OR-08 Health as a commons: paying the healer, deciding the rules and the capture of care

HEALING after the FALL, research library, OR-08

Researched 10 October 2026 by Claude Opus agent for THRIVING after the FALL, Book Four. Library document, unverified.

1. Findings by section

1.1 What the question is, and where this book stops

A village that keeps a healer, a dispensary and a stock of scarce doses has made a commons. Someone has to feed the healer. Someone has to say what the stock is for and who may take from it. Someone has to hold the key. And someone has to be able to remove the healer, or the healer becomes a lord. Every one of these questions has been answered before, by friendly societies, lodges, Chinese brigades, Rwandan mutuelles, Belgian doctors in Zaire, Benedictine abbots and Kerala's princely states. The answers left a record of what lasted and what was captured.

This report does two jobs. It sets out that record with figures. It then writes the narrow set of rules that a healer and a village need at the bedside and in the dispensary, and hands the rest to GOVERNING after the FALL, the series' third book. The division matters because the brief warns against redoing GOVERNING's work. The working line is this. HEALING owns any rule a healer must apply while caring for a patient or handling a dose: the stock list, the register, the mechanics of the two keys, the clinical criteria of triage, the poisons cupboard, the content of recertification and the ban on profiting from a prescription. GOVERNING owns any rule that settles power among households: how much each household pays and how it is collected, who is a member, how the assembly elects and dismisses, the sanctions for theft, the levelling of access against contribution, the social ordering of scarce goods and the appeal from the village to the district. The GOVERNING prompts that should own these are its commons prompt, its capture prompt, its levelling prompt and its triage prompt. Their IDs are GOVERNING's to assign [VERIFY]. Ostrom's eight design principles for long-lived commons, as summarised by the P2P Foundation (Ostrom 1990), belong to GOVERNING's commons prompt and are handed there without being worked through here.

I disagree slightly with two library placements. OR-06 says the debate over who holds a locked store belongs wholly to GOVERNING (THRIVING library, OR-06). I think the operating rule for the key is a clinical safety rule and belongs here, while the sanction for abusing it belongs to GOVERNING. HY-07 sends quarantine authority to GOVERNING (THRIVING library, HY-07), while IN-13 argues that the decision procedure itself changed outcomes in Ebola outbreaks (THRIVING library, IN-13). The payment record below supports IN-13's view: the form of payment changed what healers did to patients. Some governance is medicine.

1.2 Lodge and club practice before national insurance

Britain. Friendly societies hired "club doctors" on contract. Each member paid a fixed sum a year whether sick or well, and the doctor attended members and supplied medicine. A 1901 annotation in *The Hospital* gave club rates of half a crown to four shillings per member a year, set against a private fee of 2s 6d for a single attendance, and

one doctor's two lodges paid 3s, later 3s 6d, a head (Hospital 1901, search summary only). A Bristol editorial of 1911 called the average 4s capitation the nominal rather than the real rate (Bristol Medico-Chirurgical Journal 1911, search summary only). Green's study of working-class patients argued that this system was self-governing and widely used, and that the 1911 National Insurance Act moved control from the societies to the doctors (Green 1985, book not read, known through a review). I could not read Green's figures for membership or contract numbers, so the scale of British lodge practice is not given here [VERIFY].

The Tredegar Workmen's Medical Aid Society in South Wales is the best-documented case of members employing doctors outright. Members paid by deduction from wages. One archive description gives three pence in the pound, which is 1.25% of wages, for medical attention, medicine and appliances (Gwent Archives n.d., search summary only). By 1933 the society served 95% of the town, with five doctors, two dentists, dispensers and a nurse. In 1911 the members chose their lead doctor by ballot, 2,584 votes to 1,804 (Wikipedia, Tredegar Medical Aid Society). A 1901 contract paid a medical officer a salary of £900 and required him to hand back to the society all sums he received as medical officer, less a commission (Gwent Archives n.d., search summary only). That contract is the oldest written rule I found that separates the healer's income from the volume of his work. Aneurin Bevan took the model to the National Health Service in 1948, and the society withered once the state did the same job (Wikipedia, Tredegar Medical Aid Society).

The United States. Beito's account of American lodge practice is the source for the costs. The Fraternal Order of Eagles charged $1 a year for basic care of a member and his family, including minor surgery, and most lodges charged about $2, roughly a day's wage for a labourer (Beito 1994). Doctors were paid a salary set by the size of the membership and had to win an election by the members (Beito 1994). About 18 million Americans belonged to fraternal societies in 1920. By 1910 the Foresters and Eagles each had over 2,000 contract doctors. Over 600 New Orleans societies gave lodge practice to Black members in the 1920s (Beito 1994). Exclusions were moral as well as medical: childbirth, venereal disease and illness from drink were outside the Eagles' contract (Beito 1994).

