of the existing inefficiencies, health personnel, civil authorities and pharmacists, also have considerable influence in maintaining the present system. The law on the exercise of the profession of pharmacist for example clearly protects the commercial interests of the pharmacists at the expense of the health of

the urban poor and rural population [20]. It is unlikely that the present situation can be changed against the wishes of these three influential groups. A possible solution would be to let these groups gain profit from any new system of medicine distribution.

Another conclusion is that the present inefficiency favours exactly those who are least in need of medical help and, moreover, are most able to pay for it. In other words, the current inefficient medicine distribution perpetuates and aggravates existing inequalities both in economic and health conditions.

#### CONCLUSION AND SUGGESTIONS

My purpose in this paper has been to reveal a crucial cause of the inefficiency in public medicine distribution. I have further shown that the present inefficient system does indeed have some efficient side effects, but these do by no means warrant a continuation of the present practices.

The crucial cause of inefficiency is the high frequency of private use of medicines meant for public use. This practice, which I have termed 'corruption', is firmly embedded in the existing social and economic system. Views on corruption expressed by Scott and others apply clearly to the Cameroon situation as some of the case materials presented above exemplify. The socially accepted practice of privately using medicines belonging to the state is linked with customs of gift-giving, with the preponderance of traditional loyalties over obligations to the state, and with a proprietary view of public offices. The most important single factor promoting corruption is however, the overwhelming position of the state as the main source of goods, services and employment and the relative under-development of the private commercial sector. The fact that there tends to be a considerable education gap between office holders and citizens facilitates corrupt practices.

This paper further confirms that a poor country like Cameroon cannot afford the losses which result from corruption. Its medical services are gravely affected by the practices described here. Finally, I have argued that these practices have a strongly conservative impact on society. They tend to maintain the *status quo* in the unequal distribution of health resources and economic resources in general.

Suggestions to ameliorate the situation are hard to make. Improvement cannot be reached by simply increasing the budget for medicines, however necessary this would be, for an increase in medicines will most likely only lead to an increase in corruption. Neither will more control on medicine distribution improve the situation. On the contrary, additional control will only result in additional private demands for medicines, namely by the controllers themselves. Finally, it would be unrealistic to try to change the existing traditions and ideas which encourage corruption.

The only possible solution probably lies in reducing the importance of state resources in the field of medicines by a limited commercialization of the public sector. The fact that private health institutions, with virtually no state subsidies, function relatively well, whereas public institutions, which are financed by the state for 100%, are in a continuous state of collapse,



points clearly in this direction. It is exactly the public character of its financial basis which must be regarded as the root cause of the system's inefficiency. As I have said before, commercial impulses only lead to efficient services if the service goods belong to those who render the services. When this is not the case, it is more profitable to divert the goods to one's pockets than to distribute them freely among clients. A public sector of free distribution of medicines has, therefore, an inbuilt tendency to corruption and inefficiency. This tendency can only be reversed by making the public sector more private.

The underlying thought is that the '*expensive free distribution*' of medicines should be replaced by a *paid distribution of cheap medicines*. Let us briefly look at two elements in this suggestion: 'paid' and 'cheap'. Changing the present public system into a paid distribution of medicines requires a careful commercialization of the service. The result will be that the health worker who distributes the medicines has to buy them wholesale and sell them to patients. This arrangement will make it unattractive to the health worker to divert some of the medicines by giving them freely to relatives and acquaintances. It should be noted that this suggestion reflects to some extent what already happens. The public service has *de facto* been commercialized to a large degree. Patients visiting public health institutions often have to pay in one way or another for medicines they need. The present proposal suggests how this commercialization can be achieved without damaging the quality of the health service, as happens now. Doubts may be raised whether health workers will be able to escape claims of relatives and relevant others for free medicines once they have become the owners of the medicines they distribute. I am not saying that they will escape *all* claims, nor that they should. They will have to weigh the costs and benefits of such claims for themselves and decide upon them. Certain is that they have a variety of techniques to turn away such claims. An example is presented in case 5 below.

#### Case 5. The pharmacist and his relatives

B is a qualified pharmacist who set up a pharmacy in the area of his home-town. Several people express the view that it was foolish of him to do so because he will have all his relatives and co-villagers around who will trouble him with their continuous requests for free medicines. I ask B what he does with all those people who expect free things from him. He answers that he will only give free medicines to close relatives. Others he sometimes helps in emergency cases, but he let them sign a receipt and requires that they pay him back in the cocoa-season (which they often fail to do). His most effective technique is, however, to stay out of the shop. He has instructed his wife and personnel to refuse all requests in his absence. They simply say: "Le patron n'est pas là", which is an excuse for not giving the medicines.

The second element in the suggestion is that the medicines should be *cheap*. If the government adopts the WHO model for essential drugs it will be able to deliver the most important medicines for very low prices. Moreover, the government could further subsidize these medicines to make them still cheaper. There can be no doubt that a commercialization of essential medicines distribution is feasible involving minimum costs for patients.

A more detailed discussion of this suggestion falls outside the scope of this paper (see further [1, pp. 171–194]), but two serious objections to commercialization should at least be mentioned here. In the first place, commercialization may lead to increases of medicine prices encouraging the same inequality which resulted from the previous system.

The most effective measure against rising prices is of course making the medicines less scarce than they are at this moment. This can be achieved by a more efficient distribution as is proposed in this paper. A further measure which may help to keep prices down is the establishment of fixed prices for the whole country which are to be printed on the packages. The second objection is that maximization of profit through the sale of medicines may easily lead to overconsumption of medicines and thus harm people's health rather than improving it. A host of recent publications blame capitalism for the present crisis of Western medicine, see, for example, [22–24] and a term for the detrimental effects of commerce on health has even been coined: 'commerciogenesis'. I am aware of the seriousness of commerciogenic risks, but I believe that in the present Cameroon situation these hazards are easier to check than the negative results of the public system, which is now in existence.

*Acknowledgements*—The research was financed by the University of Amsterdam and the Netherlands Foundation for the Advancement of Tropical Research (WOTRO). Research permission was granted by the 'Délégation Générale de la Recherche Scientifique et Technique' (DGRST) of Cameroon (Authorization No. 288). Research assistance was given by Kosso Félix-Fayard, Mireille Visser, Jean-Claude Bitá and Nicolas Mbang-Bita'a.

Earlier versions of this paper were presented at the Seventh International Conference on Social Science and Medicine at Noordwijkerhout, the Netherlands and at the Africa Colloquy in Leiden. On both occasions participants offered suggestions for improvement of the paper. Useful comments were also received from an—anonymous—reader of this journal.

I want to make it clear that the critical tone of this article is meant as a constructive contribution to the solution of health problems in Cameroon. I wish to emphasize that I am not at all the first to raise the issue of mismanagement in health care. The same issue has been repeatedly mentioned in unpublished ministerial documents which I was allowed to study.

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