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Primary Healthcare in South and Southeast Asia

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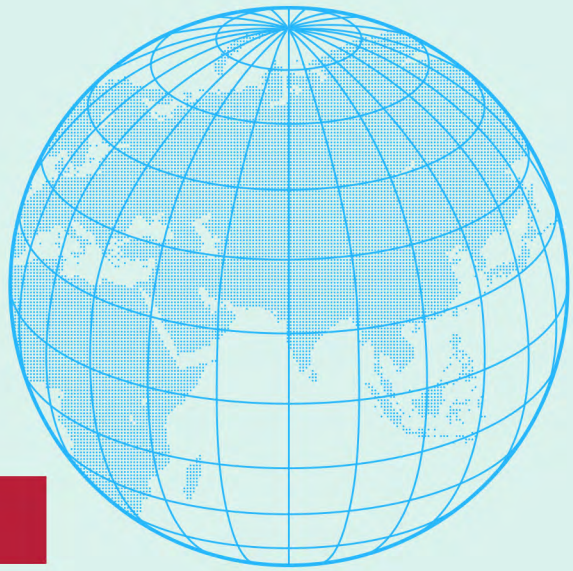

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Designed by Umesh Kumar

Primary Healthcare in South and Southeast Asia

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Abbreviations

AAM	Ayushman Arogya Mandir
ABDM	Ayushman Bharat Digital Mission
ANHSS	Asia Network for Health Systems Strengthening
ANM	Auxiliary Nurse Midwife
ASEAN	Association of Southeast Asian Nations
ASHA	Accredited Social Health Activist
BHW	Barangay Health Worker
BIMSTEC	Bay of Bengal Initiative for Multi-Sectoral Technical and Economic Cooperation
BNS	Barangay Nutrition Scholar
BPJS	Badan Penyelenggara Jaminan Sosial (Indonesia's Social Security Agency)
BRAC	Bangladesh Rural Advancement Committee
BRI	Belt and Road Initiative
CC	Community Clinics
CDC	Centers for Disease Control and Prevention
CHAS	Community Health Assist Scheme (Singapore)
CHC	Community Health Centre
CHE	Current Health Expenditure
CHO	Community Health Officer
CHS	Commune Health Station (Vietnam)
CHV	Community Health Volunteer
CHW	Community Health Worker
CPIRD	Collaborative Project to Increase Production of Rural Doctors (Thailand)
CSBA	Community Skilled Birth Attendant
CSO	Civil Society Organisation
CUP	Contracting Unit for Primary Care
DHC	District Health Centre
DOH	Department of Health (The Philippines)
DRG	Diagnosis-Related Group
ECHO	Extension for Community Healthcare Outcomes (Project ECHO)
EHR	Electronic Health Record
EMR	Electronic Medical Record
FCHV	Female Community Health Volunteer (Nepal)
GDP	Gross Domestic Product
GP	General Practitioner
HiAP	Health in All Policies
HMIS	Health Management Information System
HPH	Health Promoting Hospitals (Tambon HPHs, Thailand)
HRH	Human Resources for Health
HWC	Health and Wellness Centre (India)
ICMR	Indian Council of Medical Research
ILO	International Labour Organization
IMF	International Monetary Fund
IT	Information Technology
JICA	Japan International Cooperation Agency
JKN	Jaminan Kesehatan Nasional (Indonesia's National Health Insurance)
JLN	Joint Learning Network
LGU	Local Government Unit (Philippines)
LMIC	Low- and Middle-Income Countries
MCH	Maternal and Child Health
mHealth	Mobile Health

MOH	Ministry of Health
MOoH	Medical Officer of Health
MoPH	Ministry of Public Health
NCD	Non-Communicable Disease
NGO	Non-Governmental Organisation
NHA	National Health Authority (India)
NHG	National Healthcare Group (Singapore)
NHSRC	National Health Systems Resource Centre (India)
NHSS	Nepal Health Sector Strategy
NRHM	National Rural Health Mission (India)
NUHM	National Urban Health Mission (India)
NUHS	National University Health System (Singapore)
OECD	Organisation for Economic Co-operation and Development
OOPE	Out-of-Pocket Expenditure
P4H	Providing for Health Network
PCC	Primary Care Cluster (Thailand)
PHC	Primary Healthcare
PHCC	Primary Healthcare Centre (Nepal)
PHCPI	Primary Health Care Performance Initiative
PHI	Public Health Inspector
PHM	Public Health Midwife
PHN	Public Health Nurse
PHSEP	Primary Healthcare System Enhancing Project
PLA	Participatory Learning and Action
PMCU	Primary Medical Care Unit (Sri Lanka)
PMJAY	Pradhan Mantri Jan Arogya Yojana
PPP	Public–Private Partnership
PSSP	Primary Healthcare System Strengthening Project
Puskesmas	Pusat Kesehatan Masyarakat (Indonesia's primary health centres)
RCHCIB	Revitalization of Community Healthcare Initiative Bangladesh
RHU	Rural Health Unit (Philippines)
SAARC	South Asian Association for Regional Cooperation
SATUSEHAT	Indonesia's National Health Data Platform
SDG	Sustainable Development Goal
SEARCH	Southeast Asia Regional Collaborative for Health
SG/Healthier SG	Singapore's National Primary Care Transformation Strategy
SHI	Social Health Insurance
TACHS	The Asia Collective for Health Systems
TECNeC	Training for Enhancing Capacities in Neonatal Care (India)
UCHC	Urban Community Health Centres (India)
UCS	Universal Coverage Scheme (Thailand)
UHC	Universal Health Coverage
UMIC	Upper-Middle-Income Country
UNICEF	United Nations Children's Fund
UPHC	Urban Primary Health Centre (Bangladesh)
UPHCP	Urban Primary Health Care Project
UPHCSDP	Urban Primary Healthcare Services Delivery Project (Bangladesh)
VHV	Village Health Volunteer (Thailand)
VHW	Village Health Worker (Vietnam)
VSS	Vietnam Social Security
WHO	World Health Organization

Executive Summary

Primary healthcare (PHC) is considered to be the bedrock of resilient, equitable, and efficient healthcare systems. Evidence suggests that a PHC system that facilitates coordinated care with integration across levels of care can improve health outcomes, enhance financial protection, and reduce burden on hospitals by emphasising prevention, early diagnosis, and community-based care. Therefore, PHC has been considered as central to achieving universal health coverage (UHC) and the Sustainable Development Goals (SDGs).

The importance of PHC has been recognised by South and Southeast Asian countries. Countries have introduced a range of policies and reforms to strengthen their primary care systems. Nonetheless, the performance of primary care varies significantly across the region. Inadequate financing, shortages of healthcare workers, fragmented governance structures, and weak coordination across levels of care are some of the challenges faced by most of the countries in the region.

This paper investigates the state of PHC in 10 countries across South and Southeast Asia: Bangladesh, India, Indonesia, Nepal, Malaysia, the Philippines, Sri Lanka, Singapore, Thailand, and Vietnam. It analyses how institutional arrangements and governance mechanisms influence PHC performance and identifies opportunities for regional collaboration. The analysis focuses on five key levers derived from the UNICEF–WHO analytical framework: political commitment, financial commitment, models of care, health workforce, and community engagement.

The paper compares experiences from these countries and highlights common challenges and approaches that can inform future reforms. The paper argues that stronger regional collaboration can help countries accelerate PHC strengthening through the sharing of knowledge, technical expertise, and institutional innovations.

Changing Health Needs in Asia

The evidence suggests that South and Southeast Asian countries are undergoing major demographic, epidemiological, and social transitions that are reshaping healthcare systems. These changes are strongly correlated with the growing number of cities. The increasing urbanisation is generating new health risks associated with lifestyle changes and environmental pollution. In addition, the proportion of elderly people is increasing, fertility rates are declining, and life expectancy at birth is increasing. All these are related to the emergence of non-communicable diseases (NCDs) such as diabetes, cardiovascular diseases, and cancers, which are becoming the dominant causes of illness and death across the region (Figure ES–1).

The literature suggests that the healthcare system needs to be capable of delivering continuous, coordinated, and preventive care in order to address the emerging needs. However, healthcare systems in the region remain heavily oriented towards hospital-based treatment rather than community-based prevention and primary care. Strengthening PHC is therefore essential to ensure that healthcare systems can respond effectively to emerging health challenges.

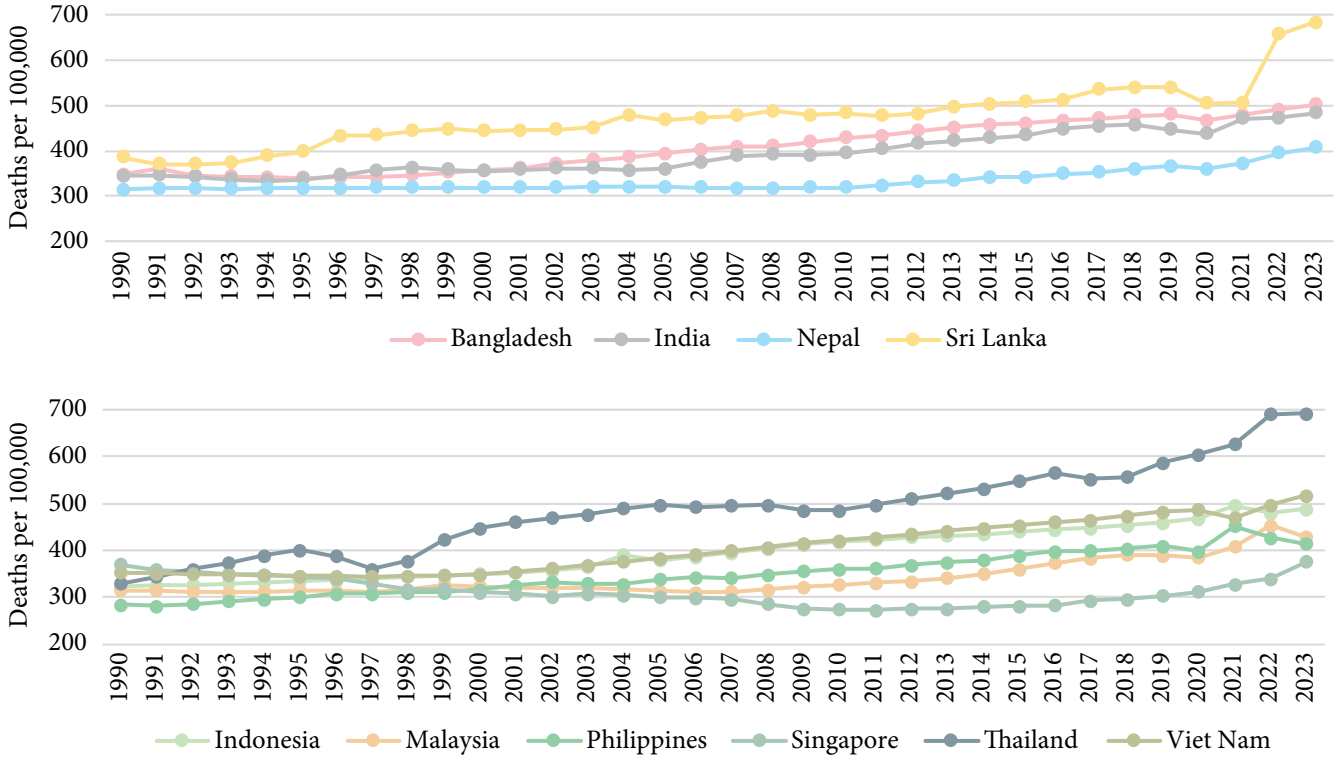
Political Commitment and Financing for Primary Healthcare

All 10 countries included in this study formally recognise PHC as central to achieving UHC. However, the level of political commitment and the extent of investment in PHC vary significantly across the region.

Some countries have demonstrated sustained political leadership in strengthening PHC systems. The Universal Coverage Scheme (UCS) in Thailand represents one of the most successful examples of PHC-oriented health reform in the region. Thailand has expanded access to healthcare through tax-funded financing and strong gatekeeping mechanisms, which eventually has led to reduced out-of-pocket expenditure (OOPE). A long-standing policy of free public healthcare, supported by strong preventive services and a well-developed public health workforce, has been the key characteristic of primary healthcare in Sri Lanka.

Indonesia has expanded health coverage through its national health insurance programme, Jaminan Kesehatan Nasional (JKN), which now covers a large share (~80%) of the population. On the other hand, a strong network of subsidised primary care provisioning is the key characteristic of the Malaysian primary healthcare system.

Figure ES–1: Mortality due to Non-Communicable Diseases in South and Southeast Asia



Source: Institution for Health Metrics and Evaluation (2023).

Note: The data include both sexes and all ages.

It is important to note that, despite these successes, many countries continue to face challenges in various dimensions of the PHC system. Political incentives often favour hospitals and specialised services, which are more visible and politically attractive than preventive care. As a result, PHC systems frequently remain underfunded despite strong policy commitments.

Models of Care, Workforce, and Community Engagement

The literature suggests that the organisation and model of service delivery vary across the region. Bangladesh, Nepal, Sri Lanka, and India rely heavily on public facilities and community health workers (CHWs) to deliver services at the community level. Primary healthcare systems in these countries often achieve strong outreach and community trust but face challenges related to workforce shortages and limited resources.

The mixed public–private systems, where both public and private providers play important roles in delivering primary care, define PHC systems in Thailand, Malaysia, Indonesia, Vietnam, and the Philippines. It has been found that even though the overall PHC systems often provide wider service availability, they also face governance challenges related to regulating private providers and ensuring equitable access.

Singapore represents another model in which private general practitioners (GPs) deliver a large share of first-contact services within a highly regulated system supported by strong digital infrastructure and government subsidies.

Inequity in the distribution of the workforce and overall workforce shortages remain major challenges across all these countries. Health workers are often concentrated in urban areas, leaving rural and remote communities underserved. CHWs play an important role in addressing these gaps by delivering preventive services and supporting outreach activities.

Community engagement mechanisms are also an important feature of many PHC systems in the region. Programmes such as Thailand's Village Health Volunteers (VHVs) and India's Accredited Social Health Activist (ASHA) illustrate how community participation can strengthen accountability and improve responsiveness of health systems.

Key Findings

Useful lessons emerged from the above discussion.

First, strong political commitment is the key to sustained public financing towards PHC systems. Second, even though countries have gone through several policy reforms, fragmentation in governance structures and institutional arrangements persists, which needs to be addressed. Third, several countries have improved workforce shortages; however, inequity in the distribution of the workforce remains. Focusing on CHWs is the key to addressing issues related to workforce shortage. Fourth, Institutionalised community participation can strengthen accountability and improve trust in health systems. Finally, regional collaboration offers an important opportunity for accelerating PHC reforms through shared learning and cooperation.

Pathways for Regional Collaboration

A key argument of this paper is that South and Southeast Asian countries can accelerate progress in PHC through regional collaboration. Although countries differ in economic development and health-system design, they face many common challenges. Therefore, cross-country learning on various institutional innovations can help respective countries to design more effective reforms.

Strengthening Political Commitment and Financing

Thailand's experience with its tax-funded UCS demonstrates how strong political leadership and sustained public financing can strengthen primary care and reduce financial barriers to healthcare. The implementation of the gatekeeping system and strategic purchasing in Thailand is a great example for countries like India, Indonesia, and the Philippines.

The national health insurance programme in Indonesia offers important lessons on expanding health coverage in large and decentralised countries. The integration of primary care services within a national insurance framework in Indonesia offers a crucial lesson for Bangladesh, India, and Nepal.

Malaysia and Sri Lanka demonstrate how long-term political commitment to publicly funded healthcare can support strong PHC systems. These experiences offer lessons for countries seeking to rebalance health spending toward preventive and community-based care.

Improving Models of Care and Governance

Coordination between primary care and hospitals has great potential in improving continuity of care. Thailand offers great insights in terms of coordinated care. The district health system in Thailand illustrates how strong coordination between primary care facilities and hospitals can improve continuity of care. India and the Philippines, which have fragmented health systems, could learn from Thailand's experience in strengthening referral systems.

The managed care in a decentralised healthcare system in Indonesia provides a valuable lesson for India and the Philippines.

Singapore has a regulated mixed public–private primary care model. The model demonstrates how governments can maintain quality and accountability while engaging private providers. Since Malaysia, Vietnam, and India have a large private sector, they could benefit from Singapore's regulatory approaches.

Advancing Digital Primary Healthcare Systems

The Ayushman Bharat Digital Mission (ABDM) in India aims to create a national digital health ecosystem linking electronic health records (EHRs), telemedicine platforms, and digital health identifiers. Bangladesh, Nepal, and Indonesia could learn from India's experience in building large-scale digital health infrastructure.

Singapore's advanced digital health systems demonstrate how integrated EHRs and strong data governance can support high-quality care. Other countries in the region could benefit from Singapore's experience in digital health regulation and interoperability.

The SATUSEHAT platform in Indonesia illustrates how national digital platforms can integrate fragmented health data systems. Countries such as the Philippines and Vietnam could draw lessons from Indonesia's approach to integrating digital tools with health insurance systems.

Strengthening the Primary Healthcare Workforce

India's ASHA inititative demonstrates how CHW programmes can expand access to healthcare services in underserved communities. Countries such as Bangladesh and Nepal could learn from India's experience in scaling and supporting CHW programmes.

The Female Community Health Volunteer (FCHV) programme in Nepal provides an example of how community-based workers can improve maternal and child health (MCH) outcomes. The VHV programme in Thailand also demonstrates how CHWs can contribute to health promotion and emergency response.

Regional collaboration could support workforce development through shared training programmes, exchange initiatives, and regional competency frameworks.

Strengthening Community Engagement

Thailand's National Health Assembly demonstrates how inclusive governance platforms can strengthen community participation in health policymaking. Other countries in the region could explore similar mechanisms to involve citizens in health system planning.

Village Health, Sanitation, and Nutrition Committees in India offer an example of institutionalised community participation at the local level. Community Clinics (CCs) in Bangladesh demonstrate how community-based facilities can serve as accessible entry points for primary care services.

Sharing these experiences across the region can help countries design more responsive and participatory health systems.

To recap, coordinated care is the key to strengthening PHC systems in South and Southeast Asia. Governments should prioritise greater public investment in primary care and preventive services. Strong governance and regulatory frameworks are also needed to improve coordination between public and private providers. Investment in the health workforce should focus on training, retention, and the equitable distribution of health workers. Digital health systems should be strengthened to improve data integration, service coordination, and the monitoring of PHC performance. Regional collaboration platforms should likewise be expanded to support knowledge sharing, technical cooperation, and joint learning across countries. By combining national reforms with regional cooperation, countries in South and Southeast Asia can build stronger PHC systems that are more equitable, resilient, and responsive to the changing health needs of their populations.

1. Introduction

Primary healthcare (PHC) is widely regarded as the bedrock of resilient, equitable, and efficient healthcare systems. A growing body of evidence indicates that PHC systems that enable coordinated care and integrate services across different levels can improve health outcomes, strengthen financial protection, and ease the burden on hospitals by prioritising prevention, early diagnosis, and community-based care. Despite this, countries across Asia demonstrate varying degrees of progress in implementing PHC. Many continue to face persistent challenges, even as others have adopted innovative approaches that provide valuable lessons. This diversity creates an opportunity to learn from experiences within the region and to identify pathways for strengthening PHC by combining regional insights with specialised technical expertise.