The profession fought it. County medical societies called it the "lodge practice evil", expelled contract doctors, denied them hospital privileges and in some cases refused to treat their patients even in emergencies (Beito 1994). By the end of the 1930s lodge practice was virtually gone (Beito 1994). Beito's later book has a chapter titled "The Lodge Practice Evil Reconsidered" (Beito 2000, known through a review). Starr's history reads the same campaign as the profession's defence of its autonomy against any organisation that paid doctors a salary, group practices included (Starr 1982, known through a review). Kessel argued in 1958 that organised medicine's control of school accreditation, hospital privileges and society membership let it discipline price cutters and discriminate in price by income, and Friedman made licensure itself the cartel's tool (Kessel 1958, and Friedman 1962 as cited in FTC n.d., both known through secondary summaries). The opposite view, that the profession's bodies exist mainly to assure quality, is attributed to Arrow and Leffler (FTC n.d., search summary only) [VERIFY]. The Flexner Report of 1910 shows how a quality standard can close doors: of the historically Black medical schools, only Howard and Meharry survived the closures that followed (Washington University n.d.).

What the household paid and got. In the United States, about a day's wage a year bought a family doctor for routine care (Beito 1994). In Tredegar, about one-eightieth of wages bought doctors, dentists, drugs and a nurse (Gwent Archives n.d.). Outcomes are thin. Beito reports that the Foresters had a death rate of 6 per 1,000 against 9 in the general population of the same age, but their doctors rejected 10 to 20% of applicants on health grounds, so the comparison is mostly selection (Beito 1994). No study I found compared the health of lodge members with similar non-members [VERIFY].

1.3 China's Cooperative Medical Scheme

The design. The scheme grew from village experiments into national policy after Mao's directive of 25 June 1965, first tried in Changyang county in Hubei (Liu Yueju et al. 2013). A member paid 1 yuan a year, including a 10 fen subsidy from the village committee. A visit cost 5 fen and medicines were free (Liu Yueju et al. 2013). At its peak

about 90% of farmers took part, some 700 to 800 million people (Liu Yueju et al. 2013), and a WHO fact sheet gives about 90% of villages (PAHO n.d.). The barefoot doctor was paid in work points from the brigade, the same unit used for field labour (Human Resources for Health 2015, snippet only). Their pay was about half a regular doctor's salary (THRIVING library, OR-01).

The collapse. Coverage fell from about 90% at the end of the 1970s to about 5% (PubMed 1287043, abstract via search summary, year of the low point not given), or from 85% in 1975 to 10% by 1997 on a World Bank figure quoted secondhand (Healthbeat n.d.) [VERIFY]. Later figures quoted secondhand are 12.8% of rural residents insured in 1993 and 9.5% in 1998 (Gao and Meng n.d., citing Liu 2004) [VERIFY]. FO-04 marked the 5% figure as unconfirmed (THRIVING library, FO-04). It does appear in a PubMed abstract, but without a year, so it should be carried as "about 5% at the trough, mid-1980s" with a [VERIFY] and not as a dated fact. The brief's "collapse in two years" is not supported by anything I read. Most sources place the collapse in the early 1980s without a two-year window [VERIFY].

Why it collapsed. Three explanations compete.

1. The standard account blames decollectivisation. Once land went to households, the brigade had no collective income from which to pay work points (Liu Yueju et al. 2013).
2. Duckett argues from government documents that a change in health policy, shaped by post-Mao elite politics, did it, and that the economic reform story is overstated (Duckett 2011, abstract).
3. Zhu and colleagues surveyed three counties in 1987 and found the scheme had been fiscally sound where it survived. Fengxian, the richest county, kept it. Where it declined, the likely cause was that local administrators believed it "no longer enjoyed the backing of the central government" (Zhu et al. 1989, abstract).

Zhu's finding is the most useful for a village after the Fall. A commons scheme died when its sponsors stopped believing that anyone above them wanted it, not when it ran out of money. In Zhu's three counties infant mortality, immunisation coverage and infectious disease all worsened where the scheme declined, even as incomes and total health spending rose (Zhu et al. 1989, abstract).

What followed. Village doctors then lived on fees and on the margin from drug sales and infusions (Liu Yueju et al. 2013). A case study of Donglan county tied the facilities' need to earn revenue to over-prescription, and found that preventive programmes and supervision declined (Gu, Tang and Cao 1995, abstract). Elsewhere, 22.93% of 20,125 village prescriptions included an injection (THRIVING library, FO-04). The 2003 successor, the New Cooperative Medical Scheme, began at about 10 yuan a person a year from the farmer, matched by government (Liu Yueju et al. 2013). It reimbursed mainly inpatient care, at 80% in township hospitals, 60% at county level and 50% at provincial level (Liu Yueju et al. 2013). Blumenthal and Hsiao describe roughly $2.50 a year from government and $1.25 from the farmer in the early pilots (Blumenthal and Hsiao 2005, known through a commentary).

