

African Traditional Healers: The Economics of Healing

Traditional healers are a source of health care for which Africans have always paid. Even with the expansion of modern medicine, healers are still popular and command fees exceeding the average treatment cost at most modern practitioners. Are traditional healers miracle workers or are they charlatans? Clearly either view is too extreme. Traditional healers are not perfect: although we have all heard stories of miraculous cures, the health status of the average African peasant cannot be reconciled with omnipotent healers. Nor, however, can they be charlatans: people cannot be continuously ignorant about the capacity of someone who lives among them. This article advances a view of traditional healers that relies on neither supernatural power nor manifest ignorance. It suggests that healers remain popular despite abundant modern medicine because they have wisely used an important economic contract to the mutual benefit of their practice and the population they serve.

While the contrasts between traditional medicine and modern medicine are many, the article focuses on the differences in the way traditional and modern healers are paid. An important element of their practice has been previously ignored: traditional healers receive the bulk of their payment only if the patient is cured.

Economic theory

When consumers purchase a service where quality matters but cannot be directly observed or evaluated, economic theory raises the possibility of a market failure. Health care is a classic example of this type of failure, commonly referred to as agency. Patients choose to visit physicians precisely because physicians know more than patients do. The patient cannot evaluate what the doctor is doing for her sake, nor can she infer physician effort from the outcome. Patients are often cured despite poor quality care, or fail to be cured despite expert care. If patients cannot tell what doctors are doing, then doctors have fewer reasons to exert extraordinary effort on the patient's behalf. Thus, although patients are willing to pay for high-quality care and physicians are able to provide it, the market may fail and high-quality health care would not be delivered.

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The standard economic solution is to force the agent (the person performing the unobservable services) to face the loss or gain of his/her actions. Thus, salespersons are paid on commission, and CEOs receive stock options. The health counterpart is the pay-only-if-cured or outcome-contingent (since payments are contingent on outcomes) contract. If patients paid their doctors only if they were cured, or more if they were cured than if they were not, the economic cost of agency would be reduced.

Despite the fact that health care suffers from a problem widely identified in theory, health economics as a whole has dismissed the economic solution to the problem as inapplicable to health care. Non-contractibility is one of the most widely cited reasons for dismissing this solution. Contractibility means that agreements about payments are enforceable. The outcome-contingent contract is considered non-contractible because patients can simply lie about the outcome of treatment and the doctor would be unable to prove his case to a third party. The definitions of

cured and not cured are inherently subjective and subject to deliberate misrepresentation.

Economic practices of traditional healers in Africa

This "ideal" but previously unobserved economic contract is exactly the method by which traditional healers in Africa do business. Patients pay traditional healers more if they are cured than if they are not cured. The results of interviews with healers in Cameroon, Tanzania, and Ethiopia reported in a publication by this author are summarized here. The healers spoken with received an initial payment and, in addition, negotiated with the patient over a payment to be made in the future. In all cases, if the treatment did not result in improvement of the condition, the patient paid nothing beyond the initial payment.

When asked about the practice of "cursing" patients for non-payment, many healers were adamant that they never engaged in the practice, though almost all admitted that their ancestors or, specifically, parents had done so. The practice traditionally operated as follows: when a patient refused to pay, the healer would either invoke a curse on the patient or revoke the cure. This practice invokes near-universal fear in rural populations, and most non-healers believed that if they failed to pay they would be cursed. All healers told stories of patients leaving without paying and then returning, sometimes years later, begging to be allowed to pay. Patients believe cursing is still practiced, allowing healers to wait until after the treatment to collect payment without fear that the patient will refuse to pay.

The outcome-contingent contract means that healers have strong incentives to provide quality care even if the patient cannot evaluate or observe this quality. But what of the non-contractibility concern? How can traditional healers agree to accept payment when the patient could lie about the outcome and refuse to make any payments? Two reasons are advanced: first, healers live in the same village as many of their patients and can therefore observe what patients are doing; second, patients believe that healers know whether they are cured.

