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Thailand's universal health coverage reform as a policy process roadmap for countries pursuing bold health system change

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Abstract

Efforts to achieve universal health coverage (UHC) in low- and middle-income countries often face structural, political, and institutional barriers. This article analyzes a case of rapid national health reform that expanded coverage across an entire population, despite limited fiscal resources. Drawing on Kingdon's Multiple Streams Framework alongside Punctuated Equilibrium Theory as organizing frameworks, this analysis examines how problem recognition, technical policy development, and political alignment converged to enable transformative health policy change. Key contributors to success included long-standing work by health system reformers, supportive civil society mobilization, and strategic engagement by political actors. The case offers broader lessons for advancing health reforms elsewhere, including the value of early technical preparation, coalition-building across sectors, and seizing policy windows when conditions align. It also underscores the importance of balancing rapid implementation with system capacity and stakeholder engagement to ensure reform sustainability.

1 Introduction

Achieving universal health coverage (UHC) remains a central goal for health systems worldwide, particularly in low- and middle-income countries (LMICs) seeking to address deep-seated health inequities [1]. Thailand's implementation of a comprehensive coverage program stands as a widely referenced example of successful reform in such settings, with rapid and near-universal enrollment achieved despite economic constraints. This reform is frequently cited as a model for LMICs aiming to expand access through publicly financed health systems [2, 3].

While several studies have documented the outcomes of this reform, fewer have analyzed the policy process that enabled its emergence. Understanding how political and institutional conditions aligned to support a rapid, large-scale shift in health financing and service delivery is critical for informing similar efforts in other LMICs, where such transitions are often stymied by competing interests, fragmented governance and capacity constraints [3–5].

This study asks: How did political, technical, and institutional factors align to enable Thailand's rapid UHC reform, and what lessons can other countries derive from this process?

To answer this, we apply two complementary policy process theories: Kingdon's Multiple Streams Framework (MSF) and Punctuated Equilibrium Theory (PET). The MSF posits that major policy change occurs when three streams, that is, problem recognition, policy alternatives, and political opportunity converge [6–9]. PET, by contrast, explains how long periods of policy stability can be interrupted by brief moments of rapid, punctuated change when attention shifts, institutional gatekeeping breaks down, or new actors seize the agenda [10, 11].

By integrating these models, we aim to provide a more layered explanation of how Thailand's UHC reform emerged, not just as a response to structural inequities, but as a case of successful policy entrepreneurship in a fluid political environment. MSF helps us understand how reformers framed problems and connected them with viable solutions during moments of opportunity, while PET allows us to explain the speed, intensity, and institutional entrenchment of the reform. Taken together, these frameworks allow us to analyze not only why reform became possible, but also how it was locked in and institutionalized so quickly.

We analyze this case using a theory-informed interpretive review of secondary sources, including peer-reviewed literature, government documents, and policy reports published between 2000 and 2024. Our goal is to extract insights that are both analytically grounded and practically useful for policymakers and advocates working to advance UHC in other settings. Rather than presenting Thailand as a universal model, we treat it as an instructive case study. In doing so, we highlight the conditions under which such reforms become politically feasible, technically credible, and institutionally sustainable, while also identifying the limits to generalizing from Thailand's experience. Ultimately, this study contributes to ongoing global efforts to understand the drivers of transformative health system change in LMICs.

2 Policy process models

2.1 Theoretical frameworks

This study uses a theory-informed policy process analysis grounded in two established frameworks: Kingdon's Multiple Streams Framework (MSF) and Punctuated Equilibrium Theory (PET). These frameworks are widely used in the policy sciences to explain agenda-setting and nonlinear policy shifts in dynamic political environments, particularly in LMICs.

MSF is used in this study as a heuristic model, a way to structure understanding of how problems, policies, and politics align during the agenda-setting phase of reform. It posits that major policy change becomes possible when three streams converge: the problem stream (recognition of an issue requiring attention), the policy stream (availability of technically feasible solutions), and the politics stream (public sentiment, electoral dynamics, and institutional leadership) [6–9]. Policy entrepreneurs play a crucial role in coupling these streams and seizing windows of opportunity.

