Advancing Universal Health Coverage in the WHO South-East Asia Region with a focus on Human Resources for Health

Ibadat Dhillon, Manoj Jhalani, Thaksaphon Thamarangsi, Amani Siyam, and Poonam Khetrapal Singh*

WHO Regional Office for South-East Asia, Delhi, India

The Lancet Regional Health - Southeast Asia 2023;18: 100313

Published Online 29 October 2023

https://doi.org/10.1016/j.lansea.2023.100313

Summary

The identification in 2014 of Universal Health Coverage, including focus on human resources for health, as a flagship priority for the WHO South-East Asia Region marked critical departure from the prior period of the Millennium Development Goals. The last decade witnessed strong political commitment and action to advance UHC across the Region. At regional level, UHC service coverage index improved from 47 in 2010 to 62 in 2021. Improved availability of human resources for health has been an important contributor, with the regional average of doctors, nurses and midwives increasing by approximately a third between 2014 and 2020. Progress on financial protection has been mixed: proportion of population impoverished declined significantly but catastrophic expenditure did not reduce. Despite important gains, progress is insufficient to achieve UHC targets by 2030. Covid-19 pandemic and subsequent economic challenges have created further urgency to accelerate progress towards UHC, with attention to strengthening primary health care.

Keywords: Universal Health Coverage; UHC; Primary Health Care; PHC; Human Resources for Health; HRH; Health systems

Introduction

Universal Health Coverage (UHC), as defined by WHO, "means that everyone receives quality health services, when and where they need them, without incurring financial hardship."[1] UHC can be understood across three dimensions: population covered, services covered, and financial protection. Critically, upon adoption of the UN Sustainable Development Goals in 2015, UHC was identified as one of its' 169 targets.[2]

Explicit global prioritization of UHC in 2015 marked a remarkable departure from the decades prior. It shifted global focus from diseases to, in the words of one of WHO's founders, the "human being—the working, creating, hoping and struggling human being."[3] The importance of UHC–and challenge to its realization–for the WHO South-East Asia Region, home to 2 billion people and still developing economies, cannot be overstated.

Of note, in 2014, prior to the advent of the UN Sustainable Development Goals, the WHO South-East Asia Region identified Universal Health Coverage, with focus on human resources for health (HRH) and essential medicines, as a regional flagship priority.

A full appreciation of the progress made towards UHC over this last decade (2014–2023) is benefitted from a historical understanding of the development of health systems and public health in the WHO South-East Asia Region. Since formation of countries in the Region, there has been a notable tension between two competing philosophies and approaches (with the latter of the two dominant across most geographies and time):

i) Desire to advance health as a human right, conscious of close linkage to social and economic contexts, and associated state responsibility; and
ii) Technology-focused and donor prioritized specific disease and condition-focused initiatives, responding to a challenge of scarcity in resources across SEAR Member States.[4–6]

Over the last several decades, with important exceptions such as Thailand, scarcity in resources, especially in human resources for health, has been a major rationale for SEAR countries and the global community to focus attention and resources towards select disease-specific initiatives or selective primary health care.[5] Increased availability of human resources for health, with historic production increases, serves as an important lens that speaks to the unprecedented opportunity in the South-East Asia Region to comprehensively address evolving population health needs in the Region.

As further historical context, in the 2006 World Health Report, WHO identified six of the eleven countries in the Region as facing critical shortages of human resources for health (i.e. below 22.8 physicians, nurses and midwives per 10,000 population), with greatest absolute shortages present in this Region as compared to

*Corresponding author.
E-mail address: dhilloni@who.int (I. Dhillon).

other WHO regions.[7] The lack of progress on addressing critical shortages was specifically raised by delegates to the 2nd Global Forum on Human Resources for Health in Thailand, 2011 with need for focused and sustained attention to overcome this fundamental challenge.[8]

In response, in 2014 Member States of the WHO South-East Asia Region agreed to a decade of health workforce strengthening as a core element of the Regional UHC flagship priority. Following, the 67th Regional Committee Resolution *Strengthening Health Workforce Education and Training* (SEA RC67/6), the Decade for Strengthening Human Resources for Health in the South-East Asia Region (2015–2024) was formally launched at a regional meeting in Bhutan with aim to ensure attention, accountability, and action by Member States, WHO and partners.

In this paper, we describe regional progress over the last decade towards Universal Health Coverage; key Member State policy actions that is expected to drive progress in the years ahead; regional progress in Human Resources for Health as both a contributor to UHC-related gains and reflective of future potential to advance UHC in the Region; and renewed focus in the Region on strengthening Primary Health Care-orientation of health systems as a means to address contemporary health, social and economic challenges faced by countries in the Region.

