Benefits and limitations of rigorous cost analyses in community health

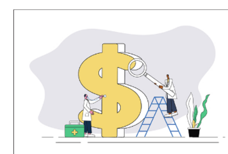
The global rise in non-communicable diseases presents several unique challenges to health systems; these diseases are many, their causes are multifactorial, and addressing them requires various coordinated interventions. Hypertension is a notable example; in many countries, the proportion of patients who successfully navigate the care cascade, from screening to awareness to linkage with care to retention in care to clinical control, is extremely low. In rural Lesotho, for example, one in three adults with hypertension are not aware of their condition and have not started treatment, and only half of adults with hypertension have adequate blood pressure control.[1] Although these observations highlight a substantial gap in relation to the 80-80-80 goal (80% screened, 80% on treatment, and 80% having clinical control),[2] the situation is far worse in other low-income settings.[3] The standard of care in many of these settings, with the majority of health-care delivery being facility-based and relying on patients to seek care, is simply not built for purpose.

In *The Lancet Primary Care,* Nicolò Spaolonzi and colleagues[4] present cost–consequence analysis data from ComBaCaL (Community Based Chronic Care Lesotho), which is a collaborative programme between Lesotho and Switzerland that develops, tests, and shares innovative approaches for expanding quality chronic disease care by, for example, developing and testing an open-source community health toolkit to aid community health workers (CHWs) screen people in rural communities for hypertension and diabetes. Although all study outcomes are not yet available, the Article by Spaolonzi and colleagues offers insights on the potential role of CHWs in the first step of the care cascade: screening. This form of active case finding, already seen in various other contexts, shows the unique functionality that CHWs are best placed to contribute, largely due to their invaluable positionality and availability.[5] In their cost–consequence analysis, Spaolonzi and colleagues assessed the screening coverage of the intervention, and provide details including lists of exact inputs, their related costs, and sensitivity analyses of different scenarios. With this information, future programme designers and implementers might be able to develop more effective plans that could yield the greatest value from health-related investments.

Such planning, however, is likely to be challenged by further, more complex questions that are not yet addressed by these data. Although CHWs are often celebrated for their contributions, health financing rarely reflects their true value. A 2021 report estimated the funding gap for at-scale CHW programmes in sub-Saharan Africa to be US$5·4 billion annually.[6] Indeed, millions of CHWs are not salaried, supervised, supplied, or offered specific training. Achieving these inputs is the focus of ongoing advocacy efforts, but too many CHWs are currently working as unsupported volunteers. Indeed, they are often overwhelmed with the need to care for community members who might present with a wide variety of issues. For instance, hypertension is important, but it is only one of the many conditions encountered by CHWs. Experience and common sense suggest that simply adding new tasks to an already busy docket might have the unintended consequence of worsening patient outcomes overall. As such, the costs of comprehensive programmes at scale are related to not only the direct costs reported in this study, but also the so-called opportunity costs—ie, the impact of shifting focus from one effort rather than another, or to one non-communicable disease instead of, for instance, maternal-child health or another infectious disease.

If integrated well, however, a new focus on hypertension and diabetes, coupled with novel diagnostic and disease-management skill sets, might be valued by community members and could further elevate the standing of CHWs in their communities. Nevertheless, every advance could meet unanticipated disruptions. For instance, will CHWs equipped with medical diagnostics and disease-management algorithms lean into a medicalisation of their role, leaving behind their more preventive and community advocacy talents? Will other medical providers be threatened by the encroachment on their therapeutic turf, especially if these skills are reimbursable for financial profit? Will the health system at the receiving end of active case finding be ready to receive an influx of new patients?

The Lesotho Government is outlining an ambitious roadmap in their Community-based Health Services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For more on the **Community Health Impact Coalition**, see https://joinchic.org/

For more on **ComBaCaL**, see https://www.combacal.org/

Strategy 2025–29 and has already shown, through previous CHW programme reform efforts, that community health in Lesotho can be a model for other countries to follow.[7] As implementers, we have found that some questions would be best answered by involving CHWs themselves in the design process. For instance, they will know better than most about what protocols will work best on the ground and what rhythm of community engagement will be most acceptable. We commend Spaolonzi and colleagues for the insights offered by their research, but also the implementers and policy makers in Lesotho who are at the cutting edge of innovative health system design and the CHWs who are at the forefront of health-care delivery.

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1 Fernández LG, Firima E, Gupta R, et al. Awareness, treatment, and control among adults living with arterial hypertension or diabetes mellitus in two rural districts in Lesotho. *PLoS Glob Public Health* 2024; **4:** e0003721.

2 Pickersgill SJ, Msemburi WT, Cobb L, et al. Modeling global 80-80-80 blood pressure targets and cardiovascular outcomes. *Nat Med* 2022; **28:** 1693–99.

3 Stein DT, Reitsma MB, Geldsetzer P, et al. Hypertension care cascades and reducing inequities in cardiovascular disease in low- and middle-income countries. *Nat Med* 2024; **30:** 414–23.

4 Spaolonzi N, Gupta R, Sanchez-Samaniego G, et al. Costs and coverage of community health worker-led hypertension and diabetes screening in rural Lesotho (ComBaCaL): cost–consequence analysis of a cohort study. *Lancet Prim Care* 2025; **1:** 100034.

5 Khetan AK, Purushothaman R, Chami T, et al. The effectiveness of community health workers for CVD prevention in LMIC. *Glob Heart* 2017; **12:** 233–43.e6.

6 Gichaga A, Masis L, Chandra A, Palazuelos D, Wakaba N. Mind the global community health funding gap. *Glob Health Sci Pract* 2021; **9** (suppl 1)**:** S9–17.

7 Andom AT, Gilbert HN, Yuen CM, et al. The impact of the Lesotho health reform in the re-structuring of the village health workers program. *BMC Health Serv Res* 2025; **25:** 124.