Practice review

Reimagining traditional healers in South Africa's private health insurance: a culturally inclusive and commercially viable integration model

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Submitted: 14 September 2025; accepted following double blind peer review: 22 October 2025

Abstract

This article aims to advance a hybrid model for integrating traditional healers into South Africa's private health insurance system, framing inclusion as both an ethical obligation and a strategic reform. Anchored in the National Health Insurance Act 13 of 2023 and informed by international precedents from Ghana and Vietnam, the model proposes regulatory councils, capitation-based reimbursement pilots, digital claims platforms and structured cross-training between traditional and biomedical practitioners. This analysis draws on cultural competency, epistemic justice and health systems strengthening frameworks, positioning traditional healers as de facto primary care providers who can alleviate strain on the public sector while addressing entrenched racial and geographic inequities in healthcare access. Although upfront costs for infrastructure and harmonisation may be significant, potential long-term returns in efficiency, care quality and community trust provide a compelling justification. This model contributes to wider debates on culturally inclusive universal health coverage by offering actionable strategies for aligning traditional healing practices with private-sector financing in pluralistic healthcare systems.

Key words

Cultural competency; Epistemic justice; Healthcare systems integration; Private medical insurance; Traditional healers

Introduction

South Africa's healthcare system, a vestige of apartheid-era segregation, remains fractured along socioeconomic lines. The private sector, accessible to a privileged 14% of the population (Statistics South Africa, 2023), contrasts sharply with the overburdened public system that serves the majority. This duality is further complicated by the enduring presence of traditional healers, who cater to 60–80% of South Africans, particularly in rural and peri-urban communities (Moshabela et al, 2016). Traditional healers are practitioners who employ knowledge, skills, beliefs and practices rooted in indigenous cultural and historical traditions to maintain health or treat illness (World Health Organization, 2025). In the UK, complementary and alternative medicine—which sometimes overlaps with traditional healing—is acknowledged, but remains largely outside statutory regulation and NHS funding (NHS, 2024).

Despite their cultural and clinical relevance, traditional healers exist in a legislative 'limbo', excluded from formal healthcare financing mechanisms. This article argues that

integrating traditional healers into private medical insurance models is not only a moral imperative, but a pragmatic strategy to address systemic inequities in South Africa. Despite legislative progress, significant implementation gaps remain, particularly in terms of standardisation, regulatory clarity and economic incentives. By examining legislative reforms, international precedents and socioeconomic barriers, this analysis charts a path toward a hybrid healthcare model that could harmonise tradition and modernity.

Contextualising South Africa's healthcare funding environment

South Africa's private health insurance sector, governed by the Medical Schemes Act 131 of 1998 (Republic of South Africa, 1998), imposes costs that are prohibitive for the majority of the population. The average monthly premium of ZAR 2500 (approximately USD $137.50) represents a substantial proportion of the median monthly income of ZAR 3500 (approximately USD $192.50) for Black South Africans (Council for Medical Schemes, 2022), rendering private health insurance largely unaffordable.

A hospital-centric reimbursement framework compounds this economic barrier. Although prescribed minimum benefits mandate coverage for a defined set of conditions, the broader reimbursement structure remains heavily oriented toward inpatient and specialist services, limiting investment in outpatient and primary care (Competition Commission South Africa, 2018; Council for Medical Schemes, 2024). Consequently, primary and preventative services, which are critical for managing chronic diseases such as hypertension and diabetes, are neglected, perpetuating a cycle of reactive, costly interventions.

Traditional healers operate as de facto primary care providers in underserved regions. In KwaZulu-Natal, for instance, these practitioners manage around 70% of mental health cases, addressing conditions such as ukufa kwabantu (ancestral illness) through rituals such as ukubhula (divination) and herbal treatments (Hoppers, 2009). Furthermore, studies have shown that up to 72% of patients with human immunodeficiency virus (HIV) in Gauteng and Limpopo consult traditional healers, often as their first point of care, underscoring their prevalent role in the healthcare system (Babb et al, 2007; Moshabela et al, 2012). The exclusion of traditional healers from medical schemes perpetuates informalisation and under-use of their potential contribution. To draw a parallel with the UK healthcare system, while complementary and alternative medicine is recognised under the NHS framework, it remains peripheral and rarely funded due to limited evidence of clinical effectiveness (NHS, 2024).

Households in South Africa already spend significantly on traditional healers; a 2011 study found that for nearly 75% of the poorest quintile, over 10% of their monthly expenditure was spent on such services (Nxumalo et al, 2011). More recent work estimating direct costs for patients with noncommunicable disease using herbal medicine also suggested substantial out-of-pocket burdens on individual users (Hughes et al, 2022). Therefore, the systemic marginalisation of traditional healers contradicts constitutional guarantees of equitable healthcare access and stifles opportunities for collaboration between biomedical and traditional systems.