Progress on Universal Health Coverage and Human Resources for Health is reported annually and biennially, respectively, to the WHO South-East Asia Regional Committee. This paper builds on regional progress reports, in particular highlighting the following three standard SDG indicators monitored at global and regional levels: (i) Coverage of essential health services (SDG 3.8.1); (2) Proportion of population with large household expenditure on health as a share of total household expenditure or income (SDG 3.8.2); and density of doctors, nurses and midwives (SDG 3.c.1).

The first indicator (SDG 3.8.1), through an index, describes the coverage of essential services based on 14 tracer indicators. The 14 tracer indicators including reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and most disadvantaged populations. The second indicator, catastrophic health spending (SDG 3.8.2) is defined as household health spending greater than 10% of the household total consumption or income, which is driven by out-of-pocket spending. The source of data for these two indicators is the WHO Global Health Observatory.

The third indicator, SDG 3.c.1: density of doctors, nurses and midwives, has been regularly monitored at regional and global levels based upon country-reported data through the system of National Health Workforce Accounts. Given importance in the Region, a range of additional occupations including community health workers, medical assistants, paramedical staff, and traditional health workers has also been analyzed. The source of this data is the National Health Workforce Accounts (NHWA) online platform. It should be noted that NHWA presents Member State-reported data; itself dependent upon the quality of the human resources for health information system and ability to comprehensively capture information from both public and private sector. Information on human resources for health has been collated from the 4th progress report on human resources for health, as shared with the 75th WHO SEA Regional Committee.[9]

The article further documents and analyzes political processes toward progress on UHC, including Member State commitments through regional resolutions, Member State policy actions, as well as published literature on the historic development of health system in the Region.

Progress towards UHC in the WHO South_East Asia Region: 2014 to 2023

Progress in UHC service coverage and financial protection

Unlike decades prior, the last decade saw clear priority by Member States and WHO to the vision and goal of Universal Health Coverage. Annual monitoring of UHC progress across the Region has, in particular, served as an important enabling mechanism to ensure focused UHC-discussion amongst senior-level policy makers at Regional Committee meetings, as well as to ensure accountability and drive UHC momentum across countries of the Region.

Countries in the Region have made significant progress in improving UHC Service Coverage Index (UHC SCI). With the regional average for the index increasing from 47 in 2010 to 62 in 2021. However, evidence also shows, that the pace of progress is not fast enough to achieve the minimum essential UHC SCI of 80 by 2030. The latest estimates (2021) further point to considerable variation among countries of the region in the UHC SCI, ranging from 46 to 82 (Fig. 1), and compared with the estimates of 2019, four countries have made slight progress (Bangladesh, Nepal, Sri Lanka and Timor-Leste), four have recorded sustained progress (Bhutan, India, Indonesia and Thailand) and three countries are in slight regression (DPR Korea, Maldives and Myanmar). The latter could be explained by service disruptions, as linked to the pandemic as well as subsequent economic and humanitarian challenges.

In the past two decades, the Region has made significant improvement across all four sub-indices of UHC SCI (Fig. 2). The regional infectious diseases sub-index has improved fastest between 2000 and 2019 (from 8 to 64) with a distinct acceleration between 2010 and 2015. Between 2019 and 2021, the regional

