Redesigning National Health Service Delivery: The Case for Community-Based Health Service Providers in Uganda

Background: Generating robust evidence on the value-for-money of integrating new service delivery platforms, like Community-Based Providers, remains a major challenge in global health policy.

Methods

Aim: Quantifying the value-for-money and potential health impact of integrating Community-Based Providers (CBPs) into Uganda's essential health package.

Model Used: Linear Constrained Optimization Model

Strategies compared:

1. Baseline: Facility-Only Delivery.
2. Integrated Strategies:
   a. Facility + Village Health Teams (VHTs)
   b. Facility + Medicine Retailers (Drug Shops/Pharmacies)
   c. Facility + Both CBPs

Outcomes measured: Outcomes Measured: Net Disability-Adjusted Life Years (DALYs) Averted, Expansion of Optimal Service Package, Average Cost-Effectiveness Ratio (ACER).

Findings

- Standalone VHT integration expanded the package by 6 interventions, with an additional 2.9 million net DALYs averted. VHTs deliver health improvements at an incredibly low cost of $42 per net DALY averted.
- Standalone medicine retailer integration led to a larger package expansion of 22 interventions, but a smaller impact of an additional 1.8 million net DALYs averted, compared to VHTs.
- Integrating both sees greatest gains - averting 4.7 Million additional net DALYs. Service package expanded by 25 interventions.
- Maximum provider level costs ($3,423 for VHTs and $19,792 for pharmacists) set a benchmark for cost-effective investment under current workforce levels - to reveal underfunded areas, strengthen allocation decisions, tackle structural constraints, and show how the existing community-based workforce can be used more effectively.

Key Takeaway: **Integrating both government-supported Community Health Workers and private medicine retailers into the wider health system is essential for expanding equitable access to essential health services and accelerating progress towards Universal Health Coverage.**

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