1.4 Rwanda, Bwamanda and community-based insurance

Rwanda. The mutuelles began as a pilot in three districts in 1999 to 2000, became policy in 2004 and law in 2008. Coverage rose from about 1% in 2000 to 85% in 2008 (Lu et al. 2012). Before 2007 a household of up to seven paid 2,500 to 11,500 Rwandan francs a year. From 2007 the premium was 1,000 francs ($1.81) per member, not per household. Premiums covered about half the scheme's cost. Members paid 200 francs per health-centre visit and 10% of hospital bills, waited a month before cover began, and the poorest 16% were exempted with Global Fund money (Lu et al. 2012). Sick under-fives taken for care rose from 13% to 33% and skilled birth attendance from 39% to 67%. Catastrophic spending fell from 11.9% to 7.7% of households between 2000 and 2006. Yet the poorest insured households still had the highest rates of catastrophic spending (Lu et al. 2012).

Bwamanda. Belgian doctors set up a district hospital insurance scheme in Bwamanda, Zaire, in 1986. Premiums were set by model, membership grew and cost recovery roughly doubled in two years (Moens 1990, abstract). Insured people used the hospital significantly more than the uninsured. Criel and colleagues asked whether that extra use went

to conditions needing a hospital at all (Criel, Van der Stuyft and Van Lerberghe 1999, abstract). I found no premium or coverage figures I could read [VERIFY].

The pooled evidence. A Cochrane overview of 15 reviews found that community-based health insurance "may increase people's use of services" (low certainty), with uncertain health effects. Effects of user fees, pay for performance, higher health-worker salaries and rural retention incentives were all of very low certainty (Wiysonge et al. 2017). A 2023 meta-analysis of 61 studies in 20 countries found that insurance raised utilisation (adjusted odds ratio 1.60 in the abstract, 1.04 to 2.47) and facility births (2.21). It also cut the odds of catastrophic spending at the 10% threshold (0.69), but inpatient use did not rise significantly. The authors concluded that it "inconsistently delivers financial protection" (Eze, Ilechukwu and Lawani 2023). On user fees, Lagarde and Palmer's Cochrane review found very low-quality evidence overall but suggested that removing or reducing fees raises use of some services, with possible unintended effects on preventive care and quality (Lagarde and Palmer 2011, summary only). Their earlier review set out how weak the evidence base was (Lagarde and Palmer 2008, summary only). Catastrophic spending is usually defined as payments above 40% of a household's income after subsistence (Xu et al. 2003, abstract via search summary).

1.5 Kerala

Kerala is usually cited as a society that got good health at low income. In the princely state of Travancore, health's share of government spending rose from 2.7% in 1873 to 1874 to 5.9% in 1937 to 1938. By 1939 Travancore had 108 hospitals and health centres and 150 ayurvedic hospitals and dispensaries, with ayurvedic clinics receiving state grants from 1896 (Tharakan n.d.). Infant mortality was 242 per 1,000 in Kerala in 1911 to 1920 against 278 for India, and 42 against 127 in 1978 (Tharakan n.d.). Tharakan's point for this report is that hospitals alone did not do it. Lower castes feared government hospitals, which a missionary in 1883 called "scarcely for the low castes". Social reform movements opened both access and household practice (Tharakan n.d.). In 1996 the People's Plan Campaign sent 35 to 40% of the state's plan budget to local governments, including for health (Elamon, Franke and Ekbal n.d., search summary only) [VERIFY]. Kerala is not a payment model. It is evidence that a public institution open to all castes, run by a government the poor could pressure, mattered more than the form of the fee.

1.6 Paying the healer: forms and what each produced

Form	Where	What it produced	Capture risk
Work points from the collective	China, 1960s to 1970s	Mass coverage, preventive work, collapse with the collective	Depends on a distant patron (Zhu et al. 1989)
Salary or capitation set by members, doctor elected	US lodges, Tredegar	Cheap routine care, member control	Attacked from outside by the profession (Beito 1994)
Fixed salary, fees handed back	Tredegar contract of 1901	Income separated from volume	Low [VERIFY]
Fee for service and drug margin	China after 1985	Injections, infusions, over-prescription, lost prevention	High (Gu, Tang and Cao 1995)
Sale of goods at a mark-up	BRAC shebikas	Reach, low pay, high dropout	Conflict of interest not studied in the sources I read
Pay by result	BRAC oral rehydration teachers	Graded teaching, 4, 2 or 1 taka per mother	Gaming possible (THRIVING library, FO-04)

Form	Where	What it produced	Capture risk
Volunteer, no pay	Rawalpindi peers, slum workers	Attrition, weaker effect	Selection of the better-off, quitting
Endowment of a house	Benedictine infirmary, medieval hospitals	Care as duty, accountable head	Alms and endowments can be diverted [VERIFY]
Gift or fee to a spiritual healer	Sangoma, vaidya	Fee scales with fear in some accounts	High (THRIVING library, TR-16)

Volunteers. The record does not support the unpaid healer. In Dhaka's slums, female volunteers who joined expecting income were almost twice as likely to stay (adjusted odds ratio 1.87, 1.22 to 2.85), and the poorest were 2.7 times as likely to stay as the richest (Alam, Tasneem and Oliveras 2011). Prestige mattered too. Workers whose standing had risen were more than three times as likely to stay (3.34), and those with community approval almost three times (2.57). Some had been told by a programme officer to expect 300 to 400 taka a month (US$4.44 to 5.92) and did not get it, and 45% of the deliveries they followed happened where they were not paid for them (Alam, Tasneem and Oliveras 2011). In a peer-delivered depression trial, paid peers in Goa lost none of their number while volunteers in Rawalpindi lost 35% (THRIVING library, MI-02). Community-financed workers leave at about twice the rate of salaried ones (THRIVING library, FO-04). Prestige is a real wage, but it is paid only while the community keeps approving.