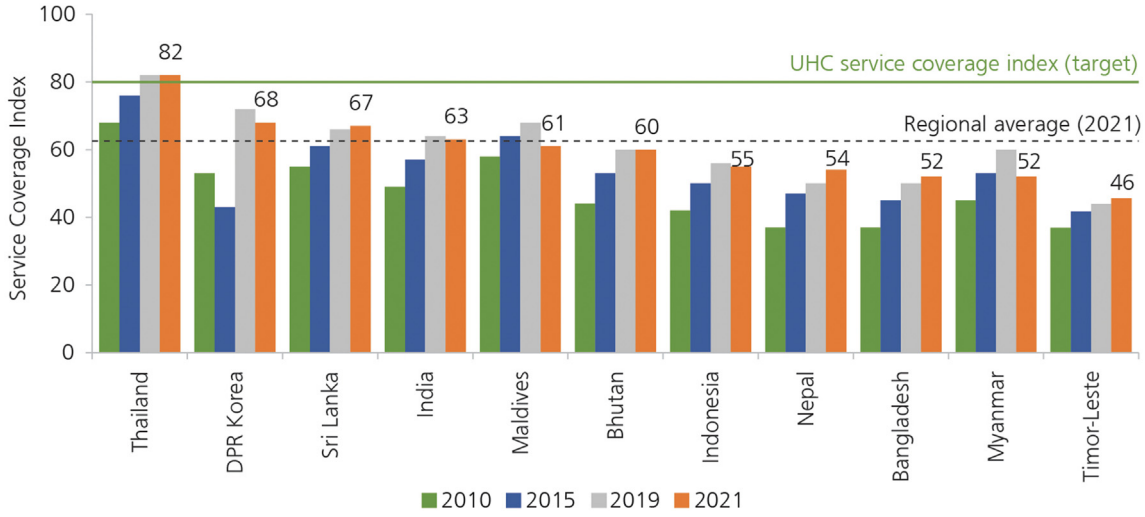

***Fig. 1:* Progress in coverage of essential health services in countries of SEA Region, 2015–2021**. Source of Data: WHO Global Health Observatory, accessed 31st July 2023.

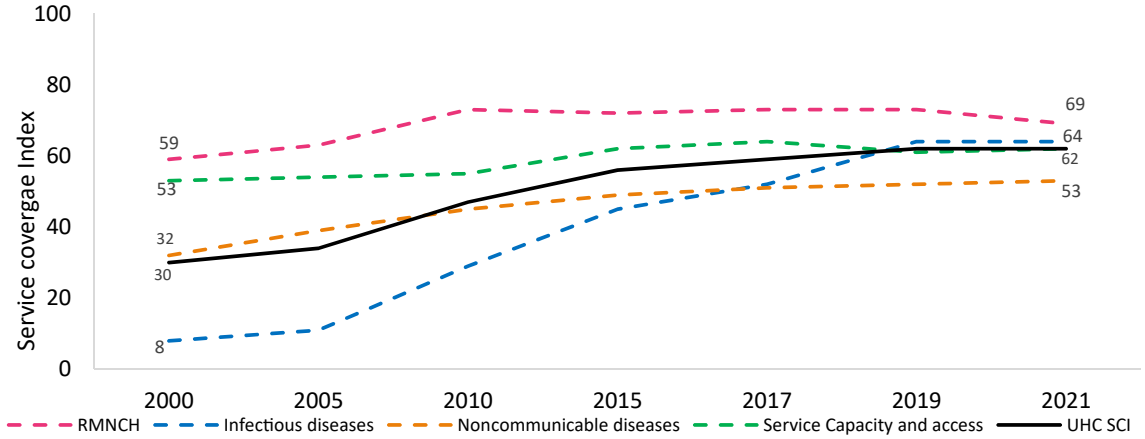

***Fig. 2:* Trend in UHC SCI sub-indices in the SE Asia Region, 2000–2021**. Source of Data: WHO Global Health Observatory, accessed 31st July 2023

infectious diseases subindex remained almost unchanged attributed to the decline in TB treatment coverage during the COVID-19 pandemic. The regional noncommunicable diseases subindex indicates the slowest pace of improvement (from 32 in 2000 to 53 in 2021) which could be attributed to suboptimal public health investments in the relevant interventions and a degree of inadequacy of the underlying data systems to monitor progress. During the COVID-19 pandemic, expectedly, all RMNCH services were disrupted the most resulting in slight decline in the regional RMNCH sub-index from 73 in 2019 to 69 in 2021.

The period between 2014 and 2020, saw the out-of-pocket (OOP) spending as a share of current total health spending in the Region decline from 42.8% in 2014 to 37.9% in 2020; with accompanied rise in government spending from 42.3% to 48.9% of total health spending. Importantly, the total population estimated to be impoverished and further impoverished due to OOP health spending (living with less than PPP$ 2.15 a day per person) pointed to declines from 12.4% in 2015 to about 6% in 2017, though limitation of data for only a two-year interval. It should be noted, however, that out-of-pocket share of current health expenditure in the Region is second highest across WHO Regions.[10]

The distribution of joint progress on both dimensions of UHC, essential health services coverage and financial protection, also varies widely in the Region (Fig. 3). Compared with the global average, most of the SE Asia Region countries lie in Quadrant IV with a