Legislative shifts and persistent challenges

The National Health Insurance Act 2023 (Republic of South Africa, 2023) and the Traditional Health Practitioners Act 2007 (Republic of South Africa, 2007) represent watershed moments in South Africa's health policy. The National Health Insurance Act envisions a unified,

primary care-driven system, explicitly acknowledging traditional medicine as a component of universal coverage. Concurrently, the Traditional Health Practitioners Act established the Interim Traditional Health Practitioners Council to regulate training, registration and ethical standards. However, the council's prolonged interim status has hindered regulatory consolidation and delayed the establishment of standardised training and accreditation pathways, underscoring persistent implementation gaps in integrating traditional practitioners within the formal health system (World Health Organization, 2013; Moshabela et al, 2017~~6~~). Accreditation processes remain nebulous, with no consensus on standardised curricula or certification for healers whose training often spans decades of apprenticeship.

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These delays may reflect deeper tensions among biomedical stakeholders and traditional healers. These tensions mirror findings from Mozambique and Tanzania, where biomedical professionals initially resisted integration, citing lack of evidence and safety concerns, until pilot collaborations demonstrated improved stigma reduction, especially in HIV/AIDS contexts (Kayombo et al, 2012; Audet et al, 2017). Furthermore, the Health Professions Council of South Africa has historically dismissed ancestral mediation as 'unscientific,' despite its efficacy in resolving psychosocial stressors that manifest as physical illness (Hoppers, 2009). Bridging this divide requires legislative nuance, as seen in Ghana's Traditional Medicine Practice Act of 2000 (Ghana Parliament, 2000), which mandates collaboration between healers and biomedical practitioners through shared training programmes.

Theoretical frameworks for integration

To provide an analytically grounded approach, this article draws on three interrelated theoretical frameworks: cultural competency, epistemic justice and health systems strengthening. These frameworks not only underpin the rationale for integrating traditional healers into South Africa's private health insurance system, but could also guide the design of practical interventions.

Cultural competency theory posits that healthcare delivery is most effective when aligned with the cultural values, beliefs and practices of the community it serves (Betancourt et al, 2003; Saha et al, 2008). Traditional healers in South Africa are more than clinical actors—they are custodians of cultural and spiritual identity. Interventions should thus aim to bridge knowledge systems and improve culturally responsive care. These exchanges can enhance diagnostic accuracy, foster respect and reduce the cultural dissonance that often leads to patient non-adherence (Moshabela et al, 2012).

Epistemic justice, particularly as conceptualised by Fricker (2007), draws attention to how marginalised groups are often denied credibility or recognition as 'knowers'. In healthcare, this manifests as the dismissal of indigenous healing systems as 'unscientific'. Therefore, formalising the Interim Traditional Health Practitioners Council and recognising healer apprenticeships as valid forms of training are not only administrative measures, but also acts of recognitional justice. These steps could help to correct historic power imbalances in how expertise is defined and valued within the healthcare system (Hoppers, 2009)

Health systems strengthening encompasses strategies aimed at enhancing equity, access, quality and efficiency throughout the healthcare delivery chain (World Health Organization, 2007). In the author's view, integrating traditional healers into insurance-based models could achieve several of this theoretical framework's goals. For instance, pilot

projects using capitation payments and digital claims platforms can enhance service reach, reduce care duplication and lower transaction costs (Kayombo et al 2012). These mechanisms could also make the system more resilient, especially in rural contexts where formal infrastructure is lacking. Moreover, incorporating traditional healers into preventative and primary care strategies could reduce pressure on hospital-centric models and support the shift toward universal health coverage (Moshabela et al, 2012; World Health Organization, 2013).

Together, these frameworks inform both the normative and structural logic of the hybrid integration model proposed in this article. They provide a cohesive rationale for designing, evaluating and scaling culturally inclusive healthcare systems that are both financially viable and socially just.

Global precedents: lessons from Ghana and Vietnam

Ghana's integration model offers a blueprint for reconciling tradition and regulation. The Centre for Scientific Research into Plant Medicine collaborates with traditional healers in Ghana to validate herbal remedies, such as cryptolepis sanguinolenta, which is now a cornerstone of national malaria protocols (Ghana Health Service, 2021). This partnership has reduced malaria mortality by 30% in pilot regions, while generating USD $50 million annually through herbal exports. Crucially, Ghana's success hinges on economic incentives: healers earn formal incomes through regulated herbal markets, fostering compliance with safety standards.