This paper aims to (1) map the state of PHCs across 10 countries in South and Southeast Asia, with a particular focus on institutions and governance structures; (2) identify strengths, weaknesses, and common patterns across the region that influence PHC performance; and (3) highlight areas of synergy and opportunities for regional collaboration, ultimately contributing to a shared regional agenda on PHC.

Although many regional analyses have assessed country performance on specific PHC components, few have compared how institutional and governance arrangements shape the effectiveness of PHC reforms or explored the scope for cross-country cooperation. By synthesising lessons, gaps, and opportunities across 10 countries—Bangladesh, India, Indonesia, Nepal, Malaysia, the Philippines, Singapore, Sri Lanka, Thailand, and Vietnam—the paper ultimately seeks to shape a South and Southeast Asia-wide narrative on PHC. In doing so, it also provides the groundwork for the PHC vertical of The Asia Collective for Health Systems (TACHS), a platform dedicated to fostering regional dialogue and cooperation. This contribution helps build a cohesive "Asia voice" on PHC, guiding strategies for regional collaboration and knowledge sharing.

The paper analyses the condition of PHC by focusing on five essential factors. These factors comprise a blend of two strategic levers and three operational levers as recognised by the United Nations Children's Fund (UNICEF) and World Health Organization (WHO). The analysis builds upon recent regional studies, including *The Lancet* (2024) series on Primary Health Care in South Asia and UNICEF's Primary Health Care Landscape Analysis for East Asia and the Pacific (2023), while extending their scope to compare trends across both sub-regions and to focus specifically on institutional and governance mechanisms.

The discussion, therefore, underscores the importance of regional mechanisms such as the Association of Southeast Asian Nations (ASEAN), South Asian Association for Regional Cooperation (SAARC), and the Asia Pacific Observatory in enhancing partnerships that can advance a comprehensive regional agenda. This agenda aims to tackle shared challenges, including the impact of rapid economic growth, demographic shifts, and urbanisation, which are transforming the demand for PHC, while also addressing ongoing issues such as fiscal constraints and the uneven distribution of the workforce. In doing so, it seeks to promote joint learning on workforce planning, digital interoperability, and PHC financing reforms, reflecting the enormous diversity in scale, institutional design, and political economy of Asia's health systems.

1.1 Context

There is compelling evidence that primary care improves health outcomes, health system efficiency, and health equity (WHO, 2018). Recent evidence highlights the imperative of a PHC approach in building a resilient health system, especially in the wake of the COVID-19 pandemic (Mosadeghrad et al., 2024; WHO 2025). Together, they reaffirm PHC as the cornerstone of strengthening health systems. PHC-oriented health systems are organised and operated to attain the highest level of health possible for all, by maximising equity and solidarity through a whole-of-government and whole-of-society approach. The primary care process supports first-contact, accessible, continued, comprehensive, and coordinated patient-focused care. Health systems built on the foundation of PHC are thus essential to achieve UHC, resilience, and equity (WHO, 2018).

As set out in the Alma-Ata Declaration of 1978, PHC is essential care that is accessible, integrated, community-based, and equitable. The principles of Alma-Ata were reinforced in the Astana Declaration

of 2018, which further reaffirmed the global commitment to prioritising sustainable PHC as a key strategy for achieving SDGs and UHC (WHO, 2018).

There is widespread and sustained commitment to PHC across countries in Asia. Indeed, many countries in the South and Southeast Asian region helped shape the Alma-Ata Declaration, drawing from their own experience of PHC. Countries like Sri Lanka, Bhutan, Thailand, and Malaysia have been global exemplars, institutionalising multi-sectoral, people-centred approaches that were rooted in their respective contexts and governance arrangements.

However, progress has been uneven across countries in the region. Resource-constrained health systems in the region have been confronted with difficult choices between advancing disease-specific programmes, often driven by global prioritisation processes, and building public-health-oriented administrations at local levels. Even relatively better-resourced geographies have tended to invest much more in the provision of acute and episodic curative healthcare at the primary level rather than the holistic PHC envisioned at Astana (Foo et al., 2023; Khoo, Lim & Vrijhoef, 2014). Additionally, newer challenges associated with demographic, epidemiological, and climatic transitions are forcing countries to rethink their PHC approaches.

A scoping analysis of PHC implementation during the COVID-19 pandemic found that equity-informed financing models, health systems, and governance frameworks were crucial enablers for multi-sectoral PHC rather than discrete service-focused primary care. The analysis also highlighted governance mechanisms that strengthened linkages between policymakers, civil society, non-governmental organisations (NGOs), community-based organisations, and private sector entities (Edelman et al., 2021). This was also reinforced by a study that reported social capital gains from more responsive governance practices and a committed health workforce, which resulted in increased trust in health services (Zakoji & Sundararaman, 2021).

A review of best practices of PHC in Southeast Asia in 2021 (UNICEF, 2023) identified several successful PHC reforms that included health in many policies, strengthening governance structures from the global to the local level, reallocation of resources from hospitals to primary care, and engagement of civil society for decision-making and community engagement (UNICEF, 2023). A primary finding from this review was that approaches to the programming of health were most successful when operational (health workforce, digital health interventions, and models of care) and strategic (political leadership, governance and policy, resource allocation, and engagement of communities) levers were interlinked" (UNICEF, 2023; WHO, 2021). Thus, effective PHC is underpinned by well-governed institutions focused on equity and people-centred care. Yet most PHC initiatives and research tend to focus on what (technical solutions) and less on the how (governance and institutions).

South–South technical collaborations and partnerships utilising lessons from regional countries on the development and implementation of PHC systems and approaches are a powerful strategy to reinforce resilient health systems in the region. Regional networks in ASEAN and the Pacific Islands Forum can also play important roles in advocating for better access to services for disadvantaged populations, including migrants, refugees, and stateless populations (UNICEF, 2023).

Asia presents a highly heterogeneous landscape in terms of ethnicity, culture, governance, population size, economies, and bureaucratic structures. Despite this diversity, countries across the region share many commonalities, particularly in developmental challenges. The urgency of threats such as climate change, epidemiological shifts, and demographic transitions is blurring borders and underscoring the need for collaboratively crafted solutions. This makes the "Asia story" increasingly relevant, with growing interest in examining the region's shared trajectories and opportunities for cooperation. The region's importance is further highlighted by its contribution to the global economy. Asia accounted for 60% of global growth in 2024 (International Monetary Fund [IMF], 2025). South Asia contributed 22.1% of the global labour force; Southeast Asia and the Pacific contributed another 10% of the global labour force (International Labour Organization [ILO], 2025). This makes Asia a region of both regional and global significance, and the rising disease burden for NCDs in the region calls for a closer look at PHC, positioning health systems as a crucial driver of sustainable growth and resilience.

The paper is organised into five main sections. Section 2 outlines the analytical approach, explaining how the analysis is structured around the strategic and operational levers identified by UNICEF and the

WHO to assess progress in PHC. Section 3 examines major regional trends shaping PHC systems, including demographic and epidemiological transitions, financing patterns, and recent health system reforms. Section 4 provides a detailed analysis of the state of PHC across the 10 focus countries, examining political commitment, financing arrangements, models of care, workforce capacity, and mechanisms for community engagement. Finally, Section 5 identifies opportunities for regional collaboration and outlines practical pathways for cross-country learning and cooperation to strengthen PHC systems across South and Southeast Asia.

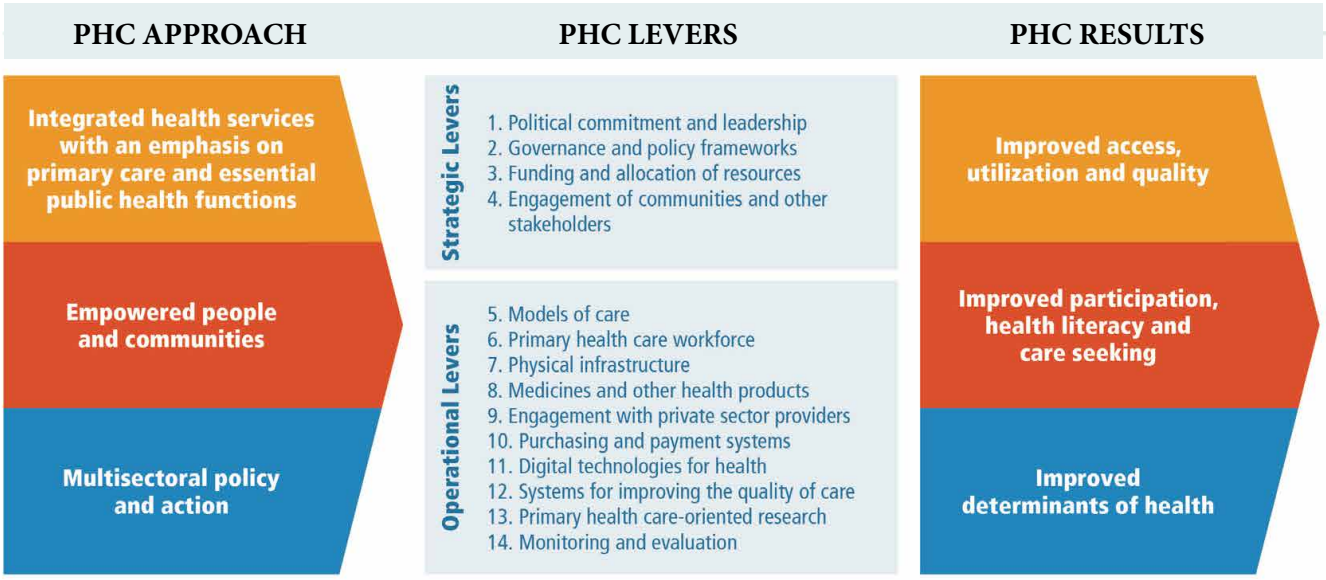
2. Analytical Approach

The WHO has identified three interrelated and synergistic components of PHC—integrated health services focusing on the delivery of comprehensive primary services; multi-sectoral policies and actions to address the upstream determinants of health; and engaging empowered people and communities in taking charge of their health and well-being. The strategic and operational levers that are necessary for progress across these three components have been further identified to support countries in accelerating progress on PHC (Figure 1).

The 10 Asian countries were selected to represent diversity in terms of level of economic development, stage of health reforms, type of health systems—publicly delivered vs mixed health systems, and health outcomes. The analysis is structured around the strategic and operational levers identified by UNICEF and WHO to accelerate PHC implementation.

Literature review is the main method applied in this paper. Policy documents, official sources, and academic research from the selected countries have been reviewed. It draws on two key regional studies: *The Lancet* (2024) series on Primary Health Care in South Asia and UNICEF's (2023) Primary Health Care Landscape Analysis for East Asia and the Pacific.

Figure 1: Primary Care Theory of Change (Operational Framework for Primary Healthcare): Transforming Vision into Action



Source: United Nations Children's Fund; World Health Organization (2020).

Note: PHC = primary healthcare; UHC = universal health coverage; SDG = Sustainable Development Goal; CHW = community health worker.

While these studies provide detailed regional insights, unlike earlier region-specific assessments, this analysis foregrounds governance and institutional processes as cross-cutting determinants of PHC performance.

This review builds on existing bodies of work to consolidate findings across both South and Southeast Asia, offering a broader comparative perspective. Furthermore, the analysis focuses on institutional and governance mechanisms, which are not analysed in detail in the existing literature, identifying key trends, innovations, and gaps that could inform the development of a collaborative agenda.

3. Trends Across the Region

The countries included in this analysis vary across Gross Domestic Product (GDP) (ranging from a low of around US$5,000 per capita Public–Private Partnership [PPP] to a high of more than US$140,000), population (from a low of 5 million people to a high of approximately 1.5 billion), and PHC expenditure. Thus, the selected countries are a group of lower-middle-income countries and high-income ones. Despite different contexts, the challenges across many are similar.

3.1 Emerging Shifts

Demographic Transition: Countries in South and Southeast Asia are experiencing demographic shifts that have significant implications for health systems. These transitions are visible in most countries, with falling fertility rates (over 50% in Indonesia over four decades and 49% in Malaysia over three decades), and an expected sharp rise in the elderly population (WHO, 2024). This will have implications for added demands on the health and social care systems.

Epidemiological Transition: NCDs are rising across the region, reflecting a shift in disease burden from infectious diseases to chronic conditions (Table 1). While the burden of NCDs has increased (diabetes-related deaths in Indonesia increased by 50% between 2009 and 2019, and eight of the 10 leading causes of death in Malaysia are now attributable to NCDs), the challenge of infectious diseases continues (tuberculosis and diarrhoeal diseases remain in the top 10 causes of mortality in Indonesia). With neonatal disorders accounting for 50% of all deaths in the first year of life, Indonesia faces a triple burden of disease. South Asia is no different, with an escalating burden of NCDs and mortality rates ranging from 66% to 83%. Despite policies, guidelines, and action plans to combat NCDs, the health system's preparedness for addressing chronic conditions remains weak.

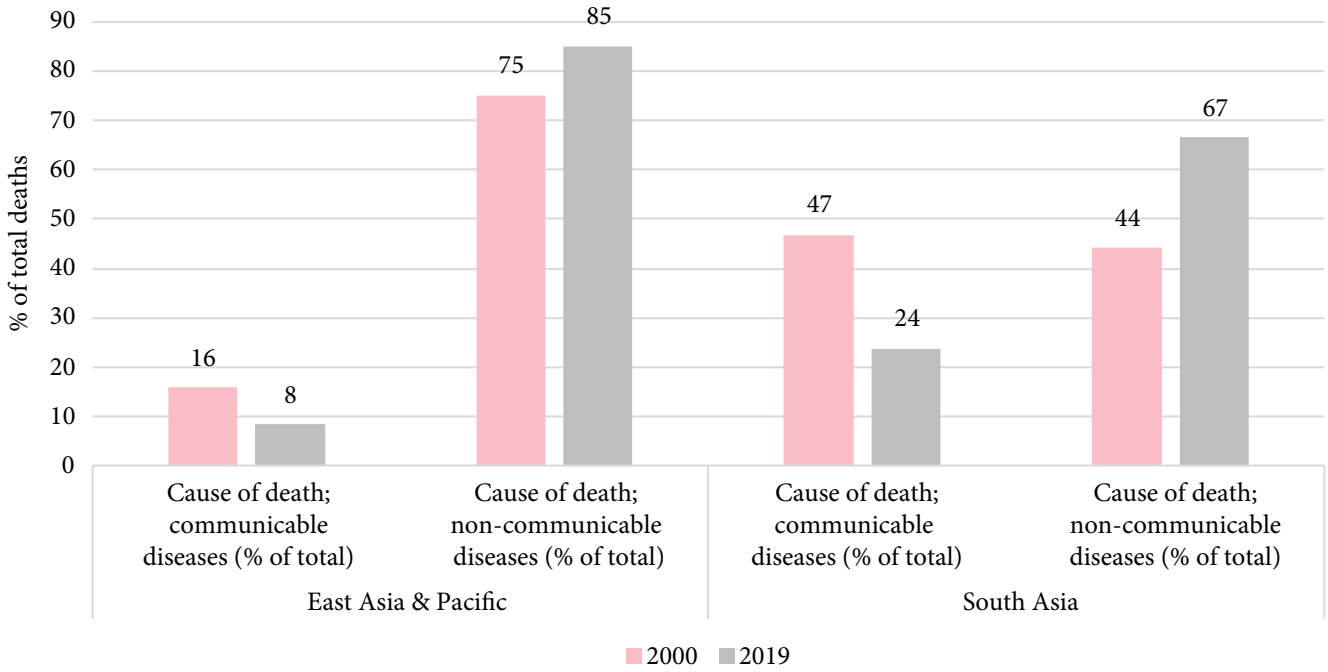
Table 1: Country Profile

Country Status	Country	GDP per capita (PPP, 2022) (US$)	Demographics (population)	CHE as % of GDP	Median age (2025) (years)
LMIC	Nepal	5,103	29,715,436	6.66	25.3
	Bangladesh	8,450	169,384,897	2.39	25.98
	India	9,207	1,425,423,212	3.31	28.83
	The Philippines	10,131	113,964,338	5.16	26.14
	Vietnam	13,905	99,680,655	4.59	33.42
	Sri Lanka	14,194	22,181,000	4.36	33.34
UMIC	Indonesia	14,285	278,830,529	2.69	30.38
	Thailand	22,243	71,735,329	5.35	40.55
	Malaysia	34,366	34,695,493	3.91	30.95
High-income country	Singapore	143,095	5,649,885	4.9	36.2

Source: World Bank (n.d.); World Health Organization (n.d.).

Note: LMIC = low- and middle-income countries; UMIC = upper-middle-income countries; CHE = current health expenditure; GDP = gross domestic product; PPP = purchasing power parity.

Figure 2: Epidemiological Transition in South Asia, East Asia, and the Pacific (2000–2019)



Source: World Bank. (n.d.).

Urbanisation: Rapid urbanisation is reshaping health needs and service delivery models across South and Southeast Asia. By 2050, the urban population in South Asia is expected to nearly double, with the majority of residents in many countries becoming urban dwellers. This shift presents significant challenges, as rapid urbanisation strains infrastructure, housing, and environmental conditions. Pollution and overcrowding disproportionately affect migrants and low-income urban populations, exacerbating health disparities.

While some progress has been made in urban health and service coverage, NCDs are rising in urban areas, reflecting lifestyle changes associated with urban living. South Asian cities are characterised by stark socio-economic disparities in health and healthcare access. Inadequate housing, lack of sanitation, and hazardous working conditions contribute to adverse health outcomes among the urban poor. Addressing these challenges requires targeted health interventions, improved urban planning, and policies that integrate healthcare with broader social determinants of health (Perera et al., 2024).

These demographic, epidemiological, and urban shifts reveal the limits of current PHC models and underscore the urgency of integrated, equity-oriented reform.

3.2 Progress and Health System Reforms

Countries have undertaken several initiatives within PHC to address existing and newer challenges (Table 2). Thailand and Vietnam continue with a strong centralised system, whereas the Indian, Indonesian, and the Philippine systems are formulated around decentralised governance. Those with decentralised governance invariably witness subnational disparities in availability and access to services. Singapore's governance attention to regulation has contributed to strong monitoring and the quality of services. Bangladesh, in contrast, has a much weaker oversight and regulation system.

Financing mechanisms range across tax financing, insurance, donor support, and private expenditure, often with a mix of these. Delivery models range from almost exclusively public to a mix, to public and private (with varying presence of private). The combination of delivery and financing models has led to varying levels of OOPE.

The health workforce, the backbone of a primary care system, has received attention in most countries, but continues to be a challenge. In response, most countries have expanded their focus on CHWs. Nepal and India have focused specifically on female community outreach workers.

