The case for community health workers in high-income countries

Azeb Gebresilassie Tesema, Dulce Osório, Rohina Joshi

Health systems in high-income countries (HICs) face multiple complex challenges, including ageing populations, multimorbidity, workforce shortages, and increasing health-care costs. Some of these challenges can be addressed by community health worker (CHW) programmes that extend first-contact access, bridge gaps in the social determinants of health, and reinforce continuity of care in the community. Although the recognition of CHWs is growing across HICs, their role remains fragmented, inconsistently financed, and often limited to pilot initiatives or marginalised populations. In this Viewpoint, we highlight the need for integrated CHW programmes in HICs that could collaboratively work with interprofessional primary care teams and communities to provide holistic, person-centred primary health care. We propose embedding CHW programmes within the existing health systems and provide a range of potential community-based services for the population. To optimise the contribution of CHW programmes to health-care systems, contextualised system-wide investments and reforms are needed, including strong political commitment, reliable funding, clear role descriptions, and accountability mechanisms. Although lessons can be taken from programmes in low-income and middle-income countries, repositioning CHW programmes as an integral part of primary care teams in HICs should be grounded in the experiences and insights gained from existing small-scale CHW programmes in these countries. A shift towards community-centred primary health care is essential if health systems in HICs are to respond to social and structural inequities in accessing health care, improving health outcomes, and achieving the UN Sustainable Development Goals.

Lancet Prim Care 2026; 2: 100068

Published Online January 12, 2026
https://doi.org/10.1016/j.lanprc.2025.100068

School of Population Health, Faculty of Medicine and Health, University of New South Wales, Sydney, NSW, Australia (A G Tesema PhD, D Osório MD, Prof R Joshi PhD); **The George Institute for Global Health, Sydney, NSW, Australia** (A G Tesema, Prof R Joshi); **Faculty of Medicine and Health Sciences, Walter Sisulu University, Mthatha, South Africa** (Prof R Joshi)

Correspondence to:
Prof Rohina Joshi, School of Population Health, Faculty of Medicine and Health, University of New South Wales, Sydney 2031, NSW, Australia
rohina.joshi@unsw.edu.au

For more on the **Declaration of Alma-Ata** see https://www.who.int/publications/i/item/declaration-of-alma-ata

Introduction

High-income countries (HICs) such as Australia, Canada, and the UK have long been recognised for their strong health systems and high quality of life for their population.[1] These countries have strong primary care systems that are augmented by robust secondary and tertiary health services, underpinned by established referral pathways.[1] Their health systems are characterised by strong infrastructure, advanced electronic health-record systems, and financial protection under universal health coverage, yet they have faced increasing financial pressures since the COVID-19 pandemic. Most HICs benefit from a favourable skilled health professional-to-population ratio. However, workforce maldistribution remains a persistent challenge, with rural and remote regions frequently lacking equitable access to health-care services compared with urban regions.[1,2]

As HICs undergo demographic transition, the needs of the ageing population are growing, with an increasing prevalence of chronic diseases, especially multimorbidity. Many HICs, often with large multicultural societies, are experiencing increasing inequities in health outcomes due to a range of barriers to health-care access, such as language and cultural difficulties, systemic discrimination and marginalisation, social stigmatisation, and an absence of comprehensive approaches to address social determinants of health.[3,4] The increasing prevalence of comorbidities, combined with rising health-care costs, indicates an unsustainable future in which most countries will not be able to afford higher rates of hospitalisation and the associated increasing health-care costs. The COVID-19 pandemic further strained health systems by exacerbating workforce fatigue, psychological stress, and burn-out. Many HICs now face severe health workforce shortages, leading to intensified recruitment from low-income and middle-income countries (LMICs) and raising concerns about global workforce equity and sustainability.[2,5]

These challenges highlight the need for better workforce planning and stronger investment in public health infrastructure, with a focus on prevention and primary health care (PHC) services. They also reinforce the vision of the Declaration of Alma-Ata, highlighting the importance of community health for better prevention and better coordination of services, with person-centredness as a core value. Based on this context, in this Viewpoint, we highlight the need for community health worker (CHW) programmes that can work collaboratively with communities, PHC teams, and hospitals to address cultural, social, and structural inequities in accessing health care and outcomes in HICs.

