

IS PAYING FOR HEALTH CARE CULTURALLY ACCEPTABLE IN SUB-SAHARA AFRICA? MONEY AND TRADITION

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Abstract—In 1987 UNICEF launched the so-called Bamako Initiative, which has as its main objective to improve the sustainability of primary health care in Africa by making people pay for it. The question is raised whether paying for health care is culturally acceptable in African communities. The author argues that 'money' is not a new phenomenon in Africa and that paying for goods and services does not need to conflict with existing traditions of reciprocity in the field of health care. Money is an artifact which is culturally incorporated in a creative manner to satisfy specific needs. Cultural objections to paying for health care, therefore, are unlikely to exist, but how payment should be realised in an effective and just way is another question.

Key words—primary health care, money, Bamako Initiative, Africa

In 1987 UNICEF launched the Bamako Initiative, a plan to rescue faltering health-care services in Sub-Saharan Africa. In the plan it was suggested to make people pay for goods and services in health care, thus making care more sustainable. How should we judge this proposal? Is making people pay for such an essential item as health care acceptable? Or is it a regrettable step back?

In most African countries until recently public health care was free of charge and governments were reluctant to change this in spite of their numerous problems to finance the system. The dark side of this 'free' health care was well known, however. In most countries government health care found itself in a deplorable condition due to inefficiency, mismanagement and lack of funds. Medicines as well as medical personnel were often lacking in the rural health centres. The paradoxical result of this state of affairs was that 'free services' turned out to be extra expensive for the population. People were frequently forced to buy their medicines in the commercial circuit and to travel long distances to find a nurse or physician. Even Primary Health Care (PHC), designed to make essential care directly available to the population, threatened to collapse under the weight of the financial and managerial crisis.

In the Bamako Initiative it is proposed to give up the ideal of free medical care. Emphasis is placed upon the suggestion to make people pay for—essential—medicines. It is envisioned that the proceeds of the sales will be used to establish a fund with which village communities can purchase new medicines and pay for other health-care facilities [1].

The plan has evoked numerous reactions. Many critics believe that the poorest people will suffer because they will be unable to pay the prices asked.

Others expect that the money earned will not or only insufficiently be invested because intermediaries will appropriate it, the state will use it to fill other gaps or because it cannot be exchanged for foreign currencies with which new medicines must be bought. Still others fear that the result will be excessive prescribing by doctors and health workers and neglect of preventive medicine [2].

These criticisms and the confusion about the exact objectives of the plan led to a conference in 1989 in Freetown, Sierra Leone. During that conference UNICEF and representatives of non-governmental organizations (NGOs) discussed their points of disagreement. The conference seems to have been quite successful in bringing the different parties closer to each other. They reached agreements on various points, including the following: communication between UNICEF and NGOs on the Bamako Initiative will be improved; the poorest section of the population will be exempted from payment; the quality of PHC and 'rational use of drugs' remain primary objectives; and independent researchers will evaluate the results of the cost-recovery projects [3].

Here I would like to focus attention on another aspect of the Bamako Initiative which rarely has been brought forward but nevertheless seems to play a role of considerable importance in the doubts and objections surrounding the plan: is it culturally acceptable to make people pay for health care? Does such a scheme conform with the ideas of local population groups concerning how the welfare of the community and its members must be ensured? Some feel that privatization and commercialization of health care conflict with the '*Gemeinschaft*'-type societies which are still presumed to prevail in large parts of rural

Africa and where collective values are considered more important than individual ones.

Chabot *et al.* [4], for example, remark that policy-makers in Africa choose a commercial solution too easily, because they assume that the cash economy has appeared and is functioning everywhere. They then point out that experience in Guinea Bissau shows that money is simply not available a large part of the year. The people there do have various—traditional—ways of surviving without money, however. One such method is the *abota*, a collective savings system whereby people insure themselves against large future expenses such as those involved in a funeral. The authors describe how *abota* is also used as a type of village-level insurance policy against illness. During the harvest period, when money is available, all village residents contribute money with which the necessary health facilities are then bought.

Their criticism underlines the importance of the question stated above: does individual payment for health care, as proposed in the Bamako Initiative, fit in the cultural context of local African communities? Should one rather, on cultural grounds, perhaps give preference to solutions which are based more on community feeling and less on commercialization?