Table 2: Primary Care Innovations

Country	Primary Care Delivery Model	Community and Workforce Innovations	Digital and Data Innovations	Financing and Insurance Models	Governance/System Strengthening and Quality
Thailand	Mixed model (dominance of public network with existence of private providers)	VHV network for outreach and mobilisation	Local HMIS pilots; growing digital PHC initiatives	UCS; primarily tax-funded (capitation/global budgets)	Strong governance under UCS; rural clinician shortages
Indonesia	Mixed model (public and private)	Village midwives, CHWs; Posyandu outreach	Telemedicine pilots integrated with JKN	JKN (BPJS-managed); mixed financing system (SHI, private insurance, and OOPE)	Decentralised governance; variable quality
Singapore	Private dominated with existence of public polyclinics	Primary Care Networks; chronic care programmes	Advanced EMR; national health IT; CHAS subsidies digitalised	Tax-funded; employer–employee contribution; and co-payment	Strong regulation; quality monitoring; equity/cost challenges
Malaysia	Mixed model (public and private)	Community outreach via clinics; public workforce programmes	Digital health policy; telemedicine pilots	Mix of public and private funding	MOH oversight; regional disparities
Vietnam	Mixed model (public and private)	CHS staff for outreach; PHC strengthening reforms	Digital health pilots (EMR/ eHealth)	SHI and private financing	Central planning; quality issues drive bypassing
India	Mixed model (public and private primary health centres)	Rural and urban ASHA; CHO at the subcentres	ABDM; eSanjeevani telemedicine	Mix of public and private funding[1]	Large-scale reforms; heterogeneity across states
The Philippines	Mixed model (public and private)	BHW; local health teams; UHC law, 2019	Telemedicine and EMR pilots; health tech startups	PhilHealth; mix of public, SHI, and private financing	Decentralised governance; uneven quality/resources
Bangladesh	Community-based and public-led	CCs; BRAC CHWs; NGO innovations	Growing mHealth; CHW data tools	Mix of government; NGO/ donor; and private financing	Fragmented NGO-government delivery; weak oversight
Nepal	Community-based and public-led	FCHV outreach	Digital CHW support pilots; HMIS strengthening	Public financing; donor support; and private financing	Community outreach strong; staff/geographic barriers
Sri Lanka	Community-based and public-led	Strong public health workforce; MCH focus	HMIS pilots for PHC modernisation	Tax-funded and private financing	Strong MCH outcomes; underfunded PHC; NCD gaps

Sources: Agustina et al. (2019); Dayrit et al. (2018); El Arifeen et al. (2013); Ministry of Health and Family Welfare, (n.d.); Haseltine (2013); Jaafar et al. (2013); Ghimire (2025); Lahariya (2020); Tan et al., 2021; Rannan-Eliya et al. (2009); Republic of the Philippines (2019); World Health Organization (2016, 2017a, 2017b, 2017c, 2017d, 2017e, 2017f).

Note: PHC = primary healthcare; HPH = health-promoting hospital; HMIS = health management information system; UCS = Universal Coverage Scheme; JKN = Jaminan Kesehatan Nasional; BPJS = Badan Penyelenggara Jaminan Sosial (Indonesia's Social Security Agency); CHW = community health worker; GP = general practitioner; EMR = electronic medical record; IT = information technology; CHAS = Community Health Assist Scheme; MOH = Ministry of Health; OOPE = out-of-pocket expenditure; CHS = commune health station; VSS = Vietnam Social Security; HWC = Health and Wellness Centre; PMJAY = Pradhan Mantri Jan Arogya Yojana; RHU = Rural Health Unit; UHC = universal health coverage; BRAC = Bangladesh Rural Advancement Committee; NGO = non-governmental organisation; PHCC = primary healthcare centre; FCHV = Female Community Health Volunteer; PMCU = Primary Medical Care Unit; MCH = maternal and child health; NCD = non-communicable disease; ABDM = Ayushman Bharat Digital Mission; ASHA = Accredited Social Health Activist; BHW = Barangay Health Worker; CC = Community Clinic; DHC = District Health Centre; mHealth = Mobile Health; Posyandu = Integrated community service posts; Puskesmas = Pusat Kesehatan Masyarakat.

[1] Funding in public facilities are mainly line item budgeting with the component of performance in the salaries of MO, CHO, and ANM. ASHA's payment is performance based in most of the states.

4. State of Primary Healthcare in Countries of Focus

UNICEF and WHO identified a range of strategic and operational levers to improve the PHC performance. To examine the status of PHC, this paper uses a combination of two strategic and three operational levers identified by UNICEF and WHO, and uses the most recent available literature and policy documents from each of these countries (Table 3). These are applied to review country performance.

The rationale for this choice is twofold:

- **Strategic levers**: Political and financial commitment are foundational to the success of PHC, as they determine the level of prioritisation, policy support, and sustained investment in health systems.
- **Operational levers**: Health workforce (a critical challenge across all countries), community engagement, and the model of care (which shapes how services are delivered and accessed) were chosen for their overarching impact on PHC effectiveness.

4.1 Political Commitment

PHC is formally recognised as central to achieving UHC across the 10 countries (Perera et al., 2024; UNICEF, 2023), yet the extent of integration and implementation varies widely due to differences in policy priorities, resource allocation, and political will. Furthermore, Indonesia and the Philippines have enacted laws and regulations to shift focus from treatment to prevention and to guide resource distribution between central and local levels (UNICEF, 2021).

Indonesia's progress toward UHC illustrates the central role of political commitment in driving health reform (Table 4). Across successive administrations—from Suharto's era to the post-democratisation period—health protection was consistently framed as both a social obligation and a political priority. The passage of the 2004 Social Security Law, combined with pressure from civil society and supportive court rulings, ultimately enabled the launch of JKN in 2014, which has since become one of the largest health insurance schemes globally. By 2020, coverage had expanded to more than 220 million Indonesians, underscoring how sustained political will, citizen engagement, and electoral incentives can reshape health systems. Overall, Indonesia's experience makes clear that UHC extends beyond a purely technical reform; it represents a political project that depends on leadership, consensus-building, and accountability (Nundy & Bhatt, 2022a).

Thailand's UHC story highlights the decisive role of political leadership. Following the 1997 Asian financial crisis, health equity became a central political issue. The Thai Rak Thai Party's electoral pledge in 2001 translated into the landmark 30-Baht Scheme in 2002, extending coverage to the majority of citizens through tax financing. Despite repeated political disruptions, UHC has been consistently protected and expanded, reducing out-of-pocket burdens and catastrophic health expenditures. Thailand's experience shows that strong political commitment, electoral accountability, and institutionalised citizen participation are vital to sustaining health reforms and achieving universal access (Nundy & Bhatt, 2022a).

Table 3: Framework to Assess Primary Healthcare

Lever	Description
Political Commitment (strategic)	Political leadership prioritising PHC within UHC efforts and its role in achieving SDGs.
Financial Commitment (strategic)	Mobilisation and allocation of financial resources to ensure equitable access and quality care.
Model of Care (operational)	Implementation of people-centred, high-quality PHC models integrating public health functions.
Workforce (operational)	Availability of a well-distributed, competent PHC workforce, including CHWs.
Community Engagement (operational)	Involvement of communities and stakeholders in problem-solving, policy dialogue, and decision-making.

Source: United Nations Children's Fund and World Health Organization (2020).

Note: PHC = primary healthcare; UHC = universal health coverage; SDG = Sustainable Development Goal; CHW = community health worker.

Sri Lanka has a long-standing preventive PHC system embedded in political discourse (Prinja et al., 2024). Sri Lanka shows how political commitment makes UHC possible. It has witnessed a cross-party, seven-decade pledge to free public care, anchored in PHC and equity. The 2016–2025 National Health Policy and the 2018 Primary Healthcare System Strengthening Project (PSSP) operationalise this commitment through empanelment, stronger NCD services, and quality improvements (Ministry of Health, Sri Lanka, 2016; WHO UHC Partnership, 2018). While out-of-pocket costs persist due to private use and medicines, the government continues to safeguard the "free health" model and pursue efficiency and accountability (UNICEF, 2021). Sri Lanka's UHC index (~67 pre-COVID) and strong population health outcomes underscore that leadership, policy continuity, and primary-care investment are decisive for reform (WHO & World Bank, 2019).

However, as Perera et al. (2024) note, reform momentum is often hindered by political reluctance to disrupt the status quo, given that the benefits of PHC reforms are rarely visible within short electoral cycles, leaving systemic changes without sufficient political force. Rajan et al. (2024) further highlight a persistent political economy mismatch in which investments favour specialist, hospital-based services over community-based generalist care, creating a cycle of underinvestment, low service quality, and eroded public trust. Another challenge is PHC's association with poverty-targeted programmes, which reinforces perceptions of it as inferior, particularly in low-income and donor-dependent contexts, further weakening stakeholder support. Finally, the prioritisation of vertical approaches with strong focuses on specific issues or sub-populations (e.g., diabetes or MCH programmes) has reduced investment in PHC in lower-income countries (Rajan et al., 2024).

Table 4: Political Commitment to Universal Health Coverage: Indonesia, Thailand, and Sri Lanka

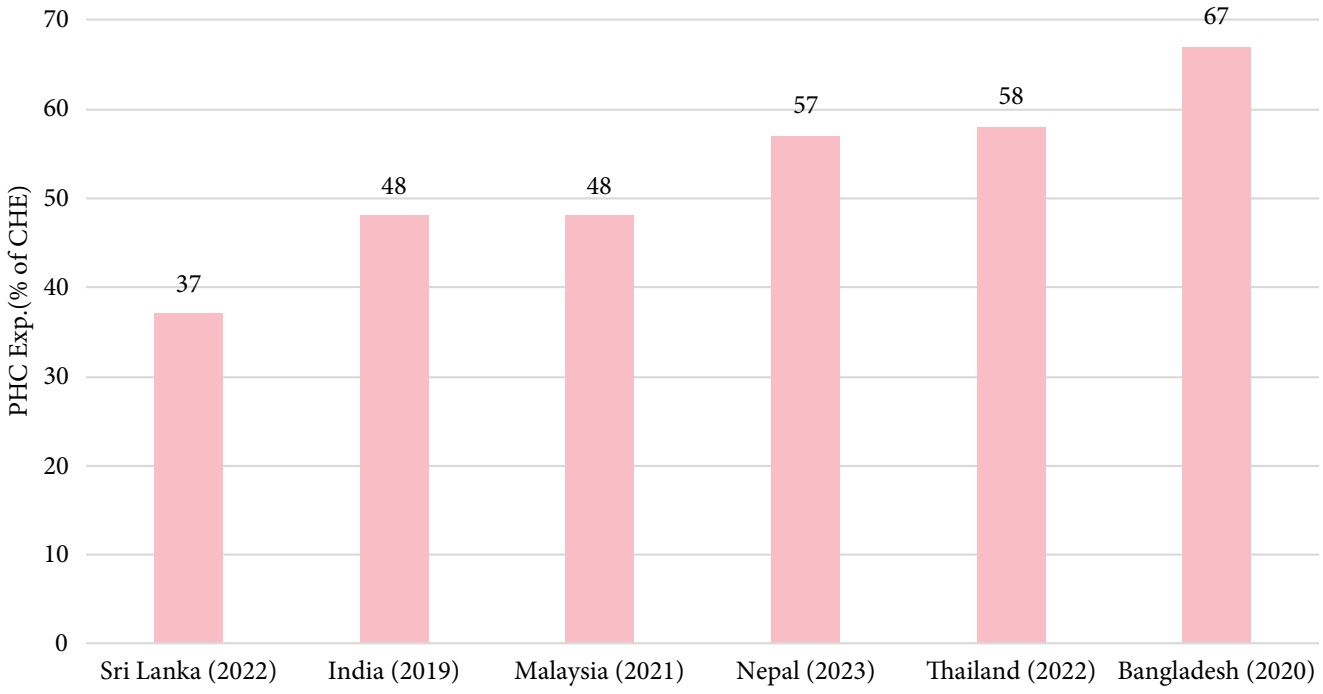
Country	Political Drivers	Flagship Reform	Financing	Governance/ Accountability	Coverage and Protection
Indonesia	Democratisation; social legitimacy post-crisis	JKN (2014) via BPJS-Kesehatan; 2004 Social Security Law	Mandatory social insurance with state subsidies for the poor	National law; BPJS governance; decentralisation with local schemes (JKN) integrated	Nationwide enrolment (> 200 million by 2020); reduced financial barriers
Thailand	Electoral pledge (2001); equity post-1997 crisis	30-Baht Scheme/UCS (2002)	General tax financing; capitation and DRG-based purchasing	Independent purchasing agency; National Health Assembly participation	Near-universal coverage; decline in catastrophic spending
Sri Lanka	Cross-party "free health" commitment since 1951	PHC System Strengthening (2018–23) under National Health Policy 2016–2025	General taxation funding free public services (no user fees)	MOH stewardship; empanelment and PHC quality reforms	High service coverage for income level; OOPE persists mainly via private outpatient use

Sources: Nundy and Bhatt (2022a); Ministry of Health, Sri Lanka (2016); World Health Organization Universal Health Coverage Partnership (2018); United Nations Children's Fund (2021); World Health Organization and World Bank (2019).

Note: JKN = Jaminan Kesehatan Nasional; BPJS = Badan Penyelenggara Jaminan Sosial (Indonesia's Social Security Agency); DRG = diagnosis-related group; MOH = Ministry of Health; PHC = primary healthcare; OOPE = out-of-pocket expenditure; UHC = universal health coverage.

4.2 Financial Commitment

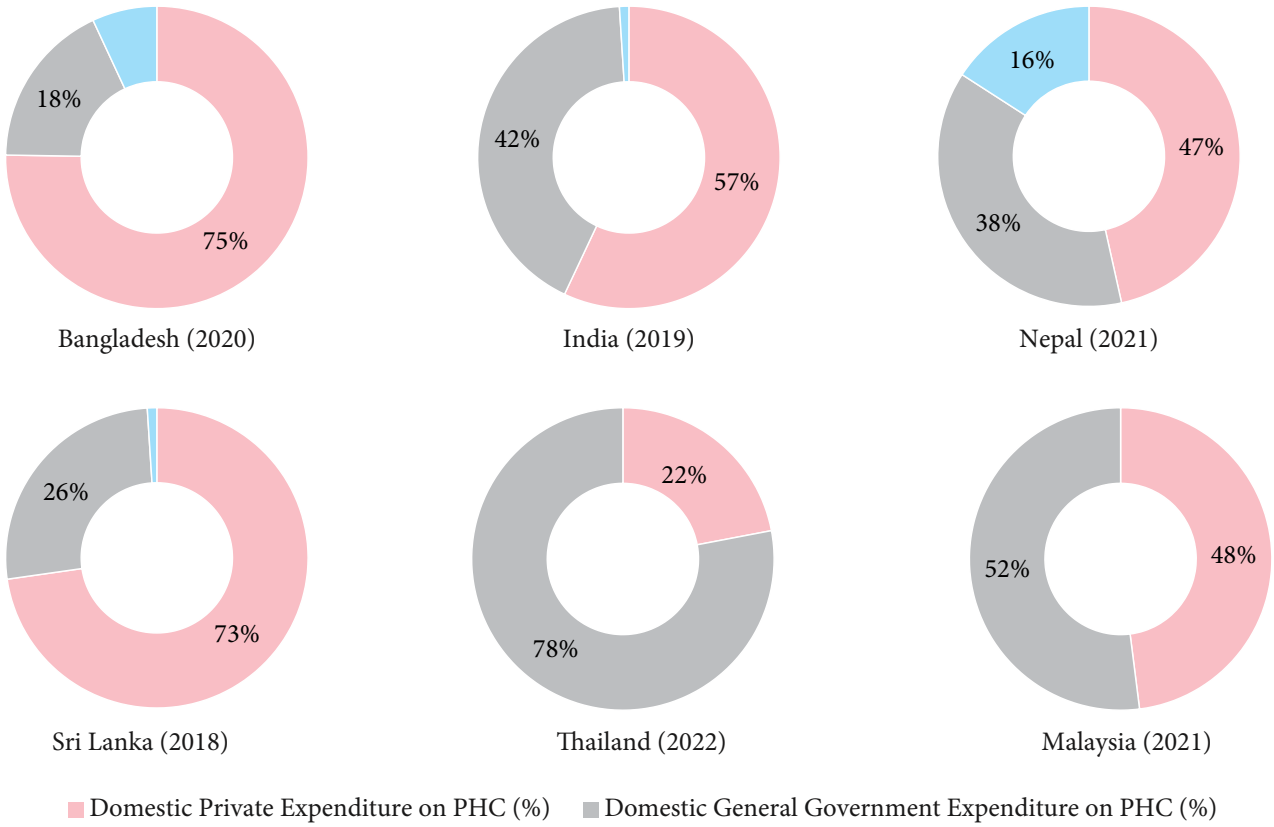
Figure 3: Primary Healthcare Expenditure as % of Current Health Expenditure



Source: World Health Organization (n.d.).

Note: PHC = primary healthcare; CHE = current health expenditure.

Figure 4: Breakup of Primary Healthcare Financing (Public, Private, and External as % of Total Primary Healthcare Expenditure)



Source: World Health Organization (n.d.).

PHC financing across Asia is characterised by a mix of public (tax-based funding, social health insurance [SHI] schemes), private (OOPE, private insurers), and external sources (donors, multilaterals) (Figure 4).

Figure 3 suggests that primary care already occupies a substantial share of total health spending across many South and Southeast Asian countries, although the exact proportion varies widely. There is no simple linear relationship with overall wealth or GDP; for example, lower- and middle-income countries such as Nepal and Bangladesh show higher shares than some relatively better-off peers. This implies that the prioritisation of primary care is determined not only by economic capacity but also by policy choices, health-system design, and historical investment patterns.

Many countries have made important progress in strengthening financial risk protection and advancing UHC. However, major challenges persist in securing sustainable financing, achieving equity in PHC financing, and reducing reliance on OOPE spending.

Tax-based financing remains central to PHC in several countries, often supplemented by targeted insurance schemes. Thailand has achieved one of the most successful reforms in the region through its three insurance schemes—the UCS, Civil Servants Medical Benefit Scheme, and Social Security Scheme. Between 2000 and 2019, the government's share of current health expenditure (CHE) rose from 55.2% to 71.7%, while OOPE payments declined from 34.2% to 8.7% (Nundy & Bhatt, 2022a). This reflects a strong policy focus on PHC and sustained government investment, linked with the political priority accorded to PHC in the country. Malaysia similarly finances PHC significantly from tax revenues, with nominal user fees and extensive subsidies ensuring broad access to services (Lee et al., 2023). Sri Lanka relies heavily on tax-based financing, offering free healthcare through the public system, though current fiscal pressures constrain capacity. While the public sector remains the primary provider of hospital services in Sri Lanka, the recent expansion of the private sector has resulted in over 50% of outpatient care now being offered outside of government facilities, particularly for PHC (Rajapaksa et al., 2021). To address these gaps, donors such as the World Bank pledged US$150 million to Sri Lanka in 2024 to strengthen the Primary Medical Care Institution System, supporting continuity of essential services, quality improvements, and community engagement.

Other countries have relied on SHI mechanisms to expand PHC coverage. Indonesia's JKN now covers over 80% of the population and has reduced OOPE spending, particularly among poorer and rural households who benefit from greater use of public PHC facilities (Nundy & Bhatt, 2022b). Vietnam has expanded its SHI coverage widely, with about 91% of the population covered by national SHI, which includes PHC (Oanh et al., 2023). However, weak gatekeeping and overcrowding in hospitals continue to undermine financial protection, as high OOPE payments for hospital care expose households to catastrophic expenditures despite insurance (Lee et al., 2019). Similarly, the Philippines' PhilHealth pools payroll contributions and government subsidies to fund PHC and hospital services, but shallow benefit packages and persistent co-payments limit its protective impact.