CHW programmes and learning from LMICs

CHW programmes are typically initiatives that train and support CHWs to deliver basic health promotion, prevention, and other health-care services. WHO defines CHWs as health-care providers who live in the community they serve and receive lower levels of formal education and training than professional health-care workers such as nurses and doctors.[6–8] The American Public Health Association defines a CHW by focusing on their relational and cultural role as a public health worker who is a trusted member of the community and has a deep understanding of the community they serve. This trusting relationship enables CHWs to serve as liaisons, links, or intermediaries between health and social services and the community, to facilitate access to health-care services and improve the

quality and cultural competence of service delivery.[9] CHWs have an innate understanding of the community and are cultural brokers between the community and the health system. In addition, they have a range of responsibilities from prevention and promotion to basic management, rehabilitation, and palliation, and often share tasks with nurses and other health-care providers. CHWs are crucial in addressing the social determinants of health in underserved populations.[10]

The concept of CHWs came from LMICs, where they were primarily used to fill health-workforce gaps. The CHW model gained attention after the Declaration of Alma-Ata and, since then, the model has transformed considerably, with some countries providing detailed training and job descriptions. Notable programmes that reflect similar approaches include India's Accredited Social Health Activists, Bangladesh's *Shasthya Shebikas*, Indonesia's *Kader Kesehatan*, and Ethiopia's Health Extension Workers.[7,11–13] CHWs have contributed to considerable improvements in health outcomes, including a reduction in maternal mortality, an increase in immunisation uptake, and a reduction in child mortality in many LMICs.[13] Since 2010, the role of CHWs has expanded to include the prevention and management of non-communicable diseases, which are now the leading causes of premature death and disability.[14,15] CHWs are also recognised as a crucial resource to provide safe and effective care in culturally appropriate ways, and to reduce health inequities.[6] The success of CHW programmes in LMICs has been driven by strong governance, sustained political commitment, and an enabling policy environment. However, many of these programmes have faced challenges related to inadequate funding, unclear roles and responsibilities, inadequate remuneration, and insufficient labour rights for CHWs.[11,13]

Roles and functions of CHWs in HICs

Although there are no system-wide examples of HICs where community health is regarded as the mainstream model,[10] Australia, Canada, the UK, the USA, and others have used CHWs to address the needs of specific demographic groups within their populations such as culturally and linguistically diverse and Indigenous populations (appendix pp 1–6).[8,10,16–21] Despite the growing recognition of their contributions, CHWs continue to be underused. This underuse is often linked to a paucity of standardised accreditation, regulatory frameworks, formal policy integration, and consistent funding.[16] CHWs perform a wide range of tasks tailored to the needs of the communities they serve and the mandates of the organisations they work for. Additionally, a range of contextual differences between and within these countries, such as health-system structure, governance, and funding mechanisms, have shaped the development and function of CHW-related programmes. For example, in Australia, the Aboriginal health workforce operates through community-controlled health organisations,[19] whereas Canadian community health representatives work within federal–provincial arrangements.[16]

CHWs often serve as health system navigators and assist individuals in accessing appropriate health care and social services. They support patients in navigating complex health-care and social-care systems and guide them in accessing preventive and routine care, helping to reduce avoidable emergency visits and hospitalisations.[18,22] Moreover, CHWs serve as cultural brokers by providing health-care workers with contextual and cultural insights that promote cultural competence and enhance patient–provider communication and trust. In their health education role, CHWs deliver culturally tailored information on chronic-disease prevention, healthy behaviours, and medication adherence and support community-based awareness and prevention campaigns.[8,10,16–18,23] In Australia, for example, through the Aboriginal Community Controlled Health Services, CHWs have a formal role within Indigenous-led health services, delivering comprehensive PHC services that are culturally safe and effective.[3,18,19] Similarly, in Canada, community health representatives often focus on specific groups, including Indigenous populations, migrants, and refugees, contributing to overcoming cultural barriers and improving access to health services.[3,16,19] In the USA, CHWs operate in clinics, homes, and community environments, delivering services that range from disease prevention to system navigation.[20,24] In these countries, where substantial disparities in health outcomes persist among specific subpopulations despite the existence of advanced health-care infrastructure, CHWs are increasingly important in supporting underserved populations, improving access to care, and addressing social determinants of health.

