Plenary: Sustainable Financing for Community Health Systems

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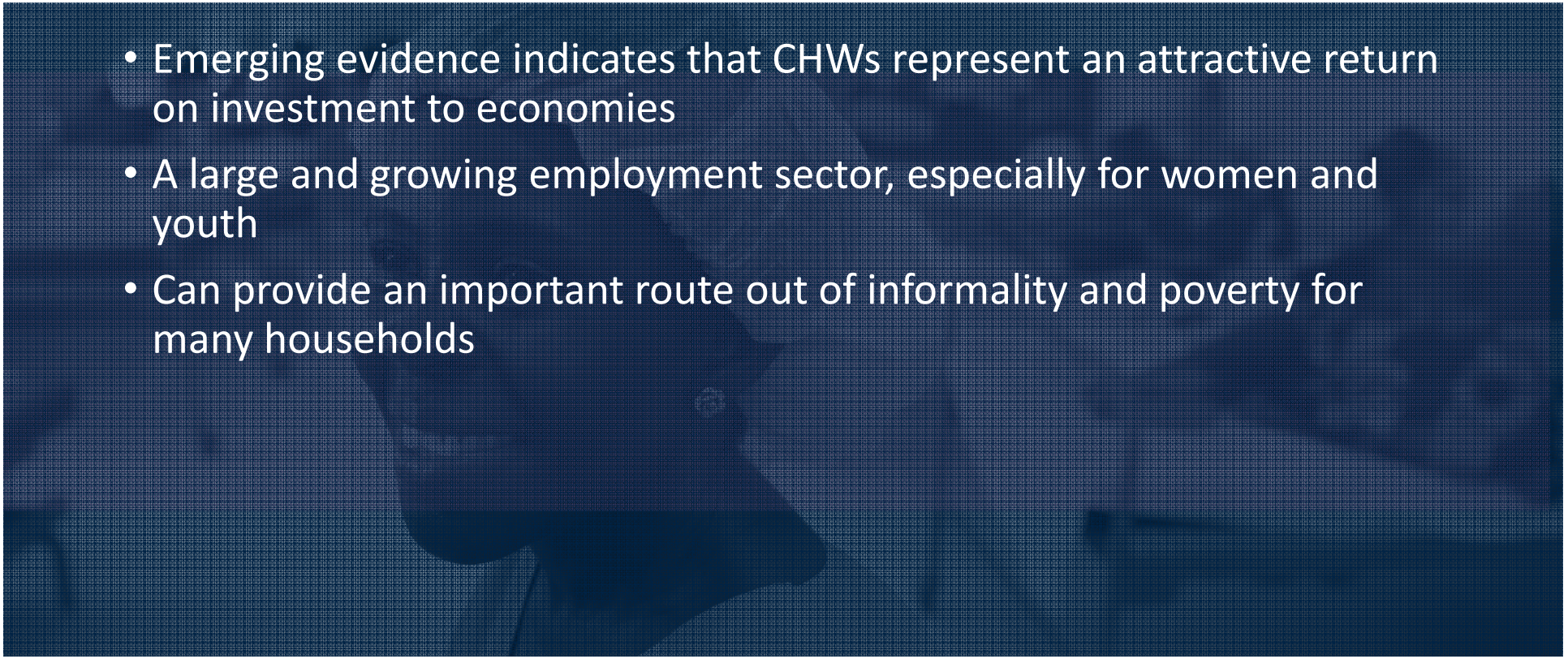
Community Health Systems is the foundation of resilient health systems and achieving UHC

