

# Advancing Preventive Health in Southeast Asia:

## RECOMMENDATIONS FOR INDONESIA AND THAILAND

US-ASEAN BUSINESS COUNCIL, INC.

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# Introduction

## From Sick Care to Health Care

Health systems across Southeast Asia are contending with a triple challenge: addressing the unfinished agenda of infectious disease and maternal and child health while absorbing a rapidly growing burden of noncommunicable diseases (NCDs) in populations that are aging quickly. Health systems remain structured to respond to illness once they have developed, with financing, service delivery, and performance incentives often weighed toward treatment rather than prevention. While treatment is essential, a predominantly reactive model is increasingly ill-suited to managing the growing NCD burden, placing additional fiscal pressures on already strained health budgets and missing opportunities to prevent avoidable illness, disability, and premature mortality.

A stronger emphasis on prevention is therefore becoming an essential component of health system reform. **Shifting from "sick" care toward "health" care, by financing and delivering prevention, health promotion, and early detection across the life-course, can improve population health while enabling health systems to use limited resources more effectively and efficiently.**





Health expenditure patterns in Indonesia and Thailand reflect the continued dominance of "sick" (or curative) care. According to the WHO Global Health Expenditure Database, curative care accounted for 70% of current health expenditure in Thailand and 63% in Indonesia in 2022, while preventive care represented just 12% and 22%, respectively (Figure 1).[1] Indonesia's preventive share dropped to 18% in 2023, underscoring the fragility of prevention financing even within systems that have strengthened primary health care (PHC) systems.[2] Notably Thailand, with one of the region's strongest PHC systems, allocates a larger share to curative care than Indonesia, suggesting that system maturity does not shift spending toward prevention without a deliberate reframing. Shifting from "sick" care toward "health" care not only requires policy intent but sustained fiscal prioritization of preventive health services and delivery across the care continuum.

# Defining Preventive Health

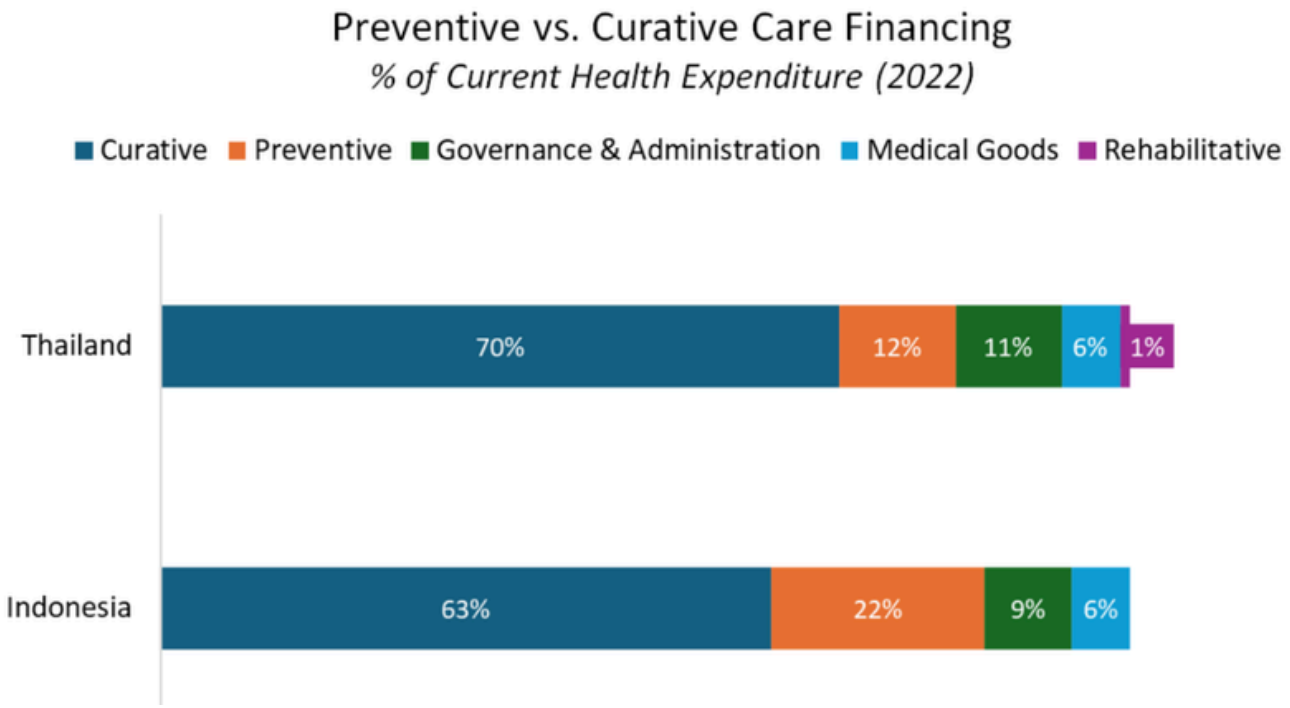



Figure 1: WHO Global Health Expenditure Database, 2022. Values as percentage of current health expenditure. Long-term care and ancillary services each <1% for both countries (not shown).

This paper is the second in a series published by the US ASEAN Business Council and carries forward the framing of the first, Advancing Preventive Health in Southeast Asia: Recommendations for Malaysia, the Philippines, and Vietnam, extending the analysis to Indonesia and Thailand while maintaining a consistent analytical framework to preventive health policy.

The World Health Organization (WHO) describes prevention broadly as the approaches and activities aimed at reducing the likelihood that a disease or disorder will affect an individual, interrupting or slowing the progress of the disorder, or reducing disability.[3] Across the continuum of care, prevention is commonly understood to encompass five levels — primordial, primary, secondary, tertiary, and quaternary prevention. As in the first paper, this report focuses on the three levels that are most directly embedded within healthcare systems:

- **Primary Prevention** — Stopping diseases before they occur, through interventions such as immunization, health promotion, and risk-factor reduction.
- **Secondary Prevention** — Detecting diseases early and enabling timely intervention through screening, diagnostics, and early treatment.
- **Tertiary Prevention** — Managing established diseases to slow progression, prevent complications, improve quality of life, and reduce morbidity through treatment, rehabilitation, and on-going care.

Taken together, these three levels represent the preventive health continuum within the healthcare system: keeping people healthy, identifying diseases at the earliest stage possible, and ensuring effective management to avoid progression and complications. Delivering this continuum requires coordinated action across the health ecosystem, including governments, healthcare providers, communities, civil society, and private sector partners.

# Prevention as a Pillar of Primary Health Care



Indonesia and Thailand share a defining feature: both have made significant progress toward universal health coverage (UHC), delivered through strengthened PHC systems. That commitment is what makes preventive health so consequential to strong PHC systems, not only as a public health priority, but also as a fiscal imperative. When a system guarantees health care to its whole population, the cost of letting disease advance is borne by the public sector, and NCDs, which increasingly drive the largest share of that cost, are among the most preventable conditions yet the most expensive to treat at later stages.

Investing in prevention and early detection is therefore a central lever for cost-efficiency in a UHC system, and an essential component of effective PHC. By identifying and addressing health risks and conditions earlier, health systems can reduce the need for more complex and costly interventions later in the care pathway, while improving outcomes and quality of life. For example, identifying diabetes early through routine screening costs a fraction of the amputation, dialysis, or cardiac event it prevents, while earlier detection of cancer can enable more timely and effective treatment and reduce the burdens associated with advanced disease.