BRAC shebikas. Shebikas get three weeks of training and small loans to start a revolving fund, and sell medicines, soap and sanitary goods at a small mark-up. There were 1,080 in 1990 and about 43,000 now, supervised by about 4,300 salaried shasthya kormi paid US$190 a month (Joardar et al. n.d.). Dropout in earlier BRAC programmes ran at 32 to 44% (THRIVING library, OR-01). None of the sources I read examined whether selling the medicine changed what was recommended [VERIFY]. China after 1985 says it would.

Jamkhed. The Penn case study gives programme costs, about $45,000 over five years for a village of about 1,500 and annual running costs of about $550,000 in 2011 including the hospital. It does not say how village health workers were paid (Penn CHIP 2012). The brief's "paid in grain and respect" is not confirmed by anything I read [VERIFY]. About two-thirds of Jamkhed workers served over two decades (THRIVING library, OR-01), which suggests that whatever the form, it held.

The monastery and the endowed hospital. Chapter 36 of the Rule of St Benedict puts care of the sick above all other duties. It provides a separate cell and a God-fearing attendant, allows baths and meat to the sick, and makes the abbot personally answerable for any neglect (Rule of St Benedict, chapter 36, search summary only). The infirmarian was not paid by the patient at all. The house fed him. Orme and Webster count over 500 English hospitals by 1300, often placed beside highways to gather alms (Orme and Webster 1995, publisher's summary only). I found no figures on tithe or endowment shares [VERIFY]. The useful part is the accountability line: one named person above the carer answers for neglect, and the carer has no income to protect.

Sangoma and vaidya fees. One study in Mpumalanga found that clients paid sangomas much as they would pay doctors, for services not limited to medicine (Africa 2009, search summary only). A small-claims case in 2018 involved a trainee seeking back R25,000 paid to a healer for initiation (Sowetan 2018). I found no reliable source on vaidya fee customs [VERIFY]. Per SY-04, these traditions should be described with attribution and without claiming knowledge they restrict (THRIVING library, SY-04). TR-16 already asks for "no fee that rises with fear" as an [OWNER] rule (THRIVING library, TR-16). I agree and would extend it to any healer.

1.7 Capture

Capture came in four shapes in the record.

1. **Capture by the profession from outside.** This happened to the lodges, the friendly societies and the Black medical schools. The weapons were society membership, hospital privileges and accreditation (Beito 1994, Kessel 1958, Washington University n.d.). Illich's wider charge is that professional control of health becomes a monopoly that disables self-care (Illich 1976, known through a review). After the Fall there is no national profession, but a district guild of healers could rebuild one quickly.
2. **Capture by the healer's income.** When income rises with volume, volume rises. China after 1985 is the clearest case (Gu, Tang and Cao 1995, THRIVING library, FO-04). Roka in Cambodia shows the end point: an unlicensed medic reusing syringes infected 242 people with HIV (THRIVING library, FO-04).
3. **Capture by the committee.** Seattle's anonymous lay committee of 1962 weighed "social worth" in choosing dialysis patients (THRIVING library, FO-08). A study of 251 health facility committees in Burundi found local elites ignored rather than captured them, which left them a façade (Falisse and Nkengurutse 2021, search summary only). Abimbola and colleagues found that committee members tend to be the elite who can pay, and serve the government's goals more than the community's (Abimbola et al. 2022, search summary only). A Sierra Leone field experiment found little capture of funds by elites, who managed projects better than randomly chosen villagers (Management Science n.d., search summary only).
4. **Capture of the scarce dose.** Insulin in 1922, penicillin in 1943, Peru's "Vacunagate" with 487 people vaccinated out of turn and Memorial hospital in 2005 all show the powerful reaching the dose first when there is no rule written in advance (THRIVING library, FO-08).

Licensing without a state. The village needs a way to say who may cut, prescribe and hold the key, without a guild that limits numbers to raise fees. The record suggests a licence with four parts: selection by the village assembly, training of two people at a time, recertification by peers from another village, and the assembly's right to dismiss after review (THRIVING library, OR-01). No programme I or the library found publishes a dismissal rule (THRIVING library, OR-01). The Tredegar ballot and the lodge elections show that members can choose a doctor (Wikipedia, Tredegar Medical Aid Society, Beito 1994). The Seattle committee shows that choosing who is treated is a different and worse task to give to a lay group without written criteria (THRIVING library, FO-08).

