

Are the fees that the traditional health practitioner charges generally lower than that of the medical practitioner?

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RESEARCH

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ABSTRACT

Background

The cost of healthcare is a matter of concern for the public and the authorities. When a new healthcare provider enters the healthcare market, specifically the private sector, it is crucial to know if the fees will be affordable, especially when that service provider claims to be able to offer a far less expensive service than his competitors. The newcomer, the traditional health practitioner, was awarded statutory status in South Africa in terms of the Traditional Health Practitioners Act No 22 (2007). Although the training and skills of the various types of health practitioners are central to their ability to deliver an effective health service and influence the specific fee that the practitioner will charge, the focus of this research is only the financial aspect. Factors such as the nature, complexity, risk and difficulty level of procedures influence fees. The question here is whether the traditional health practitioner's fees are in

general lower in comparison with that of the medical practitioner.

Aims

The study aimed to determine if the fees of the traditional health practitioner are in general lower in comparison with that of the medical practitioner.

Methods

This is an exploratory and descriptive study that makes use of a historical approach by means of investigation and a literature review. The emphasis is on using current documentation like articles, books and newspapers as primary sources to reflect on whether the fees of the traditional health practitioner are generally lower than that of the medical practitioner. The findings are offered in narrative form.

Results

The research could not uncover any evidence to support the claim that the fees of the traditional health practitioner are lower in comparison with that of the medical practitioner.

Conclusion

This research could not confirm that the fees of the traditional health practitioner are in general lower when compared with that of the medical practitioner.

Key Words

Healthcare, medical practitioner, modern medicine, service costs, statutory status, traditional health practitioner

What this study adds:

1. What is known about this subject?

Literature offers limited information on this topic.

2. What new information is offered in this study?

The study found that the argument that the fees of the traditional health practitioner are in general lower than that of the medical practitioner is not supported. It can therefore not be offered as a reason to promote traditional healing.

3. What are the implications for research, policy, or practice?

The view of the traditional health practitioner as an inexpensive healthcare provider is inaccurate.

Background

The cost of healthcare is of great importance in South Africa, especially for the poor sector of the country. The post-1994 government has exerted itself to offer an inexpensive healthcare service to the poor. Various initiatives are prominent, including both public and private delivery of healthcare. Central to healthcare delivery are the various practitioners, like nurses, dentists, medical practitioners and others. Many of these practitioners work in the public sector, but the majority in the private sector, either as employees or self-employed.

The regulation of specific groups of health practitioners in South Africa is not a new phenomenon. In the 1970s, government introduced the regulation of psychologists and later in the 1980s the allied health practitioners followed. The public demand for a specific health practitioner lies at the basis of regulation. In the case of the traditional health practitioner, the authorities and the traditional health practitioners offered certain reasons why it is of utmost importance to include this fraternity as healthcare practitioners in the private sector of the South African healthcare establishment.¹⁻⁷

One of the main pleas to regulate the traditional health practitioners claimed that these healers offer an affordable health service to the poor, especially in isolated rural areas, because the fees and costs of practice are generally less expensive than that of the medical practitioner. This plea was strengthened by the argument that there is a shortage of public and private health practitioners who work in these areas and that public services like clinics and hospitals fail to offer much needed healthcare.⁸⁻¹⁰ The aim of this study is to determine if the traditional health practitioner's fees are in fact lower in comparison with that of the medical practitioner.

Method

The research was done by means of a literature review. This method entails formulating a view based on the evidence

presented in the literature. This approach is used in modern historical research centring on topics about which there is little information. The databases used were EBSCOHost, Sabinet online and various contemporary sources like newspapers and reports for the period 2003 to 2013, articles from 1992 to 2014 and books for the period 1990 to 2014. These sources were consulted in an effort to reflect on the fees and costs of traditional health practitioners and medical practitioners.^{11,12} The findings are offered in narrative form.

Results

The available literature reveals that the implementation of the Traditional Health Practitioners Act No 22 of 2007 has been limited despite the fact that it was promulgated nine years ago. No fee structures are described in the Act and even the registration of traditional health practitioners has not progressed. Traditional health practitioner organizations also lack the internal structures and leverage to prescribe fees and to enforce pricing for diagnosis, treatment procedures and self-made medicines. Pricing is decided individually by each traditional health practitioner.