In contrast, several South Asian countries remain highly dependent on private and OOPE financing. Bangladesh finances primary health care through a mix of government budgets, substantial private spending, and donor contributions, with development partners playing an important role in supporting vertical programmes such as immunisation and disease control (Ahmed et al., 2015). However, donor funding is increasingly uncertain, raising sustainability concerns. India allocates 55.2% of its public health budget to PHC, though traditionally, spending has been skewed towards reproductive and child health, with limited resources for comprehensive primary care (Balani, Singh, & Venkateswaran, 2024). While the Ayushman Bharat programme has expanded financial protection for hospital services, investment in Health and Wellness Centres (HWCs) needs expansion. Nepal faces significant fiscal constraints, with OOPE spending accounting for about 60% of total health expenditure. Reliance on private payments contributes to inequities, as poorer households are more likely to forgo care due to cost. Sub-national disparities in financing capacity further exacerbate inequities in PHC delivery.

Some countries have adopted hybrid approaches that combine state financing with individual responsibility. Singapore's model integrates compulsory medical savings accounts (MediSave), public catastrophic insurance (MediShield Life), and direct government subsidies. This system has helped balance sustainability with financial protection, while limiting excessive reliance on OOPE spending (Tan et al., 2021).

Various Asian countries like India, Bangladesh, and Indonesia face fiscal challenges in increasing coverage of healthcare programmes. However, innovative financing mechanisms, including earmarked taxes and demand-side financing, have been introduced to address funding gaps and promote healthcare utilisation. The Philippines, for example, has raised additional health revenues through sin taxes and earmarked taxes on tobacco and alcohol, alongside partnerships with the private sector and philanthropic organisations (Pholpark et al., 2025; UNICEF, 2023). Singapore's approach highlights the role of public–private collaboration, using regulated individual contributions to MediSave while maintaining strong government subsidies for essential services.

Financing reforms have been introduced to expand access and quality. Conditional cash transfers have been leveraged in South Asia, incentivising PHC use by offsetting financial barriers. In India, programmes such as the Ayushman Bharat HWCs incorporate team-based incentives, while Nepal has experimented with capitation-based payments in its Free Health Care and Safe Motherhood Programme (Prinja et al., 2024). While these approaches have shown promise in increasing service utilisation, their long-term effectiveness in improving health outcomes requires further evaluation. Detailed assessments of these will provide insights into their effectiveness in improving PHC access and OOPE.

Despite progress across the region, systemic financing challenges remain. In Bangladesh and Indonesia, governance gaps and low facility-level absorptive capacity result in underspent budgets. Weak public financial management constrains effective PHC financing. Rising medicine costs add further strain: In Bangladesh and Nepal, stock-outs in public facilities force households to purchase medicines OOPE (Pholpark et al., 2025). In many countries, weak gatekeeping and unrestricted provider choice contribute to inefficiencies, high costs, and continued overutilisation of hospital and specialist care. Insufficient incentives for frontline PHC providers undermine workforce retention, particularly in rural or remote areas. In Bangladesh and Indonesia, CHWs face low or uneven pay, heavy workloads, and limited professional development opportunities (Pholpark et al., 2025).

High OOPE remains a defining feature across many countries, reflecting both inefficient resource mobilisation and weak pooling arrangements (Pholpark et al., 2025). Medicines, in particular, continue to impose a heavy financial burden on households. Public budgets for PHC are often insufficient, with preventive and promotive services especially underfunded, given limited fiscal space and low prioritisation of health within overall government spending. Funding is further fragmented, as PHC frequently relies on multiple domestic and donor-driven pools, resulting in duplication, inefficiencies, and blurred accountability lines. Financial rigidity adds to these challenges: Line-item budgeting continues to dominate most countries, limiting flexibility, absorptive capacity, and the autonomy of facilities to respond to local needs (Pholpark et al., 2025). This rigidity is compounded by weak incentive structures—salaries and supply-side allocations are rarely linked to performance, thereby dampening provider motivation to improve quality. Finally, poor monitoring systems and limited data on PHC expenditures, particularly where funds are fragmented, restrict governments' ability to track spending and hold stakeholders accountable.

Strengthening absorptive capacity remains a priority, where underspending (such as in Bangladesh) and cautious budget utilisation (Indonesia) demonstrate the need to invest in facility readiness, human resources, and financial autonomy at the PHC level. Imbalances in spending patterns need attention so that infrastructure alone is not prioritised at the expense of operating costs. Reducing funding fragmentation is another important concern. The experience of Indonesia and Nepal, where domestic supply-side financing interacts with multiple donor pools, highlights the difficulties of planning and accountability under fragmented arrangements. Programme-based or consolidated PHC budgeting could help mitigate these inefficiencies.

Equally critical is strengthening accountability and data systems. Weak expenditure tracking remains a major barrier, limiting governments' ability to evaluate the effectiveness of spending. Improved health information systems, standardised definitions of PHC, and systematic expenditure reporting are vital to both national governance and cross-country learning. Underpinning all these efforts is the recognition that PHC financing reforms can be deeply political. Building sustained commitments requires a whole-of-government approach and active engagement with stakeholders across multiple levels of the health system, ensuring that technical innovations are matched by political support and institutional durability.

4.3 Model of Care

PHC in South and Southeast Asia operates through diverse institutional structures and delivery models, shaped by varying degrees of decentralisation, integration, and public–private engagement. These models influence access, equity, and service quality, with countries adopting different strategies to balance autonomy, regulation, and efficiency (Figure 5).

Typology of Primary Care

Primary care delivery across Asia reflects diverse health system trajectories and policy choices. Broadly, three models emerge: community-based and public-led systems; mixed public–private systems; and private-dominated systems with government oversight.

Community-based and public-led models are prominent in lower- and lower-middle-income countries such as Bangladesh, Nepal, Sri Lanka, and India. Bangladesh relies heavily on CCs and NGO partnerships (e.g., Bangladesh Rural Advancement Committee [BRAC]), while Nepal's FCHVs are central to outreach in rural areas. Sri Lanka demonstrates a strong public health workforce integrated into preventive and curative services, achieving impressive maternal–child health outcomes despite modest funding. India's tiered PHC system, now expanded through *Ayushman Arogya Mandir*, struggles with uneven quality and reliance on the private sector.

It is important to note that even though CCs or outreach deliver preventive services to household premises, people have to go to these clinics or health posts for curative care. Therefore, it is primarily a passive model of care in the case of curative care, initiated by patients in times of need. Nevertheless, the strengths of these models include equity, outreach, and community trust, but the weaknesses lie in underfunding, workforce shortages, and variable quality.

Mixed public–private systems define Thailand, Malaysia, Indonesia, Vietnam, and the Philippines. Thailand's UCS strengthened a dense network of subdistrict health centres, supported by community health volunteers (CHVs). Malaysia offers widespread public clinics (Klinik Kesihatan), though the urban population often turns to private providers. Indonesia's Puskesmas are the backbone, but quality and referral enforcement remain uneven. Vietnam maintains an extensive commune health station (CHS) network, though bypassing hospitals reflects low trust in PHC. The Philippines' decentralised system relies on Barangay Health Stations and Rural Health Units (RHUs) under local governments, with private providers filling gaps. These models benefit from broad geographic coverage and insurance integration, but are constrained by fragmentation, underinvestment, and rising private dominance.

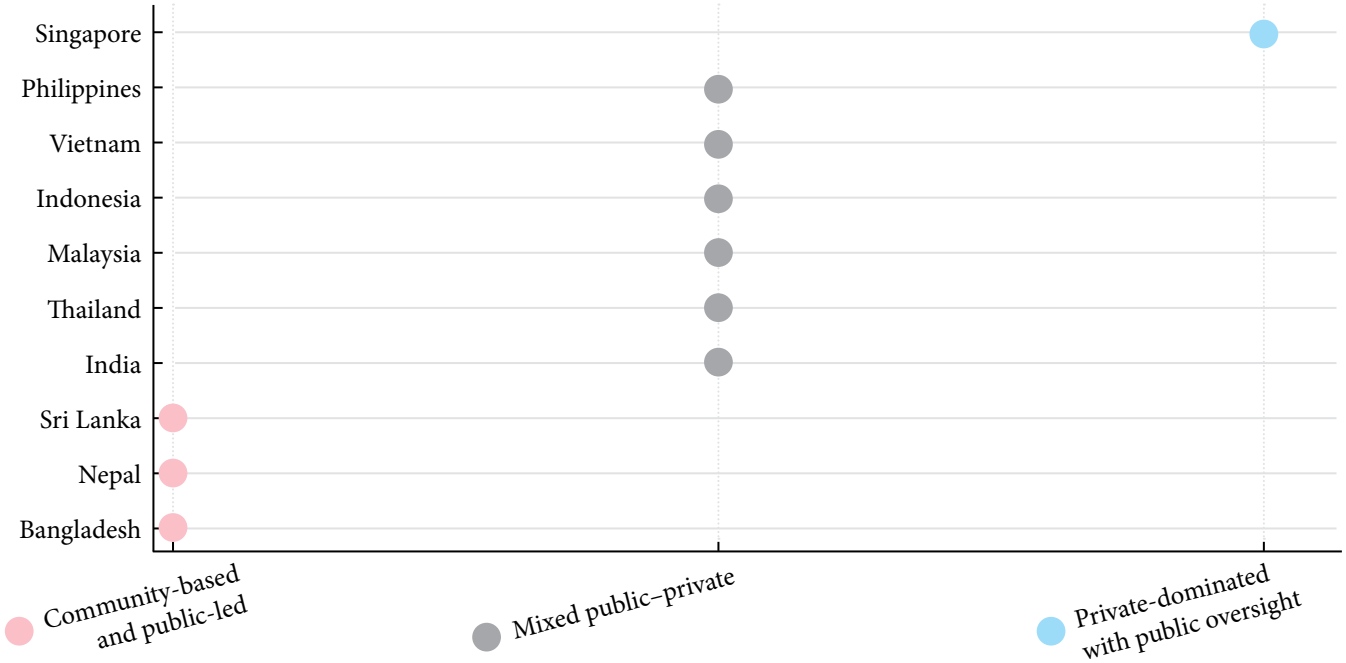
The private primary care sector is limited and complementary in Thailand; large and structured in Malaysia; fragmented but increasingly contracted in Indonesia; significant yet weakly integrated in Vietnam; and dual-tiered in the Philippines. Even though the public system dominates primary care delivery in these countries, the private sector is rapidly expanding, which has significant implications for access, equity, and regulation. Private-dominated models with public coordination are exemplified by Singapore, where polyclinics provide subsidised care, but most first-contact services are delivered by private GPs. Strong health information technology (IT) and financing schemes ensure efficiency, though equity concerns persist.

In summary, while public-led community outreach drives equity in lower-income countries, mixed systems in middle-income countries face challenges of quality and governance, and private-led models in high-income settings excel in efficiency but risk inequities. Strengthening PHC across all models requires strong stewardship and governance, sustained financing, workforce support, and trust-building in primary-level care.

Role of Institutions and Governance in Primary Care Delivery

Primary care delivery in Asia is shaped by diverse institutional arrangements and governance mechanisms, reflecting different stages of health system development (Table 5). In Thailand, Malaysia, and Indonesia, ministries of health play a dominant role, organising care through public networks (district hospitals, health centres, and CCs). These systems are strengthened by defined population norms, integration of preventive and curative services, and strong institutional anchors such as Thailand's Contracting Unit for Primary Care (CUP) and Indonesia's Puskesmas. Their governance mechanisms rely on centralised policy direction with decentralised service delivery, supported by performance monitoring and CHW engagement.

Figure 5: Models of Primary Care Delivery in Asia



Sources: Authors' compilation based on the World Health Organization Primasys reports; Asia Pacific Observatory Health System in Transition series; national policy documents.

In South Asia (India, Nepal, Bangladesh, and Sri Lanka), primary care institutions include sub-centres, primary health centres, family welfare centres, and rural hospitals. Governance is more fragmented: India has a constitutional division of power across the Central and State governments, while Bangladesh and Nepal rely heavily on donor-financed programmes. Sri Lanka, by contrast, maintains a relatively integrated public sector-driven model. Strengths include the wide physical presence of public facilities and CHW programmes, while weaknesses include resource shortages, uneven quality, and weak accountability systems.

In upper-middle and high-income countries (Singapore, Malaysia, Vietnam, and the Philippines), governance mechanisms are evolving towards greater integration of public and private providers. Singapore's national primary care transformation strategy (Healthier SG) reforms and Primary Care Networks formalise family medicine–led care, while the Philippines' Universal Health Care Act empowers local governments but struggles with capacity gaps. Vietnam's CHS forms the backbone of primary care but faces quality challenges.

The level of autonomy at different levels of governance varies. In South Asia, most countries have devolved some level of power to subnational governments, with India and Nepal empowering local governments. This has improved service utilisation in some contexts but has not consistently reduced inequities, largely due to limited financial autonomy, uneven administrative capacity, and variable political support (Prinja et al., 2024).

In Southeast Asia, countries show diverse trajectories. Indonesia's JKN gives district health offices flexibility in running public health centres (Puskesmas). In contrast, the Philippines is undergoing a full fiscal devolution under the 2022 Mandanas ruling, which significantly increases local government revenues but raises concerns about widening regional disparities in health system capacity (Alzona et al., 2024).

Thailand illustrates the tensions between centralisation and decentralisation. The 1999 Decentralisation Act mandated greater transfer of functions and budgets to local governments, and recent reforms have focused on district health boards and primary care clusters (PCCs) (UNICEF, 2023). During COVID-19, decentralised actors such as provincial governors and municipalities proved more agile than central authorities, strengthening the case for local empowerment. At the same time, Thailand's flagship UCS remained centrally regulated, with the Ministry of Public Health (MoPH) overseeing hospitals and health centres to ensure uniform standards nationwide.

While Vietnam has historically maintained a centralised administrative system, recent evidence shows that provincial, district, and local governments are increasingly assuming greater responsibility

for managing and financing social sector activities, including health and education (UNICEF, 2023).

These experiences show that decentralisation is not a uniform process but a negotiated balance between central oversight and local autonomy. While local governance can enhance responsiveness, service delivery, and community participation, its success depends on how resources, authority, and accountability are structured across different levels of the health system.

Overall, the strengths of the healthcare system across the region include strong institutional legacies, community engagement, and policy commitment to UHC. Weaknesses lie in governance fragmentation, uneven financing, weak regulation of private providers, and gaps in quality assurance. Successful models (e.g., Thailand, Malaysia, and Singapore) highlight the importance of clearly defined institutional roles, population-based planning, and robust accountability frameworks.

Extent of Integration and Continuity of Care

Across South and Southeast Asia, PHC service delivery and referral pathways exhibit considerable variation, reflecting differences in system design, workforce distribution, and gatekeeping mechanisms. In Indonesia, Puskesmas function as the primary gatekeepers for referral to higher-level facilities, covering roughly 85,000 villages. These are supported by auxiliary services—*pustu* at the sub-village level, *poskesdes* at the village level, and *posyandu* at the hamlet level—where VHVs (*kader*) organise monthly integrated health services (UNICEF, 2023).

By contrast, most South Asian countries operate three-tiered government health systems, with multi-tasking PHC teams covering defined catchment areas and some links to secondary and tertiary care. However, effective gatekeeping is generally absent due to resource constraints, inconvenient consultation hours, staff absenteeism, and weak referral mechanisms. This has led to low utilisation of government PHC facilities, with Sri Lanka being the notable exception (Prinja et al., 2024). Thailand, meanwhile, mandates through its UCS that patients first access primary care centres before referral to hospitals, reducing unnecessary admissions (Nundy & Bhatt, 2022a).

Vietnam illustrates a hybrid model. CHS serve as an entry point, but patient preference for hospitals remains high due to perceptions of superior quality. Public facilities continue to dominate, serving 83.4% of inpatients and 72.1% of outpatients (Oanh, 2023). Grassroots facilities such as CHS and district health centres (DHCs) play a key role in curative care. Yet their gatekeeping function is undermined by an open referral policy that allows inpatients to self-refer to any facility, compounded by shortages of staff, medicines, and equipment.

Across the region, countries are experimenting with measures to strengthen referral systems and continuity of care. These include facility catchment mapping, deployment of CHWs with strong sociocultural ties, integrated digital health records, staff cross-orientation across levels, demand-side financing, and evidence-based referral protocols. Persistent challenges include ensuring uninterrupted access to medicines and diagnostics—which are especially critical in the context of rising NCDs—fragmentation across providers, weak inter-sectoral communication, and uneven workforce distribution, with doctors often favouring specialist careers over PHC roles. To address these, countries are also exploring innovations such as district- or cluster-level management cadres, team-based incentives, unique patient identifiers, and patient satisfaction monitoring. Rising literacy levels and the rapid uptake of digital tools further offer opportunities to build more responsive, community-oriented PHC systems.

Public–Private Sector Engagement in Primary Healthcare

PHC in South and Southeast Asia is shaped by a dynamic interplay between public and private providers. In South Asia, the private sector delivers 50–69% of outpatient care and owns a substantial share of health resources (Prinja et al., 2024). Governments have experimented with diverse engagement models, including contracting-in, contracting-out, voucher schemes, mobile health (mHealth) services, subsidies, insurance, and even participation of informal providers in campaigns such as polio vaccination and tuberculosis treatment. Notable examples include engaging private laboratories in testing COVID-19 cases in Bangladesh and tuberculosis case notification through PPPs in India (WHO, 2020). These arrangements have increased utilisation and patient satisfaction, but challenges remain. Divergent understandings of "partnership," bureaucratic delays in payments, political resistance, and apprehension from government staff—job losses or stricter accountability—have limited effectiveness (Prinja et al., 2024).

Table 5: Institutions and Governance in Primary Care Delivery

Country	Key Institutions in Primary Care	Governance Mechanisms	Strengths	Gaps
Thailand	Tambon Health Promotion Hospitals (5,000–10,000 population); CUP (50,000–100,000 population)	Central MoPH policy; decentralised CUP networks; and strong monitoring	Population-defined coverage; integration of preventive and curative care; CHVs	Shortage of family physicians; quality variation
Indonesia	Puskesmas (30,000–50,000 population); integrated outreach posts (Posyandu)	Decentralised governance under districts; MOH sets policy; linked to JKN insurance	Defined catchments; multidisciplinary teams; outreach services	Variable quality; underfunding; rural workforce shortages
Singapore	Public polyclinics; private GPs; Primary Care Networks under Healthier SG	Centralised governance (MOH); contracting and regulation of private providers; strong IT-enabled monitoring	Strong family medicine focus; digital integration; proactive chronic care	Integration challenges with private GPs; early stage of Healthier SG
Malaysia	Klinik Kesihatan (15,000–20,000 population); private GPs	MOH-led, centralised system; regulated service standards	Multidisciplinary team model; strong preventive–curative integration	Dual system with strong private sector pull; inequities in rural areas
Nepal	Health Posts; PHCC; FCHV	Federalised governance; MOH policy with donor support	Extensive community outreach; strong FCHV network	Weak capacity at local level; underfunded facilities
Bangladesh	Union Health and Family Welfare Centres; CCs	Centralised governance, donor-supported programmes; weak local accountability	Wide network of CCs; CHWs for maternal–child care	Resource shortages; weak regulation; poor quality monitoring
India	HWCs; PHCs; CHCs; and private clinics	Decentralised governance with three-tier structure	Large public network; recent policy push for comprehensive primary care	Fragmented governance; uneven quality across states; weak regulation of private sector
Sri Lanka	Central dispensaries; Divisional Hospitals; Medical Officer of Health (MOoH) offices	Centralised governance; strong preventive programme under MOoH	Integrated preventive–curative model; strong public trust; free care	Infrastructure gaps; staff shortages; private sector under-regulated
Vietnam	CHS; district hospitals	MOH oversight; decentralised to provinces; health insurance expansion	Universal presence of CHSs; insurance-linked care	Under-utilisation; low perceived quality; bypass to hospitals
Philippines	Barangay Health Stations; RHUs; Local Government Hospitals	Decentralised governance under Local Government Code; UHC Act reforms	Strong community outreach; policy commitment to UHC	Weak local capacity; fragmentation between local and national agencies

Source: Authors' compilation based on the World Health Organization Primasys case studies; Asia Pacific Observatory Health System in Transition Reviews; national policy documents.