Limitations of integration of CHWs into broader health systems in HICs

Despite the growing recognition of their value, CHW programmes remain insufficiently integrated into broader health systems in many HICs. Although several countries have established various community health services, these initiatives often operate at the periphery of mainstream, biomedical-driven health-care systems and do not comprehensively engage with communities.[8,10,16–20,23] Instead, these programmes are typically reserved for disadvantaged regions or specific marginalised populations such as Indigenous communities, migrants, and refugees.[3,17] Additionally, CHW programmes in these countries often face structural and systemic barriers that hinder their full development and integration. These challenges include neoliberal policy orientation that shapes priorities away from community approaches, dominance of curative models of care with an emphasis on treatment over prevention and health promotion, limited recognition of the value of community-based care, and a paucity of professional qualifications and recognition of CHWs.[3,17,18] Short-term funding models are further challenges that

See Online for appendix

undermine the scalability and long-term impact of CHW programmes.[18] In terms of specific country experiences, in the USA, the CHW programme only gained recognition and visibility in 2010 through the creation of the US Bureau of Labor Statistics standard occupational classification and inclusion as a health profession in the Patient Protection and Affordable Care Act, despite operating since 1967. In Canada, the services provided by CHWs are unrecognised and unregulated. In Australia, the Aboriginal health workforce is a recognised cadre but faces multiple implementation challenges.[19] CHWs working with non-Indigenous people in Australia are minimally used, and these programmes are not well researched. These barriers collectively restrict the potential of CHWs to meaningfully and sustainably contribute to health systems in HICs, despite evidence of their effectiveness in improving access, equity, and health outcomes.

CHW programmes to reduce gaps in access to health care and outcomes

Given the population needs of HICs, growing health-care costs, and effectiveness of CHW programmes, now is an opportune time for policy makers to embed this collaborative health-care model into the community, primary care teams, and hospitals to improve population health outcomes.

Apart from benefits in population health, such integration would result in economic savings related to health and increased productivity for health systems in HICs. Rather than focusing on a specific population or community, we propose embedding CHW programmes within health systems, serving as the first point of contact between communities and the health system and providing a range of community-based services for the population. These services include linking individuals to health and social services and promoting culturally safe care. Moreover, CHWs can support behavioural changes, adherence to treatment, and lifestyle modifications for chronic-disease management through home visits and counselling.[17,18,25]

To optimise the contribution of CHW programmes in HICs, contextualised system-wide investments and reforms are needed. Although valuable lessons can be drawn from CHW programmes in LMICs, integrating such programmes into formal health systems in HICs should primarily build on the experiences and insights gained from existing small-scale CHW programmes and initiatives in these countries (panel).[26]

Using World Vision's health-systems assessment and improvement matrix framework, which was designed to evaluate and strengthen community health systems by assessing their components (ie, governance, financing, workforce, and service delivery) to guide integration into broader health systems,[28] there are key areas that should be prioritised to enhance the quality, sustainability, and integration of CHW initiatives.