It almost goes without saying that such a question cannot be answered definitively. Nevertheless, it is possible to make a few general statements in this regard. I will first discuss three assumptions which appear to be implied by the above-mentioned question. This discussion will result in some general remarks about the cultural desirability and feasibility of a payment system such as that proposed in the Bamako Initiative.

The first assumption is that recommendations for future development can be based on cultural traditions. If there is any task for cultural anthropologists with regard to development policy, it must be to investigate to what extent local ideas and customs conflict with certain developments and to make recommendations based thereon.

Second, it seems to be assumed that money did not play a role in 'traditional Africa'. Money was seen as being superfluous for two reasons: people were predominantly self-sufficient and when they had to call on others for help, this was done on the basis of reciprocity, a system of mutual obligations which functioned excellently because no money was involved. Only in certain cases was there a question of 'payment' (e.g. marriage payments), but even then this was usually payment in kind, for example, in the form of cows, alcohol or cloth.

A third assumption seems to be that 'money is the root of all evil' and that it undermines and destroys cultural traditions. This is seen as happening on the micro level because people can buy off reciprocal obligations with cash. The individual can separate himself from his kin group and no longer depends

on others because he can pay for services and goods. On the macro level, money is the means with which local economies are subordinated by Western trade centres. In order to participate in international financial transactions, African communities must gear their production to the needs of the West instead of their own needs.

CULTURALISM

The first assumption, that traditional ideas and customs determine what is possible or not in development policy, is debatable. It is based on a static and mechanistic-deterministic view of culture. 'Culture', however, is not an aggregate of unambiguous and fixed codes for thinking and acting. The anthropologists' problem is that their subject of study is continually changing. If culture is described as an aggregate of meanings which people share, this entails a considerable amount of wishful thinking. What people share, what they agree upon in their view of reality and their ideas of how one should act in various situations is namely not fixed at all. The ideas can change if that is in the interests of those involved or if their situation changes. The ambiguity of culture ultimately is due to the fact that it both produces people and is produced by them. The cultural horizon undoubtedly limits possibilities for thinking and acting but does not determine them.

Anthropologists have the thankless task of describing basic patterns of human thought and action on the one hand and of pointing out the changeability of those patterns on the other. They like to speak in terms of 'codes' but, albeit attractive, this metaphor is misleading. One can namely never speak of a code which, once decoded, 'explains' everything. Some anthropologists therefore speak of 'codes to break codes' but such meta-language is also deficient. Modesty requires it to be said that the study of culture allows us to do little more than make intelligent interpretations of human thought and action. Anthropological research deepens our insights into the situation-bound logic which underlies thought and action.

Attempts to predict the feasibility of a given policy on the basis of knowledge of a particular culture are therefore extremely precarious. The provision of 'recipes' for development on that basis is even dubious. Attempts to explain the success or failure of policies on the basis of cultural traditions are a reflection of objectionable culturalism.

MONEY AND TRADITION

The second assumption, that money played no role in 'traditional' societies, is a misconception. Discussion of that role is made difficult, however, by dissension as to what money actually is. When can one speak of 'money'? An important point of debate is the question of whether one can call some-

thing 'money' if it simultaneously is a consumer product.

Herskovits [5, p. 245] reserves the term 'money' for non-consumer goods. Einzig [6, p. 326] proposes that whatever is accepted as payment "largely with the intention of employing it for payment" be called 'money'. Firth [7, p. 38] considers such an intentional aspect unusable for a definition and is of the opinion that "to entitle an object to be classified as money, it should be of a generally acceptable type, serving to facilitate the conversion of one object or service into terms of another and used as a standard of value thereby." Sahlins [8, p. 227], who like the previous authors speaks of 'primitive money', summarizes it simply: we call money "those objects that have token value rather than use value and that serve as means of exchange". The total absence of use value in 'primitive money' is however rare, as we shall see momentarily. In most cases, according to Sahlins, money was an indirect link between two types of goods and its function could be represented as C-M-C' (commodity-money-new commodity), whereas money in modern societies has become more a goal in itself: M-C-M' [9].

Another distinction between modern and 'primitive' money is that the range of payment possibilities was usually limited for the latter, both geographically and in terms of what one could buy with it.