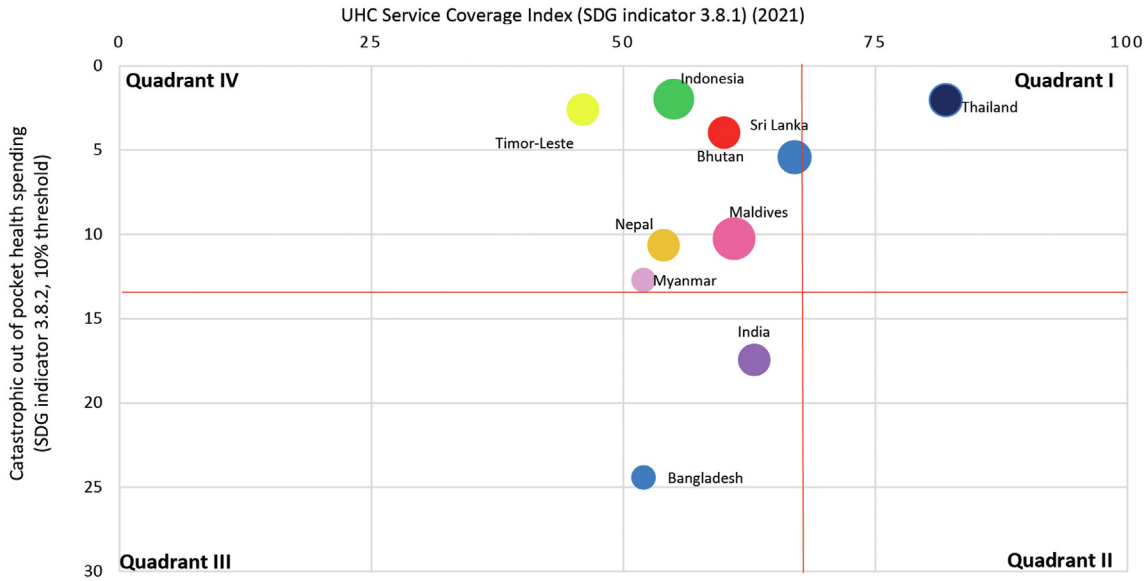

***Fig. 3*: Comparison of health services coverage and catastrophic health expenditure in Member States of the SE Asia Region**. Source of Data: WHO Global Health Observatory, accessed 31st July 2023

relatively low UHC SCI (<68) and low catastrophic health spending (<13.5%). Bangladesh and India belong to Quadrant III, which indicates a higher-than-average level of catastrophic health spending coupled with relatively low UHC SCI. Thailand is the only country (in Quadrant I) that has achieved relatively high UHC SCI (>80) and low levels of catastrophic health spending (<5%).

Sustained policy commitment and action

Sustained UHC-focused Member State policy commitment and action has been a key contributor to the quantitative improvements identified above. Following endorsement by SEAR Member States, the WHO South-East Asia Regional Strategy for Universal Health Coverage was published in 2015.[11] Universal Health Coverage has been a focused agenda at annual Regional Committee meetings over the last decade, with important UHC-focused Regional Committee resolutions and decisions with express commitments by Member State and specific actions requested for WHO (See Box 1).

Importantly, UHC-related political declarations and commitments have been followed with UHC-focused policy action. Key policy actions and achievements of Member States towards strengthening UHC in the Region is summarized in Table 1 (below). In reviewing Member State actions towards UHC, significant achievement—at times historic in scale—is evident across SE Asia Region countries. All the afore-identified actions, in countries small and large, have important meaning for populations that are served. At the same time, policy actions introduced in India and Indonesia are worth highlighting for their sheer scale; together representing the largest worldwide expansion of UHC over the last decade.

As illustration, India launched its' Ayushman Bharat or National Health Protection scheme in 2018 which provides health insurance coverage for in-patient care to 500 million of the poorest and disadvantaged population in India, while establishing 150,000 health and wellness centers for the provision of comprehensive primary health care. Similarly, in 2014, Indonesia launched "Jaminan Kesehatan Nasional" or National Health Insurance Programme, with accumulative coverage reaching over 80% of Indonesia's 270 million population. Moreover, in 2023, Indonesia launched its' ambitious Primary Health Care Integration Programme which aims to provide high quality comprehensive primary health care to the Indonesian population through standardizing 300,000 primary care service providers; with 100% regular monitoring of area and population health condition.

Across most countries of the South-East Asia Region, policy actions have been relatively recently enacted, with benefits from these actions yet to be fully realized. At the same time, strong UHC-focused policy direction, alongside increased maturity of health systems and economies, provides optimism for progress towards UHC.

Progress in human resources for health

Sustained attention to and progress in Human Resources over the last decade has been a key contributor to progress in Universal Health Coverage, especially as related to improvement in Service Coverage. The

Box1.

UHC-focused resolutions and decisions of the WHO South-East Asia Regional Committee: 2014–2022

2014: *Strengthening health workforce education and training in the region* (SEA/RC67/6).