The fact that the Traditional Health Practitioners Council (THPC) has failed to open a register and had not registered traditional health practitioners formally, makes it very difficult to distinguish between competent and incompetent healers. The information provided by these unregistered healers can be misleading.

The fees that medical practitioners may charge for diagnosis and treatment procedures are not statutorily fixed. They are free to decide on their own fees. The only price-fixing with regard to their diagnoses, treatment procedures and services is that of the medical funds and schemes that declare a maximum price-listing for each service. In many cases, the fees asked by medical practitioners, especially medical specialists are up to three times that of the maximum prices paid out by the medical funds and schemes.

It is impossible to directly compare the fees of traditional health practitioners and medical practitioners in terms of money value based on a statistical analysis.

A statistical analysis based on the presumed low fees and cost structure of the traditional health practitioner compared with the alleged high fees and costs of the medical practitioner is also unrealistic. They are two very different groups from different time frames and development levels. On the one hand one has the medical

practitioner, a very modern, skilled professional with scientific training, know-how and professional ethics, backed up by a sophisticated medical and scientific technology industry and healthcare establishment. On the other hand there is the traditional health practitioner, a pre-modern healer without any proven training or medical knowledge and with no formal professional ethics and sound formal practice control.

For a lack of statistical information, this study embarks on a literature review of publications that describe the cost of services. The findings from literature are presented in the discussion.

Discussion

One of the arguments in favour of regulating the traditional health practitioner was that modern medical practitioners charge high fees and involves cost, over against the low fees and costs of the traditional health practitioner. The fact that these arguments are prominently and constantly reflected in literature and presented to the public as true, together with the argument that there are 200,000 traditional health practitioners in South Africa and that 80 per cent of the South African public regularly consult the traditional health practitioner, justify this research.¹³⁻²¹

Fees and costs system of the traditional health practitioner

There is in fact South African literature that thoroughly investigates the fee and cost structure of traditional health practitioners versus medical practitioners.

This literature shows that the fees and costs are almost the same for the two groups, notwithstanding the higher training of the medical practitioner versus the lack of formal medical training of the traditional health practitioner.^{8-10,22}

The only clear difference between the two kinds of healers is the patient-friendly payment system of the traditional health practitioner. This group follows a far more flexible approach regarding payment than the medical practitioner in his practice. It is not necessarily always more affordable, but it does in general accommodate the personal financial needs of the clients. To make payment easy, especially in the rural areas, the traditional health practitioners accept payments in cash and in livestock. In addition, some of the traditional health practitioners also follow a policy of “no payment for none cure”. Undoubtedly, this guaranteed outcome offered by the traditional health practitioner holds financial benefits for his clients and lowers the end costs.^{8-10,22}

Some traditional health practitioners also follow a policy of once-off payments for multiple services over a period of time. This minimizes the stress on the poor client’s cash outlay every time he visits the traditional health practitioner, either for a specific ailment or for various ailments treated over an extended period. Undoubtedly, such a comprehensive service where the healer down-prices his final charge, benefits the clients. These practices can contribute to the perception of low costs.^{8-10,22}

Conversely, researchers also show that the traditional health practitioner’s fees and costs can directly contribute to the higher living costs of poor households. This may be a reason why the use of traditional health practitioners is declining when free, effective government health services and qualified healthcare practitioners are available. Researchers point out that visits to a traditional health practitioner can cost up to 10 per cent of the household expenditure per annum. In this context, a cost of 5 per cent is already a heavy burden on a poor family’s budget, while a cost of 10 per cent and above can be catastrophic and can result in even more severe poverty.^{8-10,22}

The simultaneous use of the traditional health practitioner and the medical practitioner can double the medical expenditure of poor households. This double use can wrongfully lead to a perception that the medical practitioner’s healthcare service is expensive, while the costs of the traditional health practitioner is not at all brought into consideration as a contribution to the problem. One has to further take into account that the traditional health practitioner’s treatment does not always bring healing and that the patient may in the end be forced to incur extra costs for modern healthcare treatment from the medical practitioner. Not only does this negative outcome render the service of the traditional health practitioner less inexpensive, but the extra costs and emergency services rendered by the medical practitioner to rectify the traditional health practitioner’s mistakes, erroneously reflect on the medical practitioner’s income system as normal services rendered, heightening his fees and costs profile.^{8,9,10,22}