PET, on the other hand, offers an explanatory framework to understand the rhythm of change, that is, why long periods of policy inertia are occasionally interrupted by rapid, dramatic shifts. PET emphasizes how institutional gatekeeping, policy monopolies, and

issue framing shape the stability or disruption of policy subsystems. It highlights how bursts of change can occur when new actors gain access to policymaking venues, trigger positive feedback loops, or shift the dominant framing of issues [10–11].

We selected these two frameworks to capture both the conditions that make policy change possible (MSF) and the mechanisms that drive the scale and pace of that change (PET). Although these frameworks come from different epistemological traditions, they are complementary when used together. MSF helps us identify how Thailand's UHC reform moved onto the policy agenda; PET helps explain why that reform was adopted and institutionalized so rapidly after years of incrementalism.

Used in tandem, MSF and PET allow for a richer analysis of Thailand's health policy reform than either model could provide alone. This dual-framework approach not only enhances explanatory power but also provides a structured way to extract insights for other LMICs seeking to navigate similar reforms under uncertain political and institutional conditions.

2.2 Data sources and analytical approach

This analysis draws on a structured review of secondary literature to examine the policy processes underpinning Thailand's universal health coverage (UHC) reform. The data sources include peer-reviewed journal articles, policy reports, historical accounts, and evaluations of the Thai health system published between 2000 and 2024.

Relevant materials were identified through targeted keyword searches on Google Scholar, PubMed, and JSTOR using combinations of terms such as "Thailand," "universal health coverage," "UHC reform," "30 baht scheme," "health policy process," "Kingdon," and "punctuated equilibrium." Emphasis was placed on documents authored by Thai policymakers, researchers, and international health policy experts, as well as reports from multilateral agencies such as the World Health Organization and World Bank. We included both academic literature and grey literature to capture a comprehensive narrative of events and reform dynamics. While the search was not exhaustive, it was guided by a purposive strategy to prioritize sources that discussed the origins, implementation, and political framing of the UHC reform. No primary data were collected. Instead, this is a retrospective, theory-informed policy analysis in which the authors reviewed and interpreted existing literature through the analytical lenses of Kingdon's Multiple Streams Framework (MSF) and Punctuated Equilibrium Theory (PET).

The analysis followed a deductive, interpretive approach. Events, actors, and institutional shifts described in the literature were mapped onto the theoretical components of MSF and PET. For MSF, materials were organized according to the three streams—problem, policy, and politics—with attention to how policy entrepreneurs helped couple them. For PET, we focused on identifying signs of institutional disruption, venue shifts, feedback loops, and abrupt policy change. This approach allowed us to reconstruct a structured narrative of how reform emerged, what dynamics sustained it, and how theoretical models can help interpret the case. While the reliance on secondary data limits our ability to provide firsthand accounts or verify behind-the-scenes decision-making, the sources analyzed were rich enough to support a coherent theory-driven interpretation.

While this study offers a structured, theory-driven interpretation of Thailand's UHC reform, it is based entirely on publicly available secondary sources. As such, it may not

capture all internal deliberations, dissenting views, or informal political dynamics that influenced reform processes. The analysis reflects the authors' interpretive judgments, and future work could complement this study through primary data collection, such as interviews with key policy actors.

2.3 Analytical mapping process

The analysis followed a deductive, theory-informed approach in which events, actors, and institutional dynamics described in the literature were mapped onto components of the two conceptual frameworks. For the Multiple Streams Framework, content from secondary sources was organized into the three streams: the problem stream focused on indicators of public concern or system failure, such as inequitable access and post-crisis vulnerabilities; the policy stream encompassed technical proposals and institutional arrangements developed by reform-minded bureaucrats; and the politics stream included electoral changes, civil society activism, and shifts in political leadership. Particular attention was given to identifying instances where these streams converged and to understanding the role of policy entrepreneurs who facilitated their alignment during a window of opportunity.

In relation to Punctuated Equilibrium Theory, we reviewed the literature for evidence of institutional inertia followed by abrupt policy change. Key markers included sudden legislative action, disruption of prior policy monopolies, and the entrance of new political actors or policy venues. We also examined how the reform generated positive feedback mechanisms such as broad public support and rapid service expansion that reinforced its sustainability. This analytical process was iterative and interpretive, aimed at producing a structured narrative that not only aligned textual evidence with theoretical constructs but also provided a deeper understanding of how Thailand's UHC reform moved from idea to implementation.

