11. HEALTH CARE AS POLITICS? "MISSED CHANCES" IN RURAL CAMEROON

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This brief article examines why the Cameroon government fails to make effective use of health care as a political tool to improve the acceptance of the state in rural communities. In the first section Western health care is presented as an eminent tool for political binding. In the second section the quality of rural public health care in Cameroon is investigated. In the conclusion an attempt is made to understand why the state of Cameroon 'misses this chance'. Research for this paper was carried out in 1980 and 1983 (1).

HEALTH CARE AS POLITICAL BINDER

It is hard to imagine a state without at least some awareness among its population of some kind of unity. Even states which seem to be held together by violent coercion can probably not do without a certain degree of 'populism'. Lemaire (1980: 243) has made the interesting remark that regimes which harbour extremely unequal socio-political relations tend to indicate those relations with 'binding' terms derived from kinship, religion and other cultural traditions that reflect group solidarity.

Another powerful political binder in situations of class conflict or cultural diversity is the provision of health care, in particular so-called 'Western medicine'. There are at least six reasons why Western medicine can be effectively used as a tool to create or improve social cohesion and a sense of political belonging.

The most important reason perhaps is that health care appears to be un-political. Political manoeuvres, as is well-known, 'work' best if they are not recognised as politics. Health care provides abundant facilities for such a 'cover-up'. It has the appearance of ultimate humaneness: concern about people's health. 'Health' is generally regarded as one of the basic conditions for 'happiness'. Moreover, in health care social differences seem to disappear. Firstly, everybody falls sick, independent of social position and economic status.

Secondly, in (Western) health care the sick body becomes the focus of attention, while the social person 'in' the body tends to be less emphasised.

In hospitals even social misfits may be treated with great care (not in the last place because they provide interesting medical cases) and will become less different from those who have a respected social position in everyday life. Hospital dress also allows for less social distinction. At least at first sight, health care seems to be far away from political interests. It presents, in Doyal's (1979: 43) words "the benevolent face of an otherwise unequal and divided society".

Of course, this is an ideal picture of health care. It is also what is expected of it. When the actual practice of health care does not correspond to this ideal picture and allows glaring inequality in the quality of care, health care may turn into the opposite of political binding and become political dynamite. This risk should be an extra reason for political regimes to handle the tool of health care dexterously.

The second aspect of health care making it into an effective political binder is closely related to the first one. Health care not only appears to be free of politics, it also works in a depoliticising way. Medical science and practice as developed in the West reduce sickness to bodily defects. Links between disease and the socio-political environment, for example, are largely ignored. Thus health care not only sooths social inequality, as we have just seen, it also conceals it. Western health care in particular individualises and somatises social problems. It presents the 'sickness' of society as the sickness of an individual. Not society, but that individual needs treatment. Political problems remain out of sight. It is this aspect of political-economic camouflage which has been most stressed by Marxist critics of 'capitalist medicine" (2).

The third reason is that health care lends itself eminently to the exercise of social control. Social control is the other side of physical violence. In contrast to violence, social control is based on the assumption of common values and ideas within a social group. This concept of consensus has a regulatory influence on the members of the group. Health care proves useful to excuse deviations (by declaring

them medical) and to correct them (by giving the deviant 'time-out' as a patient and by stimulating him to 'get better' and to return to his old position in society). Parsons (1951) has continuously emphasised this aspect of health care and has called physicians "agents of social control". Freidson (1970) refers to the same phenomenon by naming them "moral entrepreneurs". Szasz (1974) has applied this perspective to Western psychiatry. According to Szasz, the social control exercised by psychiatrists is ultimately based on their successful attempt to describe mental and behavioural problems in terms and metaphors derived from biomedicine. The state in the Western world has increasingly made use of the control avenues offered to it by psychiatry, and has become a "therapeutic state", in Szasz' (1974: 137) words.

The use of biomedical concepts for problems in the social domain is a wide-spread phenomenon in Western society which has been called 'medicalisation' (Zola 1973; Illich 1976; and many others). Conflicts and problems in the field of housing, inheritance, conscription, employment, law, insurance and many other, extremely diverse, social problems are increasingly 'solved' through medical verdicts (cf. De Swaan 1983: 151-219). Medicine has succeeded in acquiring an image of neutrality and objectivity which bears a remarkable likeness with the image of religion in the previous age. Both claim to be based on an unshakeable and unambiguous truth. For the clergy this was the divine revelation and the implication of a Christian 'natural law'. For the medical profession objective truth is found in the invariable and universal human biology.