2015: *Patient safety contributing to sustainable universal health coverage* (SEA/RC68/R4) and *Community-based health services and their contribution to universal health coverage* (SEA/RC68/R6).

2016: *Colombo declaration on strengthening health systems to accelerate delivery of NCD services at the primary health care level* (SEA RC69/R1).

2017: *Annual progress monitoring of UHC and health-related Sustainable Development Goals* (SEA/RC70 (1)); with inclusion of annual UHC progress monitoring as a substantive agenda item of the Regional Committee till 2030.

2018: *Delhi declaration on improving access to essential medical products in the region and beyond* (SEA/RC71/R2).

2020: *WHO South-East Asia Region Member States' Declaration on collective response to COVID-19* (SEA/RC73/R1)—with emphasis on prioritizing investments in universal health coverage and primary health care.

2021: *Declaration by the health ministers of Member States at the Seventy-fourth session of the WHO Regional Committee for South-East Asia on Covid-19 and measures to 'build back better' essential health services to achieve universal health coverage and the health-related SDGs* (SEA/RC74/R1).

2022: *Enhancing social participation in support of primary health care and universal health coverage* (SEA RC75/R3).

fast-increasing health worker production in the WHO South-East Asia Region also serves as lens for potential to accelerate progress towards UHC.

In contrast to decades prior, there has been a consistent improvement across most SE Asia Region countries in the availability of doctors, nurses and midwives (SDG 3.c.1 indicator) over the last decade (See Fig. 4).

Currently, the regional average density of doctors, nurses and midwives stands at 28.05 per 10,000 population. This represents over 30% increase from 2014. As of April 2023, nine SEAR Member States have surpassed the 2006 World Health Report threshold of 22.8 doctors, nurses and midwives per 10,000 population (see Fig. 4). Moreover, three Member States have surpassed the threshold of 44.5 doctors, nurses and midwives as identified in 2016 Global Strategy on Human Resources for Health to achieve the SDGs.[12] Importantly, progress on SDG 3.c.1 over the last decade is especially notable in the WHO South-East Asia region.[13]

Countries in the Region have also invested significantly in increasing production capacity that has set the stage for strengthened availability of health workforce into the future. As illustration, in Bangladesh, between 2010 and 2020 the number of medical colleges nearly doubled (62 in 2010 to 113 in 2020); with a quadrupling of both the number of nursing and midwifery colleges/

Bangladesh	• Developed its' essential service package in 2016 and is operationalizing it through a strengthened community and primary health care system.
Bhutan	• Initiated its Service with Care and Compassion initiative in 2018, with integration of NCD services into its established Primary Health Care system.
DPR Korea	• Launched its' 2017 Medium Term Plan for Development of the Health Sector, with strong foundation of Primary Health Care • Developed Primary Health Care Strategy, 2021–2025
India	• Launched its national initiative for Free Essential Drugs and Essential Diagnostics in 2014 to provide essential medicines and essential diagnostics free of cost in public health facilities. • National Health Policy 2017, with strong focus on UHC/PHC • Launched the Ayushman Bharat scheme in 2018, providing health coverage for in-patient care to over 500 million poor and disadvantaged, while also establishing over 150,000 Health and Wellness Centres (HWCs) for the provision of comprehensive primary health care.
Indonesia	• Introduced health financing reform in 2014 through its National Health Insurance Scheme ("Jaminan Kesehatan Nasional"), with over 80% of Indonesia's population currently covered. • Health System Transformation 2022 launched at 58th National Health Day, with PHC strengthening as the first pillar • In 2023, launched National PHC Integration programme with focus on standardization of 300,000 service providers with 100% regular monitoring.
Maldives	• Introduced 'Hunuvaa Asandha' in 2014, a universal health scheme to provides affordable and accessible health care for all Maldivians. • Introduced Maldives National Health Plan 2016–2025, with current focus on revitalizing PHC through decentralization.
Myanmar	• Introduced National Health Plan 2017, with focus on advancing UHC.
Nepal	• 2015 Constitution of Nepal provided right to free basic health services and emergency health services for all. • National Health Policy 2019 introduce to ensure constitutional rights to health services in a federal health system.
Sri Lanka	• Introduced Policy on Health Care Delivery for UHC in 2018; and is currently operationalizing a shared cluster approach to reorganize service delivery for improved efficiency and equity.
Thailand	• Enacted the Primary Health System Act 2019, as a means to strengthen the efficiency, equity and quality of primary health care; and is in the process of extending its strong UHC system to the urban context.
Timor Leste	• In 2015, launched the "Programa Nacional Saúde na Familia" to bring comprehensive package of essential services to the household level.