Crump [10, p. 213] remarks that primitive money systems showed endless variety and that it is therefore difficult to offer a general definition. Einzig [6] has written most extensively about primitive money. He has provided a geographical (Oceania, Asia, Africa, America) and historical (Ancient Times, Middle Ages, Modern Times) overview of the various forms of primitive money. Sometimes actual means of payment are involved but often it is more a question of a general standard for determining value or wealth. Many of Einzig's references, particularly those from travel reports, are anecdotal in character. To provide an impression of the enormous diversity of primitive money, I will—perhaps somewhat unusually—give an alphabetical summary of the examples which Einzig found in the literature on Africa (the summary is not even complete): almonds, arrow poison, arrows, beads (many kinds), beer, bronze objects, bullets, cakes, camels, camphor, chickens, cloth (calico, cotton, silk), copper objects, cowries, cows, dates, donkeys, fish, fish hooks, gin, goats, gold, grain, gunpowder, guns, hoes, horses, iron objects, ivory, knives, kola nuts, mats, millet, onions, ostrich feathers (and feathers from other birds), palm oil, palm-oil kernels, pottery, rat traps, rice, rings, rubber, rum, salt, sandalwood, sheep, shells (other than cowries), silver, skins, slaves, soap, spades, spear points, stones, thread, tin, tobacco, Western money (e.g. Maria Theresa dollars) and women. Einzig tried to distillate a minimal definition from this colourful variety of kinds of money in different contexts and cultures, as was noted above.

For the purpose of this discussion, however, it is sufficient to acknowledge that all kinds and degrees of 'money' and 'payment' existed on a large scale in traditional societies before they were exposed to the financial transactions of western trade centres. It does seem—though future research may correct this impression—that the development of money in precolonial Africa had not progressed as far as in Melanesia and Amer India for example. Einzig also notes, however, that the willingness of African peoples to incorporate foreign currencies into their own financial dealings was much greater than that of, for example, groups in Melanesia.

'MONEY IS DEATH'

The observation that 'money' was indeed used in transactions between people in traditional societies indicates that the third assumption, that money destroys old community patterns, is untenable, at least when it is stated so crudely. Nonetheless, many researchers have emphasized that negative effect of money. Often their arguments are accompanied by a certain romanticization of the society in question, which reminds one of Tönnies' description of the '*Gemeinschaft*'. 'The shilling takes the place of the brother', Gutmann [11] stated in a 1935 article in which he sharply criticized European interference in Africa:

Money dissolves the organic relations between men, and, where a man would make demands upon his fellow man's physical and personal strength which could be repaid by nothing else than an obligation to a similar service in return, money steps in, and in place of a human being puts a dead medium of exchange, which lets him pay his debt by giving the other man a minimum share of his fortune and enables him to use men's services without thanks or obligations . . . [W]e see the destruction of the vital interdependence of men, which is alone the source of their spiritual and moral nature—in a word, of their existence as human beings [11, p. 7].

Hyden [12, p. 18] speaks of an 'affect economy' wherein "familial and other communal ties provide the basis for organized activity." The introduction of a modern cash economy makes personal profit possible and will gradually undermine the community basis for the 'affect economy'. That process, according to Hyden, is unavoidable for 'development' in Africa.

In an unpublished note, Tieleman [13] refers to an article by Visser [14] on food production on the island of Halmahera in East Indonesia:

Rice is not sold, not only because it is food but also because it is an important metaphor for the system of social and kinship relationships. Rice symbolizes femininity and fertility; it has important ritual functions which express and confirm social relationships. Labour with regard to rice cultivation is therefore not compensated with money. Rice is exchanged within the family but money and rice exclude one another conceptually. . . . In the context of rice cultivation . . . it is said that money is 'death', i.e., that payment in cash for labour (by kin) in rice production does not

generate any new exchange of services and reciprocal obligations; it is socially sterile. A cash payment can also be considered a sign that one wants to be rid of someone else and no longer wishes to grant him/her the self-evident right to food from the garden (translated from Dutch original) [14, pp. 6–7].