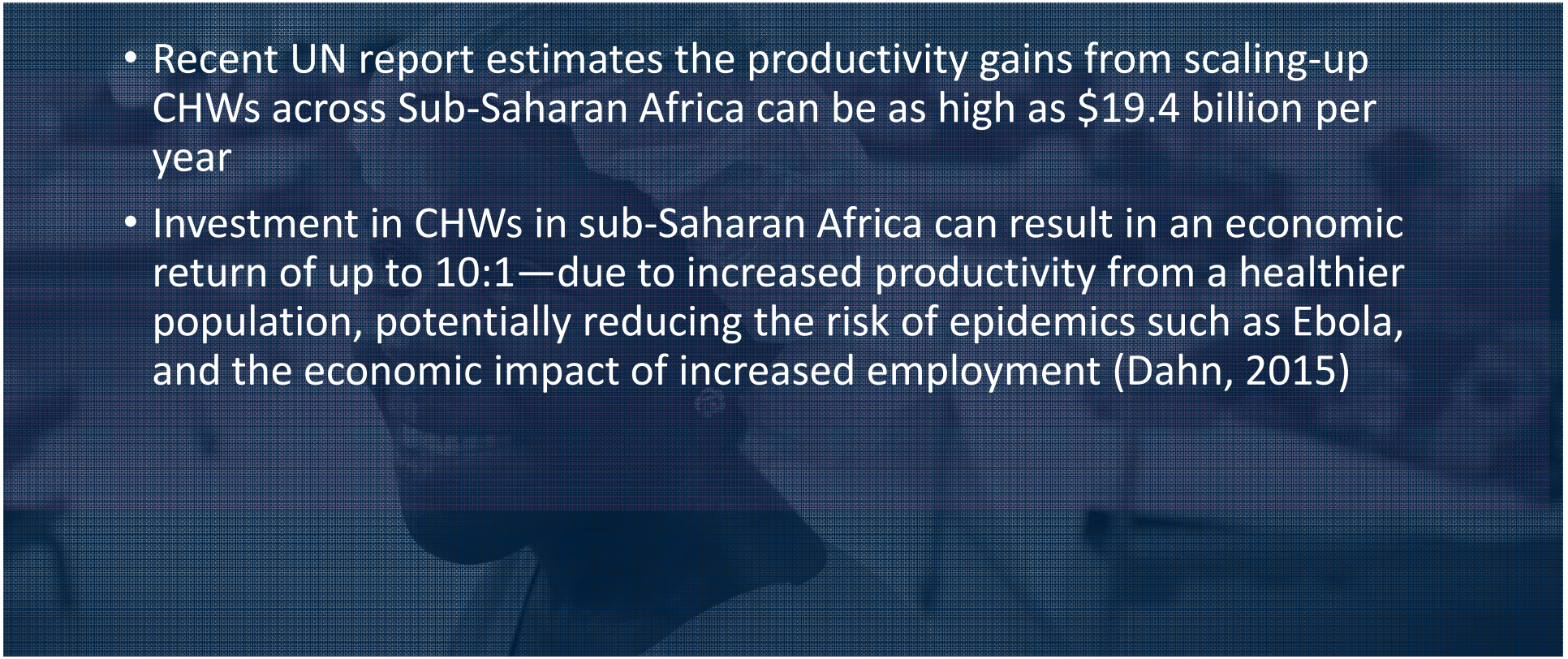
- A resilient health system works in ordinary times and delivers in extraordinary times, addressing urgent needs while maintaining core functions
- Investments in CHS epitomize the value of resilience: CHS deliver basic services while monitoring potential outbreaks and improving the system's responsiveness to health crises
- Nearly all countries will not be able to achieve UHC without CHS
- Many components of CHS that require financing. Need to make the investment case. I will use the example of CHWs

CHWs are a key component of CHS and can serve as an effective on-ramp for inclusive growth



- Emerging evidence indicates that CHWs represent an attractive return on investment to economies
- A large and growing employment sector, especially for women and youth
- Can provide an important route out of informality and poverty for many households