The benefits of prevention are well established: immunization, for example, has been one of the most successful public health interventions in history, with the WHO's Expanded Program on Immunization estimated to have averted 154 million deaths since 1974.[4]

Beyond its economic value, prevention delivers better health outcomes by reducing premature mortality, extending healthy life expectancy, and preventing avoidable disability.

It can also improve the patient experience, keeping people well and close to home rather than cycling through hospitals once diseases have progressed.

Embedding prevention and early detection throughout the health system can improve population health while helping ensure that PHC remains financially viable, equitable, and capable of delivering on its promise of accessible, quality health care for all.

**Indonesia and Thailand illustrate complementary points on similar preventive health journeys. Indonesia has built an ambitious prevention architecture and now faces the challenge of translating national priorities into consistent implementation at the district level. Its task is implementation—ensuring existing investments in prevention, nutrition, and screening translate into better measured outcomes across the life-course. Thailand, by contrast, already operates one of the region's strongest PHC systems. Its task is optimization—closing gaps in a mature system to complete screening-to-treatment pathways and to get ahead of the needs of a rapidly aging population.**

In both countries, improving coverage alone is not sufficient; expanding access to screening does not guarantee timely diagnosis; and diagnosis does not ensure effective treatment or long-term disease management. The benefits of prevention are realized only when individuals and populations are supported throughout the entire continuum of care. Strengthening these pathways, from prevention and early detection through to treatment and on-going management, is critical to improving health outcomes while enhancing the effectiveness and sustainability of both health systems.



# Report Methodology

Consistent with the first report, this paper examines Indonesia and Thailand's preventive health systems through three complementary lenses, drawing on review of publicly available policies, data, and published literature and supported by key information interviews with regional public health experts:

- **Policy** — The national strategies and legislation that govern prevention, particularly around UHC, PHC, NCDs, and immunization, and whether they translate into clear, operational standards.

- **Access** — Whether services reach people across the life-course and across the primary, secondary, and tertiary levels of prevention, and whether people complete the pathway from screening to diagnosis, treatment, and follow-up.

- **Financing** — How prevention is funded and whether resources are allocated and purchased in ways that sustain it, rather than defaulting to treatment.

Together these lenses reveal not only what a health system aspires to achieve, but whether it is able to deliver. To ensure the analysis is practical and action-oriented for governments and other stakeholders, this paper focuses on two areas where preventive health interventions have well-established dividends and where private-sector partners can make meaningful contributions: NCDs and immunization. It also examines a third priority tailored to each country's context and stage of health system development: early-life health in Indonesia, and healthy aging in Thailand.



# Indonesia

## Country Profile

| | |
|---|---|
| **Population** | 281.2 million (World Bank, 2024)[5] |
| **GDP per Capita** | USD 4,876 (2023)[6] |
| **UHC Service Coverage Index** | 67 (2023)[7] |
| **Current Health Expenditure per Capita** | USD 145 (2023)[8] |
| **Public Financing (as Share of CHE)** | 57.4% (2023)[9] |
| **Out-of-Pocket Spending (as Share of CHE)** | 28.6% (2023)[10] |
| **JKN Membership** | 277.1 million — 98.1% of Population (Sept 2024)[11] |

Sources: World Bank; WHO; National Social Security Agency (BPJS Kesehatan)

## Landscape Assessment Overview

### I. Policy Insights:

Indonesia has developed a comprehensive preventive health policy framework, alongside reforms to strengthen PHC and expand access to essential health services. Its Integrasi Layanan Primer (ILP) provides a clear model for organizing services around the life course, while broader PHC reforms have addressed workforce development, digital health, service delivery, and other system enablers needed to deliver preventive care at scale. The challenge is not the absence of policy but ensuring consistent implementation and operationalization at the district levels. Priorities include translating national policies into clear evidence standards, strengthening referral and follow-up pathways, and tracking outcomes that reflect whether people complete the full care pathway. Key measures should focus on whether people complete full care pathways, from initial screening through to treatment and sustained management.

## II. Access Insights:

While health insurance coverage is high, access to consistent and effective preventive health services remains uneven. The central challenge is no longer achieving first contact with the health system but ensuring continuity across the prevention pathways. Leveraging the community health worker (kader) network and improving digital recording and reporting systems are critical to ensuring continuity of care and minimizing loss to follow-up. The time gap between screening, confirmatory diagnosis, and treatment initiation must be reduced.

## III. Financing Insights:

Indonesia's health financing architecture is fragmented across Jaminan Kesehatan Nasional (JKN), the Bantuan Operasional Kesehatan (BOK) operational grant, and various local government budgets. JKN uses a range of purchasing models —including capitation for primary care and case-based payments for hospital services—and the extent to which these incentivize preventive service delivery varies by service package. JKN is also running a significant deficit, adding fiscal pressure to the system. As a result, preventive health services risk being deprioritized during implementation despite strong policy commitments—a risk outlined in the sections below. Aligning financing and performance incentives with prevention outcomes will be essential to shifting the system toward proactive population health management.[12]

## IV. Private Sector Insights:

Private sector engagement in Indonesia's preventive health agenda has grown but remains ad hoc. There are clear entry points where private sector capabilities —in diagnostics, digital health, delivery platforms, workforce training, and nutrition—can plug into existing government PHC structures to support ILP operationalization. Indonesia's geographic challenges create genuine need for context-specific delivery models, and precisely because standard approaches do not work in remote areas, there is space for private sector contribution and innovation.



# Indonesia's Health System: A Strong Platform for Prevention

Indonesia is an archipelago of more than 17,000 islands, with approximately 283 million people spread across 38 provinces and over 500 districts and cities.[13] This geography is a significant driver of the equity and access gaps that define Indonesia's preventive health challenge. Delivering consistent health services across this vast and diverse territory requires a health system architecture that functions effectively at the district level, where a majority of primary health care decisions and expenditures are made.



Indonesia's health system operates through a decentralized governance structure in which district health offices, Dinas Kesehatan, control a significant share of primary health care expenditure. District fiscal capacity varies enormously—the Ministry of Finance publishes annual fiscal capacity indices (Indeks Kapasitas Fiskal Daerah) that classify districts from very low to very high capacity,[14] and these disparities can contribute to differences in the availability, resourcing, and quality of health service delivery across districts. At the facility level, the financing picture is fragmented: according to an analysis produced by ThinkWell in 2025, National Health Insurance (JKN) capitation payments account for only 26% of puskesmas-level financing, while the Health Operational Assistance grant (BOK) accounts for another 12%, with the remainder coming from local government budgets and other sources.[15] This three-stream financing structure means that national insurance coverage alone does not determine the resources available for preventive care at the point of delivery.