Gumede⁸ provides a different perspective on the traditional health practitioner’s “no payment for no cure” and “once-off payment” practice as described by researchers. He mentions that there is a “small retaining fee”, a so-called “doctor’s fee for opening his doctor’s bag” for the first consultation by the traditional health practitioner (p. 90). Regarding the amount to pay for treatment at the end, Gumede⁸ says that “the fee was well known to all and

sundry; it was a beast - an ox or a cow". This means that the once-off payment for traditional health practitioners can be up to R5,000 and more. This amount is surely not a low fee or an inexpensive cost to the patient. In this instance, it must be noted that this was the fee for 1990, excluding inflation of a 26 years period.⁸

This expensive fee structure of the traditional health practitioner is also confirmed by the study of Flint and Payne²³ in the Eastern Cape. They investigated traditional health practitioners' treatment of HIV/AIDS with uBhejane (a rhino muti cure). In 2006, this cost R300 per visit, with rates as high as R2,000 if animal sacrifices are included.

The negative impact of the failed official healthcare system

Modern hospitals and medical facilities situated in urban areas are sometimes difficult to reach for many poor people, especially in deep rural areas. Journeys involve long distances, poor public transport facilities and expensive taxis. With vast areas of land and poor road and transportation systems, many people have to travel long distances on foot to reach medical help. Once they arrive, they are often required to wait in queues for hours as the shortage of clinics and resources cause overcrowding. Medicines are not always readily available at district clinics, even at hospitals. Patients are often not informed about the cause of their illness or given any information about it at all. This leads not only to personal and health insecurity, but to patients remaining uninformed about preventing or handling specific ailments. This situation creates hostility among poor patients and results in them staying away from public healthcare facilities. Alternative medical help and services, like that of the traditional health practitioner, becomes their only alternative.^{9,15}

These situations promote the services of traditional health practitioners, not necessarily because they offer trustworthy and beneficial medical services, but purely because they are the only type of health service immediately and locally available. This government failure to offer an effective medical system in the rural areas has, especially in the past, created a false impression of the traditional health practitioner's services being cheap and effective. The sub-standard health system of the government and the extra costs it brings for the poor when they have to use the traditional health practitioner as an alternative has nothing to do with the medical practitioner and his fee structure. This failed official healthcare system and incorrect reporting in research are an injustice to the South African medical practitioner as a professional. The use of these one-sided perceptions of the medical practitioner's fee structure in the literature is misleading.^{9,10,19,20,22,24-26}

The fact that the South African government fails to train enough medical practitioners also reflects badly on the medical practitioner's fees and cost structure. This can relate to his salary in public service or the income generated from his private practice. The shortage in medical practitioners has led to increased demand for their services, which pushes up their income. This failure to train enough medical practitioners is illustrated by the fact that the eight local medical schools only deliver 1,200 medical practitioners annually compared to a much poorer and under-developed Cuba's output of 50,000 medical practitioners per year. Medical training is therefore another government problem that is now incorrectly and unjustly transferred to the medical practitioner's fees and costs.²⁷⁻³⁰

It must, however, be acknowledged that the South African Government has done much since 1994 to bring free and inexpensive healthcare to the poor in rural areas. More than 1,600 clinics have been built or upgraded and staffed with qualified practitioners, while free healthcare is available for children under six and for pregnant and breast-feeding mothers. The pre-1994 healthcare system, in which hospitals were run on Apartheid principles to benefit Whites, was also successfully abolished, giving a much higher healthcare allocation to the poor. More than 260,000 healthcare professionals are now available to patients in some form. The district nurses furthermore play an important role in rural communities. These developments minimize the role of the traditional health practitioner and his services in rural healthcare. This lower demand for his services seems to force him to lower his fees to make a living.^{6,16,18,31}

Insignificant role of the traditional health practitioner in the healthcare system

Regarding the role and public use of the traditional health practitioner, it is important to note that a 2008 National Household Survey shows that the use of traditional health practitioners has declined in tandem with an increase in the wealth of patients. The poorest patient group had an average of 0.03 visits the previous month to the traditional health practitioner, while the wealthiest group had 0.002 visits to the traditional health practitioner.⁹

As reflected above, the use of the traditional health practitioner is considerably lower than the use of public sector health services, which includes the medical practitioner working in the system (0.18 to 0.09 visits). Visits to public sector health services also declined with an increase in socio-economic status as wealthier patients make considerably more use of private health services. It seems that the older age groups (median age 35 years)

make more use of traditional health practitioners than the younger and more modern groups (median age 23 years). It is clear that the new Black middle class (and upwards), who is surely in a better financial situation and are less traditional, is moving into the use of modern medicine, leaving the traditional health practitioner out in the cold.⁹