Table 1: **Select National Policy Actions to strengthen UHC in the WHO SEA Region: 2014–2022.**

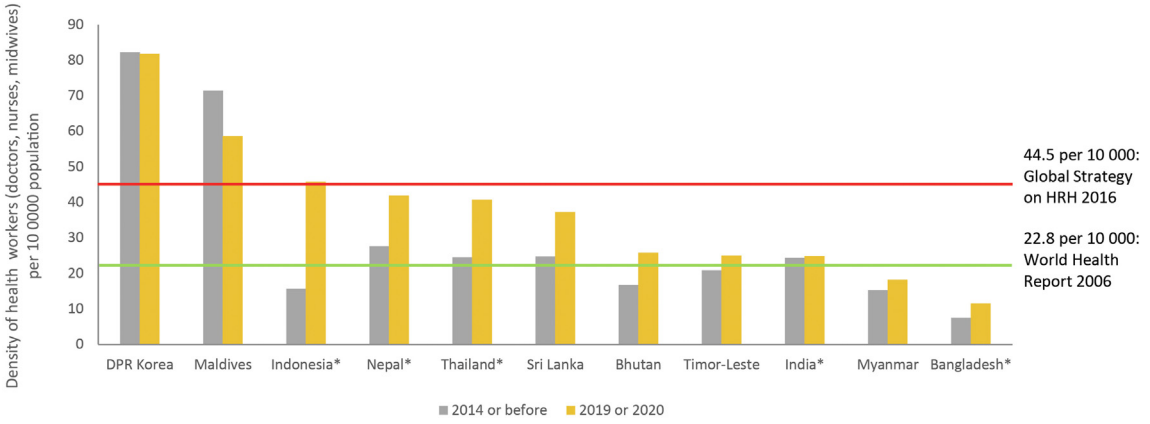

Fig. 4: **Progress in the availability of doctors, nurses and midwives in countries of the SEA Region Countries, 2014–2020**. Source: Country data reported to WHO through NHWA online platform (MoH & *Professional Bodies)

institutes (87 in 2010 to 397 in 2020) and Sub-Assistant Community Medical Officers training institutions (47 in 2010 and 209 in 2020).[14] In India, since 2014, 294 new medical colleges have been established across the country, representing a doubling in undergraduate (MBBS) seats to a total capacity today of over 100,000, and a significant improvement in geographic distribution of medical colleges and public/private mix.[15,16] Moreover, the Government of India 2023 Union Budget identifies funding for an additional 157 nursing colleges: to be co-located with 157 centrally funded medical colleges since 2014 to address geographic imbalances and ensure quality. Investments in Sri Lanka has similarly doubled university intake in nursing, pharmacy and allied sciences degree programmes. Investments in health workforce production in Bhutan and Maldives, though smaller in scale, are no less profound. The Khesar Gyalpo University of Medical Sciences of Bhutan, itself established in 2013, launched its first batch of MBBS students in 2023; while the School of Medicine at the Maldives Medical University was established in 2018 with first graduates expected in 2024.

As highlighted above, fast increasing production, requires countries in the Region to place increasingly greater focus on optimizing use of the available health workforce. Improving distribution, quality, and alignment to national health priorities are of particular importance. As illustration, in addition to well-recognized challenges with respect to the distribution of health workers across geographies and across the public and private sectors, it is worth noting that distribution of even public sector health professionals itself varies significantly across levels of care in SE Asia Region countries. Table 2 presents data on proportion of Ministry of Health staff at the tertiary versus secondary and primary levels across three countries. Table 2 presents data on proportion of Ministry of Health staff at the tertiary versus secondary and primary levels across three countries. Almost 69–75% of doctors and nurses in the MoH in Thailand and Bangladesh serve at tertiary level while 45–58% of dentists and pharmacists do the same. DPR Korea presents a different model; where 75–80% of MoH staff across occupations work at primary care level; 10–15% at county/district level; 3–5% at province level; only 0.5–1% at central level.

It is also important to recognize that countries of the South-East Asia Region, benefit from a wide array of health workers, whose contribution to both clinical care and public health is considerable: especially in community and primary care settings. Indeed, a major lesson from COVID-19, has been the need for focused attention to the array of health workers who are closest to communities.[17] Based on country-reported data, we note that a large number of community health workers, medical assistants, paramedical practitioners, and traditional health workers supplement major health professionals (See Fig. 5).