This quotation expresses an idea which is, more or less, applicable to any society: certain values should stay outside the cash economy. In Dutch society, for example, these are relationships and services within the family and political offices. Certain goods or services are so fundamental that payment for them would not only be considered inappropriate but also as essentially in conflict with their nature. In such cases money is literally evil because its use would be seen as an attempt to change the nature of the value in question: for example, an attempt to avoid a social obligation which one would honour if one were to accept a service or goods for free.

Referring to my comments on the first assumption, however, I would like to caution against a culturalistic tendency which repudiates any use of money when it is viewed as evil by prevailing tradition. The danger exists that we would then attribute too mechanistic a function and too much consistency to the local meaning of money; we would underestimate the accommodation capacity of the local culture. Hyden, too, points out that the 'affect economy' is not destroyed by intruding capitalism but that it defends itself and succeeds in partially adapting the market economy to its own needs [12, p. 19].

Anthropological research has produced many examples of such a creative subordination of modern money to old traditions. A classic case study was provided by Watson [15] on the consequences of the colonial cash economy for the Mambwe in Northern Rhodesia, now Zambia. Watson wrote his book as a reaction to the often heard idea that this new economy had disrupted societal structures in southern Africa. Labour migration to the mines in particular was supposed to have led to 'detrivialization' and 'demoralization'. Watson shows that the Mambwe already had a long tradition of dealing with money and that they sustained lively trade with nearby peoples and Arabs who engaged in long distance trade. The new money and new trade, introduced in the context of colonial occupation and mission activities, were incorporated within existing traditions. Although the new economic order certainly had an effect on existing traditions, they were not destroyed by it. Money sometimes made it possible to even strengthen old values. The social prestige of men, expressed by housing, number of women and children, could increase via earned money. Traditional marriage payments were increasingly paid in cash and money made new forms of social obligation (indebtedness) possible. Various authors (not Watson) have moreover pointed out that migratory labour acquired an old cultural meaning. The stay in the city, the hardships which had to

be suffered there and the triumphant return home with saved earnings could be viewed as a new rite of transition to adulthood. It should be noted that this 'friendly' view of migratory labour in southern Africa was criticized by later authors as cultural camouflage of economic repression. I believe, however, that the two explanations are not mutually exclusive.

Various examples of the integration of the market economy into local culture have also been registered for West Africa. The most well-known is perhaps Polly Hill's description [16] of the alert reaction of Ghanaian cocoa farmers to the world economy. Here, too, there was no question of 'disruption' of old structures; rather new possibilities were incorporated into the old family-based economic system in a creative manner. The changes and adaptations were mutual. Another example of cultural incorporation of money into the local culture of Ghana—and undoubtedly in many other countries as well—is that it began to play a large role in the organization of funerals, the most important social events. Donations by visitors and the final payment at the end have become important ingredients of the funeral ritual in southern Ghana. The greater the 'turnover', the more successful the funeral is because the greater the respect which has been shown to the deceased and his/her family.

My last example of the cultural integration of money, traditional savings systems, is especially important for the subject of this discussion. One finds traditional savings systems, which have both an economic and a social function, throughout Africa and sometimes even in places where the government has not succeeded in interesting people in savings co-operatives. Ter Weyde [17] describes two forms, the *Tontine* and the *Caisse* among the Bamileke in Cameroon. The *Caisse* functions as an insurance scheme for people who are suddenly faced with large expenses, e.g. because of illness or a death. As we have seen, such a tradition has been used consciously in Guinea Bissau in the establishment of primary health care.

Of course, it is true that every culture has certain things which cannot be sold or bought, e.g. political offices, certain kinds of food, land or children. Does this exception perhaps also apply to health care?

PAYING FOR HEALTH CARE

We now have returned to our departure point: is paying for health care culturally acceptable, for example in rural African communities? My comments on the three assumptions underlying the question have already partly provided an answer: the question can certainly not be answered: 'No'.

Even if curative and preventive health care traditionally have been seen as irreconcilable with the concept of payment in a certain community (as is the case for rice in Halmahera), the conclusion cannot be consequently drawn that this therefore must remain

so in future. As noted above, such a conclusion would imply the use of too static a notion of culture. We must be prepared to recognize that people react to new situations in a creative way.