In 2003, there was an 11.2 per cent use of the traditional health practitioner by limited segments of the population. Of this 11.2 per cent, less than 10 per cent had used the traditional health practitioner for 'medical work'. In practice, only 1.2 per cent of the total population used the traditional health practitioner as a healthcare practitioner. Since 2008, various comprehensive National Surveys country-wide showed that the use of the traditional health practitioner, especially by Black South Africans, was never more than 1.4 per cent of the total population. Official research also reflects that since 1990 there has been a constant decline in the use of traditional health practitioners, basically because they are increasingly being replaced by better and cheaper public healthcare services and practitioners. This confirms that public use of the health services offered by the traditional health practitioner is insignificant and not always as inexpensive as claimed.^{8,9,15} The arguments about the lower fees and costs of the traditional health practitioner, when compared with that of the medical practitioner, is not really accurate.^{9,16,21}

Role of socio-political intentions

There seems to be a hidden political agenda behind the rhetoric of the lower fees and costs of the traditional health practitioner compared with that of the medical practitioner. It is clear that the medical practitioner is not too expensive, below standard or provides inadequate health services. The perception of low fees and costs of the traditional health practitioner is kept alive with a political agenda to maintain the traditional health practitioner as a cultural and political institution.³²⁻³⁶

The following remark confirms these hidden intentions:²⁵ "Western medicine removes native Africans from the culture and tradition and forces them into a setting that they are not comfortable with, away from their family and traditions which are of utmost importance to them. They do not get the proper spiritual healing that their culture seeks and traditional ideology requires" (par. 1).

Strength and limitations

The study is a first to focus on dubious research that portrays the traditional health practitioner's fees and costs as lower than that of the medical practitioner.

The study was limited by a lack of official information such as income statistics on the traditional health practitioner.

Conclusion

This study could not conclude that the fees and costs of the traditional health practitioner are lower than that of the medical practitioner.

The research rather shows that the fees and costs of the traditional health practitioner are not lower than that of the medical practitioner.

The arguments put forward in 2007 claiming that the traditional health practitioner's fees and costs are lower than that of the medical practitioner is incorrect. The claim was put forward in an effort to advance the cause of regulating traditional healing as a health profession in South Africa.

References

1. African National Congress (ANC). ANC policy guidelines on health. *S Afr Med J*. 1992;82:392-3.
2. ANC. A National Health Plan for South Africa. Johannesburg: ANC; 1994.
3. ANC. The Reconstruction and Development Plan for South Africa. Johannesburg: Unanyano; 1994.
4. ANC. National Health Plan for South Africa. Johannesburg: ANC; 1997.
5. Ashforth A. Witchcraft, violence and democracy in South Africa. Chicago: University of Chicago Press; 2005.
6. Dennill K, King L, Swanepoel T. Aspects of primary healthcare: Community healthcare in Southern Africa. Oxford: Oxford University Press; 2001.
7. Richter M. Traditional medicines and traditional healers in South Africa. Discussion paper prepared for the Treatment Action Campaign and AIDS Law Project. Pretoria: Government Printers; November 2003. [Internet]. [Cited 2016 Feb 19]. Available from http://www.tac.org.za/Documents/ResearchPapers/Traditional_Medicine_briefing.pdf
8. Gumede MV. Traditional healers: a medical doctor's perspective. Johannesburg: Blackshaws; 1990.
9. Nxumalo N, Alaba O, Harris B, et al. Utilization of traditional in South Africa and the costs to patients: Findings from a National Household Survey. *J Public Health Policy*. 2011;32:S123-S136.
10. Latif SS. Integration of African traditional health practitioners and medicine into the healthcare management system in the Province of Limpopo. Masters dissertation. Stellenbosch: University of Stellenbosch; 2010.