Vietnam's dual-system approach provides complementary insights. The country's traditional medicine strategy (2021–2030) (Ministry of Health, Vietnam, 2018) integrates Thuốc Nam (traditional medicine) into all tiers of care, supported by 58 dedicated hospitals and insurance reimbursement for therapies such as acupuncture. In Hanoi, patients with diabetes who use herbal supplements reported a 40% lower reliance on insulin, illustrating the cost-saving potential of preventative care (Ministry of Health, Vietnam, 2018). Vietnam's model underscores the importance of infrastructure investment; traditional wards in hospitals normalise integration, reducing stigma and fostering patient trust.

The integration efforts in Ghana and Vietnam demonstrate both the feasibility and tangible benefits of incorporating traditional medicine into national healthcare systems.

Toward a hybrid healthcare model

South Africa's 2015 national policy on African traditional medicine outlined institutional collaboration pathways, although implementation remains limited (Department of Health, South Africa, 2008; World Health Organization, 2013). ~~A viable integration strategy must address cultural, commercial and structural dimensions. As a primary step, the author believes that formalisation of the Interim Traditional Health Practitioners Council is urgent. South Africa's parliament could expedite this by mandating representation for traditional healers on the council and adopting competency frameworks that recognise apprenticeships as valid training (Nxumalo and Alaba, 2021).~~ As a primary step, formalisation of the Interim Traditional Health Practitioners Council is necessary. South Africa's parliament could expedite this by strengthening governance structures and clarifying training and registration requirements, addressing persistent gaps in regulatory implementation and operationalisation identified in existing legislative frameworks (Abrams et al., 2020).

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~~Capitation-based reimbursement could offer a viable mechanism to rebalance South Africa's health financing system toward primary and community care, countering the incentives for hospital-centred, fee-for-service provision. Policy and empirical evidence linked to national health insurance reforms and community-oriented primary care initiatives in Soweto have demonstrated the feasibility of population-based, geographically-defined service delivery models.~~ Capitation-based reimbursement could offer a viable mechanism to rebalance South Africa's health financing system toward primary and community care, countering the incentives associated with hospital-centred, fee-for-service provision. Policy and empirical evidence linked to National Health Insurance reforms and community-oriented primary care initiatives in Soweto demonstrate the feasibility of population-based, geographically defined service delivery models (McIntyre and Kutzin, 2016; National Department of Health, 2017; Schneider et al., 2018; Rohde et al., 2017). Although large-scale implementation remains limited, emerging analyses indicate that capitation and bundled primary care approaches can better align resource allocation with patterns of household health-seeking behaviour and cost sensitivity, including the continued use of traditional medicine (Nxumalo et al, 2011; Hughes et al, 2022). Taken together, this evidence supports the potential of primary care-oriented reimbursement models to expand access and reduce financial barriers within a pluralistic health system.

Cross-training initiatives may also be beneficial in bridging epistemic divides. In the Eastern Cape, community workshops involving traditional healers and GPs co-developed protocols for managing hypertension. A follow-up observational study, described in the same unpublished NGO report mentioned above, reported a 35% improvement in medication adherence among co-managed patients. These outcomes are also consistent with broader system-level findings suggesting that integration of traditional medicine can improve patient trust and adherence (Ikhoyameh et al, 2024).

While these outcomes have not yet undergone full peer-reviewed publication, the unpublished NGO accounts suggest that integration pilots could improve coordination and adherence. These findings are reinforced by peer-reviewed analyses highlighting both household cost impacts (Nxumalo et al, 2011; Hughes et al, 2022) and broader system-level benefits of integration (Ikhoyameh et al, 2024).

Cultural equity and implementation hurdles

Integration is arguably as much about rectifying historical injustices as it is about improving healthcare access. Colonial and apartheid policies systematically suppressed indigenous knowledge systems, framing them as inferior to Western medicine (Hoppers, 2009). Recognising traditional healers as equal stakeholders in the 2023 National Health Insurance Act represents a step toward epistemic justice, aligning with constitutional values of dignity and equality. However, challenges persist. Safety concerns, such as the use of unregulated herbal preparations, necessitate the development of a national pharmacopoeia in partnership with the South African Health Products Regulatory Authority (2022). Pilot testing of 50 high-demand herbs, including artemisia afra, for respiratory ailments may establish quality benchmarks without compromising traditional autonomy.

