The schemes that the book uses to illustrate these descriptions are very heterogeneous. They include hospital-based prepaid plans in Kenya and Uganda; district-level financing plans with government involvement; a financing pool plan run by the Grameen Bank in Bangladesh; and the Cooperative Medical System, which, before its collapse in the 1980s, covered 90% of China’s rural population. Although diverse, these schemes share common goals — to mobilize financial resources for health, to protect individuals and households against costs of illness, and to give communities a say in the management of their health care.

How have community financing schemes fared in meeting these goals? The evidence is mixed. Despite a flourishing of interest in the schemes, apart from China there are no credible estimates of the numbers of people or the percentage of national populations that are covered by community financing. The ability of the plans to raise revenues for health care is generally recorded as the percentage of the recurrent, local costs of providing health care. Studies that have measured revenues and costs are not standardized; they show a wide range of estimates — generally far short of 100% cost recovery, even after excluding capital costs and centralized administration. For hospital-based plans, cost-recovery rates are much lower; for example, 2.1–7.2% for three such plans in Kenya, Uganda, and the United Republic of Tanzania.

Although there is very little evidence for the effectiveness of health-care plans in protecting against the costs of catastrophic illnesses, some plans do well in terms of social inclusion. The Grameen Bank health scheme in Bangladesh, for example, covers 58% of the poor population in its areas of operation, compared with 1.8% of the non-poor. However, the book voices the concern that many community plans may leave out the poorest groups, who are unable to pay even modest premiums or user charges. Without an external subsidy, the poorest may well be excluded from participation.

Community-based health-care plans have other weaknesses. For example, they are generally unable by themselves to raise sufficient revenues to pay the costs of curative health care for their members. This is particularly true for catastrophic illnesses — including HIV/AIDS — and chronic diseases that are increasingly prevalent in countries experiencing the epidemiologic transition. Health-care plan managers often lack the skills necessary to run health financing collection and health delivery systems. And, as long as they are based on voluntary membership, such plans are subject to the principle of adverse selection — individuals who are sick and know that they will probably need services are more likely to join than those who are healthy and present minimal risk.

Community financing plans should therefore be seen as a complement to, and not a substitute for, government involvement in health financing. Ideally, such plans provide a step in the transition toward larger, more stable, and better-financed risk protection pools. The Republic of Korea and China (Province of Taiwan) provide excellent examples of settings that have incorporated previously existing agrarian-based rural risk-sharing schemes into near-universal national health insurance programmes.

The book calls on governments to take the necessary steps to enable community-level plans to be more effective and to help make the transition to larger participant pools. Governments can subsidize the financial contributions of poor households, facilitate links with public and private provider networks, and provide reinsurance against the expenditure fluctuations that plague small insurance pools. If governments — and the donors that support them — can effectively take these steps, many of the world’s poor who are currently excluded from financial protection against the costs of health care will benefit.

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The life and death of smallpox

Authors: Ian Glynn, Jenifer Glynn
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The white horse of the Apocalypse — pestilence — is by definition a symbol of disease. Few communicable diseases appear to qualify as suitable candidates — cholera, plague, epidemic typhus, or perhaps HIV infection. (But these were arriverses awaiting “civilized” societies before they struck and spread.) As Ian and Jenifer Glynn chronicle in this book, smallpox is a good choice for Armageddon’s harbinger, since it is a disease of antiquity whose impact on humankind far surpassed other epidemic diseases. Despite its alleged natural extinction, smallpox may forever loom as a terrible threat for generations to come. In this book, the authors eloquently describe and trace this heary double-stranded DNA virus, which evolved from a mammalian virus (perhaps camelpox) over eons; it has scarified people from pre-history through to recent times, and, as they point out, may conceivably do so again in the future.

Ian Glynn, a neurophysiologist, has previously written a heady but readable book on the thinking process; Jenifer Glynn, an historian, has previously written a biography of a Victorian publisher and edited a series of turn-of-the-century letters. Her knowledge of and access to obscure historical works on epidemics and the numerous observations on smallpox, variolation and vaccinations are clearly evident. Why the authors chose this disease is not explained nor is how they may have divided their research agendas, but these questions are moot since the book is a seamless, exciting, refreshingly original work seeded with delicious detail. The authors rely on many letters and documents, sometimes choosing to editorialize on their content or question the wisdom of their writers. Often when a particular individual is identified, he/she is accompanied by a mini-biography that may have little to do with smallpox but is always fascinating in content (Charles Marle de la Condamine, while collecting cinchona seeds in the Amazon region first heard about the benefits of inoculation from Portuguese missionaries and later published them in a memoir; Daniel Bernoulli used calculus and the laws of chance to estimate smallpox mortality rates in France; Abraham Lincoln developed symptoms of smallpox a few hours after delivering his Gettysburg address; and as a youngster Edward Jenner’s England), citations and correspondences are supported in useful detail. The authors rely on many letters and documents, sometimes choosing to editorialize on their content or question the wisdom of their writers. 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