As of September 2024, JKN covers 277.1 million people (98.1% of the population) and its benefit package spans promotive, preventive, curative, and rehabilitative care.[16] Transformasi Kesehatan has further strengthened the policy foundation by re-organizing the health system around six transformation pillars,[17] advancing a life-course approach to care through the ILP model and the SEHAT program. Together, these reforms seek to expand screening, prevention, and continuity of care through the country's network of community health centers (puskesmas), auxiliary health centers (pustu), integrated health posts (posyandu), and community health workers (kaders) supported by the national SatuSehat digital health platform.[18] These efforts are underpinned by Law No. 17 of 2023, which provides the legislative framework for health system transformation.[19]

Within the primary care transformation pillar, the Ministry of Health established the ILP through Ministerial Decree No. HK.01.07/MENKES/2015/2023. ILP reorganizes puskesmas services by life course rather than by disease program, integrating promotive, preventive, curative, and rehabilitative care from prenatal through elderly stages. ILP is the foundational delivery mechanism through which preventive primary health care is operationalized in Indonesia, and the gaps identified throughout this paper are fundamentally an assessment of where ILP implementation remains inconsistent at the district level.

Indonesia's current policy landscape reinforces these reform directions. The RPJMN 2025–2029 (Presidential Regulation No. 12 of 2025) sets national development targets, including health system strengthening,[20] while the Kemenkes Renstra 2025–2029 (Minister of Health Regulation No. 12 of 2025) establishes specific health sector targets,[21] including an improved NCD control and accelerated TB elimination. This paper's recommendations are aligned with these nationally owned commitments.

While Indonesia's financing and delivery platforms are extensive, enrollment is not the same as effective coverage. JKN has been running a significant deficit, with the claim ratio rising from 104.7% in 2023 to 111.9% in 2026, creating fiscal pressure that leads facilities to prioritize acute over preventive care.[22] Additionally, 58 million JKN members were inactive as of early 2026, signaling access and engagement barriers beyond financing.[23] The central challenge is ensuring that preventive services are delivered consistently, equitably, and early enough to improve outcomes. Facility readiness, workforce capacity, diagnostic availability, digital maturity, and service delivery vary widely across the archipelago—reflecting differences in district fiscal capacities—meaning that national policy does not translate evenly into care at the local levels. The network of kaders—an estimated 500,000 or more volunteers who staff posyandu sessions—represents a critical last-mile delivery mechanism that is currently under-financed and insufficiently supported by data systems.



## Strategic Pillars for Preventive Health in Indonesia

| Pillar | What it Does | Link to Preventive Health |
|---|---|---|
| **Primary Services** | Strengthens primary and community care through Puskesmas, Pustu, and Posyandu | The main channel for life-course screening, immunization, and follow-up |
| **Referral Services** | Improves hospital and specialist capacity and referral pathways | Links positive screens to confirmatory diagnosis and treatment |
| **Health Resilience** | Builds surveillance, laboratory, and emergency-response capacity | Underpins outbreak detection and routine immunization systems |
| **Health Financing** | Reforms JKN purchasing and resource allocation | Determines whether prevention and follow-up are paid for, not just treatment |
| **Human Resources for Health** | Expands and upskills the frontline workforce | Enables outreach, counselling, and repeat follow-up in every district |
| **Health Technology** | Scales SatuSehat and digital health tools | Supports patient recall, cascade tracking, and data-driven targeting |

## Implementation Gaps in Preventive Health Delivery

Indonesia directs a comparatively high share of health expenditure to preventive care – 18% of current health expenditure in 2023, just over double the most recent global average of 8.7% across 134 countries — yet coverage data for tracer services reveal that spending levels alone do not guarantee effective delivery.[24] Indonesia has built a strong policy architecture for preventive health and has a clear delivery model in ILP. However, implementation at the district level remains inconsistent, and significant gaps persist between policy commitments and service delivery on the ground. As detailed in the sections that follow, coverage data for tracer preventive services—including immunization, cancer screening, and NCD management—reveal persistent gaps between policy ambition and service delivery. These gaps occur not because services are excluded from JKN coverage, but because of inconsistent facility readiness, workforce and supply constraints, limited follow-up systems, and the fragmented financing architecture described above.

Closing this gap will require moving beyond a model centered on financing access and service availability toward one focused on population health management. This means leveraging JKN, the ILP model, and supporting digital infrastructure to proactively identify people at-risk to ensure they receive the recommended preventive services and are supported through the full continuum of care.

# Priority 1 — NCDs: Moving from Screening to Sustained Control

Noncommunicable diseases account for approximately 73% of all deaths in Indonesia, with cardiovascular disease (35%), cancer (12%), chronic respiratory disease (6%), and diabetes (6%) as the leading contributors.[25] According to the Global Burden of Disease study, stroke and ischemic heart disease are the country's top two causes of death.[26] The 2024 GLOBOCAN estimates recorded 474,083 new cancer cases in Indonesia,[27] with breast cancer (19.7%), lung cancer (12.3%), and colorectal cancer (8.4%) as the three most common cancers overall.

The 2023 Indonesian Health Survey (SKI) found diabetes prevalence of 11.7% among adults 15+ (up from 10.9% in 2018) and hypertension of 30.8%,[28] with diagnosis running well ahead of sustained treatment and medicine adherence. Indonesia has established strong policy and program foundations for NCD prevention, including the National Action Plan for NCDs (RAN PTM) and the Integrated Approach for NCD Management (PANDU PTM), which support early detection, risk-factor management, and referral through primary healthcare facilities.[29] The challenge is to ensure that these components function as a patient-centered system that supports individuals across the full continuum of screening, diagnosis, treatment, and long-term management.



Cancer prevention illustrates both progress and remaining gaps. Indonesia's National Cancer Plan 2024–2034 identifies five priority cancers—breast, cervical, lung, colorectal, and childhood cancers—reflecting the country's significant and diverse cancer burdens.

Breast cancer is the leading cancer among women in Indonesia, accounting for 34.4% of female cancer cases according to GLOBOCAN 2024.[30] The government's CKG/PKG free health screening program has reached 14 million women, of whom 4 million received clinical breast examination;[31] however, only approximately 708,000 received ultrasound follow-up after a positive exam. This illustrates a wider prevention challenge: screening only creates value when positive findings are connected to timely diagnostic assessment, referral, treatment initiation, and follow-up.

Cervical cancer provides another example of opportunity: Indonesia's National Cervical Cancer Elimination Plan 2023–2030 adopts the WHO 90–70–90 targets for cervical cancer elimination and establishes a clear framework for accelerating prevention and early detection. However, adult screening coverage remains low: only 9.35% of target women had been screened in 2020, with wide provincial variation.[32] The priority is therefore not only to expand screening, but to ensure that positive results are connected to timely laboratory confirmation where needed, referral, diagnosis, treatment, and follow-up in ways that reflect local service capacity and affordability.

These priorities should reinforce Indonesia's existing NCD, cancer control, and primary care reforms, while closing the practical gaps between screening, diagnosis, treatment, and sustained disease control.



# Priority 2 — Immunization: Strengthening the National Immunization Program

Indonesia's National Immunization Program (NIP) has expanded significantly in recent years, including the national introduction of HPV vaccination through school-based delivery in 2023 and the addition of pneumococcal and rotavirus vaccines.[33] However, the 2025 Indonesia Immunization Coverage Survey reveals persistent gaps: only 56.4% of children aged 12–23 months were fully immunized, and an estimated 657,000 children remained zero-dose in 2025.[34] Coverage for newer vaccines fell below 40% outside Java and Bali, and geographic disparities are striking—ranging from over 95% coverage in North Sulawesi to 3.6% in Aceh.[35]

These equity gaps are particularly important in an archipelagic nation where geographical barriers and uneven health system capacity can make conventional service delivery difficult for remote and underserved communities. The Ministry of Health, working with WHO, UNICEF, and other partners, has developed the National Immunization Strategy 2025–2029, which focuses on expanding coverage through improved service delivery, introducing new vaccines, strengthening disease surveillance, and enhancing supply chain management. Priorities include reaching zero-dose children, expanding catch-up HPV vaccination to women aged 21–26 and to boys, and addressing the logistical constraints that undermine coverage in remote areas.