These health workers, central to the effective functioning of primary health care and district health systems, are often the first point of contact for those most vulnerable. They not only participate in, but also at times lead, primary health care teams. The examples are many, including both clinical and leadership roles for Bangladesh Sub-Assistant Community Medical Officer (3-year clinical training) and Community Clinic Health Providers (3 months training); Bhutan's multi-skill Health Assistants (Bachelor's Degree); and Nepal's Health Assistants (3-years clinical training). An array of community health workers, paramedical practitioners, and recognized traditional health workers further support care provision close to communities. Box 2 highlights, in particular, the importance of community

Countries	Doctors (%)	Nurses (%)	Dentists (%)	Pharmacists (%)
Bangladesh (under MOHFW)	75.3%	75.0%	57.8%	49.3%
Thailand (under the MOPH PS)	68.9%	75.0%	44.7%	51.2%
Democratic People's Republic of Korea	Across occupations: 75–80% at primary health care level; 10–15% at county/district level; 3–5% at province level; 0.5–1% at central level			

Source: Bangladesh, MIS DGHS/WHO Health Labour Market Analysis, 2021; Thailand, MOPH, 2022; DPR Korea, National Health Report, 2017

Table 2: **Proportion (%) of Ministry of Health staff working at tertiary level in selected countries of SEAR.**

health workers, as especially evident during the COVID-19 response, in India and Thailand respectively.

Finally, transformative education has been a key area of focus in the SEA Region. Transformative education seeks to not simply increase the quantity of health workforce, but also ensure its' quality and relevance to population health needs.[18] Critically, countries have initiated measures to address challenges related to the cost, quality, and distribution of health workforce education institutions. These include the Nepal Medical Education Act, 2019, India National Medical Commission Act, 2019, Bangladesh Non-governmental Medical and Dental College Act, 2022, and the Indonesia Health Omnibus Law, 2023. These reforms aim to align education with respective health needs, allow affordable and high-quality education, and to promote equitable distribution of health services. Thailand also saw ratificaton of "Transformative health professional education in response to population health needs under Thai context" through the National Health Assembly and establishment of the Thai Foundation of National Health Professional Education Reform.

Challenges

As highlighted in the above sections, there has been substantial progress in UHC and human resources for health across all SEAR Countries. Yet even without considering the impact of COVID-19 and subsequent economic challenges, the rate of progress in achieving UHC is insufficient for most SEAR countries to reach the global target of 80 by 2030. Also, key challenges remain particularly around low public spending in health, and for health workforce not just in the number of health workers, but perhaps as, if not more importantly, in their distribution, quality and performance, especially with respect to providing care close to communities.

Interpreting these numbers need caution as many of the recent significant institutional reforms (ie Ayushman Bharat programme in India and/or National PHC Integration in Indonesia), have not had time to make the full impact. At the same time, these figures also do not fully reflect the significant disruptions to services and health systems due to COVID-19. Decadal progress towards UHC achievement, as identified earlier, is under