1.8 The keys and the poisons cupboard

OR-06 gives the dispensary one or two key holders, a two-signature register for controlled drugs and an inner cupboard, and leaves the full poisons rules to this report (THRIVING library, OR-06). ME-07 allows one narrow-margin plant, foxglove, to be prepared in a village, by one named preparer, with a logbook and a locked chest, while pure drugs stay at the district (THRIVING library, ME-07). MI-12 asks for two keys and a death register, and that no one accuse the healer until a review has met (THRIVING library, MI-12). These fit together. The rule in Protocol B below puts the inner cupboard under two keys held by two different households, neither of them the healer's. Every dose out is signed by both. Counts are read aloud at the monthly assembly. The healer may open the outer cupboard alone, because a healer who has to fetch two neighbours for a dressing will stop dressing wounds [VERIFY].

1.9 What the village needs from this book, and what it needs from GOVERNING

The village needs one page from HEALING, set out as Protocol A. The rest belongs to GOVERNING's prompts.

- **Commons:** membership, levy, arrears and the boundary against strangers.
- **Capture:** sanctions, audit, the separation of powers between healer, key holders and council.
- **Levelling:** whether the poor pay less, and whether contribution earns priority. It should not.
- **Triage:** the lottery machinery and appeal.

MI-13 expected this report to cover the institutions that endow and sustain care (THRIVING library, MI-13). It does so only as far as the healer's keep and the mutual fund, and leaves the endowment of a district infirmary to GOVERNING.

2. Evidence grades

Grades: A, several consistent studies or a systematic review. B, one good study or a consistent record. C, a single case, an abstract or a secondary summary. D, an inference or analogy. X, contradicted or unsupported.

Claim	Record	Inference for the village	Grade
Insurance or prepayment raises use of care	Two reviews (Wiysonge et al. 2017, Eze et al. 2023)	A levy-funded healer will be visited more than a fee-charging one	A for the record, D for the inference
Prepayment protects the poorest	Inconsistent, poorest least protected in Rwanda (Lu et al. 2012)	Exemptions must be written and funded	B, D
Fee and drug-margin pay causes over-treatment	China after 1985 (Gu et al. 1995, FO-04)	Never let the prescriber profit from a dose	B, D
The CMS collapsed because of decollectivisation	Contested (Duckett 2011, Zhu et al. 1989)	A scheme dies when its patron withdraws	C, D
CMS coverage fell to about 5%	Abstract without year	Use “about 5%” with a flag	C
“Collapse in two years”	Nothing read	Drop the phrase	X
Volunteers leave more than paid workers	Alam 2011, MI-02, FO-04	Pay the healer	B, D
The profession destroyed lodge practice	Beito 1994, Starr through review	A district guild can do the same	B, D
Lodge members were healthier because of lodge care	Selection by medical examination (Beito 1994)	No outcome claim can be made	X
Elected doctors served members well	Tredegar ballot, lodge elections, no outcome data	Election is feasible, its quality effect unknown	C
Elites capture health committees	Mixed (Falisse 2021, Abimbola 2022, Sierra Leone)	Capture is a risk, not a certainty	C
Jamkhed paid workers in grain	Nothing read	Drop the claim until checked	X
Kerala’s low mortality came from open public institutions and reform	Tharakan, single historian	Open access matters more than fee form	C, D

3. Means ledger

Level	Paying the healer	Deciding the rules	The key and the stock	Dismissal
Hands	Labour on the healer’s field, firewood, a meal	The household agrees who it will call	Nothing to lock	The household stops calling

Level	Paying the healer	Deciding the rules	The key and the stock	Dismissal
Hearth	Food and fuel from each household on fixed days	Household heads meet	A box with a simple lock for household remedies	Not applicable
Garden and still	A share of the medicinal garden's work is part of the levy	The village decides what is grown and distilled	Still and spirit under two keys (THRIVING library, MI-06)	The preparer can be replaced by the assembly
Village dispensary of 300	Fixed levy per member in kind or labour, healer's keep set each harvest	Assembly sets rules in public in advance, council of three applies them	Outer cupboard to the healer, inner cupboard under two keys, monthly count	Assembly after peer review
District infirmary of 3,000	Mutual fund with per-member premium, exemptions, salaried staff	Elected board, outside auditors	Pure drugs and narrow-margin stock held here (THRIVING library, ME-07)	Board with appeal to a district assembly
Hospital before the Fall	Tax or insurance, salaried or fee-paid staff	State, profession, licensing body	Pharmacy controls, controlled-drug registers	Licensing bodies

The village of 300 can afford one healer only if most households pay. At about five people a household there are 60 households [VERIFY]. One healer whose household lives at the village average needs one sixtieth of the village's food and fuel, about 1.7% of each household's keep [VERIFY, my arithmetic]. That is of the same order as Tredegar's 1.25% of wages (Gwent Archives n.d.).