# Priority 3 —Early Life Health: Protecting and Extending Progress



Preventive health in Indonesia begins before birth, where the country has made meaningful progress in reducing stunting, with overall prevalence declining from 21.5% (2023) to 19.8% (2024) against a 14.2% target by 2029.[36] Progress has been supported by initiatives such as the National Strategy to Accelerate Stunting Reduction, the First 1,000 Days of Life (1,000 HPK) approach, and the health priorities outlined in the RPJMN 2025–2029.[37] [38] [39]

Yet, national progress masks significant geographic and socioeconomic disparities, underscoring the need for more targeted approaches in the next phase. In 2024, stunting prevalence ranged from 8.7% in Bali to 37% in East Nusa Tenggara, while children in the lowest socioeconomic quintile experienced stunting at roughly 29.8%, compared with around 12% in the highest quintile.[40] At the same time, approximately half of all children experiencing stunting were concentrated in six provinces—West Java, Central Java, East Java, North Sumatra, East Nusa Tenggara, and Banten—highlighting the importance of combining geographic targeting with attention to vulnerable populations.[41]

Indonesia already recognizes that early-life health begins before birth through antenatal care, the 1,000 Days of Life approach, and efforts to expand ultrasound access at the primary care level. The next priority is implementation: ensuring these commitments are targeted to high-burden and underserved regions, supported by ultrasound and point-of-care diagnostics, trained providers, referral connectivity, and follow-up systems that help identify maternal and fetal health risks earlier.

The next phase of progress will therefore require more targeted resources and interventions directed toward the populations and areas with the greatest need. Priorities include integrated nutrition interventions spanning adolescent and maternal nutrition, micronutrient supplementation, supplementary feeding, breastfeeding support, immunization, sanitation, growth-monitoring follow-up, and stronger linkages between antenatal screening, referral, and postnatal care. Emerging programs, such as the Free Nutritious Meal Program, should be aligned with broader nutritional goals, guided by evidence-based targeting, and closely monitored to assess progress against targets. This more targeted approach can help Indonesia translate national gains into more equitable improvements in maternal, child health and nutrition.

# Policy Recommendations for Indonesia

## Pillar 1 — Policy: Translate National Strategy into a District-Level, Life-Course Service Guarantee

ILP and SPM Kesehatan defines what preventive services should be delivered—the priority is ensuring *puskesmas* delivers them consistently, with minimum standards for each life-course stage and outcome tracking focused on completed care pathways rather than service contact. Despite near-universal JKN enrollment, only 17.3% regularly access primary care,[42] pointing to a gap between coverage on paper and service delivery in practice. Closing this gap requires consistent performance standards across districts, supported by financing reforms outlined in Pillar 3.

## Pillar 2 — Interventions: Complete Prevention Pathways, Not Just Service Delivery

**Three operational priorities can help accelerate implementation of Indonesia's preventive health agenda:**

- **Develop innovative interim digital solutions** for provider-level data access and clinical decision-making that are designed to be interoperable with SatuSehat standards even while it is not yet fully operational for frontline clinical workflows.[43] Priority investments should focus on ensuring providers have access to quality data now, including completion-tracking dashboards and patient recall systems, while aligning with SatuSehat's interoperability requirements.

- **Sharpen targeted delivery for high-burden maternal, child health, and nutrition pathways.** Indonesia already prioritizes stunting reduction and aligning the Free Nutritious Meal Program with high-burden areas; the next step is to ensure targeting is implemented consistently at district and community levels, using geographic, socioeconomic, and health-risk data to reach vulnerable pregnant women, infants and children. In high-burden districts, nutrition support should be linked with antenatal screening, maternal nutrition, growth monitoring, immunization, sanitation, and postnatal follow-up so that early-life prevention starts before birth and continues through the first 1,000 days.

- **Scale diagnostic and imaging connectivity as part of completed prevention pathways.** Indonesia is expanding ultrasound and diagnostic capacity, but gaps in equipment, trained operators, and specialist access limit timely follow-up across frontline settings. For breast cancer, maternal health, and cardiometabolic pathways, mobile and AI-guided point-of-care devices, combined with hub-and-spoke diagnostic connectivity, can help extend diagnostic reach across the archipelago. Cloud-based remote reading can link specialists in Jakarta or regional centers with frontline facilities, helping positive screening results move faster to diagnosis and referral without requiring specialist deployment at every site.

- **Use high-burden districts to test pathway-completion** before wider scale-up. Rather than introducing stand-alone programs, Indonesia could use selected districts to demonstrate how existing reforms—ILP, CKG, SatuSehat, JKN, and nutrition programs—work together as completed prevention pathways. Demonstration models could focus on breast cancer screening-to-ultrasound follow-up, antenatal risk screening-to-referral, cardiometabolic risk detection-to-control, and stunting prevention-to-growth recovery. Private-sector partners can support these models through diagnostic technology, workflow design, clinical training, connectivity, and evidence generation, while reinforcing public-sector delivery.

## Pillar 3 — Financing: Align Health Financing to Support Prevention Across the Care Continuum

Indonesia's financing architecture has not yet caught up with its prevention ambitions. At the facility-level, BOK and JKN create competing incentives—one rewards prevention, the other curative services—and together account for less than 40% of facility resources, with the rest locked into salaries and fixed costs.[44] Simplifying these financial flows and testing blended financing models that give districts flexibility to direct resources toward integrated care, rather than fragmenting them across siloed funding streams, would better support ILP's objectives. At the same time, the benefits package must keep pace with screening investments: not all essential cancer diagnostic examinations and treatments are covered by JKN[45] and patients face significant financial toxicity even with coverage.[46] A priority is therefore to review whether the current benefits package and financing arrangements adequately cover the services needed to act on screening results, as prevention spending only delivers returns when connected to a financed pathway from detection through treatment.



## Private-Sector Engagement: Strengthening, not Replacing, Public Systems

Private-sector partnerships add the most value when they reinforce government systems. With only 52.4 doctors per 100,000 people in Indonesia—well below the Southeast Asian average of 77—private sector contributions to workforce development and technology deployment are critical to extending preventive care reach.[47] Priority opportunities include diagnostic infrastructure and clinical training; digital tools for provider-level data access, patient recall, and diagnostic connectivity; immunization cold-chain and last-mile delivery; and innovative purchasing or co-financing models that reward completed prevention pathways.

# Thailand

## Country Profile

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|---|---|
| **Population** | 71.70 million[48] |
| **GDP per Capita** | USD 8,110[49] |
| **UHC Service Coverage Index** | 82.0 (2023)[50] |
| **Current Health Expenditure per Capita** | USD 327[51] |
| **Public Financing (as Share of CHE)** | 77.9%[52] |
| **Out-of-Pocket Spending (as Share of CHE)** | 9.9%[53] |
| **UHC Population Coverage** | Over 99.5% (UCS, SSS, CSMBS schemes)[54] |

Sources: World Bank; WHO; National Health Security Office (NHSO).