3 Thailand's universal health coverage expansion

3.1 Problem stream: health inequities in Thailand's health system

Prior to 2001, Thailand's health system was characterized by significant inequities. About 30% of the population had no health insurance coverage whatsoever [2, 5]. The existing system consisted of multiple schemes: the Civil Servant Medical Benefit Scheme for government employees, the Social Security Scheme for formal sector workers, and limited programs like the Medical Welfare Scheme for the poor and the Health Card Scheme, which offered voluntary coverage [12]. This fragmented approach created a system with profound disparities. The Civil Servant scheme, for instance, received significantly higher per-capita allocations (1780 baht) compared to the Low-Income scheme (225 baht) [13]. Furthermore, healthcare resources were disproportionately concentrated in Bangkok and urban centers, with rural areas facing severe shortages of facilities and medical personnel. The 1997 Asian financial crisis exacerbated these issues by increasing economic hardship among Thais, particularly in rural areas, highlighting the inadequate social protection systems [13]. This growing recognition of health inequities established a clear problem requiring attention.

3.2 Policy stream: technical solutions and network of reformers

The solution to Thailand's health coverage problem emerged from a group of reform-minded bureaucrats within the Ministry of Public Health (MoPH). This network of "Rural Doctors," formed in the 1970s, had been developing policy alternatives for decades through their work in Thailand's underserved regions [14]. Dr. Sanguan Nitayarumphong, a prominent figure in this network, had been piloting a community-based health insurance scheme in Ayutthaya province that served as a precursor to the national program [15].

The reformist bureaucrats created several technical solutions that would be incorporated into the universal coverage scheme: (1) a capitation-based payment system rather than fee-for-service, (2) contracting units for primary care as gatekeepers to the system, and (3) a separation of purchaser and provider functions through the creation of the National Health Security Office [5, 15]. These technical elements represented viable policy solutions that had been refined through years of experimentation and adaptation.

By the late 1990s, these bureaucrats had established the Health Systems Research Institute, International Health Policy Program, and other organizations that generated evidence supporting universal coverage [14]. Their long-standing work in the policy stream created a ready set of technically viable alternatives when the political opportunity emerged.

3.3 Politics stream: constitutional reform and Thai Rak Thai

The politics stream underwent significant transformation with the adoption of Thailand's 1997 "People's Constitution." This constitution introduced new electoral rules that incentivized political parties to develop more coherent, programmatic policy platforms rather than relying solely on patronage politics [4].

This constitutional reform coincided with the formation of the Thai Rak Thai (TRT) party under telecommunications tycoon Thaksin Shinawatra. TRT became the first Thai political party to employ sophisticated polling and marketing techniques and to center its electoral campaign on specific policy promises, including universal healthcare [4]. The 1997 financial crisis had created an atmosphere conducive to reform, as voters sought new approaches after the perceived failures of traditional politicians to address economic challenges, further amplifying public receptiveness to progressive health policy proposals.

The political momentum for universal health coverage was further strengthened by significant civil society mobilization. A crucial development was the "People's Bill" initiative, through which civil society organizations collected over 50,000 signatures to propose legislation supporting universal healthcare [16]. This grassroots campaign demonstrated substantial public support for health system reform and placed additional pressure on political actors to address healthcare inequities. The campaign was coordinated by a coalition of NGOs, consumer protection groups, and health advocates who effectively framed universal coverage as a basic right rather than a privilege [13, 17]. This civil society movement created a supportive environment for reform by raising public awareness about healthcare disparities and mobilizing constituencies that would benefit from universal coverage. The convergence of this bottom-up pressure with top-down political calculations strengthened the politics stream and contributed significantly to the policy window that enabled Thailand's universal health coverage reform.