It is moreover highly unlikely that traditional health care in African communities was completely excluded from the money economy. The fact that traditionally health care was often embedded in religion does not mean that it was situated outside the realm of economic transaction. The image of the traditional healer who offers his services free of charge is usually the product of Western imagination. Yearning for a more humane type of health care in our own society is projected onto a utopia on the other side of the world. Anthropologists, especially, have provided a basis for such romanticization [18]. There are, however, sufficient indications that the opposite could be the case. Staugard [19, p. 63] mentions that herbalists in Botswana are paid, usually when their treatment has proved successful. Mullings [20, p. 219] describes how a patient and healer negotiate the price of a treatment in Ghana. Van Amelsvoort and Muller [21, p. 40] report that, in 1970, 30% of the families in a Tanzanian village had paid an average of about £ 10.—for traditional health care, a relatively high amount. Hours [22, p. 50] recorded the following statements by patients who had visited local healers in Cameroon: "They like money too much" and "They are too thirsty for money" Crapanzano [23, p. 211] remarks about these healers that they "... extract as much money as they can."

One could retort that these observations reflect a system which had already been affected by money and commercialization. Earlier observations also emphasize, however, that traditional healers almost always were paid in some way for their services. In a letter to *The Lancet*, Ofosu-Amaah, a UNICEF worker, writes that: "In the African traditional system, every community and family understood the need to compensate the providers of health and other services in some form" [24]. Foster is also of that opinion and adds that members of traditional communities were realistic enough not to expect healers to do their work "solely for the good of their fellow men" [25, p. 111].

Compensation of healers need not undermine mutual solidarity, however. Ofosu-Amaah [24] remarks that the poor who could not pay such compensation were helped by their families. Perhaps this characterization is too optimistic but it generally seems correct. Free health care, according to Ofosu-Amaah, conflicted with this tradition and undermined it. It made help by others superfluous. This is an interesting line of reasoning: money does not kill; rather, gifts kill if they come from nobody, i.e. the state.

The killing effects that 'free' medical services may have on people's sense of communal responsibility were amply demonstrated during my research on

medicine distribution in Cameroon [26]. The free drugs provided by the state were generally regarded as no one's good and 'free to grab'. Health workers and people with political influence used the medicines for their private gain and many patients had to do without them. Since the medicines were 'free', patients had no control over their distribution. They were reduced to 'beggars without choice'. Paradoxically, people often preferred medical services for which they had to pay to those that were free. They felt they received better treatment in the former. Some doctors and nurses who functioned poorly in the morning while working in a government institution, proved dedicated workers in their private practice later in the day. The problem with medicine provided gratis is that it easily becomes gratuitous.

Anthropologists have described how smoothly Western health care is incorporated into the arsenal of already existing medical images and practices. The way in which the old and new are blended recalls the painting by Chagall who placed the Parisian Notre Dame in his Russian village of birth. Some anthropologists have used concepts such as 'cultural reinterpretation' and 'indigenization' to indicate that Western health care changes during that process of accommodation. It is understood in terms of the concepts which people have concerning illness and health and is used in a way which accords with those concepts. But it would be incorrect to state that those concepts are well-delineated and static. It is precisely in the field of health care that ideas are often characterized by vagueness and adaptability. Expressions related to not feeling well can be interpreted in a multitude of ways. Last [27] who did research in Northern Nigeria, even characterizes local medical ideas there as 'not knowing'. Just about anything can be incorporated into a medical thought system with so little order. On the basis of his research in India, Gould [28, p. 502] noted that the framework for thought may be somewhat fixed but that people demonstrate a 'rustic pragmatism' in their action, i.e. they do not allow themselves to be influenced in their choice of therapy by medical dogmas. They simply use their 'common sense'.

One could expect similar 'rustic pragmatism' with regard to the acceptance of new methods of payment. There are no economic dogmas which *a priori* exclude the use of money or private enterprise in health care. Money is just as cultural as medicines. Both can be reinterpreted in various ways and be accorded a place in local culture.

An interesting example of the way in which money can be 'tamed' in a specific culture can be found in an article by Plattner [29] which does not refer to Africa but to a North American city: St Louis, Missouri. Plattner shows that in a local market, where vegetables and other food products are sold, money does not play the de-socializing role of which it is often accused. Rather, money is used to lay

contacts between sellers and buyers and continuing relationships between them develop. The market vendors can bind their clients to them and the clients consider it advantageous to remain 'faithful' in their consumption behaviour. In a modern market situation it therefore seems that reciprocity and mutual trust are valued. The money involved does not undermine reciprocity; rather, it oils its wheels. If this is possible in a competitive market situation in an American city, we can certainly be optimistic about the cultural reinterpretation of a money economy in an African village, even when health care is involved.