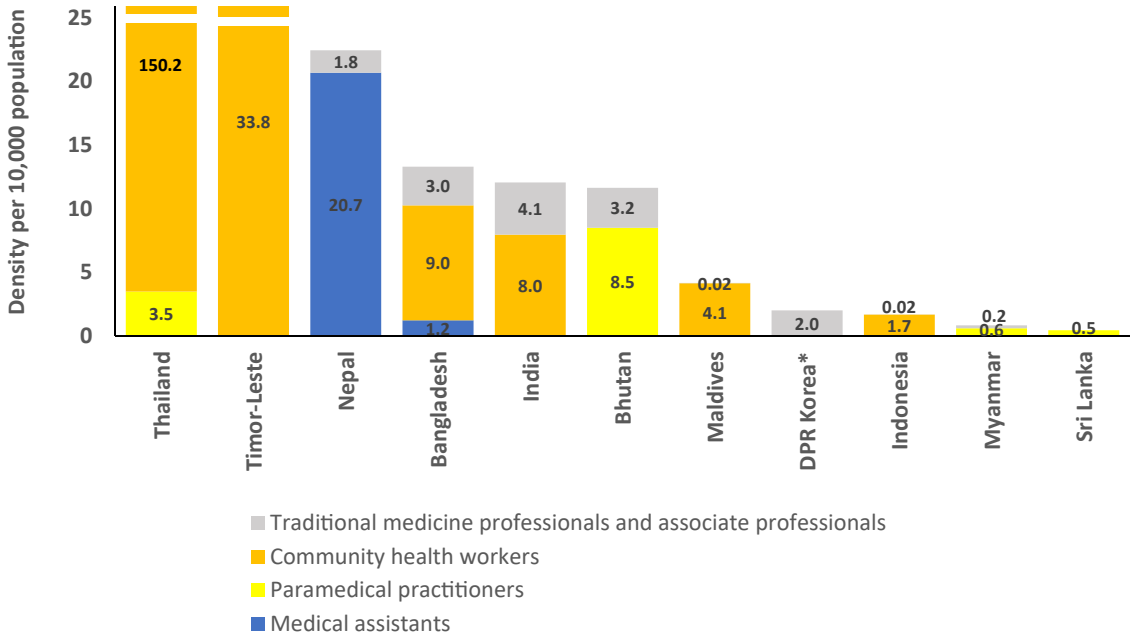

Fig. 5: **Density of select community-based health workforce in Member States of SEA Region.**

Box 2.

Recognition of India's ASHA workers and Thailand's Village Health Volunteers for efforts to Covid-19 response

Accredited Social Health Activists (ASHA) are the more than one million accredited female health workers in India. ASHAs play a crucial role in connecting the community with the health system to ensure delivery of primary health care services. Under India's National Health Mission, every village in the country has a trained ASHA selected from and accountable to the village where she works. In 2022, India's ASHAs were among the six recipients of the WHO Director-General's Global Health Leaders Award for their contribution during COVID-19, both with respect to response and maintenance of essential health services. ASHAs played a key role as part of the COVID-19 response, including household visits, surveillance, screening, awareness generation, contact training, vaccination, and facilitating access to services.

Thailand's over a million strong Village Health Volunteers, managed by the Ministry of Public Health, were similarly and widely recognized for their fundamental role in COVID-19 response and maintaining essential health services. Each village health volunteer caters to 10 households and is selected by their communities based upon public mindedness and commitment to the health of their communities. Thailand's Village Health Volunteer programme has been an exemplar globally for the last four decades and fundamental to Thailand's success in realizing the promise of UHC.

threat. Demographic transition, epidemiological transition reflected in rise of non-communicable diseases including mental health conditions, emergence of new and novel pathogens, growing anti-microbial resistance, rapid urbanization and climate change are placing significant stress on the current organization of health systems.

Conclusion

Reflecting on contempotary challenges, and drawing upon lessons from COVID-19, Ministers of Health in the Region identified a "once-in-a-century opportunity to advance transformation towards resilient PHC-oriented health system as the means to achieve population health, well-being, and prosperity in the SEA region."[19] To guide, support and monitor PHC-oriented health system transformation, and as requested by Member States, WHO launched the South-East Asia Regional Strategy for Primary Health Care: 2022–2030 (SEAR PHC Strategy) on UHC Day in 2021.[20] The SEAR PHC Strategy elaborates a set of 7 values and 12 strategic actions to support PHC-oriented transformation in the Region and has been endorsed by SEAR Member States. Importantly, across Member States of the Region there is strong recognition that addressing evolving health needs in the Region requires focused attention to Primary Health Care, with focus on wholistically strengthening district and sub-district health systems. Moreover, WHO and partners, as requested by Member States, have also launched the South-East Asia Regional Forum for Primary Health-care Oriented Health System to collectively strengthen implementation-focused learning and synergy in PHC-related actions across the Region.[21]

Over the course of this past decade, countries of the South-East Asia Region have made progress on Universal Health Coverage and Human Resources for Health through strong political commitment and action. Key challenges remain and, in recent, years have intensified. At the same time, there is strong understanding amongst senior policy makers in the Region that the actions needed to accelerate progress to UHC are the same as needed to respond to emerging challenges of health security, urbanization and climate change: strengthening Primary Health Care-orientation of health system. As health systems and associated institution have developed, perhaps best illustrated by the growth in the availability of health workers in the Region, the long-held desire of "health for all" is closer in reach than periods prior. At the same time, sustained policy commitment and operational focus is needed to realize this vision for the 2 billion people residing in varied economic, geographic, and social contexts in the Region.

Contributors

PKS and MJ conceptualized, guided and supervised production of the article. ID, TT, and AS collected the information for the article and wrote the original draft. All the authors reviewed and revised the manuscript.

Declaration of interests

The authors declare they have no conflict of interest. All authors are WHO SEARO employees. The views expressed are of the authors and not an officila position of the WHO or any institutions to which they are affiliated. The authors declare no conflict of interest.

Acknowledgement

Funding: None.

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21 Bangkok. *WHO press release, regional Forum for primary health care-oriented health systems launched to strengthen implementation-focused learning and cooperation*. 2022.