A fourth explanation of the political importance of health care lies in the fact that a healthy population produces most. The state, therefore, has a direct interest in an adequate health care system which keeps its labour force fit for work. Doyal (1979) writes that the British National Health Service came into being because the economy needed it. The introduction of Western health care in African colonies served the same economic purposes, according to a number of authors (see for example Lasker 1977 for Ivory Coast; and Turshen 1984 for Tanzania). The political authorities charged the medical profession with the task of watching over the health of the

population. Two 18th century German physicians described this task in terms of 'medical police' (see Breilh 1981; and Rose, 1974). The economic importance of health care is still prominent in the ideas of the World Bank and the World Health Organization. The following quotation is typical.

> 'Health can ... reduce absenteism, increase labor availability and productivity, and facilitate exploitation of natural resources' (World Bank 1980: 33).

The fifth reason underscoring the political importance of health care is somewhat related to the previous one. International development organisations have come to realise that economic growth figures are defective and deceptive indicators of 'development' (e.g. Agbonifo 1983). Some development planners slowly shifted their attention from 'econocratic' variables to criteria which said more about people's well-being. Health criteria seemed an obvious choice, certainly if 'health' was defined in the broad (and vague) way of the WHO: "a state of complete physical, mental and social well-being". The argument clearly was that economic growth should not be called 'development' if the quality of life did not improve for the majority of the population. 'Better health' seemed a reasonable indication of better quality of life. So health became a new measure for 'development'.

But how do we calculate 'health', taken in the meaning of the WHO definition? How can 'physical, mental and social well-being' be measured? Mortality and morbidity statistics, if they are reliable (and they are not in many developing coutries), reveal at their best a small part of well-being. By a strange twist of reasoning statistics about number and distribution of medical services are often brought in to complement the limited knowledge of health conditions. It is assumed, apparently, that more hospitals, health centres, physicians, nurses, etc. means better health. Thus health care provisions become indicators of 'development' and a testimony of the quality of a political regime. Effective curative health care, by consequence, contributes considerably to the legitimisation of a regime (3). It is

one of the most appreciated calling cards of a regime both in and outside the country.

A last aspect of (Western) health care which makes it an effective weapon to bring separate groups and individuals together into a larger collective is its art of undermining autonomy. In many countries Western medicine has succeeded in ousting local medical traditions which were mainly based on self-help and has made people dependent on a foreign, highly technical, medical knowledge and practice. Where the state becomes the provider of this new type of health care, it creates dependence.

In many respects self-help is an obstacle to state formation. When people are convinced that they can rely on themselves, they have no interest in joining a larger political unit. The outside world is often viewed with some mistrust and its actions tend to be judged negatively: foreign interference, tax paying, loss of certain freedoms and threats to the traditional way of living. Every peaceful undermining of self-reliance, therefore, is an contribution to the encapsulation of a group into the state. Health care is an eminent example where such dependency can be achieved. It seems likely that people are prepared to accept new therapies if their greater efficiency can be made plausible, because better health is one of their prime concerns. Western medicine, in particular its pharmaceutical products, is in fact widely believed to have an extra-ordinary efficacy.

Western medicine, however, cannot simply be copied on a local level (4). It is highly technical and, above all, it is expensive. Lay people miss the knowledge and material resources to produce it for themselves. They have to depend on others for it. It is essentially alienating. Only organisations with substantial financial strength can offer the entire gamut of western medical services, from simple primary health care up to specialized hospital medicine. The state is the most likely 'organisation' to provide these. Thus a political regime can use health care to establish a favourable image: it becomes "Father State" who cares for his children. Politicians skillfully use health care to reward or punish voters. They become providers of desirable gifts and privileges, for example roads, schools, sanitary

provisions and of course medical services, but only if the population 'behaves well'. The state assumes a clientelistic structure (5). It is further noteworthy that politicians are most likely to promise benefits which can be materialised within their period of office. In 'democratic' systems this period is usually about five years. It means that they will favour only short-term improvements of health care which may prove dubious and erratic in the long run.