Note: MoPH = Ministry of Public Health; CUP = Contracting Unit for Primary Care; MOH = Ministry of Health; JKN = Jaminan Kesehatan Nasional; GP = general practitioner; FCHV = Female Community Health Volunteer; CHW = community health worker; PHC = primary healthcare; PHCC = primary healthcare centre; CHC = Community Health Centre; HWC = Health and Wellness Centre; UHC = universal health coverage; CHS = commune health station; RHU = Rural Health Unit; CC = Community Clinic; CHV = Community Health Volunteer; IT = information technology; Posyandu = Integrated community service posts; Puskesmas = Pusat Kesehatan Masyarakat.

Country experiences highlight both the potential and pitfalls of private sector engagement. In Nepal, only 25% of private providers offer immunisation services, whereas in Bangladesh, over 80% of childhood diarrhoea treatment is sought from private facilities (Prinja et al., 2024). This reliance on unregulated, fee-based care often exacerbates inequities. In Singapore, government polyclinics provide 20% of PHC, and about 2,000 private GP clinics account for the remaining 80%. Yet only 55% of chronic patients are managed by GPs, leaving polyclinics with a disproportionate burden. To address this, Singapore is piloting new models. For example, the Frontier Family Medicine Clinic (private GP), developed with the National University Health System (NUHS), applies the Patient-Centred Medical Home model to bring chronic care into community settings with team-based care, shared EHRs, and improved referral systems (Khoo et al., 2014).

Elsewhere in Southeast Asia, governments are also working to integrate private providers more systematically. Thailand's UCS uses strategic purchasing to contract private clinics; India's Ayushman Bharat scheme expands access through private empanelment; and the Philippines' PhilHealth covers private providers in both inpatient and outpatient benefit packages, including an NCD medicines scheme delivered through accredited pharmacies (Dayrit et al., 2018). Uneven distribution of facilities and high OOPE spending continue to perpetuate urban–rural gaps. Bangladesh also offers a model where NGOs and social enterprises, such as BRAC and the Jamkhed Comprehensive Rural Health Project, enhance PHC services, for example, by helping extend coverage to remote areas.

High utilisation of the private sector for curative care remains a major characteristic of healthcare systems in the region. An unregulated private sector, including informal providers, delivers outpatient curative care to many underserved communities, particularly in India and rural Bangladesh. Informal collaborations with NGOs and private providers exist in the region, such as for routine immunisation in Sri Lanka, Bangladesh, and India (Perera et al., 2024). Additionally, some formal, discrete public–private arrangements support general PHC services. The COVID-19 pandemic served as a catalyst for PPPs in diagnostics and hospital care in South Asia. However, the lack of long-term stewardship and a failure to ensure continuity beyond the pandemic response may limit the sustained impact of these partnerships (Perera et al., 2024).

Several Asian countries operate in highly pluralistic healthcare systems where public, private, and traditional healthcare providers coexist, often with poor coordination. Indonesia and Vietnam have highly market-driven PHC models, leading to an excessive focus on diagnosis and treatment rather than preventive care (WHO, 2019). Bangladesh and India experience high OOPE costs due to the dominance of private providers operating with limited regulation (WHO, 2019). This fragmentation complicates PHC integration, referral pathways and quality control, making it difficult to establish standardised service delivery protocols (WHO, 2019). In the Philippines, "the Department of Health (DOH) proposes to integrate public health functions into the local health system through (a) the implementation of evidence-based health promotion strategies for social and behavioural change; (b) building epidemiological surveillance systems and emergency preparedness capacity; and (c) strengthening population-based programmes in areas such as vector control, water and sanitation, and nutrition" (UNICEF, 2023).

Digital Health Innovations

Digital health is emerging as a key lever to strengthen PHC across Asia, with countries adopting diverse approaches shaped by system design and regulation. In India, the Ayushman Bharat Digital Health Mission, implemented by the National Health Authority (NHA), is laying the foundation for an integrated national ecosystem. Meanwhile, subnational initiatives are also underway. For example, Karnataka has pioneered a tele-mentoring model for drug addiction management, where NIMHANS (one of the pioneering institutions for mental health) functions as the hub and PHC doctors as spokes through the low-cost Extension for Community Healthcare Outcomes (ECHO) platform, enabling remote training and specialist-supported care (Vasanthan et al., 2024). NGO-led innovations are also advancing access, as seen with Noora Health's scaling of multimedia-based caregiver training across India, Bangladesh, and Indonesia (Yi et al., 2024).

Indonesia is building SATUSEHAT, a national health platform to integrate fragmented data and engage startups (Raghavan, n.d.). Malaysia, after repeated setbacks in EHRs, is developing the Malaysia Health Data Warehouse, which links hospitals and clinics alongside startup collaborations (Raghavan, n.d.). Singapore, a frontrunner, combines advanced EHRs with robust support for startups and consumer-facing tools, though stricter data regulations are limiting cross-border sharing (Raghavan, n.d.).

Across Asia, the promise of digital health is tempered by rural infrastructure gaps, uneven access to technology, and fragmented implementation. Countries are increasingly realising that sustainable progress depends on integrated ecosystems rather than siloed apps, the active engagement of communities and frontline health workers, and regional cooperation to harmonise standards, data systems, and protection laws (Yi et al., 2024).

Emerging Models of Care Reform

Recognising evolving global health challenges, numerous nations are actively re-evaluating their PHC models to foster resilience and responsiveness. Malaysia, for instance, in its 12th Malaysia Plan (2021–2025), explicitly addresses the dual burden of NCDs and communicable diseases. This necessitates a more integrated approach encompassing disease prevention and chronic disease management across the care continuum (Economic Planning Unit, 2021). The nation is strategically advancing primary care networking and hospital clustering, a critical initiative aimed at enhancing coordination among PHC, secondary, and tertiary healthcare services (Economic Planning Unit, 2021). Parallel efforts towards health system integration are evident in Thailand and the Philippines, where policy objectives centre on ensuring seamless care transitions and improving overall health system efficiency. Thailand's approach emphasises multi-sectoral action and integrated health services towards UHC (WHO, 2024), while the Philippines' Universal Health Care Act of 2019 provides a framework for an integrated and comprehensive health system (Republic Act No. 11223, 2019).

Singapore's progressive Healthier SG framework strategically prioritises preventive care, comprehensive chronic disease management, and robust community-based interventions. This proactive approach is designed to mitigate long-term healthcare costs and enhance population health outcomes (MOH Singapore, 2022). Concurrently, Sri Lanka's PHC system, traditionally anchored in a strong community health foundation, continues its evolutionary trajectory through targeted investments in both preventive and curative services (MOH Sri Lanka, 2016; WHO, 2018). The imperative for integrating PHC with hospital services remains a regional priority, as countries collectively strive to enhance care continuity, alleviate hospital overcrowding, and ultimately improve population health metrics (WHO, 2023).

Furthermore, countries highly vulnerable to climate disasters, such as Indonesia and Nepal, are proactively working to mainstream climate considerations into their health strategies, particularly in remote and underserved areas. Indonesia is generating evidence-based data to inform adaptation policies in its health sector (UNICEF Indonesia, 2022), while Nepal has developed a Climate Change Health Adaptation Strategy and Action Plan to build a climate-resilient health system (MOH and Population Nepal, 2024). This critical adaptation underscores the intersection of environmental health and primary care provision. PHC, inherently positioned at the nexus of health and social care, mandates a fundamental reorientation of existing local and national institutions. This reorientation calls for the adoption of an integrated life-course approach, deftly combining models of facility-based care, community-based care, and self-care in adaptive and responsive modalities (WHO, 2023). Given the evident complementarity of progress observed across countries in the region, there is substantial scope for sharing lessons and collaboratively redeveloping health institutions, resources, and processes. Such collaboration is pivotal in supporting incremental progress towards the establishment of resilient, people-centred PHC systems across the region (WHO, 2023).

Whole-of-Society Coordination

Rapid urbanisation, malnutrition, air pollution, adolescent health challenges, tobacco use, and climate change impacts pose significant public health challenges across Asia, necessitating a coordinated multi-sectoral response. In Indonesia, for example, addressing these issues has led to the development of a structured Health in All Policies (HiAP) approach, integrating various health considerations into policies across the sectors such as urban planning, environment, and education.

The Thai National Health Assembly provides one example of an institutional mechanism to synergise government, academia, and civil society stakeholders in a whole-of-society approach to improve health outcomes. In the Philippines, Local Government Units (LGUs) play a crucial role in enabling multi-sectoral collaboration through the local planning process. This process provides a platform for PHC engagement with local governments, civil society organisations (CSOs), and community stakeholders, fostering shared efforts on key public health priorities such as reducing maternal mortality and improving nutrition.

Across the region, countries are increasingly adopting whole-of-government and whole-of-society approaches to address PHC challenges. Climate change poses escalating risks to health systems, with countries like Nepal, the Philippines, and Vietnam being particularly vulnerable to rising temperatures and extreme weather events that threaten PHC infrastructure and service delivery (WHO, 2019). The growing burden of NCDs and mental health disorders underscores the need for stronger cross-sector collaboration between health, education, and social protection systems. Furthermore, the COVID-19 pandemic has highlighted the importance of emergency preparedness, with Nepal, Vietnam, and the Philippines prioritising intersectoral coordination for pandemic and disaster response (WHO, 2019). Drawing on cross-country lessons to establish clear country-specific strategies or mechanisms for making policies with several stakeholders, including civil society, the private sector, and multi-sectoral coordination with government agencies, is important for all countries in the region.

4.4 Workforce

The PHC workforce in South and Southeast Asia comprises a diverse range of health professionals, including doctors, nurses, midwives, and CHWs, each playing a crucial role in service delivery (Table 6). Many countries have not yet achieved the WHO's recommended density of 44.5 health workers per 10,000 population.

Table 6: Urban–Rural Workforce Distribution and Primary Healthcare Institutions

Country	Health Workforce Density (Doctors, Nurses, Midwives per 10,000)	Urban Workforce Distribution	Rural Workforce Distribution	Urban PHC Institutions	Rural PHC Institutions
Bangladesh	~13.9	Doctors and nurses heavily concentrated in major cities such as Dhaka and Chittagong	Rural areas rely heavily on CHWs and paramedics due to shortage of physicians	UPHCSDP, UPHCP-II with reproductive health centres, PHC centres, and satellite clinics	CCs under RCHCIB
India	~24.4	Approximately 77% of qualified health workers are located in urban areas, where about one-third of the population resides	Rural areas have much lower density (~3 health workers per 10,000) despite hosting most (77%) of the population	NUHM (Urban Health Posts, UPHCs, UCHCs) focusing on slum populations	NRHM (sub-centres, PHCs, and CHCs)
Indonesia	~37.6	Health workers concentrated in urban provinces, particularly Java and major cities	Remote islands and eastern provinces face shortages of doctors and nurses	Puskesmas and auxiliary networks; "Healthy Cities" initiative with local health forums	Puskesmas for rural + Posyandu and village-level integrated posts
Nepal	~51	Doctors concentrated in Kathmandu Valley and urban centres	Rural mountainous areas depend heavily on nurses and FCHVs	Tiered public system (health posts, PHCCs); urban reliance on private pharmacies	Health posts, PHCCs, basic health centres; many rural areas lack infrastructure

Country	Health Workforce Density (Doctors, Nurses, Midwives per 10,000)	Urban Workforce Distribution	Rural Workforce Distribution	Urban PHC Institutions	Rural PHC Institutions
Malaysia	~64	High concentration of doctors in urban states such as Kuala Lumpur and Selangor	Sabah and Sarawak experience shortages and rely more on public clinics	Public Health Clinics and private GP clinics	MOH clinics, district hospitals, flying doctor service, mobile teams, CCs
Philippines	~55.8	Physicians and specialists concentrated in Metro Manila and other major urban regions	Rural municipalities face shortages and depend on RHUs and BHWs	Mix of public (health centres, health stations) and private providers; UHC Law (2019)	RHUs, Barangay Health Stations, and rural primary-care pilots
Sri Lanka	~33.9	Higher doctor density in urban districts such as Colombo	Rural areas depend more on MOH areas and preventive health staff	Divisional Hospitals, PMCUs, public and private hospitals	PMCU and Divisional Hospitals; PSSP with empanelment
Thailand	~42	Doctors concentrated in Bangkok and major urban hospitals	Government introduced compulsory rural service programmes to address rural shortages	PCCs under UHC, private hospitals, CHVs, and the Health Promotion Temple Project	Subdistrict HPH, VHVs, and CPIRD rural doctor recruitment
Vietnam	~25.5	Urban hospitals employ the majority of physicians and specialists	Rural areas rely on CHS with fewer trained doctors	District hospitals/ DHCs; Polyclinics; CHS (urban wards)	CHS; DHCs; VHWs and community health networks
Singapore	~93.9	Entire workforce concentrated in urban integrated health networks	Not applicable (city-state)	SingHealth, NHG, NUHS polyclinics	Not applicable

Sources: Rao et al., (2016); Ahmed et al. (2011); Angara (2009); Asian Development Bank (n.d.); Bangladesh Center for Communication Programs (n.d.); Bhandari & Baral (2013); Brahmapurkar et al. (2018); Dang & Huong (2016); Dhippayom & Saetang (2017); Fong & Chin (2018); Thekkur et al. (2022); Government of Nepal, Ministry of Health (2017); Hanvoravongchai & Mikkelsen (2022); Healthier SG (n.d.); Huque et al. (2014); Improving Primary Health Care (2022, n.d.); Jayasinghe et al. (2017); Katsuhide (2006); Kularatna et al. (2024); Lim et al. (2014, 2017);Nundy & Bhatt (2022b); Ministry of Health (2017, 2024); Ministry of Health and Family Welfare (2022); Muharram et al. (2024); Nantana & Winitthammawong (2019); National Health Mission (n.d.); National Library Board (2024); NowServing (n.d.); Luong (2018); Philippine Institute for Development Studies (2020); Player (2019); Poudel et al. (2024); Sadiq (2020); Singapore Health Services (2024); Smile Foundation (n.d.); The Borgen Project (n.d.); The Manila Times (2025); Vietnam News (2024); Witthayapipopsakul et al. (2019); Karkee and Jha (2010); World Bank (2020, 2025); World Health Organization (2019, 2021).

Note: PHC = primary healthcare; UPHCSDP = Urban Primary Healthcare Services Delivery Project; RCHCIB = Revitalization of Community Healthcare Initiative Bangladesh; NUHM = National Urban Health Mission; UPHC = Urban Primary Health Centre; UCHC = Urban Community Health Centre; NRHM = National Rural Health Mission; CHC = Community Health Centre; RHU = Rural Health Unit; MOH = Medical Officer of Health or Ministry of Health, as context requires; PMCU = Primary Medical Care Unit; PSSP = Primary Healthcare System Strengthening Project; UHC = universal health coverage; PCC = Primary Care Cluster; CHV = community health volunteer; VHV = Village Health Volunteer; CPIRD = Collaborative Project to Increase Production of Rural Doctors; CHS = commune health station; NHG = National Healthcare Group; NUHS = National University Health System; DHC = district health centre; BHWs = Barangay Health Workers; CC = Community Clinic; CHW = community health worker; HPH = Health Promoting Hospitals; PHCC = primary healthcare centre; Posyandu = Integrated community service posts; Puskesmas = Pusat Kesehatan Masyarakat; UPHCP = Urban Primary Health Care Project; VHW = Village Health Worker.

Sri Lanka has achieved 1 doctor per 1,000 people, whereas Nepal now has more than 3 nurses per 1,000 people, up from 1.6–2.8 per 1,000 people between 2012 and 2017 (World Bank, n.d.). However, a significant proportion of doctors (25–40%) and nurses (47–62%) work in the private sector, except in Sri Lanka, where over 90% of professionals are public sector employees (Perera, 2015).

Workforce distribution remains a major challenge across most countries, as human resources for health (HRH) are often concentrated in urban areas. Countries have implemented various strategies to address these disparities, including financial incentives for rural service, mandatory rural postings, and the creation of new cadres of health workers with shorter training durations. For example, Indonesia integrates CHWs into its Puskesmas network to support primary care, while Bangladesh struggles with a relatively low ratio of nurses and midwives compared to doctors (Claramita, 2023).

CHWs play a particularly important role in bridging accessibility gaps in rural and underserved areas (Table 2). In Bangladesh, a large government-supported cadre of frontline workers underpins this outreach system, with a large government cadre of Health Assistants and Family Welfare Assistants (approximately 21,000 and 23,500 sanctioned posts, respectively) delivering community-based family planning and primary health care services, despite some vacancies in the workforce (Roy et al., 2021). India's ASHAs have similarly mobilised community resources and raised health awareness, contributing to improved maternal and child health outcomes (Scott et al., 2019). A total of 983,032 ASHAs are in place, against the target of 1,034,630 under the National Health Mission (95% in position), following the norm of one ASHA for every 1,000 rural residents and one for every 2,500 in urban areas (National Health Systems Resource Centre [NHSRC], 2021). Indonesia's Posyandu (integrated health posts) and Bangladesh's BRAC initiatives also extend PHC into rural areas (Chowdhury et al., 2013). Thailand has over 1 million VHVs, while Vietnam deploys Village Health Workers (VHWs) across more than 95% of its villages (UNICEF, 2023).

Informal healthcare providers also play a significant role in primary care, particularly in areas where formal health services are limited. In India, for instance, a survey found that 68% of the private sector workforce in rural villages consisted of informal providers, who often operate without formal qualifications or medical licenses (Sharma, 2020).

However, workforce shortages, remuneration issues, and heavy workloads continue to undermine service quality and retention (WHO, 2022). The most persistent challenge is the divide between rural and urban areas, which reflects longstanding inequities in workforce distribution, infrastructure, and access. These issues remain despite the existence of institutional mechanisms intended to address them. In countries with large rural populations, most citizens live in areas underserved by doctors, nurses, and PHC institutions. By contrast, urban centres concentrate human resources and private facilities, reinforcing inequalities in both access and quality of care. Examples illustrate the extent of this divide: Kathmandu has one doctor per 1,000 people, while rural Nepal has as few as one for 41,000. In India, 75% of infrastructure is concentrated in cities, leaving rural areas with an 80% staffing shortfall. Even in better-resourced countries such as Malaysia and Thailand, physicians often migrate from rural postings to urban private practice, perpetuating imbalances.