CHWs provide significant return on investments

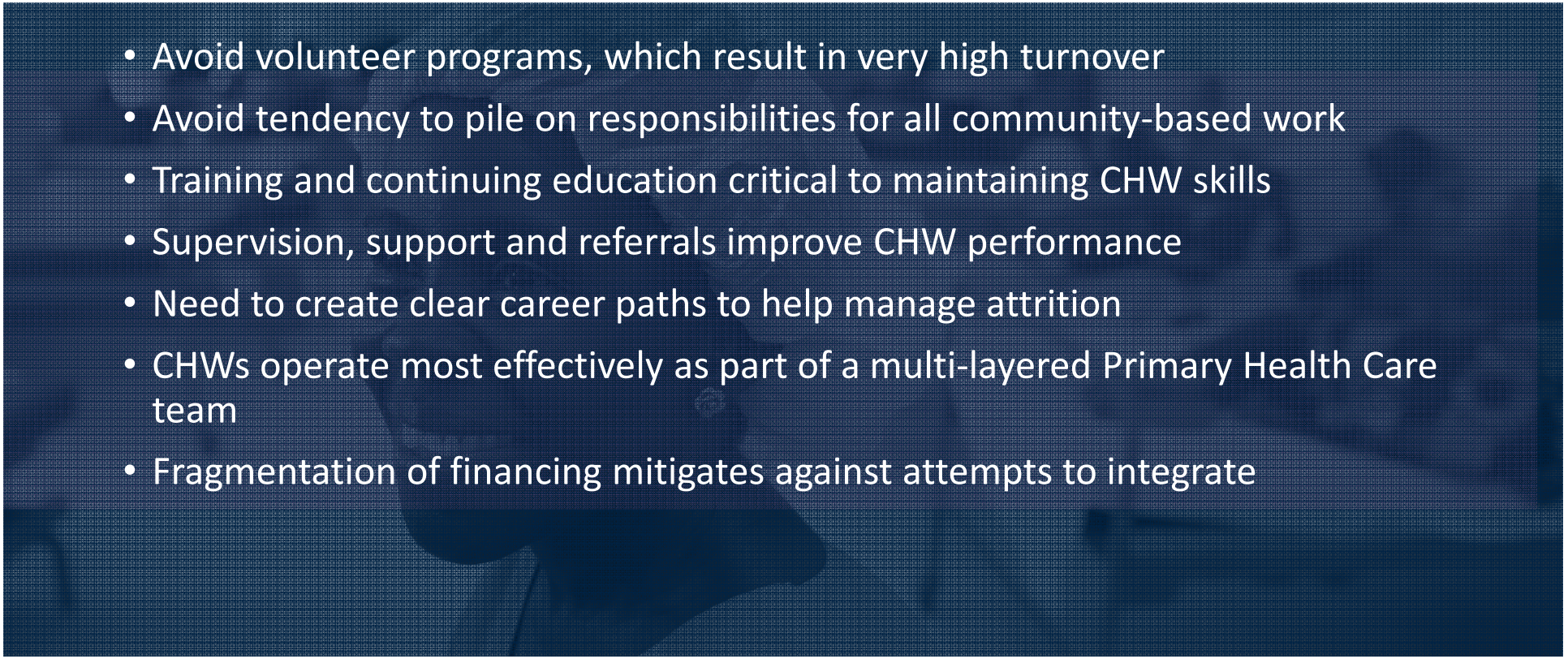


- Recent UN report estimates the productivity gains from scaling-up CHWs across Sub-Saharan Africa can be as high as $19.4 billion per year
- Investment in CHWs in sub-Saharan Africa can result in an economic return of up to 10:1—due to increased productivity from a healthier population, potentially reducing the risk of epidemics such as Ebola, and the economic impact of increased employment (Dahn, 2015)

CHW programs contribute to job creation

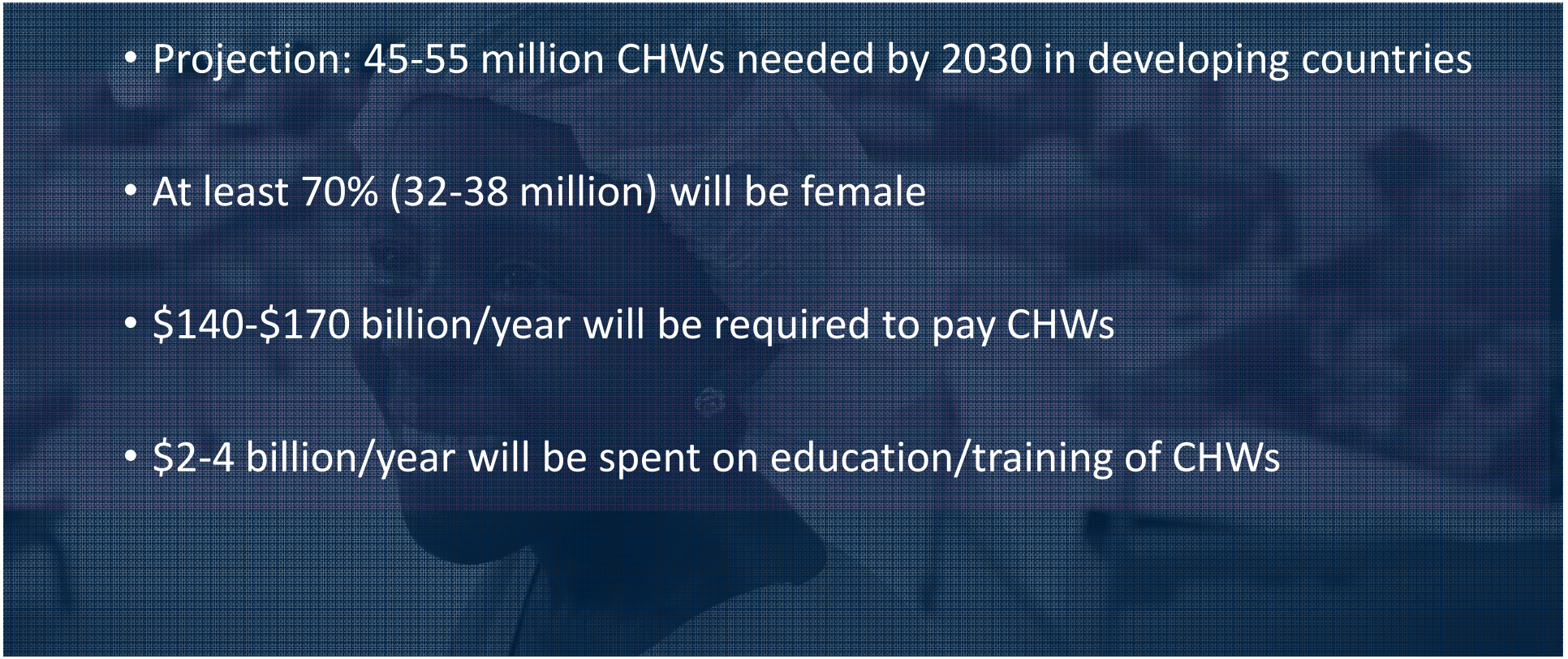
- In sub-Saharan Africa, increased government spending on CHWs estimated is estimated to yield up to $1.6 billion annually in economic activity (Dahn, 2015)
- Paid CHW programs also yield greater societal benefits by increasing in income for poor households – particularly empowering women and youth