Biomedical resistance remains another hurdle. Professional councils such as the Health Professions Council of South Africa must evolve beyond paternalistic attitudes, perhaps through mandatory cultural competency training. Biomedical resistance to integration is a well-documented barrier across many pluralistic healthcare systems. For

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example, research in Nigeria has reported mixed attitudes among orthodox clinicians: Lagos-based doctors acknowledged potential benefits of herbal medicines yet expressed concerns regarding safety and evidence (Awodele et al, 2012). Similarly, in Kenya, research on healer involvement in managing sexually transmitted infections in Nairobi found that, despite strong community reliance on healers, biomedical practitioners expressed concerns about quality control and safety (Kusimba et al, 2003). These findings mirror broader lessons from UNAIDS guidelines on healer collaboration in HIV prevention, which highlight both the potential of community partnerships and the persistence of biomedical resistance (UNAIDS, 2006).

India's Ministry of Ayush—arguably the most institutionalised traditional health model globally—has also faced interprofessional tensions, with biomedical practitioners often questioning the scientific legitimacy of Ayurvedic interventions, leading to siloed practices even within the same facilities (Patwardhan, 2014). These examples show that regulatory alignment alone is insufficient; cross-training, interprofessional dialogue and mutual respect are necessary to bridge these epistemic divides.

Early programme evaluations have shown that integrating community-based education and support can improve HIV outcomes. For example, the Soul City 4 Impact Evaluation demonstrated measurable improvements in knowledge and behaviour relating to HIV prevention and treatment adherence in South Africa (Soul City Institute for Social Justice, 2004). More recently, a doctoral thesis submitted to the University of Pretoria by Le Tape (2017) evaluated the Soul City HIV and AIDS intervention for young people in the Northern Cape. Although this is not a peer-reviewed study, the finding that community-based health communication strategies enhanced awareness, reduced stigma and improved uptake of preventative services is of interest here.

While not healer-specific, these examples illustrate the public health potential of integrating culturally resonant, community-driven actors—such as traditional healers—into HIV prevention and support frameworks.

Ethical safeguards and intellectual property protections

While integration of traditional healers into private health insurance frameworks could increase access and equity, it also raises significant ethical concerns that must be proactively addressed. Foremost among these is the need to protect vulnerable populations, particularly patients in rural areas who may rely exclusively on traditional medicine due to cultural or financial constraints. In the absence of stringent regulatory safeguards, there is a risk that exploitation, misinformation or inappropriate treatments will be normalised within formal healthcare frameworks.

Informed consent protocols must be expanded to reflect culturally contextualised risk communication, ensuring that patients understand the scope and limitations of both traditional and biomedical interventions. Healers themselves should be trained in bioethical standards, including confidentiality, patient autonomy and harm minimisation.

Intellectual property concerns further complicate the integration process. Many herbal remedies and healing practices are embedded in communal knowledge systems, often passed down through generations orally. Without appropriate legislation, there is a risk of biopiracy—the commercial exploitation of indigenous remedies by pharmaceutical or

insurance actors without benefit-sharing or attribution. To mitigate this, South Africa could adopt frameworks similar to India's Traditional Knowledge Digital Library, which documents indigenous practices while maintaining community control over access and commercial use (World Health Organization, 2013).

Incorporating these ethical safeguards is essential to ensure that integration does not become a vehicle for epistemic or economic appropriation. Respect for healer autonomy, community consent and the communal nature of traditional knowledge must remain non-negotiable principles within any hybrid healthcare model.

Stakeholder engagement and cost-benefit analysis

Multi-stakeholder roles and responsibilities

Effective integration of traditional healers requires a coordinated, multi-stakeholder approach. The author believes that insurers should develop inclusive coverage policies and digital tools for claims processing that are accessible to healers, while provincial departments of health should pilot models with designated integration teams comprising traditional healers, biomedical staff and health economists. Community-based organisations could facilitate dialogue between healers and the broader healthcare ecosystem, ensuring community ownership of integration processes.

Academic institutions and public health faculties should lead the development of standardised training modules and research integration outcomes. Meanwhile, traditional councils must play a gatekeeping role to protect the legitimacy and cultural integrity of traditional practice.

Cost–benefit considerations

Initial integration costs could be substantial, especially in the short term, including training, regulatory harmonisation and infrastructure upgrades. Costs would likely involve the development of digital claims platforms, the expansion of regulatory bodies such as the Interim Traditional Health Practitioners Council, and the delivery of accredited cross-training programmes for both biomedical and traditional practitioners. These outlays may trigger resistance from private insurers concerned about operational complexity and government actors facing fiscal constraints amid broader healthcare reform.