4. Harm test

Rule	Possible harm	Mitigation
Fixed levy whether sick or well	Excludes households that cannot pay	Care never refused for arrears [OWNER], arrears go to GOVERNING
Per-member premium	Burdens large poor families (Rwanda moved to it in 2007, Lu et al. 2012)	Cap per household [OWNER]
Healer's keep fixed, not per visit	Healer may underserve	Visits logged, peer review, assembly can dismiss
Two keys for the inner cupboard	Delay in an emergency	Emergency dose list kept in the outer cupboard, opened by the healer alone and logged
Assembly may dismiss the healer	Scapegoating after a death	No accusation before review (THRIVING library, MI-12), peer reviewer from another village
Public lottery among equals	Feels cruel, may be rigged	Drawn in public, witnessed, recorded (THRIVING library, FO-08)

Rule	Possible harm	Mitigation
Elected healer	Popularity over competence	Only candidates who have passed district recertification may stand
Paying healers at all	Ends gift relations, invites haggling	Pay is a keep, not a price, set by assembly, not by the healer
Ban on selling remedies	Healer loses income	The keep replaces the margin

5. Red flags

Each sign below means capture has begun and the council should meet within seven days [OWNER]. The seven-day window is my suggestion [VERIFY].

- The healer sells what the healer prescribes, or a relative does.
- A key holder is kin to the healer or to the other key holder.
- The monthly count is skipped or read by the person who holds the key.
- Injections or infusions rise without a matching rise in illness (THRIVING library, FO-04).
- A fee appears that rises with the patient's fear or wealth (THRIVING library, TR-16).
- The allocation of a scarce dose is decided after the patients are known, or in private (THRIVING library, FO-08).
- Exemptions from the levy grow without an assembly record.
- The healer refuses peer review, or a district body starts to limit how many healers a village may train.
- The scheme depends on one outside patron and no one in the village knows what happens if the patron withdraws (Zhu et al. 1989).
- Volunteers start leaving. That is the first sign that the keep is too small (Alam, Tasneem and Oliveras 2011).

6. The case against

The libertarian reading. Beito and Green argue that voluntary mutual aid gave working people cheap, member-controlled care until organised medicine and the state destroyed it (Beito 1994, Beito 2000, Green 1985). On that reading the village should not levy anyone. It should let households form clubs and hire healers. My answer is that lodges excluded the sick at entry, rejecting 10 to 20% of applicants, and excluded childbirth and venereal disease (Beito 1994). A village of 300 cannot leave out its sick or its births. The record of voluntary schemes is good on use and poor on protecting the poorest (Lu et al. 2012, Eze et al. 2023).

The socialist reading. The CMS shows that a collective can give 90% of a vast rural population a healer for a yuan a year (Liu Yueju et al. 2013). On that reading the village should pool everything. My answer is that the scheme rested on a collective economy and on central backing. When local administrators believed the backing had gone, it fell even where it was solvent (Zhu et al. 1989, Duckett 2011). A village that copies it must supply its own backing.

The profession's reading. Doctors in 1901 and 1911 complained that contract rates were too low to give proper care (Hospital 1901, Bristol Medico-Chirurgical Journal 1911). The quality view of professional bodies is attributed to Arrow and Leffler (FTC n.d.). This is self-interested, but not empty. A healer on a fixed keep with too many patients will rush. The protocols therefore cap the list per healer.

Illich. Any rule that names who may heal creates a monopoly and weakens self-care (Illich 1976). The village rules here license a healer and lock a cupboard. Illich would say they start the process he warned of. The answer is to keep the licence local, revocable and open to apprentices, and to train every household in hearth care.

Werner and Maes. Werner asked whether the community health worker is a lackey of the system or a liberator of the community (THRIVING library, FO-04). Maes showed millions of unpaid Ethiopian volunteers carrying a

state programme (THRIVING library, FO-04). Both warn that the village's "healer" can become an unpaid arm of whoever holds the district stock.

Criel. More use is not better use (Criel, Van der Stuyft and Van Lerberghe 1999). A levy that makes visits free may fill the healer's day with complaints that hearth care would settle.

The elite-management finding. The Sierra Leone experiment found elites ran projects better and captured little (Management Science n.d.). A headman might run the dispensary better than a council. I do not adopt this, because the dispensary holds poisons and scarce doses, and the cost of one capture is death. But the finding should stop the book from assuming that every leader steals.

7. 10-line summary

1. Every lasting health commons separated the healer's income from the volume of treatment.
2. Fee and drug-margin pay produced over-treatment wherever it replaced a keep (China after 1985).
3. Lodges and clubs gave cheap, member-run care for about a day's wage a year, then the profession destroyed them.
4. Tredegar's members paid about 1.25% of wages, elected their doctor and covered 95% of a town.
5. China's scheme reached about 90% for a yuan a year and fell to about 5% when its patron seemed to withdraw.
6. Community insurance raises use (odds ratio about 1.6) but protects the poorest least.
7. Volunteers leave. Expected income nearly doubles retention, and prestige counts only while the village approves.
8. Capture came from the profession, from the healer's income, from committees and at the scarce dose.
9. The village needs one page: who pays, who decides, who holds the keys, who may be dismissed.
10. The rest belongs to GOVERNING's commons, capture, levelling and triage prompts.