To strengthen governance, countries have introduced accreditation bodies, decentralised recruitment, and workforce information systems, particularly in Sri Lanka, Bangladesh, and Nepal. These efforts signal progress but remain uneven in scope and enforcement.

Institutional mechanisms frequently include both urban and rural programmes, often linked to national health missions or community-based initiatives. India's National Urban Health Mission (NUHM) targets slum populations through urban posts and centres, while National Rural Health Mission (NRHM) anchors rural sub-centres and CHCs. Bangladesh operates urban PHC projects such as UPHCSDP alongside RCHCIB. Indonesia and Thailand rely heavily on Puskesmas and Subdistrict Health Promoting Hospitals (HPHs), supported by cadres like Posyandu and VHVs. Countries with dispersed geographies, such as Malaysia and the Philippines, deploy mobile and flying doctor services to reach remote populations. Vietnam's Project 1816 redistributes doctors from urban hospitals to rural areas, while Sri Lanka is piloting empanelment models to better integrate care across regions.

Despite these efforts, problems persist: Retention remains low, professional development opportunities are limited, and PHC roles are undervalued compared to specialised medicine. Medical brain drain also weakens workforce sustainability, with India recording the highest number of emigrating physicians globally (Prinja et al., 2024).

Fragmentation between urban and rural delivery models produces uneven quality and duplication of services. In Bangladesh, donor-supported PHC projects benefit urban areas, while rural CCs face resource and staffing shortages. In Vietnam, Commune Health Centres are underutilised due to low confidence in service quality, driving patients towards higher-level urban hospitals and perpetuating overcrowding. Worker migration towards cities or overseas further exacerbates shortages, as seen in the Philippines and Nepal. Decentralisation adds another layer of difficulty, as local governments often lack resources to finance or staff rural facilities equitably.

Meanwhile, rapid urbanisation has created a parallel challenge. Cities now face overburdened and fragmented PHC systems. Vietnam, for example, reports widening inequalities in urban PHC, with informal settlements and migrant workers having poor access to quality care. In Malaysia, migrant and indigenous populations in rural Sabah are classified as "hard-to-reach" due to cultural and logistical barriers (Noor et al., 2020). Despite innovations such as telemedicine, mobile clinics, and mHealth interventions, they have yet to fully bridge access gaps. The region also faces a growing need for coordination across municipal health systems to ensure effective PHC delivery in urban settings.

Broader systemic issues further constrain workforce capacity. Infrastructural deficits, international migration, and weak accountability mechanisms compound challenges. Gaps in technical skills, leadership, and motivation also undermine PHC delivery. Regulatory fixes, such as fingerprint scanners to curb absenteeism, have had limited impact, while traditional classroom-based training often fails to translate into better service delivery. More promising approaches include long-term, institutionalised mentoring that combines skill-building with professional support. For example, in India, UNICEF and Equalize Health partnered with the Government of Chhattisgarh to scale up Training for Enhancing Capacities in Neonatal Care (TECNeC), a tele-mentoring programme that builds nurses' confidence and capacity in handling neonatal emergencies. Similarly, reflective practice and Participatory Learning and Action (PLA) approaches in India have helped build capacity, confidence, and participatory learning processes among health system actors (Mishra et al., 2022; UNICEF, 2022).

Most countries have also created HRH units within Ministries of Health to oversee planning, deployment, and workforce management. However, the mandates, authority, and effectiveness of these units remain uneven. A WHO South-East Asia Regional Office-facilitated questionnaire on workforce capacity issues reveals some critical challenges among countries in the region (Commetto et al., 2019). For example, Bangladesh's HR branch cites a lack of leadership and political will as core bottlenecks, while Nepal has multiple divisions and directorates managing HRH functions, resulting in policy incoherence, especially in workforce registry management and private sector oversight.

Another systemic weakness is the lack of robust HRH information systems. Nepal, for instance, reports poor-quality, disaggregated data and no mechanisms for regular sharing. Such data gaps limit evidence-based planning, hinder accountability, and perpetuate inefficiencies in HRH deployment.

The distribution and retention of healthcare personnel in rural and remote areas continue to be the most frequently cited workforce challenges. Thailand identifies rural retention as a major challenge, while Indonesia reports shortages of specialists and difficulties staffing peripheral health centres. Decentralisation across 514 Indonesian districts has also led to uneven HRH prioritisation, undermining national strategies. India and Sri Lanka face shortages of skilled providers, alongside weak career pathways, poor task-shifting, and low motivation. Sri Lanka's experience highlights the benefits of free medical education in retaining doctors within the public PHC system, ensuring high-quality outpatient care (Prinja et al., 2024). However, other health worker cadres, including nurses, laboratory technicians, and pharmacists, often face limited career progression and skill retention opportunities (Prinja et al., 2024). Furthermore, the quality of pre-service education remains a concern, as curricula are not always aligned with evolving population health needs, leading to suboptimal competencies among health workers (Prinja et al., 2024).

Countries are experimenting with institutional mechanisms and policy innovations, with mixed results. Indonesia's HRH Board targets remote and border areas but struggles with weak IT infrastructure and rigid civil service structures. Nepal is developing a strategic HRH roadmap for 2030 and a national registry. These reflect a growing recognition of HRH as a policy priority, yet capacity and governance challenges persist.

At the governance level, structural barriers remain entrenched. Decentralisation in Indonesia and Nepal has created accountability gaps between central and local authorities. Inadequate financial resources, civil service rigidities, and limited regulatory oversight of the private sector (as in Nepal and India) exacerbate inequities in workforce distribution and quality assurance. Ministries of Health often face severe capacity constraints, including underdeveloped HR planning skills, a lack of autonomy, and limited enforcement authority.

In South Asia, PHC programmes in urban areas have been criticised for being transplants of rural models, focusing on low-income populations. Since urban areas have complex administrative, institutional, and governance structures that often work in parallel without convergence, it is important to design an urban healthcare delivery model contextualised to the structure and needs of the urban population. In Bangladesh, NGOs have evolved CHW programmes such as the Shasthya Shebika and Shasthya Kormi models that have been contextualised and adapted to the conditions of urban slums (Shrestha et al., 2024). Well-supported community structures, social networks, and robust referral systems enabled these urban CHWs to accelerate progress on maternal and newborn care. However, further research is needed to develop institutionalised urban PHC models that account for provider diversity, population structure, and the roles of local bodies, the private sector, and civil society.

4.5 Community Engagement

Developing a participatory health system culture supported by systematic engagement between governments and civil society is an integral part of PHC. The UNICEF PHC Landscape Analysis for East Asia and the Pacific highlights the need for investment in frontline workers and community-based health action to address persistent health inequities (UNICEF, 2023). In South Asia, efforts to reform PHC have emphasised integrated services, multi-sectoral collaboration, and community empowerment, as outlined in a series of papers on PHC in South Asia (Prinja et al., 2024). Collaborative engagement across health professionals and communities is also a key lever to promote healthy ageing and mental health services through timely identification and support for the elderly and affected populations within communities.

Thailand has set up an institutional mechanism to promote and facilitate systematic and ongoing community input into policymaking through the National Health Assembly. Participatory committees are also a feature of the Indian health system, such as the Village Health, Sanitation, and Nutrition Committees and Jan Arogya Samitis (People's Health Committees) that enable community engagement at primary care levels. Community health clinics in Bangladesh have been a key reform to promote community engagement. Each of these examples offers lessons for how meaningful community engagement can be leveraged to strengthen PHC, presenting opportunities for cross-country knowledge exchange (Table 7).

5. Collaboration and Cooperation Across the Region

Countries across South and Southeast Asia face a shared set of structural challenges in delivering high-quality, equitable PHC. These include constrained fiscal space, imbalances between preventive and curative spending, workforce shortages, weak gatekeeping, fragmented governance, and uneven community engagement. At the same time, the region exhibits areas of relative strength—robust CHW models, maturing digital ecosystems, strong political commitment in several countries, and innovative approaches to public–private engagement—that offer substantial opportunities for cross-learning.

Regional collaboration provides a pathway to accelerate progress towards UHC by pooling knowledge, reducing duplication, and enabling countries to collectively address challenges that no single government can solve alone. The pressures of demographic change, climate-induced disease patterns, rising NCDs, and emerging zoonotic threats underscore the need for better health systems governance, where countries coordinate not only technical initiatives but the institutional and governance mechanisms that underpin PHC reform.

Table 7: Community Engagement

Country	Presence of CHWs	Examples of Health Workers
Bangladesh	Yes	Community healthcare providers, Family Welfare Assistants, Health Assistants, VHW, NGO-supported CHWs (e.g., BRAC, Shasthya Shebikas, Shasthya Kormis, and Pushti Kormis), and CSBA
India	Yes	ASHAs, ANMs, Multipurpose Health Workers, PHC Workers
Indonesia	Yes	Village Midwives (Bidan Desa), Posyandu Kaders, Nurses, and Auxiliary Health Workers
Malaysia	Yes (limited role)	CHWs, PHNs, and Assistant Medical Officers (formerly known as dressers)
Nepal	Yes	FCHVs, ANMs, Health Assistants, and Midwives
Philippines	Yes	BHWs, BNSs, Midwives, Nurses, Public Health Physicians, and Rural Health Midwives
Sri Lanka	Yes	PHMs, PHNs, PHIs, and MOoH
Singapore	Yes	GPs, Polyclinic Nurses, Family Physicians, and Community Health Ambassadors/Volunteers, and Allied Health Professionals
Thailand	Yes	VHVs, CHV, Nurses, and Midwives
Vietnam	Yes	Commune Health Workers, VHW, Assistant Doctors, and Auxiliary Health Personnel

Sources: Prinja et al. (2024); United Nations Children's Fund (2023).

Note: CHW = community health worker; ASHA = Accredited Social Health Activist; ANM = Auxiliary Nurse Midwife; PHC = primary healthcare; FCHV = Female Community Health Volunteer; BHW = Barangay Health Worker; BNS = Barangay Nutrition Scholar; PHM = Public Health Midwife; PHN = Public Health Nurse; PHI = Public Health Inspector; MOoH = Medical Officer of Health; GP = general practitioner; VHV = Village Health Volunteer; VHW = Village Health Worker; BRAC = Bangladesh Rural Advancement Committee; CHV = Community Health Volunteer; CSBA = Community Skilled Birth Attendant; Posyandu = Integrated community service posts.

A region-wide approach strengthens the institutional resilience of PHC systems by supporting ministries of health in their stewardship roles, facilitating cross-sectoral action, and providing platforms for joint problem-solving. Importantly, as many countries are engaged in rethinking the "how" of PHC reform—through decentralisation, task-sharing, digitalisation, or restructured financing—regional collaboration offers a mechanism to adapt innovations to varied institutional contexts rather than transplanting models uncritically.

Thus, the case for regional collaboration rests not on uniformity but on shared purpose: building PHC systems that are integrated, people-centred, financially sustainable, accountable, and resilient.

Existing Partnerships

Previous studies by institutions such as the National University of Singapore and Prince of Songkla University have made a strong case for strengthening regional knowledge-sharing on PHC (Chongsuvivatwong et al., 2011; SEARCH, 2024). These analyses highlight the need to (i) strengthen collaboration on transnational health challenges such as disease surveillance and outbreak control; (ii) facilitate multi-sectoral reform by engaging actors across health, trade, labour, and the environment; (iii) empower regional institutions—including ASEAN, SAARC, and Bay of Bengal Initiative for Multi-Sectoral Technical and Economic Cooperation (BIMSTEC)—to assume stronger health mandates; and (iv) develop regional intellectual property and shared platforms for medical countermeasures.

Momentum for such collaboration has grown. "At the 74th session of the WHO Regional Committee for South-East Asia, Ministers of Health committed to reorienting health systems towards PHC through increased public investment, recognising PHC as central to resilience, UHC, and the health-related SDGs" (WHO, 2021).

Asia already hosts a broad and diverse ecosystem of PHC-related partnerships:

- South-East Asia Regional Forum for PHC-oriented Health Systems: Facilitates implementation-focused learning among 11 Member States (WHO, 2022).
- Southeast Asia Collaborative for Health (SEARCH): Supports UHC-oriented research, strategic purchasing, and PHC governance reforms (SEARCH, 2024).
- The RESEARCH platform, led by the Indian Council of Medical Research (ICMR), fosters cross-border innovation and research collaboration across South and Southeast Asia (ICMR, 2025).
- WHO frameworks such as the South-East Asia Regional Strategy for PHC 2022–2030, the UHC Partnership, and the Primary Health Care Performance Initiative (PHCPI) Vital Signs Profiles offer structured guidance and benchmarking tools.
- Providing for Health Network (P4H) Asia, Asia Network for Health Systems Strengthening (ANHSS), CONNECT for Social Health Protection (CONNECT), and the Joint Learning Network (JLN): Provide platforms for technical exchange on health financing, governance, and social protection (Asia Pacific Network for Health Systems Strengthening, n.d.; CONNECT for Social Health Protection, n.d.; JLN for UHC, n.d.; P4H Network, 2025).
- Bilateral partnerships further complement these efforts. India collaborates closely with Nepal, Sri Lanka, Bhutan, Timor-Leste, and Bangladesh on PHC reforms (Press Information Bureau, 2025); Japan International Cooperation Agency (JICA) remains a long-standing partner in supporting community health infrastructure in Bangladesh and other countries (JICA et al., 2025); and ASEAN Plus Three frameworks integrate China, Japan, and Korea into regional health system strengthening. The US and China—through the Centers for Disease Control and Prevention (CDC), public health research partnerships, and digital health collaborations—also shape the regional governance landscape.

These networks have enabled notable achievements: shared digital health pilots, training exchanges, cross-country engagement on PHC financing reforms, and expanded use of measurement frameworks. Yet gaps remain. Collaboration is uneven across thematic areas; many initiatives depend heavily on external funding and mechanisms for sustained, implementation-focused, and governance-oriented learning—particularly around private sector regulation, accountability, and institutional reform—are still limited.

These platforms have enabled significant progress in technical exchange, capability strengthening, and shared measurement. Bilateral engagements illustrate growing political appetite for cooperation. Meanwhile, major global actors, including the US and China, continue to shape the regional health architecture through investments in disease surveillance, digital health, and public health research. Their involvement focuses on capacity building, health security, and technical assistance, especially China's Health Silk Road, launched in 2017 as part of the broader Belt and Road Initiative (BRI).

Despite these gains, challenges persist. There are more academic/research-based initiatives than governmental, implementation-oriented programmes with an explicit focus on PHC. Many initiatives rely on external funding cycles, and few focus squarely on the institutional and governance processes that determine whether PHC reforms succeed. Issues such as quality assurance, private sector regulation, referral management, and accountability remain inconsistently addressed across platforms. To understand where collaboration can go next, it is essential to examine the country-wise strengths and weaknesses that create opportunities for meaningful cross-learning (Table 8).

Table 8: Cross-Cutting Insights for Regional Collaboration

Dimension/Lever	Regional Strengths	Collaboration Opportunities
Political and Financial Commitment	Thailand and Sri Lanka sustain political prioritisation of PHC.	Underinvestment in preventive care; need joint PHC financing advocacy.
Model of Care and Governance	Thailand's gatekeeping and Singapore's digital integration are regional benchmarks.	Weak referral and regulation systems; scope for shared contracting models.
Workforce	CHW networks (India, Bangladesh, Nepal, and Thailand) provide regional outreach strength.	Low pay, uneven skills; joint CHW competency framework and exchange.
Community Engagement	Institutionalised participation and accountability mechanisms in India and Thailand.	Need for regional knowledge-sharing on participatory governance.

Source: Authors' compilation based on the discussion in the main text.

Note: PHC = primary healthcare; CHW = community health worker.

Institutions, Governance, and Processes as the Cornerstones of Primary Healthcare Strengthening

As countries confront an increasingly ageing population, emerging and re-emerging disease burdens due to environmental and climate disruptions, fiscal challenges arising from geopolitical instability, and the retreat from globalisation, PHC, as the foundation of health systems, is being reimagined. This is fundamentally an institutional and governance challenge, focusing on actors and the mechanisms of PHC reform, i.e., the "who" and the "how."

Effective institutions are central to strengthening PHC systems, ensuring that ministries of health provide the necessary stewardship, direction, and resources to implement reforms. Strengthening PHC governance requires multi-sectoral collaboration, as many health outcomes are shaped by policies beyond the health sector. However, the ministries of health often lack the authority to drive cross-sectoral action, leading to fragmented approaches in areas such as nutrition, NCD prevention, and environmental health. Addressing these gaps calls for networked governance models that foster coordination across ministries, local governments, and civil society actors, prioritising transparency, accountability, and the efficient use of resources.

A top-down, hierarchical approach to governance may be insufficient in addressing the complex realities of PHC delivery. Instead, a governance ecosystem built on trust, transparency, and accountability—with meaningful participation from local governments, community groups, and frontline health workers—may help shape more responsive and resilient health systems.

PHC in Asia reflects a diverse interplay of institutional legacies, governance structures, and evolving processes of service delivery. Across low-, middle-, and high-income settings, the institutional landscape is anchored in public sector networks. Institutions define the service platform, population coverage norms, and workforce models, with varying degrees of integration between preventive and curative care.

Governance structures shape how these institutions perform. In countries such as Thailand and Malaysia, centralised ministries of health set clear policy direction while delegating service delivery to district and sub-district networks. In India, Nepal, and the Philippines, governance is more fragmented, with federal or decentralised arrangements leading to uneven capacity and accountability. Singapore represents a more centralised and digitally enabled model, while Indonesia operates under a decentralised framework with strong links to SHI.

Processes of governance—planning, financing, regulation, and quality assurance—remain uneven across the region. Thailand's integration of preventive and curative services under a UCS, Malaysia's multidisciplinary teams, and Sri Lanka's robust preventive programme offer learning experiences to other countries. Fragmented financing, weak regulation of private providers, and shortages of trained workforce, especially in rural or remote areas, remain areas of governance gaps across many countries. Efforts at digitalisation, insurance expansion, and community engagement are reshaping governance processes, but challenges of coordination, quality monitoring, and sustainability remain.

Overall, the primary care challenge in Asia lies not only in expanding coverage but in aligning institutional design, governance mechanisms, and governance processes to deliver integrated, person-centred, and accountable care across diverse contexts.

Pathways to Strengthen and Build Upon Existing Partnerships

The country configurations and collaboration pathways outlined in this section are grounded in the strategic and operational levers used in this paper's analytical framework. At the strategic level, collaboration on political and financial commitment seeks to sustain PHC as a priority within UHC agendas and improve the mobilisation and allocation of resources towards preventive and primary care. At the operational level, the pathways focus on strengthening models of care, health workforce, and community engagement, recognising that the effectiveness of PHC reform ultimately depends on how services are organised, delivered, and experienced at the frontline.

Rather than promoting uniform solutions, these pathways present opportunities to reflect on how countries with complementary strengths can work together to operationalise PHC reforms in ways that are institutionally feasible, context-sensitive, and aligned with existing governance arrangements.