11. Bless C, Higson-Smith C. Fundamentals in Social Research Methods. An African Perspective, 2nd ed. Kenwyn: Juta; 1995.
12. Louw GP. A guideline for the preparation, writing and assessment of article-format masters dissertations and doctoral theses. Faculty Education, Mafikeng Campus: North-West University; 2013.
13. Clarke L. Traditional healers are key players in the battle against HIV. Health System Trust 2014. [Internet]. [Cited 2014 Feb 3]. Available from <http://www.hst.org.za/news/traditional-healers-are-key-players-battle-against-hiv>
14. Campbell SS. Called to heal. Halfway House: Zebra Press; 1998.
15. Gqaleni N, Moodley I, Kruger H, et al. Traditional and complementary medicine. In: S Harrison, R Bhana, A Ntuli, eds. S Afr Health Review. 2007;12:175–188.
16. Hassim A, Heywood M, Berger J. Traditional and alternative healthcare. In: A Hassim, M Heywood, J Berger eds. Health and democracy. Westlake: Siber Link; 2007.
17. Mbatha N, Street RA, Ngcobo M, et al. Sick certificates issued by the South African traditional health practitioners: Current legislation, challenges and the way forward. S Afr Med J. 2012;102(3):129–31.
18. Mbola B. Africa needs access to affordable medicine. Health Systems Trust 2014. [Internet]. [Cited 2014 Feb 3]. Available from <http://www.hst.org.za/news/africa-needs-access-affordable-medicine>
19. Rautenbach C. Some comments on a new legislative for female traditional healers in South Africa. Academia edu. 2014;113–32. [Internet]. [Cited 2014 Feb 19]. Available from http://www.academia.edu/4007428/Some_Comments_on_a_new_Legislative_Framework_for_Female_Traditional_Healers_in_South_Africa
20. Truter I. African traditional healers: Cultural and religious beliefs intertwined in a holistic way. S Afr Pharm J. 2007;7(8):56–60.
21. Wilkinson K. Do 80 per cent of South Africans regularly consult traditional healers? The claim is false. AFP Foundation, Africa Check. 2013 July 3;1–13. (Electronic copy store on Africa Check web-site: <http://www.africacheck.org/reports/do-80-of-s-africans-regularly-consult-traditional-healers-the-claim-is-false/3>).
22. African Technology Policy Studies (ATPS). Analysis of traditional healers in Lesotho: Implications on intellectual property systems [Pitso Masupha, Lefa Thamae, Mofihli Phaqaane]. ATPS Working Paper Series. 2013;68:1–47.
23. Flint A, Payne J. HIV/AIDS and reconciling the irreconcilable? Establishing middle ground between the traditional and biomedical sectors in South Africa. (Bristol: University Bristol: School of Sociology, Politics and International Studies; Working Paper No 10-11: 1–27). Forum Dev Studies. 2013;40(1):47–68.
24. Golooba-Mutebi F, Tollmann SM. Shopping for health: Affliction and response in a South African village. Afr Soc Review. 2007;11(2):64–79.
25. Traditional African medicine. Wikipedia Free Encyclopaedia. [Internet]. [Cited 2014 June 22]. Available from http://en.wikipedia.org/wiki/Traditional_African_medicine
26. Traditional health practitioner's graduation ceremony kicks off successfully. [Internet]. [Cited 2016 Feb 20]. Available from http://www.dut.ac.za/Traditional_Health_Practitioners_Graduation_Ceremony_Kicks_Off_Successfully/
27. James W. Kop-in-sand terwyl SA se mense ly. Rapport. 2014 Oct 5; p. 7.
28. Mulholland S. Cuban medicine not a tonic for SA. Sunday Times. 2014 Apr 20; p. 12.
29. Mulholland S. Healthy assets an exclusive asset. Sunday Times. 2014 Apr 27; p. 12.
30. "Skills crunch". Sunday Times, 2014 June 15; p. 4.
31. Healthcare in South Africa. Doctor Shortage. [Internet]. [Cited 2016 Feb 20]. Available from <http://www.southafrica.info/about/health/health.htm#>
32. Mangcu X. Leiers wat hul steun wegvreet. Rapport, 2014 Sept 21; p. 7.
33. Mthomboti B. It's the leaders who failed South Africa – and the rest of Africa too. Sunday Times, 2014 Apr 20; p. 21.
34. Mthomboti B. We will just have to wait out Zuma and his cabinet of cronies. Sunday Times, 2014 June 1; p. 19.
35. Mthomboti B. What are we bid for this shining set of principles, barely used? Sunday Times, 2014 Oct 5; p. 21.
36. Williams F. 'n Blik op 2024: ANC uit...DA lyk anders... Rapport, 2014 Oct 5; p. 3

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