8. Open questions

1. What did a British friendly-society member pay in all, sick pay included, as a share of wages? Green's figures are needed.
2. Exactly when and how fast did CMS coverage fall? Was the trough before or after 1985?
3. Did shebikas who sold medicines recommend more of them than salaried workers did?
4. How were Jamkhed's village health workers paid in the first decade?
5. Did lodge members have better outcomes than comparable non-members, once selection at entry is allowed for?
6. Does an elected healer serve better than an appointed one? I found no comparison.
7. What share of a medieval hospital's income came from endowment, tithe and alms?
8. What fee customs did vaidyas follow, and did any tradition forbid a fee before cure?
9. Can payment in kind work at district scale, for 3,000 people and several salaried staff (THRIVING library, FO-04)?
10. Where should the line fall between the healer's emergency stock and the two-key cupboard?

9. Sources to read in full

1. Green 1985, *Working Class Patients and the Medical Establishment*, for the British club figures and the 1911 transfer of control.
2. Beito 2000, *From Mutual Aid to the Welfare State*, chapter "The Lodge Practice Evil Reconsidered".
3. Zhu et al. 1989, Bulletin of the WHO, full text, for county data on collapse and outcomes.
4. Duckett 2011, China Quarterly, for the policy explanation of the collapse.
5. Lu et al. 2012, PLoS ONE, already read, to be kept as the model of a scheme that scaled.

6. Criel, Van der Stuyft and Van Lerberghe 1999, for who benefited from Bwamanda.
7. Ostrom 1990, *Governing the Commons*, for GOVERNING's commons prompt.
8. Starr 1982, *The Social Transformation of American Medicine*, for the profession's campaign against contract practice.
9. Orme and Webster 1995, *The English Hospital 1070 to 1570*, for endowment and staffing.
10. Alam, Tasneem and Oliveras 2011, already read, for the design of volunteer pay.

10. At the bedside after the Fall

The household. The household gives its share of the healer's keep on the fixed days whether anyone is sick or not. It calls the healer for what hearth care cannot settle and does not pay at the door. If the healer asks for payment for a dose, or proposes a remedy and offers to sell it, the household tells a council member. When a scarce dose is short, the household does not plead at the healer's door. It asks the council for the written rule and the lottery date. A household that cannot pay its share still calls the healer [OWNER].

The village of 300. One healer and one apprentice serve the village. The healer is kept by the levy in food, fuel and field labour (THRIVING library, MI-12) and handles no money from patients. The outer cupboard holds dressings, oral rehydration salts, common remedies and the emergency list, and the healer opens it alone and logs each use. The inner cupboard holds controlled drugs, the foxglove chest and any pure drug lent by the district, under two keys held by two other households (THRIVING library, OR-06, ME-07). The council of three, of which the healer is not chair, meets monthly. At that meeting the counts are read aloud and the healer's log is open to any member. When a scarce dose has to be allocated, the council applies the rule written before the shortage (THRIVING library, FO-08). The healer gives the clinical facts and does not choose.

The district of 3,000. Ten or so villages form a mutual. Each member pays a fixed premium, exemptions for the poorest are funded and written down in advance, and new members wait a month before cover begins (Lu et al. 2012). The district keeps salaried staff whose pay is not tied to the number of treatments. It holds the pure drugs and narrow-margin stock and recertifies village healers each year. It sends a healer from another village to review any death or complaint. The board is elected and its accounts are read by two auditors from outside the district [OWNER]. The district must have a plan for the day its outside supplier or patron withdraws (Zhu et al. 1989).

11. Protocols

Protocol A. The village health rules on one page [OWNER]

Read aloud and agreed by the assembly before the first winter. Re-read each year at harvest.

Who pays 1. Every household gives the healer's keep in food, fuel or labour on fixed days: after harvest, at midwinter and at sowing [OWNER]. 2. The keep is set by the assembly each harvest. Total keep equals the healer household's needs plus the apprentice's share. Divide by the number of households. In a village of 60 households this is about 1.7% of each household's keep [VERIFY]. 3. No patient pays the healer for a visit, a dose or a remedy. The healer sells nothing to patients. 4. Care is never refused for arrears. Arrears go to the assembly, not to the healer [OWNER]. 5. Strangers are treated in an emergency. Their household or village is asked to pay afterwards [OWNER].

Who decides 6. The assembly writes the rules in public, before they are needed, including the rule for scarce doses (THRIVING library, FO-08). 7. A council of three applies the rules. The healer advises the council but is not one of the three and never chairs it [OWNER]. 8. The forbidden reasons for priority are wealth, kinship, rank and contribution to the levy.

Who holds the key 9. The inner cupboard has two locks and two keys, held by two households that are not kin to each other or to the healer [OWNER]. 10. Key holders change every year. No one holds a key for more than two

years in five [OWNER]. 11. Every dose out of the inner cupboard is entered in the register and signed by both key holders.