Summarizing, Western health care provision seems a convenient tool for binding dispersed groups into a larger political unit. It provides the avenue for a gentle penetration by the state on the local level. A satisfactory system of health care, as we have seen, produces a powerful legitimisation of the state. One would, therefore, expect new states, which face extreme cultural diversity and other centrifugal forces, to use this political binder as well as possible. In the next section I describe the situation for rural Cameroon. To my surprise I found that the Cameroon authorities are 'missing chances' by their de facto disregard for the political utility of health care in its rural communities.

HEALTH CARE IN RURAL CAMEROON

In 1980 the Cameroon Ministry of Health received 6.1% of the national budget, which is comparable to what other developing countries spend on it. The highest budget in 1980 was allotted to education (15.9%), followed by central presidential services (15.3%) and defence (12.3%). Health received the fifth biggest share. An analysis of the health budget shows that personnel costs have grown continuously at the expense of pharmaceuticals and technical materials. In 1975/1976 70.9% of the budget was spent on personnel; in 1977/1980 this percentage had increased to 77.7. Money spent on pharmaceuticals and other materials decreased in that same period from 17.4% to 11.9%. The consequence is that ever more, and more highly trained staff has to work with ever fewer materials. This again has as a consequence that a great deal of public health care does not function well, as we shall see in a moment.

A second striking aspect of the health budget is that in 1977/80 no less than 50% of it remained in the two largest cities, because 30% went to the central administration and 20% to the central hospitals of Yaoundé and Douala. Regional hospitals received 39% and only 7% was allotted to rural health care. The figures demonstrate that the government's priority does not lie with the rural areas where more than 70% of the total population lives ('urban' are towns with more than 20.000 inhabitants).

The low priority given to rural health care also shows itself in the way it actually functions. In 1980 I conducted fieldwork in the Ntem Division in the South of the country. The research, in which four assistants took part, focused on the distribution of - Western - pharmaceuticals both in and outside regular health care institutions. Health care itself was also studied because it constituted an important context of medicine distribution (6). Initially the research was restricted to this one Division, with a surface of about half the Netherlands and a population of 140.000 according to the 1976 census. Later on I included comparative data for other parts of the country by studying reports and other research materials, by interviewing regional and ministerial staff and by visiting other regions. An extensive ministerial report of a national survey on the supply and distribution of pharmaceuticals proved particularly useful (M.S.P. 1980). A brief follow-up visit was carried out in 1983. In the presentation that follows I shall mainly speak about the Ntem Division but it should be borne in mind that I have found conditions in other parts of the country to be fairly similar.

I tend to believe that public health care is indeed <u>designed</u> as a political binder. Medical treatment and drugs are free of charge in the state health care system, whereas they have to be paid for in church-related and other private institutions. On paper we find a widespread network of public health centres and hospitals. This network has expanded enormously since Independence in 1960. Before Independence the country had only 12 hospitals and 65 health centres (both public and private). By 1978 the number of hospitals in the public sector alone had risen to 99 and the number of health centres to 650.

Actual practice, however, shows a different picture. Drugs, which should be distributed free of charge, are often in short supply. Patients in remote villages visiting their health centre are often sent away with a prescription for medicines which they perhaps can buy in a nearby propharmacy or drug store but they may well have to travel to the divisional capital Ebolowa where the only pharmacy of the entire Division is. For some this may entail a journey of more than 50, even more than 100 km over bad roads and with rare means of transport. Obtaining the medicines may take a few days and involves considerable costs in terms of transport fees, time and drug prices.

The statistics which show an impressive network of health centres are misleading. Many of these centres hardly function at all, some only a few months per year after the annual supply of drugs has arrived. As soon as the stock is exhausted - and this may be very soon for essential drugs - the patients stop coming. I am aware that I am using somewhat vague indications ('many', 'some') but it is not possible to give exact and reliable figures about how many centres do not function for how long a period. Official statistics are unreliable and may cover up poor functioning. My conclusions are not based on 'hard figures', but on interviews with villagers and health workers, random visits to a large number of centres and systematic observation of two centres.