Stein [30] has pointed out that a 'money taboo' exists among physicians in the United States. They find it painful and disturbing (i.e. damaging to their therapeutic efficacy) if the subject of 'money' is broached while they are treating a patient. Money is viewed as being in conflict with the care and dedication which are expected from doctors. Money has a bad name. At first sight, this idea seems to confirm the 'money-is-death' thesis. We know, however, that health care in the United States—and elsewhere—largely revolves around money. Medical care is one of the most lucrative enterprises. In no other area are people willing to pay such high amounts as for health care and nowhere else are consumption and production articles as expensive as in the medical sector. A simple example: a pair of scissors which is used for medical purposes is more than ten times more expensive than a pair of 'ordinary' scissors. On further consideration we must therefore recognize that the taboo does not apply to money itself but to talking about money. In other words, the health-care system shows how the money factor can be allowed to play a major role despite cultural (moral) resistance. This happens via a division of labour. The 'dirty work' of asking for money is performed by the administrative staff and insurance companies. The doctor thereby keeps his hands free to perform his exalted medical work and can continue to play the role of the healer who does not care about money but about the patient's well-being. The existence of a money taboo in a system which is so dominated by money illustrates that: (1) the accommodation capacity of cultures is almost unlimited and (2) one cannot conclude, on the basis of statements about money, that a culture actually opposes paying for health care.

The question of whether payment for health care should be introduced and, if so, whether a communal savings system such as that in Guinea Bissau or a more commercial approach should be chosen cannot be answered by simply referring to local tradition. That tradition can change drastically and adapt itself to new possibilities.

The question could also be put in another way: under which circumstances should cash payment for health care be introduced and when should a different approach be preferred? Above I have argued that:

(1) Africa cannot be conceived without money and a market economy but (2) their existence need not necessarily mean that communal care and responsibility are disappearing. That social tradition can be continued with money as well. Ofosu-Amaah's [24] remarks are important in this regard. It was not the introduction of money but the introduction of free health care which undermined solidarity. That is what made help from family and neighbours superfluous. What was granted free by the state was not experienced as communal help—though it is, strictly speaking. These free facilities created no obligations. It is rather paid health care which makes group solidarity possible.

The difference between a 'commercial' approach and one like that in Guinea Bissau is therefore smaller than it at first appears. In both systems health care is in fact paid for. It is only the way in which payment is made that differs. In both systems mutual solidarity is also possible. Indeed, Western experience shows that co-operatives and insurances blossom in a market economy.

The above does not deny that in actual fact the increasing influence of the market economy in Africa has been accompanied by individualization. And I am also convinced that money facilitated this process. Old methods of payment were controlled by traditional heads of families and helped maintain social dependence. Now, the individual can earn money everywhere on the free market and remove himself from his family's influence. This observation can never be a reason for opposing payment for health care, however. Self-help and mutual solidarity remain possible in a money economy; moreover, the clock cannot be set back. The metaphor of the clock—a cliché in fact—is intentional. The encapsulation of African communities within the market economy—however much this occurs by leaps and bounds—is part of an unstoppable world-wide process. It would be naive to attempt to escape from it. On the contrary, it would be better to establish conditions for a more just distribution of health care within that development process.

In short, I cannot imagine a situation in Africa where payment for health care should be rejected for cultural reasons. Seen in that light, the Bamako Initiative can be realized both in a system characterized by 'fees-for-service' and a system based on a communal insurance scheme. A consideration which must carry great weight—and which indeed did so in the Guinea Bissau project—is whether the local population has any money available at all. It is obvious that a cash payment system will not work in a society in which people do not have money during certain periods. In such cases technical measures must be taken to enable payments to be made. An insurance scheme can offer a solution as can payments in kind or reduced prices. But then we are no longer speaking of cultural conditions. My

conclusion is thus that objecting to the Bamako Initiative on cultural grounds is unjustifiable.

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