Recent reviews of CHW programs yield important insights on how to achieve better results



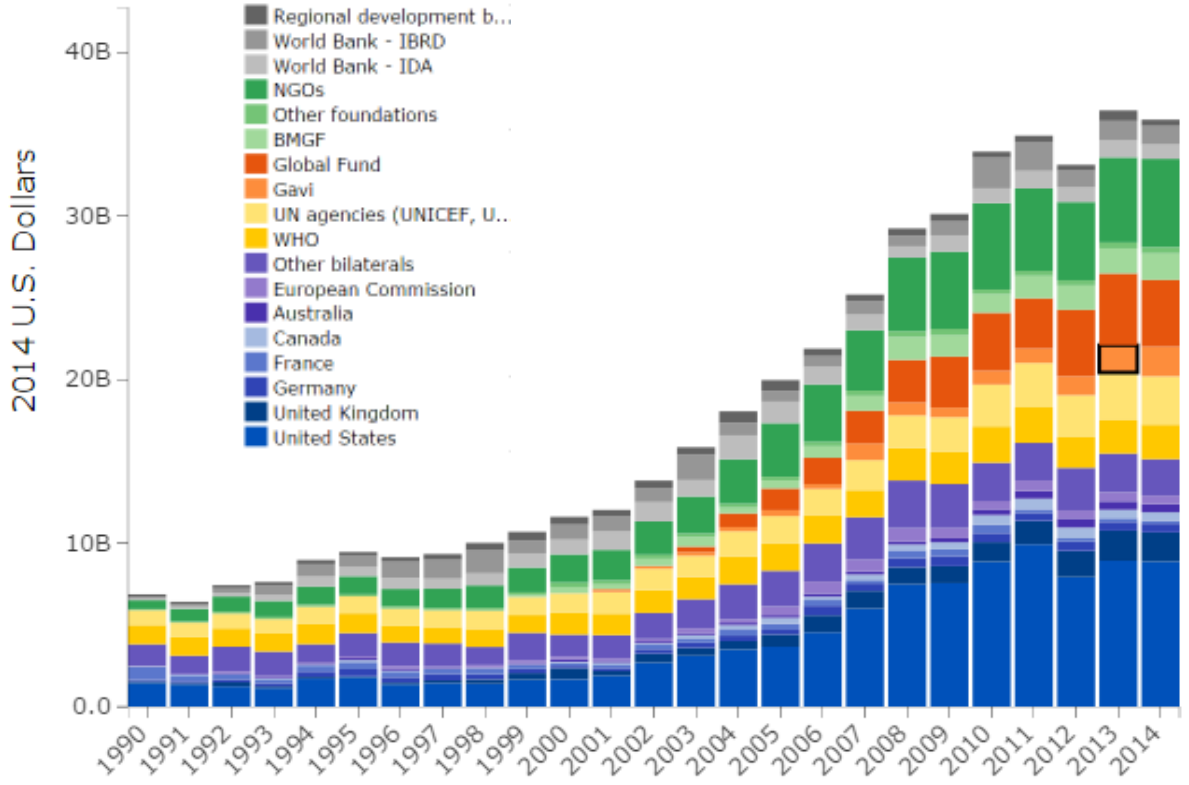
- Avoid volunteer programs, which result in very high turnover
- Avoid tendency to pile on responsibilities for all community-based work
- Training and continuing education critical to maintaining CHW skills
- Supervision, support and referrals improve CHW performance
- Need to create clear career paths to help manage attrition
- CHWs operate most effectively as part of a multi-layered Primary Health Care team
- Fragmentation of financing mitigates against attempts to integrate