There were, in the Ntem Division, in 1980, four 'developed', fifteen 'elementary' and thirteen 'community' health centres. The first two categories received each year a (too small) supply of medicines from the Ministry. The last category depended on the local council for its supply. These community health centres had received practically no medicines over at least the past five years and had come to a virtual standstill. Some of them had even delapidated in the litteral sense of the word. I saw two of these centres which had become the residence of the staff. The conditions for the other two typescountry's political centre, both in geographic and in bureaucreatic terms.

Statistics about public health personnel are no less misleading. It is generally known that nurses and doctors are often not present at their work. The absence can have many different reasons, for example a

family visit, perhaps in connection with the sickness or death of a relative. Health workers seem to be frequently sick themselves as well (cf. Hours 1982). The absence can however also be caused by that person's side activities. One of my assistants kept a diary about all kinds of events related to health in his home community. He wrote that it was a common practice for all seven health workers in the local ('developed') health centre to leave for their farms early in the morning while the centre remained closed.

The case below presents an extreme, but not exceptional, example of the breaking down of public health care in a remote village. The case is extreme because it deals with a 'community' health centre, the type of centre which is most neglected.

The health centre at B.

The health centre is a solid little building. The small mud hut behind it, which is the health worker's official residence, forms a sharp contrast with it. It is not surprising that the nurse has occupied a few rooms of the health centre to live in. The nurse is not present. His children walk around. The door of the consult room is open. I enter and see an indescribable chaos. I cannot tell the difference between refuse and medicines. Left-overs from Italian drugs and melted suppositories are strewn over the desk. There is also a notebook in which the names of some patients have been registered. I take a few pictures. The people who have come to meet me let me look around and do not oppose my taking pictures.

Since I cannot interview the health worker, I propose to some of the villagers to organize a group discussion about their problems of health care. The suggestion is accepted. In a nearby house about twelve people meet. They tell me that during the past five years the centre has twice received a very small allotment of medicines. On religious feastdays, however, some Italian Roman Catholic sisters or a priest visit them and distribute Italian medicines under the Catholics. What remains is given to the nurse to treat the sick.

I ask what they do when someone falls sick. Those with some money go to Ambam (a small town, 75 km over a new, or 25 km over a very bad road). Others let themselves be treated by a traditional doctor. Some travel to the town with a prescription written by the nurse. Sometimes pedlars visit the village. In the cocoa-season, when the people have money, the pedlars sell one Tetracyclin capsule for 50 francs (about 40 Dutch cents), in the 'dead season' the same capsule costs about half that price. A young man tells me: "I give injections, I have learned it from a nurse who had employed me as a 'garçon de salle'. Now I have my own syringe and help my family. The health worker never goes out in the night. So if in the night a child is attacked by malaria or some other sickness, people come and knock on my door and I give the child an injection. I do not have medicines myself, but the family of a sick person brings the medicine along. I give the injection free of charge, because we all belong to one family, but if

someone wants to give me say 100 francs I do not refuse them". It turns out that three people, besides the health worker, administer injections in the village.

Those present tell me that they prefer the Presbyterian health centre in Ambam. "It is expensive but you are well treated and you feel safe there. Anyway, nowadays you have to pay everywhere, even in the governmental hospital of Ambam where everything is supposed to be free of charge. One of our cousins spent six days in that hospital with a broken leg, without anybody taking notice of him. The doctor was absent. In the end we have brought him to the Presbyterian centre."

Transport to Ambam costs 500 francs (about 4 guilders) over the old and 650 francs over the new road.

On the way back to Ambam we stop in another village and by coincidence meet the health worker of B. He is visiting some friends but as soon as I make myself known and inform him about the research he tells me that he is 'on trek' to search for lepra cases. Later on the people travelling with me say that "he is lying". I try to have a short interview with him but he remains vague and elusive in all his answers. Some of his answers, I find out, are squarely false.

That same day I meet some people of the town council and the supervising doctor. They tell me that the centre received a small supply of medicines just over four years ago. The money value of that supply was almost 400.000 francs which was then nearly f. 4000,-, but that value was the retail price in the pharmacy of Ebolowa. If they had ordered the drugs from the Ministry or directly from the wholesaler they would have had twice as many medicines. I mention some of the drugs that were delivered at the time: 625 vials of injectable antibiotics (pennicillin, bi-pennicillin, etc.), 15.000 tablets Nivaquine (good for about 950 treatments of malaria), 250 tablets Notézine against filaria, and 400 Asperin tablets.