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In contrast, outcome-contingent contracts are not used in the practices of modern medicine anywhere in the world. Instead, patients pay a fixed fee for all services delivered whether they are cured or not. No one expects this type of payment scheme to deliver quality. Instead, the assumption is that quality care is assured by restrictions on the activity of practitioners that come from other sources (including, but not limited to medical associations, referral networks, hospital networks and direct regulation of the practitioner.) In Africa, physicians at modern facilities such as government or not-for-profit health systems (primarily church-operated) are regulated through hierarchical supervision, where physicians evaluate the quality of other physicians and employment status or bonuses depend on the result of the evaluation. Since the payment (or well-being) of the practitioner depends, not on the outcome, but the effort s/he exerts, this is referred to as an *effort-contingent contract*. Note that in order to regulate another doctor you need to be at least as well trained as s/he is: only doctors can regulate other doctors.

Comparing outcome-contingent to effort-contingent contracts

The outcome-contingent contract of traditional healers gives them good reason to exert effort in the treatment of patients even if the patient cannot evaluate what the healer is doing. However, if a modern physician practices in an organization that cares about quality, s/he will also have a good reason to produce high-quality care; her/his employers will insure that s/he does. Thus, while it would appear that the contract of the traditional healer does not offer any additional benefit over a well-implemented contract at any modern provider, this is not quite true.

The fact that healers contract on outcomes rather than effort has important repercussions on their practices. Take, for example, a patient with asthma who smokes. A modern doctor treating this patient can be evaluated based on what s/he does for this patient by another physician who knows what s/he is supposed to do. S/he can be

evaluated on tests ordered, treatments prescribed, or advice given but will not be evaluated on whether the patient is cured (or in this case, whether his/her symptoms are alleviated). If the patient refuses to quit smoking s/he will not be cured, but this does not matter to the modern physician.

The traditional healer, on the other hand, has no chance of being paid if the patient does not quit smoking. If he is unable to convince the patient to quit, he could refuse to take the case, or at the very least, refuse to accept the outcome-contingent contract. The difference between the two types of contracts emerges not from the amount of medical effort finally delivered, but from the difference in the relationship between the efforts of practitioners and the efforts of patients. Because outcomes (and not inputs) matter, a traditional healer cares more than the modern doctor about the actions that patients take.

Patient perception of the practice of healers

Economic theory suggests that the contract used by healers will lead them to provide high-quality effort in health care. Modern practitioners may also provide high-quality effort, but they will not work as well with patients in situations where patient effort is important to outcomes.

How do patients use traditional healers? If the theory is correct, traditional healers should have an advantage (holding other factors constant) when patients suffer from illnesses that require both medical and patient effort. They will not have an advantage in situations in which special equipment or skills are required. Contrast the example of asthma with malaria and appendicitis. Malaria is comparatively easy to diagnose and does not require extensive effort on the part of either physicians or patients — instead, it requires widely available medication. Patients should visit the least expensive provider who has the appropriate medicine without concern for quality. Appendicitis, on the other hand, requires surgery — a service for which hospitals are much better equipped than traditional healers; patients should seek skilled treatment.

Indeed, across Africa there are consistent patterns in the choice of health care practitioner according to illness condition: certain conditions tend to lead to visits to certain practitioners. This author tested these patterns to see if they fit the patterns that would be predicted by theory. In order to do this, each individual illness condition is examined by physicians who evaluated the degree to which the outcome depends on the efforts of the practitioner and the efforts of the patient.

In the southwest province of Cameroon, patients are more likely to visit a mission facility over a government facility when they suffer from conditions that require substantial amounts of medical effort. Since mission facilities are well regulated compared to government facilities, this makes sense; patients seek and are willing to pay for this particular measure of quality only when they deem that it really matters. In addition, as would be predicted by economic theory, patients are more likely to visit a traditional healer (even over the high-quality mission facility) when they suffer from a condition that requires large amounts of both medical and patient effort. Patient behavior follows the patterns predicted by an economic understanding of the payment scheme used at traditional healers.

Conclusion

While traditional healers perform many roles in their societies, this article focuses on one important feature of their practices: they use an economically rational tool in their practices and their behavior and the behavior of patients reflects the use and benefits of this tool. The pay-only-if-cured or outcome-contingent contract provides traditional healers

with the right incentives to provide high-quality care, and patients behave as if they are aware of the implications of this contract. Importantly, the magical or mysterious elements of their practices are essential to the proper functioning of this contract. Without the belief that healers know the outcome of treatments, the outcome-contingent contract would be non-contractible. Thus, although this contract appears to be very successful for healers, it cannot be widely adopted.

Traditional healers, far from duping a gullible population, behave as if they are rational and serving a rational population. As long as modern medicine is delivered in a context in which quality is uncertain, traditional healers will continue to attract patients.

Selected references

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