1. Political and Financial Commitment

a) Gatekeeping and Referral System (Thailand ↔ Malaysia ↔ Sri Lanka ↔ India [select states]):

- Thailand's mature gatekeeping model and Sri Lanka's strong preventive platform provide templates for countries struggling with PHC bypassing and weak referral structures.
- Malaysia's integrated clinic system and quality regulation offer lessons for mixed-service delivery contexts.
- India (e.g., Tamil Nadu and Kerala) could benefit from structured exchanges on gatekeeping design and district-level governance.

Collaboration Focus:

- Referral protocols, empanelment models, and shared contracting frameworks for private providers.
- Designing PHC governance structures in decentralised systems (India, Indonesia, the Philippines, and Nepal).

b) PHC Financing and Strategic Purchasing (Thailand ↔ Indonesia ↔ Vietnam ↔ the Philippines ↔ Malaysia):

- Thailand's tax-funded UHC, Indonesia's JKN, Vietnam's SHI model, and the Philippines' sin-tax financing reforms create an ideal cluster for collaboration on financing design.
- Malaysia's regulated private–public mix offers insights on blended financing and purchasing.

Collaboration Focus:

- Costing PHC benefit packages, capitation formulas, and strategic purchasing tools.
- Shared frameworks for quality regulation of private PHC providers.
- Joint modelling of fiscal sustainability.
- Designing PHC provider payment systems that incentivise prevention and continuity.
- Contracting templates and accountability mechanisms.
- Designing PHC networks that integrate private primary care without exacerbating inequity.

2. Models of Care and Governance (Thailand ↔ Malaysia ↔ Sri Lanka ↔ India [select states]):

a) PHC Integration and Public–Private Mix Regulation: Singapore ↔ Malaysia ↔ Thailand ↔ India:

- Singapore's tightly regulated private-led model and Malaysia's public–private balance provide lessons for countries where private provision is dominant but poorly regulated.
- Thailand offers example of empanelment and integrated care.
- India's contracting and public health insurance mechanisms (e.g., PMJAY) can contribute practical experience.

Collaboration Focus:

- Shared frameworks for quality regulation of private PHC providers.
- Contracting templates and accountability mechanisms.
- Designing PHC networks that integrate private primary care without exacerbating inequity.

b) Decentralised PHC Governance and Local Capacity Strengthening: Nepal ↔ Indonesia ↔ the Philippines ↔ India (federal states):

- Designing PHC governance structures in decentralised systems (India, Indonesia, the Philippines, and Nepal).
- Nepal's local governance reforms, Indonesia's district-level variation, and the Philippines' barangay-level PHC model provide natural avenues for learning with India's state-driven PHC reforms.

Collaboration Focus:

- Local planning processes, budgeting tools, and accountability structures.
- Models of supportive supervision and district-level quality assurance.
- Solutions for uneven subnational capacity.

c) Digital PHC and Health Information Systems: India ↔ Singapore ↔ Malaysia ↔ Vietnam ↔ Indonesia:

- India's digital public goods (ABDM, eSanjeevani), Singapore's primary care networks and data architecture, Malaysia's integrated Health Management Information System (HMIS), and Vietnam's digitalisation pilots represent complementary strengths.
- Indonesia's decentralised digital landscape provides testbeds for interoperability solutions.

Collaboration Focus:

- Regional minimum digital PHC standards.
- Shared sandbox environments for testing digital PHC tools.
- Joint cybersecurity and data governance principles.
- Cross-border continuity of care for migrant populations.

3. Health Workforce Development and Deployment (India ↔ Bangladesh ↔ Nepal ↔ Thailand ↔ Philippines ↔ Indonesia):

- Constraints in the availability, distribution, and capability of the PHC workforce remain among the most binding challenges across South and Southeast Asia.
- Countries with large CHW platforms (India, Bangladesh, Nepal, and Thailand) and those relying on village-level cadres and local government-employed health workers (Indonesia and the Philippines) face shared issues of uneven skills, weak career pathways, high workloads, and persistent rural retention challenges.

Collaboration Focus:

- Regional competency frameworks and harmonised training curricula for PHC and CHWs.
- Digital tools for supervision, performance support, and continuing education.
- Exchange programmes for district health teams, trainers, and CHW supervisors.
- Shared approaches to task-shifting, remuneration, and supportive supervision.

4. CHW Platforms and Community-based Care (India ↔ Bangladesh ↔ Nepal ↔ Thailand):

- India's ASHAs, Bangladesh's BRAC CHWs, Nepal's FCHVs, and Thailand's VHVs represent the world's densest concentration of community-based PHC models.
- Each model faces different challenges—remuneration, supervision, and integration with formal systems—making cross-learning highly relevant.

Collaboration Focus:

- Joint competency frameworks, training modules, and digital tools for CHWs.
- Cross-country supervision models, performance-based incentives, and supportive governance.
- Community engagement and local accountability mechanisms.

Taken together, these collaborative pathways demonstrate how regional cooperation can act as a practical mechanism for advancing PHC reform across all five levers. Joint action on financing and strategic purchasing reinforces political and financial commitment; collaboration on gatekeeping, referral systems, and public–private integration strengthens models of care and governance; shared approaches to health workforce development address availability, quality, and distribution constraints; and learning on community-based platforms and accountability mechanisms deepens community engagement. By linking country configurations to these levers, regional collaboration moves beyond knowledge exchange towards implementation-oriented system strengthening.

References

Agustina, R., Dartanto, T., Sitompul, R., Susiloretni, K. A., Suparmi, Achadi, E. L., Taher, A., Wirawan, F., Sungkar, S., Sudarmono, P., Shankar, A. H., & Thabrany, H. (2019). Universal health coverage in Indonesia: Concept, progress, and challenges. *The Lancet, 393*(10166), 75–102. https://doi.org/10.1016/S0140-6736(18)31647-7

Ahmed, S. M., Alam, B. B., Anwar, I., Begum, T., Huque, R., Khan, J. A. M., Nababan, H., & Osman, F. A. (2015).*Bangladesh health system review.* World Health Organization, Regional Office for South-East Asia.

Ahmed, S. M., Hossain, M. A., Chowdhury, A. M. R., & Bhuiya, A. U. (2011). The health workforce crisis in Bangladesh: Shortage, inappropriate skill-mix and inequitable distribution. *Human Resources for Health, 9*, Article 3. https://pmc.ncbi.nlm.nih.gov/articles/PMC3037300/

Alzona, G., Cabanizas, G. G., Jamaica, M. J., Bianca, J., & Arvin, J. (2024). Implications of the Mandanas-Garcia ruling on local health systems. *Acta Medica Philippina, 58*(13). https://doi.org/10.47895/amp.v58i13.8131

Angara, S. (2009, May 27). *Angara bats for more medical scholars in Senate bill* [Press release]. Senate of the Philippines. https://web.senate.gov.ph/press_release/2009/0527_angara1.asp

Asian Development Bank. (n.d.). *Urban Primary Health Care Services Delivery Project*. https://www.adb.org/projects/42177-013/main

Balani, K., Singh, A. K. and Venkateswaran, S. (2024). *Strengthening primary care in India: Opportunities and challenges* (CSEP Working Paper 77). Centre for Social and Economic Progress.

Bangladesh Center for Communication Programs. (n.d.). *Urban Primary Health Care Services Project (UPHCP II)*. https://www.bangladesh-ccp.org/

Bhandari, K., & Baral, B. (2013). Distribution and skill mix of health workforce in Nepal. *Journal of Nepal Health Research Council, 11*(24), 126–132.

Brahmapurkar, K. P., Zodpey, S. P., Sabde, Y. D., & Brahmapurkar, V. K. (2018). The need to focus on medical education in rural districts of India. *The National Medical Journal of India, 31*(3), 164–168.

Chongsuvivatwong, V., Phua, K. H., Yap, M. T., Pocock, N. S., Hashim, J. H., Chhem, R., Wilopo, S. A., & Lopez, A. D. (2011). Health and health-care systems in southeast Asia: diversity and transitions. *The Lancet, 377*(9763), 429–437. https://doi.org/10.1016/S0140-6736(10)61507-3

Chowdhury, A. M. R., Bhuiya, A., Chowdhury, M. E., Rasheed, S., Hussain, Z., & Chen, L. C. (2013). The Bangladesh paradox: Exceptional health achievement despite economic poverty. *The Lancet, 382*(9906), 1734–1745. https://doi.org/10.1016/S0140-6736(13)62148-0

Claramita, M., Hilman, O., Ekawati, F. M., Syah, N. A., Arisanti, N., & Fujiati, I. I. (2023). *Indonesia: A primary health care case study in the context of the COVID-19 pandemic*. World Health Organization.

Cometto, G., Buchan, J., & Dussault, G. (2020). Developing the health workforce for universal health coverage. *Bulletin of the World Health Organization, 98*(2), 109–116.

CONNECT for Social Health Protection. (n.d.). *CONNECT – For social health protection*. https://connectshp.com/

Dang, T. P., & Huong, L. T. (2016). *Health system of Vietnam*. World Health Organization. https://www.ncbi.nlm.nih.gov/books/NBK310721/

Dayrit, M. M., Lagrada, L. P., Picazo, O. F., Pons, M. C., & Villaverde, M. C. (2018). The Philippines health system review. *Health Systems in Transition, 8*(2). World Health Organization.

Dhippayom, T., & Saetang, S. (2017). Rural retention of new medical graduates from the Collaborative Project to Increase Production of Rural Doctors (CPIRD): A 12-year retrospective study. *Rural and Remote Health, 17*(1), 4057.

Economic Planning Unit. (2021). *12th Malaysia Plan, 2021–2025: A prosperous, inclusive, sustainable Malaysia*. Prime Minister's Department, Malaysia. https://www.epu.gov.my/en/12th-malaysia-plan

Edelman, A., Taylor, J., Ovseiko, P. V., & Sheikh, A. (2021). Modified scoping review of the enablers and barriers to implementing primary health care in the COVID-19 context. *Health Policy and Planning, 36*(7), 1163–1186.

El Arifeen, S., Christou, A., Reichenbach, L., Osman, F. A., Azad, K., Islam, K. S., Ahmed, F., Perry, H. B., & Peters, D. H. (2013). Community-based approaches and partnerships: Innovations in health-service delivery in Bangladesh. *The Lancet, 382*(9909), 2012–2026.

Fong, S. Y., & Chin, C. P. (2018). Distribution of medical doctors in Malaysia: A case for health policy reforms. *International Journal of Social Science Research, 6*(1), 1–15. https://core.ac.uk/download/pdf/275906747.pdf

Foo, C. D., Chia, H. X., Teo, K. W., Farwin, A., Hashim, J., Koh, G. C.-H., Matchar, D. B., Legido-Quigley, H., & Yap, J. C. H. (2023). Healthier SG: Singapore's multi-year strategy to transform primary healthcare. *The Lancet Regional Health – Western Pacific, 37*, 100861. https://doi.org/10.1016/j.lanwpc.2023.100861

Ghimire, A. (2025). Beyond doctors and hospitals: Nepal's Female Community Health Volunteer model—A new paradigm for global health. *Frontiers in Public Health, 13*, 1587360.

Government of Nepal, Ministry of Health. (2017). *Nepal Health Sector Strategy (NHSS) implementation plan 2016–2021*. Nepal Health Sector Support Programme. http://www.nhssp.org.np/

Hanvoravongchai, P., & Mikkelsen, S. (2022). Thailand's universal health coverage: Lessons for other countries. *BMJ Global Health, 7*(Suppl. 2), e018076. https://gh.bmj.com/content/10/Suppl_2/e018076

Haseltine, W. A. (2013). *Affordable excellence: The Singapore healthcare story*. Brookings Institution Press.

Healthier SG. (n.d.). *Why is it important to choose a family doctor?* Ask.Gov.sg. https://ask.gov.sg/healthiersg/

Huque, R., Nasreen, S., Akter, S., Nargis, M., & Mandal, B. N. (2014). *Improving primary health care using community clinics in rural Bangladesh*. COMDIS-HSD. https://assets.publishing.service.gov.uk/

Indian Council of Medical Research. (2025). *RESEARCH platform: Regional exchange for advancement in science and health.*

Institute for Health Metrics and Evaluation. (2023). *GBD compare: Global Burden of Disease data visualization*. University of Washington. https://vizhub.healthdata.org/gbd-compare/

International Labour Organization. (2025, April 29). *Statistics on the population and labour force*. https://ilostat.ilo.org/topics/population-and-labour-force/

International Monetary Fund. (2025, April 24). *Asia can boost economic resilience amid surging trade tensions*. https://www.imf.org/en/Blogs/Articles/2025/04/24/

Jaafar, S., Mohd Noh, K., Abdul Muttalib, K., Othman, N. H., Healy, J., Maskon, K., Abdullah, A. R., Zainuddin, J., Abu Bakar, A., Shaikh Abd Rahman, S., Ismail, F., Yuen, C. Y., Baba, N., & Mohd Said, Z. (2013). *Malaysia health system review*. World Health Organization, Regional Office for the Western Pacific; Asia Pacific Observatory on Health Systems and Policies.

Japan International Cooperation Agency, Koei Research & Consulting Inc., & IC Net Limited. (2025). *Information collection survey on health sector programs in Bangladesh: Final report* (JICA Report No. 12390365). https://openjicareport.jica.go.jp/pdf/12390365.pdf

Jayasinghe, S., Fernando, G. T., & Senanayake, S. (2017). Distribution of medical officers and factors influencing their retention in rural hospitals in Sri Lanka. *Sri Lanka Journal of Medicine, 26*(1), 11–19.

Joint Learning Network for Universal Health Coverage. (n.d.). *About us*. https://jointlearningnetwork.org/about-us/

Karkee, R., & Jha, N. (2010). Primary health care development: Where is Nepal after 30 years of Alma-Ata declaration? *Journal of Nepal Health Research Council,* 8(2), 93–99.

Katsuhide, S. (2006). *An overview of the Malaysian health care system*. Ministry of Health, Labour and Welfare, Japan. https://www.mhlw.go.jp/

Khoo, H. S., Lim, Y. W., & Vrijhoef, H. J. (2014). Primary healthcare system and practice characteristics in Singapore. *Asia Pacific Family Medicine, 13*(1). https://doi.org/10.1186/s12930-014-0008-x

Kularatna, M. P. G., Kulatunga, V., & Jayamanne, S. F. (2024). The health workforce in Sri Lanka: An overview of the challenges and opportunities. *medRxiv*. https://doi.org/10.1101/2024.01.10.24301140v1

Lahariya, C. (2020). Health & Wellness Centres to strengthen primary health care in India: Concept, progress and ways forward. *Indian Journal of Pediatrics*.

Lee, H.-Y., Oh, J., Hoang, V. M., Moon, J. R., & Subramanian, S. V. (2019). Use of high-level health facilities and catastrophic expenditure in Vietnam: Can health insurance moderate this relationship? *BMC Health Services Research, 19*(1). https://doi.org/10.1186/s12913-019-4115-0

Lee, S. W. H., Amer Nordin, A., Saw, P. S., Wong, Y. T., Osman, N. N., Mohan, D. S. R., Abdul Halim, N. H., Ab Rahim, F. I., & Muhamad Assri, N. S. (2023). *Malaysia: A primary health care case study in the context of the COVID-19 pandemic*. World Health Organization.

Lim, H. M., Sivasampu, S., Khoo, E. M., & Mohamad Noh, K. (2017). Chasm in primary care provision in a universal health system: Findings from a nationally representative survey of health facilities in Malaysia. *PLOS ONE*. https://pmc.ncbi.nlm.nih.gov/articles/PMC5308860/

Lim, M., Lee, W., Abdul-Ghani, I., Zaini, N., & Hassan, S. (2014). Role of family doctors in Malaysia. Global Family Doctor.

Luong, H. V. (2018, November 19). *Strengthening commune health centers in Vietnam: Assessing the impact of the Atlantic Philanthropies 2008–16.* Social Science Research Council.

Ministry of Health and Family Welfare, India. (2022). *Rural Health Statistics 2021–22*. https://mohfw.gov.in/

Ministry of Health and Family Welfare. (n.d.). *Ayushman Arogya Mandir.* Government of India. https://aam.mohfw.gov.in/

Ministry of Health and Family Welfare. (2017, March 15). *National health policy 2017*. https://mohfw.gov.in/sites/default/files/9147562941489753121.pdf

Ministry of Health and Population Nepal. (2024). *Climate Change Health Adaptation Strategy and Action Plan*. Government of Nepal. https://www.atachcommunity.com/

Ministry of Health, Sri Lanka. (2016). *National Health Strategic Plan 2016–2025*. Government of Sri Lanka.

Mishra, A., Singh, A. K., Parida, S. P., Pradhan, K. S., & Nair, J. (2022). Understanding community participation in rural health care: A participatory learning and action approach. *Frontiers in Public Health, 10*, 860792. https://doi.org/10.3389/fpubh.2022.860792

Mosadeghrad, A. M., Afshari, M., Isfahani, P., Ezzati, F., Abbasi, M., Farahani, S. A., Zahmatkesh, M., & Eslambolchi, L. (2024). Strategies to strengthen the resilience of primary health care in the COVID-19 pandemic: A scoping review. *BMC Health Services Research, 24*(1). https://doi.org/10.1186/s12913-024-11278-4

Muharram, F. R., Sulistya, H. A., Swannjo, J. B., Firmansyah, F. F., Rizal, M. M., Izza, A., Isfandiari, M. A., Ariningtyas, N. D., & Romdhoni, A. C. (2024). The Indonesia health workforce quantity and distribution. *medRxiv*. https://doi.org/10.1101/2024.03.31.24305126

Mulakala, A. (2024). *Complementary U.S. and China public health engagements in Southeast Asia: Opportunities for synergy*. Asia Society Policy Institute. https://asiasociety.org/

Nantana, J., & Winitthammawong, C. (2019). The global and Thai health workforce: Challenges and opportunities. *The Southeast Asian Journal of Public Health, 8*(1), 21–25.

National Health Mission, India. (n.d.-a). *Accredited Social Health Activist (ASHA)*. https://www.nhm.gov.in/

National Health Mission, India. (n.d.-b). *National Urban Health Mission*. https://nhm.gov.in/

National Health Systems Resource Centre. (2021). *Annual ASHA update 2020–21*. Ministry of Health and Family Welfare, Government of India. https://nhsrcindia.org/sites/default/files/2022-07/Annual%20ASHA%20Update%202020-21.pdf

National Library Board, Singapore. (2024, May 17). *Healthcare in Singapore*. https://www.nlb.gov.sg/

Noor, N. M., Khalidi, J. R., & Muzafar, P. M. M. (2020). *Social inequalities and health in Malaysia: The state of households 2020 Part III*. Khazanah Research Institute. https://www.krinstitute.org/

NowServing. (n.d.). *Rural healthcare access in the Philippines*. https://nowserving.ph/

Nundy, M., & Bhatt, P. (2022a). *The health system in the Kingdom of Thailand: Reforms, achievements, and challenges* (CSEP Working Paper 45). Centre for Social and Economic Progress.

Nundy, M., Bhatt, P., (2022b). *Health system in the Republic of Indonesia: Reforms, transformations, and challenges* (CSEP Working Paper 43). Centre for Social and Economic Progress.