I understand from the various conversations that several irregularities have taken place with the supply of those drugs and that intermediaries have benefitted from the transactions, at the expense of the inhabitants of B.

I have already pointed out that the poor functioning of the centres is directly related to the shortage of pharmaceuticals. Patients regard medicines as an indispensable part of therapy and do not see the use of visiting a clinic if there are no medicines. It is on this point that public and private health institutions differ considerably. The latter always have a reasonable amount of drugs in supply. The lack of medicines and other materials which are necessary for effective health care discourages personnel in public centres and leads to a general feeling of malaise and fatigue (Hours 1982). Moreover, the quality of their work does in no way affect their income. Health workers who have not seen patients for months or even

longer continue to receive their salary. Obviously, that would be impossible in a private practice.

It soon became clear that the presence or absence of both medicines and personnel were directly related to the private or public character of the institution. The national survey about the supply and distribution of medicines mentioned above (M.S.P. 1980), noticed that in most of the centres visited only half the amount of the allotted drugs did in fact arrive, at least in a good state allowing them to be used. The authors of the report blamed the public-sector factor for this development. The notion of urgency does not exist, nor does competition, and profitmaking is not possible. In other words, three important incentives for an effective health care system are missing. They conclude that those working in the Central Pharmacy, which is responsible for the supply of drugs to public institutions, have no interest in an effective management. They rather cultivate a bureaucratic attitude for the sake of bureaucracy, which squarely opposes the health needs of the population. Ordering pharmaceuticals from the Central Pharmacy in 1979 took between eight months and two years, but orders in the private sector were met within about three weeks.

In the Ntem Division I investigated the drug supply to six public centres, five of them 'elementary', one 'developed'. In the year 1979-1980 they received on average only about 65% of the medicines they were supposed to receive, while it should be taken into account that even 100% would not have been sufficient.

Drug shortages are not only the result of inefficiency but also of mismanagement. Their scarcity makes pharmaceuticals even more wanted. Health care workers are under continuous pressure of relatives, acquaintances and social superiors to provide them with free medicines. Most health workers are probably prepared to give in to many of these demands because the products are not their own property and they have temselves far more advantage than disadvantage in giving out drugs. They 'grease' their social and family relationships. Some health workers also sell medicines in a parallel 'private practice' at home, or wholesale them to drug vendors. It is impossible to provide exact figures about the amount of drugs which

thus disappears, but my own research and casual conversations with villagers has shown that the 'social handing-out' of drugs is a common and more or less accepted practice. The selling of drugs which are meant to be distributed free of charge among patients is more frowned upon but is also believed to be fairly common. On the basis of my research I estimate that perhaps about 45% of drugs planned for use in public health care actually reach the patients, but I must emphasise this in only a guess.

As I have already indicated this situation contrasts sharply with the practice in private institutions. In the rural areas these are usually church-related health centres, once founded by Christian missionaries. Strictly speaking these institutions have no commercial ends. They have probably been started for missionary of humanitarian purposes. However, all of them have to be 'commercial' to some extent in order to continue functioning. They receive practically no government support and often have to live from their own incomes. They cannot afford to lose clients because of poor service. Lack of medicines and absence of personnel rarely occur. Most of their profits derive from the sale of medicines and from surgery.

People sometimes complain about the high costs in private institutions, but most also agree that the service is prompt and reliable. Collecting case histories of illness I was often told about frustrations in a state hospital or public health centre. Some told me they had not visited a public institution to avoid such frustrations. Ironically, the rural public health care has become exemplary of the state's failure to care for its rural population. Free health care turns out to be extra expensive. Services which apparently have been especially designed for the poor benefit the rich, because the latter are in the best position to acquire free gifts of medicines. Health care seems planned as a political tool to tie rural communities closer to the state administration through a wide network of services. In practice, however, it further 'peripherilises' the periphery, because, as we have seen, the quality of health care decreases the further one gets from the political centre.