However, the long-term benefits are compelling. For example, prevention and early intervention, particularly for mental health and chronic diseases, could reduce downstream hospital admissions. Ghana's pilot models demonstrated a 30% reduction in malaria mortality, resulting in both saved lives and reduced healthcare system costs (Ghana Health Service, 2021). In Vietnam, integration has been associated with a decrease in insulin dependence among individuals with diabetes, resulting in lower pharmaceutical costs (Ministry of Health, Vietnam, 2018).

Integrating traditional healers into primary care could reduce pressure on South Africa's outpatient services while improving efficiency and access. Culturally aligned, community-based care may lower duplication of services, enhance treatment adherence, and reduce indirect patient costs (Nxumalo et al, 2011; Moshabela et al, 2017; Hughes et al,

2022). A phased implementation approach with cost-sharing mechanisms could support sustainable adoption and enable effective evaluation during early rollout.

Future research agenda

To support evidence-based policymaking, a robust research agenda is essential. In the author's view, future studies should include:

- Randomised control trials comparing traditional and biomedical approaches to managing common conditions (e.g. hypertension, anxiety disorders)
- Economic impact assessments to quantify the effects of integration on household health expenditure, provider incomes and insurer margins
- Longitudinal studies of patient adherence, satisfaction and outcomes in hybrid care models
- Ethnographic research on the epistemological foundations of traditional healing and how patients navigate dual systems
- Comparative policy reviews across other pluralistic healthcare systems in sub-Saharan Africa, Asia and Latin America.

Collaborative research frameworks involving healers, biomedical professionals and health policy scholars could enhance methodological rigour while maintaining cultural sensitivity.

Limitations

This article is conceptual and, as such, is subject to several limitations. While it draws on international case studies from Ghana and Vietnam to inform the proposed integration model, direct generalisation to South Africa must be approached with caution.

Beyond broad political, social and economic differences, these countries also exhibit significant variations in terms of healthcare infrastructure, epidemiological profiles and structural positioning of traditional medicine within national policy frameworks. For instance, Vietnam has an extensive network of traditional medicine hospitals and university programmes supporting formal training, whereas South Africa's traditional healing sector remains informal, mainly decentralised and community-based (World Health Organization, 2013; Ministry of Health, Vietnam, 2018). Similarly, Ghana's integration of herbal pharmacology into its national malaria strategy was facilitated by investments in laboratory infrastructure and regulatory bodies, such as the Centre for Scientific Research into Plant Medicine—conditions not yet matched in the South African system.

Moreover, the modalities of traditional healing differ substantially. While Ghana's integration centred on standardised herbal preparations, South African traditional healing incorporates complex spiritual and ancestral dimensions, such as divination and ritual cleansing, which may pose unique challenges for codification and reimbursement. These distinctions suggest that South Africa's integration model must be adaptively localised, not merely transplanted.

Finally, much of the supporting data on South African pilot programmes is drawn from grey literature or self-reported sources, which may introduce bias. Future empirical studies are essential to validate the assumptions and assess long-term outcomes using mixed-

methods approaches that account for both biomedical metrics and culturally relevant indicators of health and healing.

Conclusions

The integration of traditional healers into South Africa's private medical insurance system represents both a cultural necessity and a strategic reform. Traditional healers remain central to healthcare access for the majority of South Africans, and their exclusion from formal healthcare financing perpetuates inequity. Learning from Ghana's regulatory inclusivity and Vietnam's infrastructural integration, South Africa could adapt international lessons while recognising its own pluralist health heritage. Key reforms suggested in this article include formalisation of regulatory councils, introduction of capitation-based reimbursement and promotion of cross-training between biomedical practitioners and traditional healers. These measures could potentially improve treatment adherence, strengthen community trust and generate cost savings by shifting care from hospitals to preventative and primary settings.

Experiences with complementary and alternative medicines in other countries, including the UK, illustrate how biomedical dominance can limit pluralist approaches. South Africa has the opportunity to go further by embedding cultural equity into system design. Success will depend on regulatory clarity, multi-stakeholder engagement and sustained political will to harmonise tradition and modernity in pursuit of universal health coverage.

Acknowledgement

Before submitting this article to the journal, the author used an AI-based tool to assist with language editing and reference formatting. All content has been checked and finalised by a human author.

Conflicts of interest

The author declares that there are no conflicts of interest.

Key points

- South Africa faces structural inequality, limiting equitable access to healthcare.
- Funding models in South Africa prioritise biomedical services, shaping what care is accessible and legitimised.
- Traditional healers remain peripheral despite sustained patient demand, reflecting epistemic exclusion.
- South Africa could lead by integrating traditional healing into formal systems, offering lessons for more inclusive care that could potentially be applied to other healthcare systems, such as the UK NHS.

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