## Landscape Assessment Overview

### I. Policy Insights:

Thailand has a comprehensive preventive health policy landscape, but responsibilities are distributed across multiple institutions—including the Ministry of Public Health, National Health Security Office (NHSO), ThaiHealth Promotion Foundation, local governments, and disease-specific programs. Policy coherence and effective multisectoral collaboration remain challenges, particularly in integrating health objectives into policies and actions beyond the health sector and across national and local levels. This fragmentation can make accountability for overarching prevention less clear. Healthy aging remains an area where stronger policy integration is needed. While screening and long-term care services exist, stronger links with early risk reduction, functional maintenance, and care coordination would support prevention across the life course.

### II. Access Insights:

Thailand's life-course preventive health benefits are broad, but access and uptake remain uneven across populations such as urban populations, informal workers, migrants, border communities, and older adults facing digital barriers. Alongside remaining access gaps, a key challenge is ensuring continuity after initial screening. Diagnostic capacity at subsequent stages can be constrained, creating bottlenecks between screening and definitive diagnosis. Individual-level information is also not consistently linked across levels of care, limiting referral, follow-up, and continuity from diagnosis to treatment.

At the community level, village health volunteers provide an important mechanism for outreach and follow-up, but this model tends to function more effectively in rural communities and is less suited to reaching diverse and mobile populations in large urban areas, which fall under different governance structures. These gaps can prevent individuals identified through screening from receiving timely diagnosis, treatment, referral, and on-going support.

## III. Financing Insights:

Thailand has achieved strong financial protection through its UHC system, but financing for preventive health remains distributed across national and local governments and other mechanisms, limiting visibility into overall investments and the ability to assess whether resources are aligned with prevention priorities. More detailed tracking of primary and preventive care expenditure would help access the adequacy, composition, and trends of investment. Current financing approaches continue to reward discrete service delivery and downstream dependency management over completed prevention pathways, early intervention, and upstream healthy aging strategies. While capitation provides incentives for population-based and preventive care, the transition towards purchasing based on prevention outcomes remains constrained by limited evidence on which outcomes should be incentivized, how they should be measured, and whether alternative payment mechanisms would improve outcomes without unintended consequences. There is an opportunity to align specific purchasing mechanisms with measurable prevention outcomes rather than to add new funds alone.



# Thailand's Health System: A Mature UHC Platform

Thailand's preventive-health challenge is defined less by geography than by demographics. The country is aging faster than almost any other in the region: it became a "complete-aged society" in 2023, with more than 14 million people aged 60 and above, and the United Nations projects that close to 30% of the population will be 65 or older by 2050—driving the old-age dependency ratio up from roughly 12 older adults per 100 working-age adults in 2019 toward 50 per 100 by mid-century.[55] This transition places structural pressure on a health system that must manage a rising chronic-disease burden with a shrinking working-age tax base.[56] These pressures are not evenly distributed: health vulnerability among older adults concentrates in the lower-income, under-resourced provinces of the Northeast and North, where access to geriatric and specialist services trails the central region.[57] Demographic change is the unifying pressure behind Thailand's preventive health agenda, shaping the policy stakes across NCD prevention, life-course immunization, and healthy aging.

Thailand provides coverage to more than 99% of the population through three main schemes—the Universal Coverage Scheme (UCS), established under the National Health Security Action (2002)[58]; the Social Security Scheme (SSS); and the Civil Servant Medical Benefit Scheme (CSMBS). These three schemes operate under distinct legislative frameworks and are organized largely by employment status: the Universal Coverage Scheme, administered by the NHSO, covers the roughly three-quarters of the population outside formal employment—informal workers, dependents, and the unemployed; the Social Security Scheme, administered by the Social Security Office (SSO), covers formal-sector employees through tripartite employer–employee–government contributions; and the CSMBS covers civil servants, retirees, and their dependents.

The NHSO benefit package includes a broad range of preventive and promotive services across the life-course for all Thai citizens, regardless of their health insurance scheme. The SSS and CSMBS provide some additional scheme-specific preventive benefits for their beneficiaries, but these are relatively limited, such as periodic or annual health check-ups.[59] Additionally, a nationwide network of more than one million Village Health Volunteers (VHVs)[60] extends health promotion and prevention activities into households and communities, while strong public financing covers approximately 78% of health spending, with out-of-pocket spending remaining below 10%. These figures reflect some of the most robust financial protection in the region.  How the system pays for care shapes what it delivers. Under the UCS, the NHSO purchases care through a blended model rather than funding each service directly: an age-adjusted capitation payment for outpatient and primary care, a closed-end global budget with diagnosis-related-group weighting for inpatient care, and separate fee schedules for designated high-cost services.[61] NHSO contracts with district-level provider networks—typically a district hospital linked to ten to twelve sub-district health centers serving a catchment of about 50,000 people—which makes the district the practical unit of preventive-care delivery.[62]

Thailand's health system is guided by the 20-Year National Strategic Plan for Public Health (2017–2036)[63], with recent reforms—such as the nationwide expansion of the "30 Baht Treatment Anywhere" policy in 2025,[64] and the continued development of the Mor Prom digital health platform,[65]—aimed at improving access, coordination, and continuity of care. Like Indonesia, Thailand pursues prevention within a structured, nationally-owned reform agenda: the Primary Health System Act B.E. 2562 (2019) gave primary care a statutory foundation, mandating delivery through family-care teams and primary care clusters and setting a target of some 2,500 primary care units covering around 25 million people.[66]

Within this framework, the operational "three-doctor" model organizes first-contact prevention around the Village Health Volunteer at community level, the sub-district Health Promoting Hospital at sub-district level, and a family physician at district or provincial level.[67] These sub-district health promoting hospitals and volunteers are central to delivering preventive primary care. The ongoing transfer of sub-district health promoting hospitals to Provincial Administrative Organizations makes clear responsibilities and coordination across providers and local governments increasingly important.[68] The recommendations in this paper are designed to advance these existing commitments—the 20-Year Plan, the National NCD Action Plan (2023–2027), the National Cancer Control Program (2024–2032), and the third National Plan for Older Persons (2023–2037)—rather than to introduce parallel ones.[69]

Thailand's challenge is therefore distinct from Indonesia's: the country has established a mature health system foundation, the next phase requires strengthening effective prevention across the life course. NCDs remain the dominant cause of mortality, and major behavioral and metabolic risk factors—including unhealthy diets, physical inactivity, tobacco and harmful alcohol use, obesity and hypertension—remain prevalent.[70] Further progress requires addressing the upstream behavioral, environmental[71] and commercial determinants[72] that generate NCD risk. Strengthening primary prevention will therefore require action beyond the health sector, including healthier food and physical environments, stronger regulation of commercial determinants of health, and more effective multisectoral action at national and local levels. These challenges become increasingly important as Thailand ages. Although community-based long-term care has expanded, financing remains largely targeted to people who have already reached functional dependency, with continuing gaps in funding, benefit design, monitoring, and coordination across health and social care.[73]

A more comprehensive healthy-ageing approach would therefore need to strengthen prevention of functional decline and better integrate health, rehabilitation, social care and community support before and after dependency develops.[74]

High coverage does not automatically translate into service uptake; the 2023 Health and Welfare Survey found that more than 4 million people who sought outpatient care did not use their entitled services, citing factors such as perceived mild illness, waiting times, and lack of convenience.[75] Closing these utilization gaps remain critical to ensuring that Thailand's UHC system delivers the full value of its preventive health investments. High enrollment, however, is not the same as effective coverage, which also depends on which services are included and whether people can reach them: benefit packages and provider capacity still differ across the three schemes.