The fact that non-governmental agencies are able to provide a much better quality of health care although they do not receive any

help form the state, exacerbates the embarrassment. Instead of political binder and legitimisation, public health care rather seems a cause of anti-propaganda for the political regime. Why does the government 'miss this chance'?

DISCUSSION AND CONCLUSION

A certain dose of consensus seems to be indispensable for building up a state. It is unlikely that such a 'consensus' can be forced upon a population by mere physical coercion. 'Positive means' are probably more effective in bringing about the belief in common interests, although such positive means may envelop rather than remove opposite interests.

Reasoning from the point of view that political power needs legitimisation, one would expect state governments to apply such positive means and make people feel that the state is important to them, that it provides them with things which are beyond their own reach, for example the guarantee of peace and public order, a reliable market for their products, a just and strong judicial system, education and also effective health care.

As we have seen, the use of health care as a political binder for the state is not successfully applied in rural Cameroon, in spite of the country's considerable efforts. If we want to understand the government's failure to make effective use of health care as political 'cement', we should take at least five points in consideration.

The first point is of course the problem of financing. Cameroon, as many other low-income countries, canot afford high expenditure on health care. This financial problem presents a vicious circle. Low state income prevents the governent from spending more on health care; this leads to a lukewarm attitude among peasants to produce more which reduces state income. Myrdal's concept of 'soft state' also applies to Cameroon. The ineffective health care is both cause and consequence of the state's 'softness'.

The second point to consider is beautifully summarised in Ahrend's (1970: 56) dictum that violence is not a sign of power but of lack of power. The frequent resort to violence in new African states

indicates the lack of real political power. That violence would not be necessary if state authority were accepted and regarded as beneficial. Violence therefore is a testimony of political weakness. the Nigerian political economist Ake (1980: 210) has the following to say about state violence in Africa:

> 'There is no country in Africa that does not impose unspeakably harsh punishment - sometimes up to a decade in prison - for petty theft. There is no African country which is not freely using state power to imprison, banish, or murder political dissenters. What is happening in Africa is a reflection, not of the uniqueness of the character of Africans, but rather of social forces which have the same effect wherever they occur. In all very poor countries where the rulers maintain exploitive relations and where the struggle for the surplus is very grim, the established order can be maintained only by ruthless coercion verging on fascism'.

Open state violence has decreased in Cameroon over the last ten years, but the threat of violence still remains an important factor in the imposition of power. State control through police and army remains considerable. The fact that the government expects more security from physical force than from a 'humanitarian face' shows that it still feels insecure.

A third important point to consider is the unequality between rural and urban health care. The concentration of medical services on urban populations, on police and on army are all part of the same phenomenon: satisfying those who represent the greatest risk to the regime. The absence of a common political awareness among the rural population prevents it from becoming a threat to the government. The state, therefore, is inclined to neglect rural health care facilities. Food riots in several African cities have reinforced this attitude in recent years. Price increases which were favourable to the rural peasant producers were hastily cancelled after political unrest in the cities. African states can afford more oppression of rural than of urban populations.

The negligence of rural health care is somewhat hidden behind an official policy of primary health care in village communities. In actual practice, however, primary health care is of little significance. Moreover, primary health care is supposed to encourage

self-reliance, which clearly clashes with the government's policy of increasing state dependence.

The fourth point to take into account is the state's centralisation policy and its systematic discouragement of local initiatives which may improve self-reliance or separate cultural identity. The Cameroon government is for example suspicious of locally organised cooperatives, cultural associations, religious movements and attempts to revive local languages. Geschiere (1984: 351) remarks that the authorities are inclined to view such initiatives as subversion. The lack of appreciation of indigenous medical (or for that matter: argricultural) traditions is significant. It is another example of discouraging autonomy. Positive remarks about traditional medicine, which have become fashionable, should not be taken very seriously. Praising traditional medicine is mainly a new way of speaking to express respect for non-western cultures but which is unlikely to have practical consequences. Both politicians and representatives of the medical profession are opposed to such medical autonomy and even the rural population itself does not want it, because it has learnt to regard Western medicine as superior to most of their own traditions.