***Panel:* UK community health and wellbeing workers**

Inspired by Brazil's Family Health Strategy, UK community health and wellbeing workers (CHWWs) were recruited from the local community in London and tasked with conducting regular household visits to approximately 120 households per month, to provide health information, support access to primary care, and connect families with social and community services.[26,27]

The programme is explicitly integrated into primary care networks and coordinated with local authorities, ensuring alignment with the broader health system. CHWWs have four core features: universal (ie, all households in the CHWW's mandate visited), hyperlocal (ie, based around a defined geographical area), comprehensive (ie, cover all issues within a household rather than specific conditions), and integrated (ie, CHWWs work with the primary care team with access to patient records).[27] The model has been scaled in other areas beyond pilot implementation in London. An evaluation of the programme found substantial improvements in cancer screening, immunisation uptake, and health-checking participation, alongside reductions in general practitioner consultations and hospital admissions.[26]

Policy and governance

The health system should formally recognise CHWs within national health strategies, with clear policies that define their scope and links to primary care systems. This process should use lessons from existing global CHW programmes. Establishing and strengthening a dedicated community health unit at the ministry or state level would provide essential leadership and coordination for effective implementation of CHW programmes.

Successful programmes require coordination and integration with the formal PHC system, with some autonomy for CHWs.[29] Programme success is associated with effective integration of the programme into the health system, including supportive supervision, availability and quality of continuous training, and accountability mechanisms. In addition, sufficient and reliable funding is essential for programme implementation and scale-up.[30–32]

Financing

Securing sustainable, long-term financing through national budgets with transparent costing and accountability mechanisms is crucial. Free or low-cost services at the community level are required to improve the accessibility and affordability of services. Providing fair and equitable compensation for CHWs is key in supporting their integration into broader national health systems.

Role and recruitment

CHW roles should be clearly articulated and aligned with local needs. CHWs can be trained and integrated into teams of allied health professionals to support delivery of comprehensive PHC services. Recruitment should prioritise trusted community members who reflect the populations they serve and are equipped to address social and cultural barriers to care. Increasing awareness among health

Search strategy and selection criteria

We searched PubMed and Google Scholar databases from Jan 1, 2010, to July 31, 2025, to identify peer-reviewed and grey literature using a combination of the terms "Community Health Workers", "CHW", "CHW roles", "CHW functions", "CHW programs", and "task sharing", with the names of high-income countries (HICs) as classified by the World Bank 2024–25 income groups (eg, "Australia", "Canada", "Japan", "UK", "USA"), without language restrictions. The search included both MeSH terms and all fields in PubMed. To capture broader evidence, we also consulted the CHW Central database and conducted manual searches of the websites of key global health organisations such as WHO. We also manually searched the reference lists of key articles and reviews to identify additional relevant publications. Inclusion criteria were intentionally broad and focused on documents that described the design, implementation, or evaluation of CHW programmes in HICs and the literature, highlighting roles, functions, training, and integration of CHWs within health systems in HICs. Given the exploratory nature of this Viewpoint, no formal quality appraisal was applied.

professionals and managers about the roles of CHWs can foster their integration into multidisciplinary PHC teams.

Training

Standardised, competency-based training should be provided; tailored to the HIC context; and include core skills in health promotion, system navigation, and chronic-disease support.

For the **CHW Central database** see https://chwcentral.org/resources/

Supervision and performance

Supportive supervision structures should be in place to provide regular feedback, mentorship, and integration with primary care teams, thereby enabling quality assurance and CHW retention.

Referral and linkages

Formal referral pathways between CHWs and higher levels of care should be established where they do not exist and strengthened where they are already in place. Protocols for CHW involvement in multidisciplinary care teams should be established, and mutual recognition and communication between CHWs and primary care staff should be ensured.

Supply chain

CHWs should have access to essential tools and supplies required for their roles and CHW commodity needs should be integrated into federal or state logistics, procurement, and distribution systems. Use of digital technologies can expand the reach and effectiveness of CHW programmes.

Health-information systems

CHW-collected data should be integrated into national health-information systems.

Community engagement

CHW programmes should be co-designed and monitored for community involvement to ensure community trust, relevance, responsiveness, and accountability.