Finally, population aging, a shrinking workforce, rising NCD costs, and slower economic growth are tightening Thailand's long-term fiscal space. Cost-effective prevention and healthy ageing are therefore central to the system's sustainability rather than peripheral to it.



## Strategic Pillars for Preventive Health in Thailand

| Pillar | What it Does | Link to Preventive Health |
|---|---|---|
| **Promotion, Prevention, & Protection Excellence** | Prioritizes health promotion, disease prevention, and risk protection | The pillar that most directly frames prevention across the life-course |
| **Service Excellence** | Strengthens service delivery and primary-care networks | Determines whether screening links to diagnosis and treatment |
| **People Excellence** | Develops the health and community workforce, including VHVs | Enables household outreach, follow-up, and healthy-aging support |
| **Governance Excellence** | Improves financing, digital health, and regulation | Aligns purchasing and data systems with completed prevention |

# Priority 1 — NCDs: Close the Gap between Screening and Follow-up

NCDs represent Thailand's largest health challenge, accounting for approximately 75% of deaths and generating significant economic costs estimated at THB 1.6 trillion (9.7% of GDP).[76] The National NCD Action Plan (2023–2027) targets a 25% cut in premature NCD mortality across five disease groups and five shared risk factors,[77] supported by ThaiHealth, which is financed by a 2% tobacco and alcohol surcharge and fiscal measures including as the sugar-sweetened-beverage tax.[78] By cause, cancers, ischemic heart disease, and stroke are the leading contributors to mortality, and diabetes is both rising and increasingly affecting younger adults. As these conditions share metabolic risk factors, Thailand's next gains will come less from screening single diseases in isolation than from an integrated cardiometabolic approach that detects and manages diabetes, hypertension, and cardiovascular risk comprehensively.[79]

Thailand has also established comprehensive cancer prevention programs, including population-based colorectal screening for adults aged 50-70 and primary HPV DNA testing for cervical cancer, through the National Cancer Control Program (2024–2032).[80]

The key challenge is no longer expanding access to screening but rather ensuring completion of the care pathway. For example, between 2020 and 2024, only 63.7% of women aged 30–60 with abnormal cervical results received follow-up colposcopy,[81] while timely access to colposcopy depends on local capacity. Thailand's next phase of NCD prevention should focus on strengthening referral, diagnosis, treatment initiation, and long-term management rather than creating additional screening entry points alone. The burden itself points to where the pathway must widen: GLOBOCAN 2024 estimates that breast cancer is now the most common cancer among Thai women (23.5% of female cases), ahead of colorectal and lung cancer, while liver cancer—driven substantially by cholangiocarcinoma in the Northeast—is the leading cancer among men (20.6%), ahead of lung and colorectal cancer.[82] Breast cancer illustrates an opportunity: the NHSO added mammography and ultrasound to the UCS benefit package in 2025, but coverage is currently limited to women aged 40 and above with a first-degree family history, so population-based screening for average-risk women—despite breast being the leading female cancer—remains to be built out, alongside the diagnostic capacity to act on results.[83] Extending pathway-completion tracking to breast cancer, alongside cervical and colorectal, would align prevention with the actual burden.

Diagnostic and imaging capacity is the practical constraint on completing these pathways. Thailand trains around 135 new radiologists a year even as demand for imaging examinations grows an estimated 8–12% annually, which lengthens the interval between an abnormal screen and a confirmed diagnosis.[84] Mobile, AI-guided point-of-care imaging that lets non-specialists capture diagnostic-quality images, combined with hub-and-spoke connectivity that allows specialists in Bangkok or regional centers to read images captured at district hospitals and sub-district facilities, offers a way to extend diagnostic reach without deploying scarce specialists to every site.[85]

## Priority 2 — Immunization: Sustain Childhood Coverage and Build a Life-Course Approach

Thailand's Expanded Program on Immunization is a major public health success, maintaining high childhood vaccination coverage at 96–99% for decades and continuing to expand its portfolio to include rotavirus and HPV vaccination.[86] The next opportunity is to extend this success across the life-course by strengthening adult immunization. Core childhood vaccines exceeded 90% coverage in 2024—BCG at 99%, the first dose of DTP at 96%, and the first dose of measles-mumps-rubella at 93%—and the National Immunization Program has sustained polio-free status since 1997, eliminated maternal and neonatal tetanus, and, since introducing rotavirus vaccination in 2020, contributed to a roughly 20% fall in child diarrheal mortality.[87] Despite high national coverage, localized immunization gaps persist among migrant and non-Thai children in border areas, where population mobility and disrupted immunization services in neighboring countries can increase the risk of vaccine-preventable disease importation and re-emergence.[88]

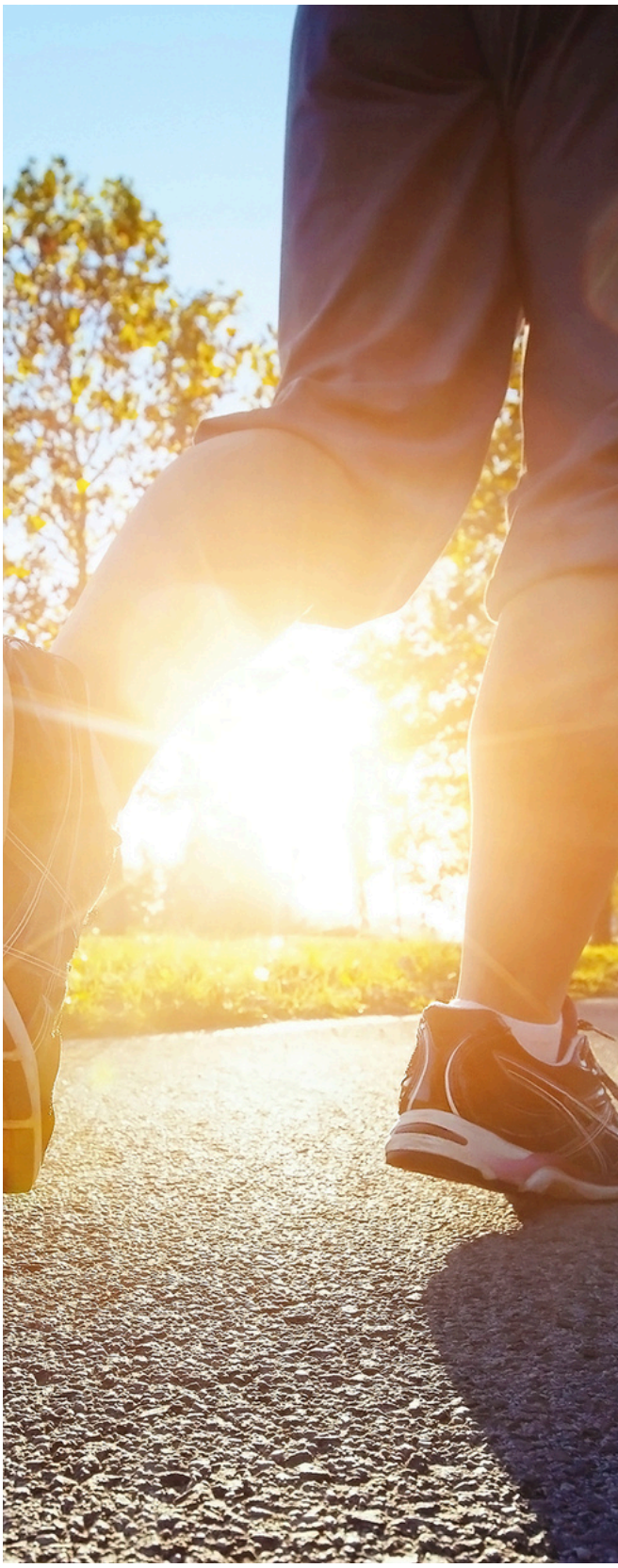
Vaccines targeting older adults and at-risk populations—including pneumococcal, RSV, and shingles—remain less developed as routinely reimbursed benefits compared with childhood immunization schedules. As Thailand's population ages, and the prevalence of chronic disease increases, strengthening the evidence base for the health and economic benefits of adult immunization will be an important step toward expanding preventive health services beyond childhood and early adolescence. The gaps are quantifiable: influenza coverage among older adults was about 47% in 2024, pneumococcal uptake remains below 20% among older adults, and HPV one-dose coverage reached 57% but does not extend to boys.[89] ThinkWell's analysis points to practical financing options—extending the sin-tax-financed Elderly Welfare Fund to age-specific vaccines such as pneumococcal and RSV, and building on subnational procurement of influenza and pneumococcal vaccines already trialed in provinces such as Pathum Thani and Chonburi.[90] The two public financing channels are complementary: the NHSO is the vehicle for population-wide coverage, while the SSO is the natural vehicle for the working-age population providing free influenza vaccination for insured persons under Section 33 and Section 39 who are aged 50 years and above. Extending SSO-funded influenza vaccination to younger, economically productive cohorts (i.e., persons who are aged 40 years and above), and resolving the legislative constraint that prevents pharmacies from administering vaccines—building on the precedent set during COVID-19—would help close the community-access gap between the two channels and bring greater preventive health benefits to the economy.[91]