The government's strong centralising tendency has led to a contradictory situation: on the one hand it advertises Western medicine and discourages medical self-help; on the other hand it is not able to guarantee an adequate provision of what it advertises. The result is that rural communities fall in between and end up with very little.

A final point to discuss here follows directly from my research data, viz. the finding that public health care functions poorly <u>because</u> it is public. In earlier publications and in conversations with Cameroon authorities I have therefore suggested that a certain degree of privatisation may improve the efficiency of public health care. This suggestion has always been rejected by political spokesmen. In particular the proposal that patients may be better off if they are made to pay something was vehemently criticised. The idea was regarded as unrealistic and politically impossible. One government representative called it 'putting back the fingers of the clock'. My argument that continuation of the present so-called free medicine

distribution worked out very expensively for most rural poor, failed to convince them. Apparently the illusion of free medicines was regarded a safer political tool than effective improvement which implied formal payment for medicines and services. Moreover, the system of 'free' medicines, which is tantamount to inefficiency in drug distribution, is clearly advantageous to commercial pharmacists, who provide the medicines which are lacking in the public system. One could say that they make a living out of the failures of public health care. It is no wonder therefore that they support the present system and oppose measures which would improve public drug distribution and thus harm their business. Two other categories of people who benefit from the present system and will probably oppose 'solutions' are political elite members and health care personnel. Both groups have direct access to free medicines under the present system (cf. Van der Geest 1982a).

In conclusion one could say that the state in Cameroon is 'missing the chance' of enhancing its acceptance among the rural population through the provision of effective health care. State authority over rural Cameroon, it seems, is still mainly based on (the threat of) force. That situation reflects the political weakness of both the state and the rural population. The state has not yet succeeded in presenting itself as a 'physician caring for his patients', thus creating a sense of voluntary dependency; but the rural population is not able to present itself as one political front, demanding its rights and posing a political threat. As a consequence, the Cameroon government can afford to be weakly represented in the rural areas and to continue pouring privileges on urban groups and elites. Hyden (1980) has coined the term 'uncaptured peasantry' to indicate the peasants' successful opposition to encapsulation by the state in Tanzania. Its rural population remains extremely volatile for state control. The indifference of the Cameroon authorities vis-à-vis their rural population and its slugginess to improve health care in the villages suggest that - inversely - political power also remains volatile to rural inhabitants. The elusiveness is mutual. From the point of view of Cameroon peasants one could speak of an 'uncaptured state'.

NOTES

1. The research for this paper was financially supported by the University of Amsterdam and the Netherlands Foundation for the Advancement of Tropical Research (WOTRO, No W.52-211). It was further facilitated by the assistance of Mireille Visser, Kosso Félix-Fayard, Bita Jean-Claude, Mbang-Bita'a Nicolas, and Robert Rempp. Many others were also helpful during and after the research. The research was approved by the Cameroon government (DGRST Autorisation No. 288). This paper criticises health care in Cameroon, but it does so to provide a constructive contribution to the improvement of it, especially among the rural population. It does not intend to belittle the results which have been achieved in health care.

2. Two prominent examples are Navarro (1976) and Doyal (1979). Both see health care as a tool for the capitalist state to maintain and reproduce its class structure and its bourgeois ideology:

> The social utility of medicine is measured primarily in the arena of legitimation. Medicine is indeed socially useful to the degree that the majority of people believe and accept the proposition that what are actually politically caused conditions can be individually solved by medical intervention. From the point of view of the capitalist system, this is the actual utility of medicine - it contributes to the legitimation of capitalism (Navarro 1976: 208).

3. But Plato, in The Republic had pointed out that the need for many doctors and hospitals shows that there must be something wrong with the health conditions in that particular society.

4. The 'appropriation' of Western medicine in local cultures of medical self-help does however occur to some extent in the wide-spread use of Western pharmaceuticals outside professional medical supervision. Western pharmaceuticals are culturally reinterpreted and accomodated in syncretistic popular beliefs all over the world (see for example Bledsoe & Goubaud 1985). But even there people remain dependent on foreign, usually imported, products.

5. The clientelistic structure of the state of Cameroon is discussed extensively by Bayart (1979) and Geschiere (1982; 1984).

6. Preliminary reports of that research are among others: Van der Geest 1981, 1982a, 1982b, 1985.

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