Conclusions

Although medicine and health technology have progressed tremendously, this progress has not benefited society equitably. Health services should move beyond specialist care models, and workforce-care models should ideally focus on prevention using generalist skills and holistic care. This goal can potentially be achieved through community care to support a life-course approach for chronic-disease prevention and management. CHW programmes can promote holistic, preventive, and comprehensive health care; enhance community trust and connections; and lead to better and more cost-effective health outcomes. Given health-care worker shortages, changing demographic and epidemiological needs, and increasing health-care costs, CHW programmes are necessary to deliver equitable, accessible, and sustainable health care. Therefore, harnessing the potential of community-based and interprofessional primary care teams that include CHWs is essential for HICs to achieve the UN Sustainable Development Goals.

Contributors

RJ conceived the paper. DO conducted the literature search and review. All authors wrote the first draft of the manuscript, and AGT and RJ contributed to the subsequent iterations. All authors critically reviewed the manuscript and approved its final submission.

Declaration of interests

We declare no competing interests.

References

1 Tikkanen R, Osborn R, Mossialos E, Djordjevic A, Wharton G. 2020—international profiles of health care systems. December, 2020. https://www.commonwealthfund.org/sites/default/files/2020-12/International_Profiles_of_Health_Care_Systems_Dec2020.pdf (accessed Sept 17, 2025).

2 Organisation for Economic Co-operation and Development. Health at a glance 2023. Nov 7, 2023. https://www.oecd.org/en/publications/2023/11/health-at-a-glance-2023_e04f8239.html (accessed Sept 17, 2025).

3 Baum F, Freeman T. Why community health systems have not flourished in high income countries: what the Australian experience tells us. *Int J Health Policy Manag* 2022; **11:** 49–58.

4 Ogbeiwi O, Ilyas A, Harper M, Khan W. Ethnic disparities in access to mental health services for Black and Asian migrants in major resettlement countries. *J Racial Ethn Health Disparities* 2024; published online Sept 5. https://doi.org/10.1007/s40615-024-02168-w.

5 UN. 55 countries face a health worker crunch linked to COVID-19: WHO. March 14, 2023. https://news.un.org/en/story/2023/03/1134562#:~:text=No%20less%20than%2055%20countries,(WHO)%20said%20on%20Tuesday (accessed Sept 24, 2025).

6 WHO. WHO guideline on health policy and system support to optimize community health worker programmes. Aug 6, 2018. https://www.who.int/publications/i/item/9789241550369 (accessed Sept 24, 2025).

7 Perry HB. Health for the people: national community health worker programs from Afghanistan to Zimbabwe. April, 2020. https://soph.uwc.ac.za/wp-content/uploads/2021/04/PA00WKKN.pdf (accessed Sept 9, 2025).

8 WHO. What do we know about community health workers? A systematic review of existing reviews. April 12, 2021. https://www.who.int/publications/i/item/what-do-we-know-about-community-health-workers-a-systematic-review-of-existing-reviews (accessed Sept 24, 2025).

9 American Public Health Association. Support for community health worker leadership in determining workforce standards for training and credentialing. Nov 18, 2024. https://www.apha.org/policy-and-advocacy/public-health-policy-briefs/policy-database/2015/01/28/14/15/support-for-community-health-worker-leadership (accessed Sept 24, 2025).

10 Perry HB, Zulliger R, Rogers MM. Community health workers in low-, middle-, and high-income countries: an overview of their history, recent evolution, and current effectiveness. *Annu Rev Public Health* 2014; **35:** 399–421.

11 Glenton C, Javadi D, Perry HB. Community health workers at the dawn of a new era: 5. Roles and tasks. *Health Res Policy Syst* 2021; **19** (suppl 3): 128.

12 Oo WH, Gold L, Moore K, Agius PA, Fowkes FJI. The impact of community-delivered models of malaria control and elimination: a systematic review. *Malar J* 2019; **18:** 269.

13 Black RE, Taylor CE, Arole S, et al. Comprehensive review of the evidence regarding the effectiveness of community-based primary health care in improving maternal, neonatal and child health: 8. Summary and recommendations of the expert panel. *J Global Health* 2017; **7:** 010908.

14 Tesema AG, Mabunda SA, Chaudhri K, et al. Task-sharing for non-communicable disease prevention and control in low- and middle-income countries in the context of health worker shortages: a systematic review. *PLoS Glob Public Health* 2025; **5:** e0004289.