Who may be dismissed 12. The healer, the apprentice, the key holders and the council may each be dismissed by the assembly. 13. No healer is accused or dismissed until a review that includes a healer from another village has met (THRIVING library, MI-12). 14. Grounds for dismissal of a healer: selling to patients, refusing review, two failed recertifications, abuse of a patient or theft from the cupboard [OWNER]. 15. A dismissed person may appeal to the district once [OWNER].

Protocol B. The dispensary key and register

1. Set up two cupboards. The outer one is for dressings, rehydration salts, common remedies and the emergency list. The inner one is for controlled drugs, the foxglove chest (THRIVING library, ME-07) and district drugs.
2. Keep three books: the healer's log of every outer-cupboard use, the inner register, signed by both key holders for every dose, and the death register (THRIVING library, MI-12).
3. Count the inner cupboard weekly in front of both key holders. Count the outer cupboard monthly.
4. Tolerances: for counted doses, none. A single missing tablet or ampoule calls the council within 24 hours. For bulk dried herbs weighed on the village scale, a loss up to 5% a month may be put down to drying and handling [VERIFY, my figure].
5. Read the counts aloud at the monthly assembly. Members may inspect the books at any time in daylight.
6. Emergencies: if a key holder cannot be found within 15 minutes, the healer may open the inner cupboard with the council chair as second witness and enter it in the register [OWNER, VERIFY].

Protocol C. Setting the healer's keep each harvest

1. List what the healer's household needs for a year: grain, other food, fuel, clothing and the labour lost from their own fields. Price it in grain.
2. Add the apprentice's share, half the healer's [OWNER].
3. Add a stock reserve for remedies the village cannot grow, as advised by the district.
4. Divide the total by the households. Exempt households are listed by name and approved by the assembly.
5. Compare the result with last year's. If it rises more than 10%, the assembly debates it [OWNER].
6. Check the healer's list. One healer for 300 is the plan. If the village grows past 400, train a second healer rather than raise the keep [VERIFY].

Protocol D. Allocating a scarce dose

1. Before any shortage, the assembly agrees the clinical criteria for who benefits, using the triage rules (THRIVING library, FO-08).
2. When the shortage comes, the healer lists the patients who meet the clinical criteria and gives the list to the council.
3. The council checks the list against the forbidden reasons.
4. If the doses are fewer than the eligible patients, they are drawn by public lottery, witnessed by two people who are not kin to any patient, and recorded.
5. Any exception for the healer or for workers whose work keeps others alive is the narrow one in FO-08 and is announced before the draw.
6. Appeal goes to the council after the event, never before the draw. The machinery belongs to GOVERNING's triage prompt.

Protocol E. Review and dismissal

1. A complaint or an unexpected death is entered in the death register or the complaint book within one day.

2. The council sends for a healer from another village within seven days.
3. The review meets within 14 days. It hears the healer, the family and the record, and writes a finding.
4. The finding is read to the assembly. The assembly may do nothing, require retraining, suspend the healer or dismiss them.
5. Before review, the healer may be suspended only for harm still in progress, such as reused needles or theft from the inner cupboard (THRIVING library, FO-04).
6. Appeal goes to the district within 30 days [OWNER].

Protocol F. Founding a district mutual of 3,000

1. Members are individuals, not households, but the premium is capped per household [OWNER].
2. Exemptions for the poorest share are fixed in advance and funded from the general levy, not from other members' premiums alone. Rwanda exempted 16% (Lu et al. 2012).
3. New members wait one month for cover (Lu et al. 2012).
4. A small co-payment at the hospital, as in Rwanda's 10%, may limit unnecessary use (Criel, Van der Stuyft and Van Lerberghe 1999). None is charged at the village healer [OWNER].
5. Keep a reserve of one year's average claims [VERIFY].
6. Staff are salaried and hand back any fees, as in Tredegar's 1901 contract (Gwent Archives n.d.).
7. Two outside auditors read the accounts each year. The board is elected every two years [OWNER].

12. Numbers to carry

1. 1.25%: Tredegar's three pence in the pound of wages, which bought doctors, dentists, drugs and a nurse (Gwent Archives n.d.).
2. About $2 a year, about a day's wage, bought a lodge doctor in the 1900s United States (Beito 1994).
3. 1 yuan a year and 5 fen a visit: the Chinese scheme at its peak (Liu Yueju et al. 2013).
4. About 90% to about 5%: China's scheme from its peak to its trough [VERIFY on the trough].
5. Odds ratio about 1.6: community insurance and use of care (Eze, Ilechukwu and Lawani 2023).
6. 16%: Rwanda's exempted poorest (Lu et al. 2012).
7. 1.87: retention odds when a volunteer expected income (Alam, Tasneem and Oliveras 2011).
8. 2,584 to 1,804: the members' vote for Tredegar's doctor in 1911 (Wikipedia, Tredegar Medical Aid Society).
9. 22.93%: village prescriptions with injections once doctors lived on drugs (THRIVING library, FO-04).
10. About 1.7%: each of 60 households' share to keep one healer at the village average [VERIFY].

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