By 2030, CHWs represent an enormous opportunity – and cost



- Projection: 45-55 million CHWs needed by 2030 in developing countries
- At least 70% (32-38 million) will be female
- $140-$170 billion/year will be required to pay CHWs
- $2-4 billion/year will be spent on education/training of CHWs

The golden era of development assistance for health (DAH) is over



Challenge: CHW scale up requires going beyond traditional sources of financing

- Both start up and recurring costs needed to finance CHW deployment
- National health financing strategies need to reconcile high returns with the substantial investments necessary to expand CHW systems within a broader framework of financing for UHC.
- While there is no blueprint for financing CHW program scale ups, traditionally governments have tapped two sources: international funding and domestic resources, including current revenue and borrowing mechanisms.
- Single public sector financing is not the only mechanism; private sector financing for training/deployment could be a potential source.
- Development assistance can play a catalytic role in financing necessary upfront investments.
- Significant, system-wide efficiency gains from investing in CHWs will only materialize when countries succeed in increasing the relative share of resources available for frontline services.

Financing Alliance for Health

		Examples (in no particular order)
A Domestic funding	1	**County/Community health budgets**
	2	**Overall health sector budget** (including IDA allocations)
	3	**Taxes** (e.g. corporate health tax for health)
	4	**Cross-ministry synergies** (e.g. vehicles etc.)
B "Existing" donor	5	**Global Fund** (all three diseases and HSS if there is a separate component)
	6	**Gavi** (HSS component)
	7	**World Bank** (various mechanisms)
	8	**USAID** (often through implementers)
	10	**Other Bi-laterals** (e.g. JICA, DFID, EU, etc.)
	11	**Foundations** (e.g. BMGF, CIFF, Big Win etc.)
C Private sector	9	Corporate support from **local companies with large catchment areas**
	12	Corporate support **large international corporates (i.e. health) with a company interest** in stronger health markets
	14	Revenue-generation through CHAs
D "New" sources	13	Disease surveillance, preparedness and global health security funding/mechanisms
	15	Unemployment, education and economic growth programs (e.g. ADB)
	16	Philanthropic outcome funders for social impact bonds

s to support political prioritization, the analytical case needs to be strong (case, national

WBG is strategically integrating CHW scale up as an explicit focus in our priority initiatives

- Global Financing Facility for Every Women, Child and Adolescent
  - Results-based incentives for CHWs
- Post-Ebola Recovery Plans
  - Support to scale-up CHWs in Guinea, Liberia, Sierra Leone
- Pandemic Preparedness Plans
  - CHWs trained as part of outbreak alert and surveillance, community engagement and behavior change
- Early Childhood Development
  - CHWs expand reach and effectiveness of nutrition and stimulation programs in the first 1,000 days of life
- China Health Study
  - Promotes role of CHWs in shift to primary health care and for health promotion/treatment for NCDs
- Fragile and Conflict/Crisis Settings
  - CHWs to re-establish and maintain front-line services
- Roadmap for UHC in Africa (TICAD VI)
  - CHWs required to overcome workforce bottlenecks holding back UHC