# Priority 3 — Healthy Aging: Invest before Dependency

Thailand's rapidly aging population represents its defining long-term prevention challenge: 56% of people aged 60 and older report having at least one chronic condition,[92] increasing the importance of interventions that preserve functional ability and independence. While Thailand has expanded support for older adults through screening initiatives and long-term care services—including NHSO funding for community caregivers supporting dependent older adults (THB 1.1 billion to hire 18,600 community caregivers in 2025)[93]—the current approach remains skewed toward managing health needs after dependency develops.

Building on Thailand's existing community-based healthy aging infrastructure, there is opportunity to strengthen the integration of screening, risk stratification, and follow-up care, with a focus on maintaining function, including frailty and sarcopenia screening, fall-risk assessment, bone health and body-composition assessment, nutrition evaluation, physical activity promotion, and rehabilitation referral. Community-based models, including those delivered through primary care and VHV networks—including those demonstrated in provinces such as Chiang Mai—show the potential to embed healthy aging within existing health system architecture.[94] Moving upstream from dependency management toward prevention is essential to supporting healthy longevity and sustaining Thailand's UHC system. Screening can start with simple, scalable approaches to identify individuals at risk of sarcopenia, such as SARC-F, calf circumference, or the Yubi-wakka test. Those identified as at-risk can undergo further assessment of muscle strength—including hand-grip strength testing—escalating to bone and body-composition assessment such as DXA scanning, which captures bone density and body composition in a single scan, where warranted. Critically, it should use thresholds calibrated for Asian populations, such as the Asian Working Group for Sarcopenia (AWGS 2025) cut-offs, rather than European-derived benchmarks that can misclassify risk.[95]



# Policy Recommendations for Thailand

## Pillar 1 — Policy: Strengthen Accountability for Prevention Outcomes



- **Track pathway completion nationally** by defining target populations, referral timelines, and completion indicators for breast, cervical, and colorectal cancer, diabetes and hypertension, TB/HIV, and functional decline. The "30 Baht Treatment Anywhere" platform can serve as a key mechanism for recording and coordinating care, ensuring greater flexibility in access does not result in fragmented care pathways.
- **Establish a healthy-aging pathway** for adults aged 60 and above that includes frailty and sarcopenia screening, fall-risk and nutrition assessment, and referral for exercise and rehabilitation interventions. This pathway should be supported by appropriate bone health and body-composition assessment, point-of-care imaging or assessment tools, and digital care-coordination solutions that help clinicians assess risk, guide referrals, and connect primary care, rehabilitation, and specialist services. The objective is to identify older adults at risk of frailty, sarcopenia, falls, and functional decline earlier, while maintaining functional ability and delaying dependency through coordinated health, rehabilitation, social care, local-government, community, and VHV support. Screening metrics should use Asian-calibrated thresholds where available. The pathway should be anchored in the third National Plan for Older Persons.[96]
- **Strengthen multisectoral accountability for upstream prevention** by aligning prevention objectives and indicators across health, local government, urban planning, transport, education, and other relevant sectors, with particular attention to healthy food environments, physical activity, and commercial determinants of health.
- **Formalize a public-private prevention partnership mechanism** across MOPH, NHSO, and ThaiHealth, with clear standards for data protection, affordability, clinical quality, and equity. This would ensure that private-sector engagement strengthens UHC rather than creating parallel systems.

## Pillar 2 — Interventions: Complete Prevention Pathways and Extend to Communities

- **Close the screening-to-diagnosis gap** by scaling pathway-completion models that link result notification, diagnostic scheduling, patient reminders, and referral tracking, complemented by a clinician-to-clinician diagnostic connectivity layer—mobile, AI-guided point-of-care imaging and hub-and-spoke remote reading—so that limited specialist capacity is used efficiently.
- **Embed prevention in workplaces and community aging settings** through SSO-supported workplace services and community programs delivered via elderly groups, sub-district hospitals, VHVs, municipalities, pharmacies, and community organizations.

- **Workplace services should combine immunization** for the working-age population (i.e., 40 and above) alongside NCD and age-appropriate risk screening with clear referral links to diagnostic confirmation, including imaging where clinically indicated. For large urban areas, Thailand should complement household-based outreach with more accessible prevention points in workplaces, pharmacies, municipal services, and trusted community organizations.

- **Expand digital-enabled pathway management** through platforms such as Mor Prom and Health Link, using reminders, missed appointment alerts, and referral tracking. Digital tools should be complemented by offline support through VHVs and call centers to ensure access for populations vulnerable to digital barriers.

## Pillar 3 — Financing: Shift Investment Toward Completed Prevention Pathways

- **Work with NHSO to introduce and evaluate pathway-completion payment models within existing UCS purchasing mechanisms** that reward providers for successfully moving individuals from screening to clinically appropriate diagnosis, treatment initiation, and follow-up aligned with NHSO's on-going payment reform efforts. To reduce overdiagnosis, overtreatment, and avoidable fiscal pressure, models should use evidence-based eligibility criteria, referral thresholds, quality indicators, claims review, and monitoring of downstream diagnostic and treatment use. These programs should assess effectiveness, feasibility, provider incentives, fiscal impact, and unintended consequences before wider implementation.