Oanh, T. T. M., Thang, N. T., Thu, C. N. T., & Tuan, K. A. (2023). *Viet Nam: A primary health care case study in the context of the COVID-19 pandemic*. World Health Organization.

OC Academy. (2025, August 21). *South Asia health collaboration: ICMR drives regional public health*. https://www.ocacademy.in/

Organisation for Economic Co-operation and Development. (n.d.). *Purchasing power parities (PPP).* https://www.oecd.org/en/data/indicators/purchasing-power-parities-ppp.html

P4H Network. (2025). *Evolving healthcare in Southern and Southeast Asia*. https://p4h.world/

Perera, D. S. (2015). *Primary Health Care reforms in Sri Lanka: Aiming at preserving universal access to health.* Orient Blackswan. https://www.ncbi.nlm.nih.gov/books/NBK316262/

Perera, S., Ramani, S., Joarder, T., Shukla, R. S., Zaidi, S., Wellappuli, N., Ahmed, S. M., Neupane, D., Prinja, S., Amatya, A., & Rao, K. D. (2024). Reorienting health systems towards Primary Health Care in South Asia. *The Lancet Regional Health – Southeast Asia, 28*, 100466. https://doi.org/10.1016/j.lansea.2024.100466

Philippine Institute for Development Studies. (2020, March 27). *About 75% of cities, towns in the Philippines lack health workers*. https://www.pids.gov.ph/

Pholpark, A., Mon, H. M., Lim, L. T., Tsilaajav, T., de Oliveira Cruz, V., & Hanvoravongchai, P. (2025). Challenging inadequate and fragmented primary health care financing: Findings from Bangladesh, Indonesia, Maldives, and Nepal. *The Lancet Regional Health – Southeast Asia, 38*, 100613. https://doi.org/10.1016/j.lansea.2025.100613

Player, J. (2019). *Healthcare access in rural communities in India*. Ballard Briefs, Brigham Young University. https://ballardbrief.byu.edu/

Poudel, P., Koirala, B., Shrestha, S., & Shrestha, S. (2024). The status quo of nursing in Nepal: Challenges, opportunities, and future prospects. *Journal of Health and Social Sciences*.

Press Information Bureau, Government of India. (2025a, August 23). *South & Southeast Asian nations unite to strengthen health research systems through collaboration* [Press release]. https://www.pib.gov.in/

Press Information Bureau, Government of India. (2025b, October 16). *India renews commitment to healthy ageing at 78th session of the WHO Regional Committee of South-East Asia* [Press release]. https://www.pib.gov.in/

Primary Health Care Performance Initiative. (2022). *Indonesia: Organisation of services*. Improving Primary Health Care. https://www.improvingphc.org/

Primary Health Care Performance Initiative. (n.d.). *Thailand: Access*. Improving Primary Health Care. https://www.improvingphc.org/

Prinja, S., Purohit, N., Kaur, N., Rajapaksa, L., Sarker, M., Zaidi, R., Bennett, S., & Rao, K. D. (2024). The state of primary health care in South Asia. *The Lancet Global Health, 12*(10), e1693–e1705. https://doi.org/10.1016/S2214-109X(24)00119-0

Raghavan, A. (n.d.). *Asia's digital health innovations: The role of cross-border health data sharing.* Asia House.

Rajan, D., Jakab, M., Schmets, G., Azzopardi-Muscat, N., Winkelmann, J., Peiris, D., Di Ruggiero, E., Naledi, T., Jantsch, A. G., Trindade, T., Gitahi, N., Lessof, S., Khalid, F., Dalil, S., & Figueras, J. (2024). Political economy dichotomy in primary health care: Bridging the gap between reality and necessity. *The Lancet Regional Health – Europe, 42*, 100945. https://doi.org/10.1016/j.lanepe.2024.100945

Rajapaksa, L., De Silva, P., Abeykoon, P., Somatunga, L., Sathasivam, S., Perera, S., Fernando, E., De Silva, D., Perera, A., Perera, U., Weerasekara, Y., Gamage, A., Wellappuli, N., Widanapathirana, N., Fernando, R., Wijesundara, C., Seneviratne, R., & Weerasinghe, K. (2021). *Sri Lanka health system review.* World Health Organization, Regional Office for South-East Asia.

Rao, K. D., Shahrawat, R., & Bhatnagar, A. (2016). Composition and distribution of the health workforce in India: Estimates based on data from the National Sample Survey. *WHO South-East Asia Journal of Public Health,* 5(2), 133–140.

Rannan-Eliya, R. P., & Sikurajapathy, L. (2009). *Sri Lanka: "Good practice" in expanding health care coverage* (Research Studies Series No. 3). Institute for Health Policy.

Republic Act No. 11223. (2019). *An Act Instituting Universal Health Care for All Filipinos, Prescribing Reforms in the Health Care System, and Appropriating Funds Therefore*. Supreme Court E-Library, Philippines. https://elibrary.judiciary.gov.ph/

Roy, S., Pandya, S., Hossain, M. I., Abuya, T., Warren, C. E., Mitra, P., Rob, U., Hossain, S., & Agarwal, S. (2021). Beyond institutionalization: Planning for sustained investments in training, supervision, and support of community health worker programs in Bangladesh. *Global Health: Science and Practice, 9*(Suppl 1), S144–S156.

Sadiq, A. S. (2020). Understanding of individual rationality and institutional constraints: The case of deficiency of doctors in rural Bangladesh. *Journal of Global Health Reports*.

Scott, K., George, A. S., & Ved, R. R. (2019). Taking stock of 10 years of published research on the ASHA programme: Examining India's national community health worker programme from a health systems perspective. *Health Research Policy and Systems, 17*(1), 29. https://doi.org/10.1186/s12961-019-0427-0

SEARCH. (2024). *Strategic health purchasing and primary healthcare in Southeast Asia: Roundtable report.* National University of Singapore, Saw Swee Hock School of Public Health.

Sharma, N. C. (2020, June 29). *68% rural healthcare providers have no formal training; Southern states have better quality of doctors: Study.* Mint. https://www.livemint.com/

Shrestha, P., Afsana, K., Weerasinghe, M. C., Perry, H. B., Joshi, H., Rana, N., Memon, Z. A., Khaled, N., Malhotra, S., Bhardwaj, S., Kafle, S., Inagaki, Y., Schmidt, A., Hodgins, S., Neupane, D., & Rao, K. D. (2024). Strengthening primary health care through community health workers in South Asia. *The Lancet Regional Health – Southeast Asia, 28*, 100463. https://doi.org/10.1016/j.lansea.2024.100463

Singapore Health Services. (2024, February 21). *Beyond coughs and colds: Getting more GPs involved in chronic care*. https://www.singhealth.com.sg/

Smile Foundation. (n.d.). *Addressing workforce gaps in India's rural healthcare system*. https://www.smilefoundationindia.org/

Tan, C. C., Lam, C. S. P., Matchar, D. B., Zee, Y. K., & Wong, J. E. L. (2021). Singapore's health-care system: Key features, challenges, and shifts. *The Lancet, 398*(10305), 1091–1104. https://doi.org/10.1016/S0140-6736(21)00252-X

The Borgen Project. (n.d.-a). *Addressing healthcare in Nepal*. https://borgenproject.org/

The Borgen Project. (n.d.-b). *Transforming lives through healthy cities in Indonesia*. https://borgenproject.org/

The Manila Times. (2025, August 14). *Philippines faces doctor shortage, falls short of WHO standards.* https://www.manilatimes.net/

Thekkur, P., Fernando, M., Nair, D., Kumar, A. M. V., Satyanarayana, S., Chandraratne, N., Chandrasiri, A., Attygalle, D. E., Higashi, H., Bandara, J., Berger, S. D., & Harries, A. D. (2022). Primary health care system strengthening project in Sri Lanka: Status and challenges with human resources, information systems, drugs and laboratory services. *Healthcare, 10*(11), 2251.

UNICEF. (2022, May 27). *Strengthening new-born health workforce in Chhattisgarh by tele-mentoring.* https://www.unicef.org/india/stories/strengthening-new-born-health-workforce-chhattisgarh-tele-mentoring

UNICEF (2022). *Evidence-based data and information on impact of climate change in the health sector in Indonesia*. https://www.unicef.org/indonesia/

UNICEF. (2021). *Budget brief: Health sector – Sri Lanka*. https://www.unicef.org/srilanka/media/2716/file/

UNICEF. (2023). *Primary health care landscape analysis East Asia and Pacific*. https://www.unicef.org/eap/

Vasanthan, L., Natarajan, S. K., Babu, A., Kamath, M. S., & Kamalakannan, S. (2024). Digital health interventions for improving access to primary care in India: A scoping review. *PLOS Global Public Health, 4*(5), e0002645. https://doi.org/10.1371/journal.pgph.0002645

Vietnam News. (2024, May 2). VN targets 15 doctors per 10,000 people by 2025. https://vietnamnet.vn/

Witthayapipopsakul, W., Cetthakrikul, N., Suphanchaimat, R., Noree, T., & Sawaengdee, K. (2019). Equity of health workforce distribution in Thailand: An implication of concentration index. *Risk Management and Healthcare Policy, 12*, 13–22.

World Bank. (n.d.). *Cause of death, by communicable diseases and maternal, prenatal and nutrition conditions (% of total) – Bangladesh.* https://data.worldbank.org/indicator/SH.DTH.COMM.ZS

World Bank. (n.d.). *Physicians (per 1,000 people).* World Development Indicators. https://data.worldbank.org/indicator/SH.MED.PHYS.ZS

World Bank. (n.d.). *Nurses and midwives (per 1,000 people).* https://data.worldbank.org/indicator/SH.MED.NUMW.P3

World Bank. (2020). *Vietnam's health system: The challenge of change*. https://openknowledge.worldbank.org/

World Bank. (2022). *Development projects: Sri Lanka: Primary Healthcare System Enhancing Project (PHSEP) – P181564*. https://projects.worldbank.org/

World Bank. (2024a). *Nurses and midwives (per 1,000 people) – Nepal* [Data set]. https://data.worldbank.org/

World Bank. (2024b). *Sri Lanka: Primary Healthcare System Enhancing Project (PHSEP) (P181564)*. https://documents1.worldbank.org/

World Bank. (n.d.). *World Development Indicators* [Data set]. https://data.worldbank.org/

World Health Organization & World Bank. (2019). *UHC Service Coverage Index*.

World Health Organization UHC Partnership. (2018). *Sri Lanka's journey to UHC—Primary health care on the road to UHC*.

World Health Organization. (2020). *Engaging the private health service delivery sector through governance in mixed health systems: Strategy report of the WHO Advisory Group on the Governance of the Private Sector for Universal Health Coverage.*

World Health Organization. (2021). *South-East Asia regional strategy for primary health care: 2022–2030.* https://www.who.int/publications/i/item/9789290229094

World Health Organization. (2016). *Primary Health Care Systems (PRIMASYS): Case study from Malaysia*.

World Health Organization. (2017a). *Primary Health Care Systems (PRIMASYS): Case study from Thailand*.

World Health Organization. (2017b). *Primary Health Care Systems (PRIMASYS): Case study from Indonesia*.

World Health Organization. (2017c). *Primary Health Care Systems (PRIMASYS): Case study from Viet Nam*.

World Health Organization. (2017d). *Primary Health Care Systems (PRIMASYS): Case study from Bangladesh*.

World Health Organization. (2017e). *Primary Health Care Systems (PRIMASYS): Case study from Nepal*.

World Health Organization. (2017f). *Primary Health Care Systems (PRIMASYS): Case study from Sri Lanka*.

World Health Organization. (2018a). *Declaration of Astana*. https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf

World Health Organization. (2018b). *Building the economic case for primary health care: A scoping review*. https://www.who.int/publications/i/item/WHO-HIS-SDS-2018.48

World Health Organization. (2019). Primary Health Care systems in Sri Lanka: Strengthening with a focus on human resources for health. *WHO South-East Asia Journal of Public Health, 8*(1), 21. https://iris.who.int/

World Health Organization. (2021). *Strengthening primary health care in the COVID-19 era: A review of best practices to inform health system responses in low- and middle-income countries*. https://iris.who.int/handle/10665/351476

World Health Organization. (2022, November 29). *Regional forum for primary health care-oriented health systems launched to strengthen implementation-focused learning and cooperation*. https://www.who.int/southeastasia/

World Health Organization. (2023a). *Primary health care in the South-East Asia*. https://www.who.int/southeastasia/

World Health Organization. (2024). *WHO results report 2020–2021: Thailand*. https://www.who.int/

World Health Organization. (2025). *Primary health care country case study compendium*. https://www.who.int/teams/primary-health-care/

World Health Organization. (n.d.). *Global Health Expenditure Database*. https://apps.who.int/nha/database/Select/Indicators/en

Yi, S., Yam, Y., Cheruvettolil, K., Linos, E., Gupta, A., Palaniappan, L., Rajeshuni, N., Vaska, K. G., Schulman, K., & Eggleston, K. N. (2024). Digital health innovations in low- and middle-income healthcare systems: Perspectives from South and Southeast Asia. *Journal of Medical Internet Research, 26*, e57612. https://doi.org/10.2196/57612

Yu, C. P., Whynes, D. K., & Sach, T. H. (2008). Equity in health care financing: The case of Malaysia. *International Journal for Equity in Health, 7*(1). https://doi.org/10.1186/1475-9276-7-15

Zakoji, M., & Sundararaman, T. (2021). Emerging good practices and lessons learnt to maintain essential health services during the COVID-19 pandemic. *WHO South-East Asia Journal of Public Health, 10*(Suppl. 1), S26–S29.

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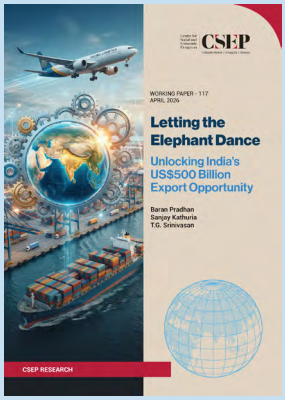
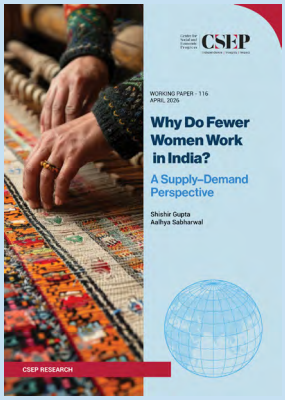
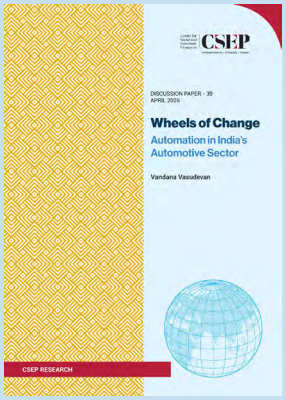
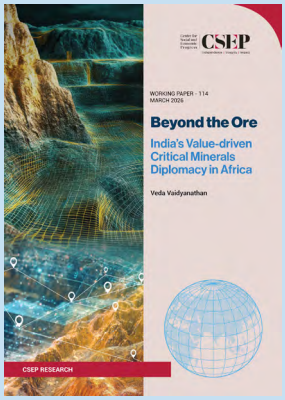
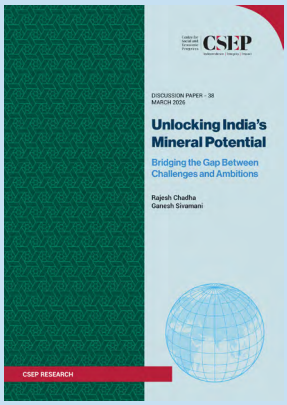
Other publications

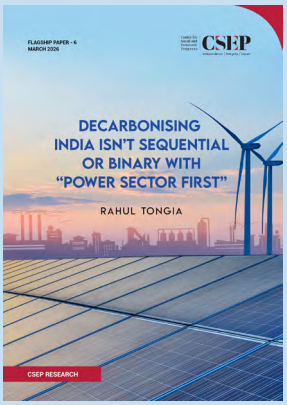


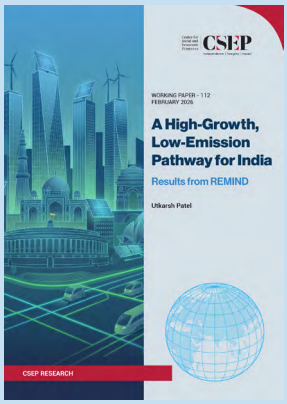


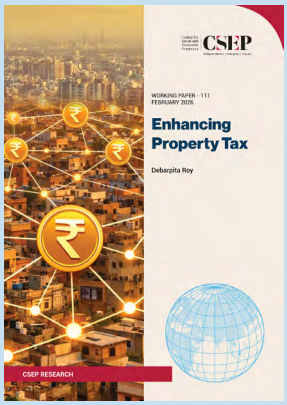


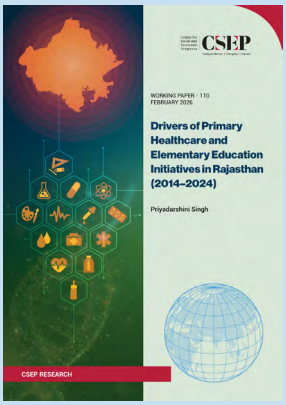


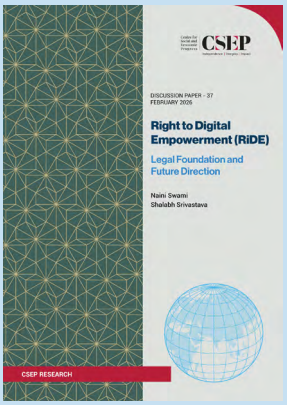


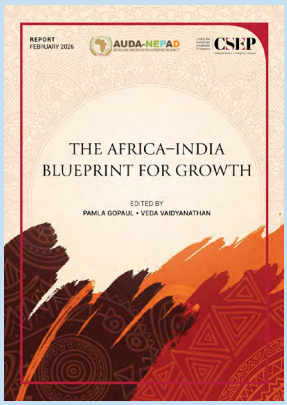


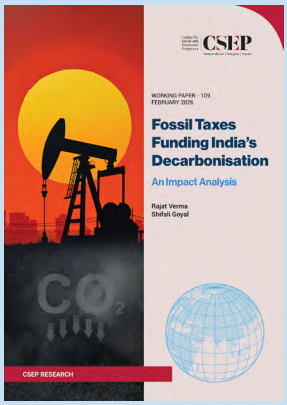


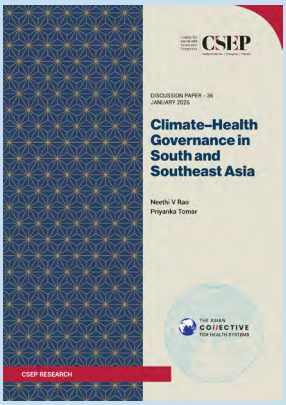


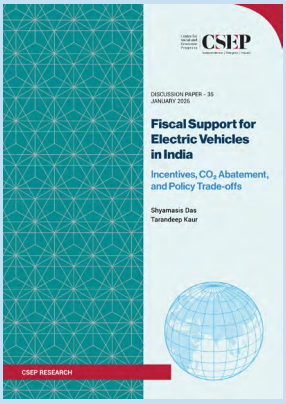












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