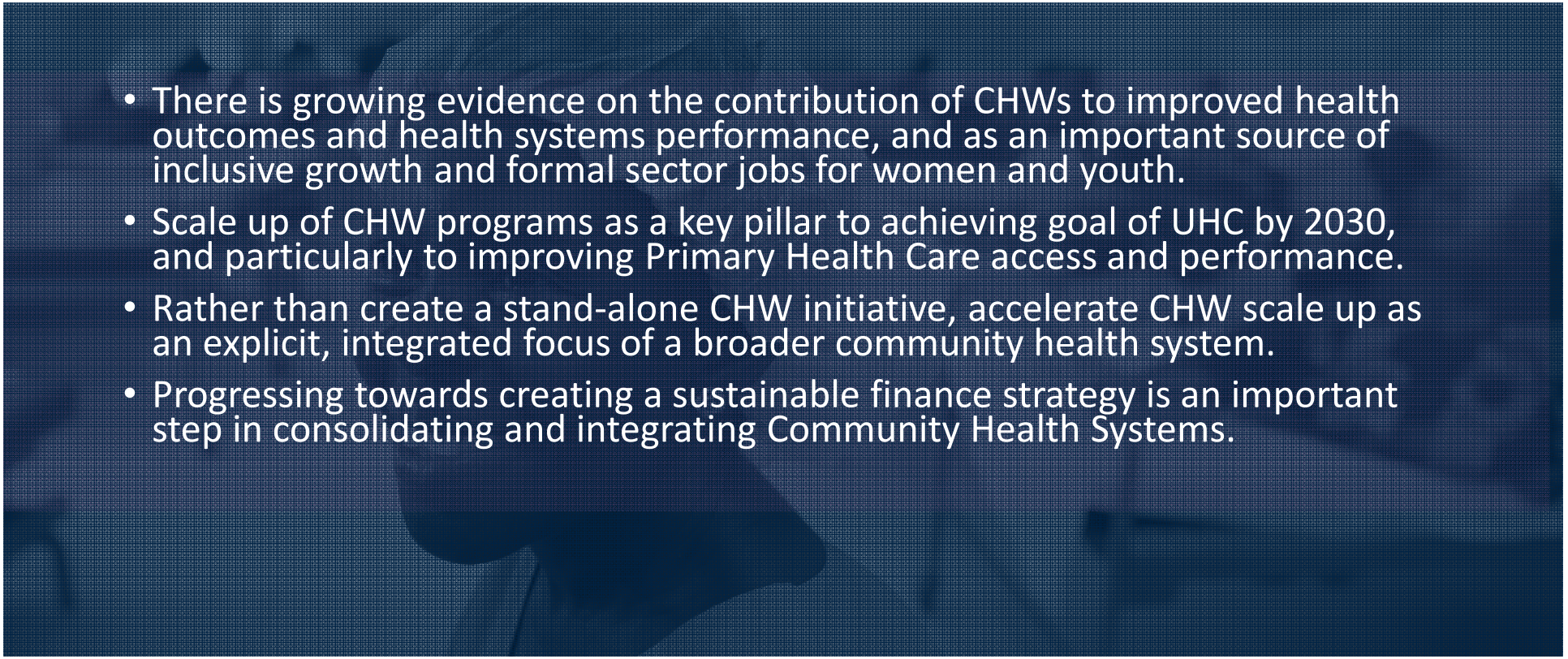
GFF and IDA working to support smart, scaled, and sustainable financing for CHWs

- CHW scale-up initiatives have been experimenting with a range of innovative financing models
  - Federal incentives to local governments to co-invest financing floors or matching grants
  - Integrating parallel CHW programs for different priorities has led to new approaches to joint budgeting
  - CHWs working as social entrepreneurs, contracted by CSOs
- Through GFF, we are integrating CHW investments into national health financing strategies for UHC
  - Realizing full benefits of CHWs requires shifting greater resources toward frontline health services
  - Improving local payment policies to improve retention of CHWs
  - Planning transition from internationally-financed to domestically-financed programs

Challenge: Experience points to limits of adopting a stand-alone focus on scaling up CHWs for 2030

- Direct focus efforts to date e.g. 1 million CHWs in (rural) Africa have met with limited success
- Investor appetite for investment in increasing “results” greater than for “jobs”
- CHWs are too fragmented and context-specific to be an overarching investment focus
  - no clear standards exist for classifying or counting CHWs
- Financial models for paying scaled-up CHW workforce need more testing
  - Should they be on government payroll? Or contract employees? Or other?
- Financial models for educating/training CHWs not amenable to scale investments
  - Linguistically fragmented, too much on-the-job training

Summary



- There is growing evidence on the contribution of CHWs to improved health outcomes and health systems performance, and as an important source of inclusive growth and formal sector jobs for women and youth.
- Scale up of CHW programs as a key pillar to achieving goal of UHC by 2030, and particularly to improving Primary Health Care access and performance.
- Rather than create a stand-alone CHW initiative, accelerate CHW scale up as an explicit, integrated focus of a broader community health system.
- Progressing towards creating a sustainable finance strategy is an important step in consolidating and integrating Community Health Systems.