15 Joshi R, Peiris D. Task-sharing for the prevention and control of non-communicable diseases. *Lancet Glob Health* 2019; **7:** e686–87.

16 Najafizada SAM, Bourgeault IL, Labonte R, Packer C, Torres S. Community health workers in Canada and other high-income countries: a scoping review and research gaps. *Can J Public Health* 2015; **106:** e157–64.

17 Van Iseghem T, Jacobs I, Vanden Bossche D, et al. The role of community health workers in primary healthcare in the WHO-EU region: a scoping review. *Int J Equity Health* 2023; **22:** 13.

18 Javanparast S, Windle A, Freeman T, Baum F. Community health worker programs to improve healthcare access and equity: are they only relevant to low-and middle-income countries? *Int J Health Policy Manag* 2018; **7:** 943–54.

19 Jeyakumar R, Patel B, Coombes J, Madden T, Joshi R. "We're on the ground, we know what needs to be done": exploring the role of Aboriginal health workers in primary health care. *Front Public Health* 2023; **10:** 1010301.

20 Washburn DJ, Callaghan T, Schmit C, Thompson E, Martinez D, Lafleur M. Community health worker roles and their evolving interprofessional relationships in the United States. *J Interprof Care* 2022; **36:** 545–51.

21 Knowles M, Crowley AP, Vasan A, Kangovi S. Community health worker integration with and effectiveness in health care and public health in the United States. *Annu Rev Public Health* 2023; **44:** 363–81.

22 Mistry SK, Harris E, Harris M. Community health workers as healthcare navigators in primary care chronic disease management: a systematic review. *J Gen Intern Med* 2021; **36:** 2755–71.

23 Abdel-All M, Thrift AG, Riddell M, et al. Evaluation of a training program of hypertension for accredited social health activists (ASHA) in rural India. *BMC Health Serv Res* 2018; **18:** 320.

24 Lohr AM, Ingram M, Nuñez AV, Reinschmidt KM, Carvajal SC. Community–clinical linkages with community health workers in the United States: a scoping review. *Health Promot Pract* 2018; **19:** 349–60.

25 Allen LN, Rasanathan K, Mash R, Uribe MV, Martinez-Bianchi V, Kidd M. Models of global primary care post-2030. *Lancet Prim Care* 2025; **1:** 100027.

26 UK Government. Fit for the Future. 10 Year Health Plan for England. July, 2025. https://assets.publishing.service.gov.uk/media/6888a0b1a11f859994409147/fit-for-the-future-10-year-health-plan-for-england.pdf (accessed Sept 24, 2025).

27 Tredinnick-Rowe J, Byng R, Brown T, Chapman D. Piloting a community health and well-being worker model in Cornwall: a guide for implementation and spread. *BMC Prim Care* 2024; **25:** 367.

28 World Vision. Health systems: assessment and improvement matrix (S-AIM). 2023. https://preprod.wvi.org/sites/default/files/2023-05/S-AIM%202023%20Draft%20May%202023.pdf (accessed Sept 8, 2025).

29 Schneider H. The governance of national community health worker programmes in low- and middle-income countries: an empirically based framework of governance principles, purposes and tasks. *Int J Health Policy Manag* 2019; **8:** 18–27.

30 Ministry of Health Ethiopia. Realizing universal health coverage through primary health care: a roadmap for optimizing the Ethiopian health extension program 2020–2035. July, 2020. http://repository.iphce.org/handle/123456789/1176 (accessed Sept 17, 2025).

31 Kok MC, Dieleman M, Taegtmeyer M, et al. Which intervention design factors influence performance of community health workers in low- and middle-income countries? A systematic review. *Health Policy Plan* 2015; **30:** 1207–27.

32 Hill Z, Dumbaugh M, Benton L, et al. Supervising community health workers in low-income countries—a review of impact and implementation issues. *Glob Health Action* 2014; **7:** 24085.