3.4 The convergence of streams: policy window

The critical convergence of the three streams described above occurred when Dr. Surapong Suebwonglee, a former Rural Doctor who had become a key TRT advisor, connected the reformist bureaucrats with Thaksin. Despite TRT's polling suggesting healthcare was not voters' top priority, the bureaucrats convinced Thaksin of the political potential of a universal healthcare policy [14]. Thaksin recognized the electoral appeal of such a program and rebranded it as the "30 baht treats all diseases" scheme, highlighting the affordable copayment of 30 baht (less than one US dollar) per visit. This convergence exemplifies Kingdon's coupling process: the problem (health inequities) was connected to a solution (the comprehensive coverage plan developed by the reformist bureaucrats) at a politically opportune moment (the emergence of a reformed electoral system and a new party seeking distinctive policies). The reformist bureaucrats and their civil society allies served as policy entrepreneurs, strategically coupling these streams during this critical window of opportunity.

3.5 Policy adoption and implementation: punctuated change

The implementation of the universal coverage scheme reflects a punctuated change in Thai health policy. After years of incremental improvements and limited schemes, the system underwent dramatic transformation within a remarkably short timeframe. Following TRT's election victory in January 2001, a pilot program was launched in six provinces by April, expanded to fifteen provinces by June, and reached nationwide coverage by October 2001, with full implementation by April 2002 [5].

The rapid implementation was driven by strategic decisions by key actors. Dr. Mongkol na Songkhla, the permanent secretary at the MoPH, advocated for swift implementation partly out of concern that political support might waver [14]. This strategy created a "lock-in effect," making it politically difficult to reverse the policy once citizens began receiving benefits [4].

The policy was institutionalized through the National Health Security Act of 2002, which established the National Health Security Office as an autonomous purchasing agency separate from the MoPH [5]. This legislative framework ensured the policy's durability beyond any single government. While implementation faced resistance from sections of the medical profession and more conservative elements within the MoPH, the policy had generated sufficient political momentum to overcome these obstacles.

4 Reflections

4.1 Lessons for advancing health coverage in other settings

Thailand's experience offers a valuable policy process roadmap for countries pursuing bold health system reforms under resource and institutional constraints. Rather than prescribing a fixed model, the Thai case illustrates how strategic alignment across technical, political, and institutional domains can unlock transformational policy change. Several lessons emerge that may guide reformers in other low- and middle-income countries.

First, the case underscores the importance of long-term technical preparation. The Rural Doctors' decades of work developing viable policy alternatives ensured that when a political opportunity emerged, a technically sound and politically sellable plan was immediately available. Other countries may benefit from investing in local research

capacity, pilot programs, and institutional memory even in periods when reform seems unlikely.

Secondly, the Thai experience highlights the role of strategic policy entrepreneurs who can recognize and exploit windows of opportunity. The reformist bureaucrats were positioned to connect with TRT at a critical moment, presenting their policy in terms that appealed to the party's electoral interests. This suggests the value of developing networks that span technical agencies, civil society, and political parties to facilitate such connections when opportunities arise.

Third, Thailand's decision to fund UHC through general taxation rather than contributory insurance mechanisms suggests a model that may be more feasible for countries with large informal sectors. While fiscal space is a constraint in many LMICs, Thailand's approach shows that redistributive financing is possible with strong political commitment, especially when linked to popular support and electoral legitimacy.

Finally, Thailand's rapid implementation strategy helped generate early public support and created a "lock-in" effect that made reversal politically difficult. By delivering visible benefits quickly, reformers built momentum and public trust. However, the experience also suggests that speed must be balanced with system capacity, a theme explored in greater depth in Sect. 4.2. Countries may benefit from combining strategic quick wins with phased implementation of complex financial and administrative reforms to avoid overstretching fragile delivery systems.

Taken together, these lessons do not imply a one-size-fits-all blueprint. Rather, they offer a navigational guide for countries seeking to adapt core process principles like technical readiness, reform coalitions, context-fit financing, and strategic rollout to their own institutional and political landscapes.

4.2 Broader reflections on health policy-making in LMICs

While the operational strategies behind Thailand's UHC reform offer practical lessons, they also reflect deeper truths about policymaking in resource-constrained environments. Thailand's case challenges the widely held assumption that comprehensive social policies are unaffordable in low- and middle-income countries. The reform was introduced shortly after a major financial crisis, with no large influx of donor funding. Rather than relying on new revenue streams, the government reallocated existing resources and improved efficiency through institutional restructuring and provider payment reform [13].