- **Develop a healthy-aging prevention sub-package** within older-person benefits, covering frailty and sarcopenia screening, fall-risk and nutrition assessment, exercise programs, rehabilitation, and caregiver support. Frailty and sarcopenia screening should include access to clinically appropriate assessment tools for bone health, body composition, cardiometabolic risk, and functional decline, including DXA where indicated, with clear referral criteria to avoid unnecessary testing or treatment. The sin-tax-financed Elderly Welfare Fund could also be extended to cover age-specific adult vaccines such as pneumococcal and RSV, which are not currently covered under the NHSO UHC benefit.[97]

- **Strengthen the evidence base for preventive health investment** through national prevention cost-effectiveness assessments, enabling resources to be directed toward interventions with the greatest health, economic, and societal returns. Priority assessments include expanding breast screening from high-risk to broader population groups and defining a reimbursed adult-immunization schedule.

- **Improve tracking of prevention and PHC expenditure** across NHSO, MOPH, ThaiHealth, local governments, and other financing mechanisms, including through more granular National Health Accounts, to assess whether overall investment is aligned with national prevention priorities.

## Private-Sector Engagement: Strengthening, not Replacing, Public Systems

Thailand's mature UHC system offers well-defined opportunities for private-sector partnerships that complement public provision of service delivery and help close pathway gaps. Potential areas of engagement include contracting private hospitals, laboratories, and diagnostic providers to expand timely access to confirmatory testing and imaging where clinically appropriate; extending prevention access through pharmacies, workplaces, and retail health settings linked to NHSO and SSO referral pathways; supporting adult immunization and healthy-aging initiatives through evidence generation and provincial demonstration projects; and exploring private insurance models that incentivize completed prevention pathways and improved health outcomes. Payment and purchasing reform, however, should be led by the insurers and financing ecosystem. The private-sector role is to strengthen public systems—through diagnostic capacity, digitally-connected care pathways, workforce capability, and evidence generation—while maintaining affordability, equity, and UHC objectives.



# Conclusion and Recommendations

## From Policy to Implementation

Indonesia and Thailand have both established strong foundations for preventive health through national strategies, UHC, primary care reforms, disease-control programs, digital health initiatives, and financing mechanisms. The remaining challenge is translating these commitments into consistent delivery.

Across both countries and the identified priority areas, the same implementation gaps emerge: coverage does not automatically mean access; screening does not automatically mean diagnosis; diagnosis does not automatically mean treatment; and treatment does not automatically mean sustained risk reduction.

The next phase of reform must therefore focus not on expanding service availability alone, but on making prevention operational, measurable, and sustainable—embedding prevention into routine health system performance and ensuring that individuals successfully complete the full continuum of care. This is the practical meaning of the shift from "sick" care to "health" care, and the key to improving outcomes while managing costs within UHC systems like Indonesia and Thailand.

Building on the experiences and priorities identified in the two countries' assessments, this paper proposes three recommendations to advance preventive health in Indonesia and Thailand – and as models for the broader ASEAN region:

### 1. Clarity:

### Define Core Prevention Pathways and Measure Completion

Governments should clearly define and regularly update a core package of preventive services across the life-course, specifying what is available for respective populations at each stage. This package should include established priorities—such as immunization, antenatal care, growth monitoring, and NCD and cancer screening—while incorporating emerging needs reflective of the region's changing demographics and subsequent health priorities. For countries that have already defined core preventive packages, like Indonesia and Thailand, the emphasis here is less on defining new commitments than on keeping packages current and delivering them consistently across demographics, geographies, and schemes. Importantly, clarity should extend beyond service availability to measuring whether people complete prevention pathways. Success should be assessed through indicators such as vaccination schedule completion, timely diagnostic confirmation after abnormal screening results, treatment initiation where clinically appropriate, sustained NCD control, and connection of older adults at risk of functional decline to nutrition, exercise, rehabilitation, and other supportive services. Measurement should also identify where people are lost between screening, diagnostic confirmation, treatment initiation, and follow-up, so governments can target capacity gaps accordingly.



## 2. Innovation:

### Bring Prevention Closer to Communities and Anticipate Demographic Shifts

Preventive health cannot solely rely on facility-based delivery. Indonesia and Thailand should continue testing and scaling community-based models that bring prevention closer to where people live, work, and learn—including through schools, workplaces, pharmacies, mobile clinics, community centers, and home-based care. These models should not only expand screening access, but also connect individuals with abnormal findings to timely diagnostic confirmation, appropriate referral, and follow-up care. Such approaches can serve as practical examples for the broader ASEAN region and reflect the type of people-centered innovation that is important as populations age.

Digital platforms can support this transition by strengthening patient recall, referral coordination, and pathway tracking. Indonesia's SatuSehat and ASIK platforms and Thailand's Mor Prom, Health Link and "30 Baht Treatment Anywhere" initiatives provide opportunities to improve continuity of care. Digital platforms should be paired with offline support mechanisms–including community health workers, call centers, and facility-based navigation—so that populations facing digital access barriers are not excluded. Provider-facing innovations such as remote diagnostic review, specialist consultation, and interoperable referral tools should align with national digital standards as they mature, targeting continuity of care and loss to follow-up rather than creating duplicate platforms.

## 3. Efficient Spending:

### Reward Completed Prevention, Not Isolated Contacts

Screening without diagnosis, diagnosis without treatment, and treatment without follow-up generate limited health gains and can weaken public confidence in health systems. Governments should therefore explore financing approaches that better align resources with completed prevention pathways, for example: cervical screening-to-treatment; colorectal screening-to-colonoscopy, HPV-dose completion, and stunting reduction pathways. Improving efficiency also requires greater visibility into how prevention resources are allocated across ministries, insurers, and programs. Efficient spending does not mean reducing investment in health; it means directing resources toward high-value interventions that improve outcomes, reduce avoidable future treatment costs, and strengthen sustainability of UHC systems.

# Public-Private Partnerships for Preventive Health Implementation

The private sector has a strategic opportunity to support Indonesia and Thailand in moving from preventive health policy to preventive health implementation**.** The most effective partnerships will strengthen public systems rather than create parallel channels and, in doing so, improve pathway completion, expand equitable access, strengthen diagnostic capacity, support digital continuity, generate evidence, and maintain affordability.

Priority areas for engagement include: cancer and NCD screening-to-follow-up initiatives; testing and laboratory capacity building; cardiometabolic monitoring tools; workplace- and pharmacy-based prevention models; patient navigation, referral-tracking, and digital recall systems; immunization cold-chain and last-mile delivery solutions; nutrition and growth-monitoring support; healthy-aging initiatives focused on frailty and sarcopenia; and health economic studies that strengthen governments' strategic purchasing and benefit-package design.

Indonesia and Thailand demonstrate that ASEAN's preventive health vision is increasingly well-established, but implementation will determine the breadth, depth, and timeframe of its impact. Greater clarity in what must be delivered, innovation in how services reach populations equitably, and financing approaches that reward completed prevention pathways—ensuring that screening reliably leads to diagnosis, treatment, and sustained follow-up— will enable health systems to move from "sick" care toward proactive, sustainable, and people-centered "health" care.



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Published: November 2026

# Acknowledgments


**This report was authored by Access Partnership**

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