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Primary Health Care as the Foundation of Universal Health Coverage in Thailand

Associate Professor Dr. Jukkrit Wungrath

ASEAN Institute for Health Development (AIHD)
Mahidol University, Thailand

UHC becomes real through strong primary health care.

OPENING FRAME

UHC is not only coverage — it is effective access

Formal entitlement matters, but people experience UHC through services they can actually reach.

- A health card or insurance scheme creates entitlement, but not automatically access.
- Effective UHC requires care that is nearby, affordable, acceptable, continuous, and trusted.
- Primary health care is the bridge between national policy and people’s everyday lives.

Core question: covered for what, where, by whom, and with what quality?

THAI EXPERIENCE

Thailand’s UHC journey: financing reform built on PHC

The 2002 Universal Coverage Scheme was a major policy milestone — but it worked because a local service platform already existed.

- Decades of investment in rural health infrastructure created a district-based delivery system.
- Community hospitals, health centres, primary care teams, and community actors formed the base.
- Financing reform expanded entitlement; PHC made entitlement deliverable.

Lesson: health insurance can create entitlement; PHC creates access.

Thailand’s PHC architecture: district to community

PHC works because it is organised as a local ecosystem, not as a single facility.

- District health systems connect community hospitals with primary care units and local services.
- Subdistrict health-promoting facilities and primary care teams provide close-to-home care.
- Village health volunteers link households, communities, and the formal health system.
- Referral pathways connect primary care to higher-level hospitals when needed.

CORE FUNCTIONS

Five PHC functions that make UHC real

PHC is the operational engine that turns national coverage into practical care.

- First contact: an accessible entry point into the health system.
- Continuity: follow-up for chronic conditions, older people, and families over time.
- Comprehensiveness: prevention, promotion, treatment, rehabilitation, and palliation.
- Coordination: referral and navigation across levels of care.
- Community trust: local relationships that make services acceptable and usable.

PHC is not “basic” care; it is the foundation of system performance.

PHC FUNCTION 1–2

First contact and continuity: close to home, over time

For UHC to matter, people need an entry point they can reach — and a team that continues to know them.

- PHC reduces the distance between people and the health system, especially outside major cities.
- Continuity is essential for hypertension, diabetes, elderly care, maternal-child health, and mental health.
- Follow-up, monitoring, health education, adherence support, and early detection are PHC strengths.

Hospitals treat episodes; PHC follows people through the life course.

PHC FUNCTION 3

Comprehensive PHC: beyond treatment

A sustainable UHC system cannot rely only on hospitals and curative care.

- PHC integrates health promotion, disease prevention, basic treatment, rehabilitation, and palliative care.
- It supports immunization, maternal and child health, NCD screening, elderly care, and home visits.
- A strong PHC base shifts the system upstream — from treating complications to preventing them.

The more hospital-centred UHC becomes, the more expensive and fragmented it risks becoming.

PHC FUNCTION 4

Coordination: right care, right level, right time

Modern patients move across many services; PHC helps them navigate the system.

- PHC can act as a gatekeeper, but more importantly as a care coordinator.
- Good referral pathways reduce unnecessary use of high-cost services and improve follow-up after referral.
- Coordination matters for complex patients with multiple conditions and social needs.

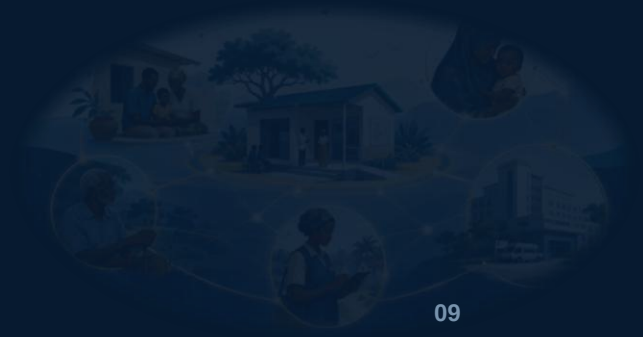
The aim is not to restrict care — it is to connect care.

PHC FUNCTION 5

Community trust: Thailand’s distinctive PHC asset

Community trust is not a soft issue; it is health system infrastructure.

- Village health volunteers connect the formal health system with households and local communities.
- They support health promotion, prevention, surveillance, home visits, and public communication.
- Their value comes from proximity, local knowledge, cultural understanding, and long-term relationships.



The next test: quality, equity, ageing, and NCDs

Thailand’s UHC has achieved much, but the next phase requires stronger and smarter PHC.

- Ageing increases demand for long-term care, rehabilitation, home care, and palliative care.
- NCDs require prevention, early detection, behaviour support, and continuous management.
- Equity gaps remain for remote communities, migrants, stateless persons, urban poor, and people with complex needs.
- Quality must move from service availability to effective coverage and better outcomes.

The future of UHC depends on whether PHC can manage complexity close to people.

FUTURE DIRECTION

Next-generation UHC: what PHC must become

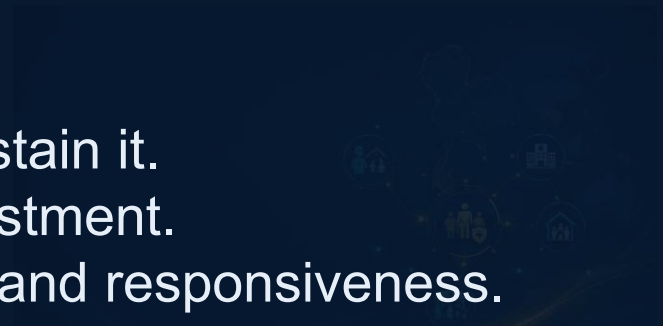
The future agenda is not simply more coverage — it is better, fairer, and more resilient care.

- From coverage to effective coverage: measure whether services improve health outcomes.
- From hospital-centred care to people-centred PHC: bring care closer to homes and communities.
- From fragmented services to integrated care: connect health, social care, and local support.
- From community participation as a programme to community participation as a system function.

CLOSING

Lessons for Asia-Pacific

UHC may begin with national policy, but it becomes real at the primary care level.



- Political commitment starts UHC; strong local systems sustain it.
- Financing reform must be matched with primary care investment.
- Community trust is a strategic asset for equity, resilience, and responsiveness.
- PHC is where medical care meets public health — and where policy meets people.

UHC gives people the right to care. PHC makes that right reachable.

THANK YOU

Questions & Discussion

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