The case also illustrates the critical importance of bureaucratic capacity and autonomy. The reformist bureaucrats within the MoPH not only possessed the technical expertise to design viable alternatives but also operated with sufficient autonomy to advance proposals that diverged from the status quo. This suggests that building a motivated, technically competent civil service may be as important as securing external financing in achieving health system transformation.

Equally important was the role of domestic ownership and local adaptation. Although Thailand's reformers drew inspiration from international models and global health discourse, the ultimate design of the system reflected the country's institutional history, administrative realities, and cultural norms. This emphasizes the need for countries to tailor reform initiatives to their own political economies, rather than importing models wholesale.

Finally, the Thai case reinforces that political institutions and incentives matter. The constitutional reforms of the late 1990s introduced programmatic electoral competition and created space for new political actors to offer bold, policy-driven platforms. Without this shift in political dynamics, the reformist coalition may have lacked the leverage needed to advance universal coverage. For other countries, structural political economy factors such as electoral rules, party systems, and civic pressure may be as determinative of reform success as health system characteristics.

4.3 Transferability and limitations of the Thai experience

While the Thai UHC reform provides a compelling case of rapid and inclusive health system transformation, its applicability as a roadmap for other countries must be approached with caution. The success of the reform was shaped by a unique combination of factors: a technically sophisticated cadre of reformers embedded in the MoPH, a strong tradition of rural health service delivery, a reformist electoral moment created by constitutional change, and relatively stable macroeconomic conditions in the post-crisis period.

These conditions may not be present in other low- and middle-income countries, where bureaucratic capacity may be weaker, political institutions more fragmented, or fiscal space more constrained. Additionally, Thailand's reliance on general taxation to finance UHC may not be politically feasible in contexts with lower revenue mobilization or weaker social contracts.

Despite these limitations, the case offers useful comparative insights. Countries may draw from Thailand's example in policy process areas such as cultivating long-term technical capacity, framing health as a right in electoral discourse, and designing simple, visible benefit packages that build popular support. However, successful adaptation will require tailoring to each country's political economy, administrative capabilities, and health system baseline.

5 Conclusion

Thailand's achievement of universal health coverage represents a compelling case of successful health policy reform in a middle-income country. By applying Kingdon's Multiple Streams Framework alongside Punctuated Equilibrium Theory, this study examined how problem recognition, policy design, and political opportunity converged to create a window for transformative change. The strategic actions of policy entrepreneurs, coupled with bureaucratic readiness and institutional alignment, were essential in translating reform ideas into a national program that achieved near-universal coverage within a year.

While many accounts of Thailand's UHC success focus on its financing model or service expansion, this analysis highlights the underlying policy process that made reform possible, and durable. The convergence of long-standing technical preparation, electoral incentives, and civil society pressure created conditions for a rapid, yet politically grounded transformation. The dual-framework approach allowed for a richer understanding of both the agenda-setting phase (MSF) and the institutional shift and policy lock-in that followed (PET).

Importantly, this study affirms that bold reform is not beyond reach for countries facing fiscal and political constraints. Thailand's experience offers not a rigid template, but a

policy process roadmap demonstrating how sustained technical work, political entrepreneurship, and institutional agility can align to overcome inertia and deliver equity-oriented health system change. While this analysis uses established theoretical frameworks to organize insights rather than test new theoretical propositions, it offers practical guidance for reformers navigating similar policy challenges. For other LMICs, the key takeaway is not to replicate Thailand's model in form, but to adapt its strategic logic to local contexts, building on the principles of preparedness, alignment, and political timing.

Author contributions
E.A. conceived the study, led the policy analysis, and drafted the main manuscript text. K.A.H. contributed to the theoretical framework development and literature review. S.K. supported data synthesis and revised multiple manuscript sections for clarity and coherence. E.N.A. reviewed the final draft and contributed to the interpretation of findings from a comparative health systems perspective. All authors reviewed and approved the final manuscript.

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All data generated or analysed during this study are included in this published article.

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