Forcing the Genie Back in the Bottle: Sociological Change, Institutional Reform, and Health Policy in Thailand

Allen Hicken and Joel Sawat Selway

In 2007, those behind the 2006 coup drafted a new constitution specifically aimed at turning back the political and policymaking clock to the pre-1997 era. However, in the preceding decade a significant transformation of Thai politics had taken place. Specifically, social cleavages had become politicized and particized in ways we have not seen before, and policy-focused, popular party programs had become part and parcel of serious party campaign strategies. Focusing on health policy, we thus argue in this article that institutional reforms have had predictable and observable implications for policymaking in Thailand, but only when considered in the context of changes to the broader social structure and other political conditions. While the 1997 reforms brought about a well-documented shift toward a more centralized, coordinated, and nationally focused policymaking environment, the 2007 reforms have been less successful at reversing that impact. In short, the coup makers are finding it harder than they supposed to force the genie back into the bottle. Keywords: Thailand, political parties, institution, health, health policy, policymaking

In less than a decade, Thailand adopted two constitutions, both of which were designed to drastically reshape the nature of Thai politics. In 1997 and again in 2007, constitutional drafters reworked the electoral system, changed the manner of selecting the Senate, and amended the powers of the prime minister. What effect, if any, did these new institutional settings in Thailand have on the policymaking environment? We argue that the 1997 reforms brought about a well-documented shift toward a more centralized, coordinated, and nationally focused policymaking environment and that this shift corresponded with a shift in health policy from narrowly targeted and particularized spending (e.g., spending on hospitals and clinics) toward spending on more broadly targeted programs such as the 30-baht health scheme. The 2007 constitutional
changes, by contrast, aimed to refragment the policymaking environment and undermine the incentives for nationally focused policymaking, which, all things being equal, we would expect to correlate with a shift in funding away from universal health programs like the 30-baht scheme, and back toward more particularized forms of health spending.

However, two confounding effects made it impossible for those behind the 2006 coup to force the genie back in the bottle. First, in the intervening ten years, a radical change in the social contract had taken place in Thailand, signaled by the passing of numerous welfare-enhancing policies. The effects of this change in the policy landscape were that voters developed both “commitments” to specific policies (e.g., universal health care) as well preferences for similar policies of a broad, national nature. The development of these commitments and preferences increased the costs of entry for small parties and restricted the range of fiscal policies politicians could pass, thus locking in the type of broad, nationally oriented political parties that had emerged in the 1997–2007 era (Haggard and Kaufman 2008; Pierson 2004).

Second, significant changes to Thailand’s social structure mitigated against the tendency toward fragmentation that was the norm pre-1997. Specifically, partisan identities were weak and national social cleavages were not politically salient in the pre-1997 era. The 1997 reforms brought about a new style of nationally oriented policies, however, that fashioned broad coalitions of support running across long-dormant national social cleavages, such as region, class, and the urban-rural divide. In addition, partisan identity significantly strengthened during this era. The result was that the reintroduction of the pre-1997 institutions in 2007 failed to refragment the policymaking environment in the way the 2006 coup leaders had hoped.

This research has theoretical implications for the study of institutions. First, the search for the effects of political institutions on policy outcomes is not fruitless. Rather, we argue that political science theory regarding the effect of electoral rules on policymaking should systematically incorporate countries’ underlying social structure and distribution of preferences in the same way that the literature on the effect of electoral rules on the number of parties has done (e.g., Duverger 1954; Cox 1997; Clark and Golder 2006). Institutions do not operate in a vacuum. If our goal is to understand and even predict the effect of institutions on policymaking, we must first understand how they interact with the broader political environment. Where the social structure undergoes a dramatic change, we can expect similar sets of institutions to produce very different outcomes. In short, political institutions, such as electoral systems, in-
teract with the broader political environment to shape the capabilities and incentives of policymakers.

Between 1997 and 2007, Thailand’s political environment underwent just such a dramatic change, and understanding this critical juncture is crucial if we want to explain the effect of electoral rules on political outcomes. This critical juncture emerged in Thailand starting with the development of strong commitments to the new, nationally focused policies, followed by a dramatic change in the salience of certain social cleavages in Thailand and a strengthening of partisan identities. Critical junctures have been long recognized by historical institutionalists, but the conditions underlying their emergence have been undertheorized. We argue that a realignment of both the country’s social structure and the populace’s relationship to political actors (in this case parties) constitutes a critical juncture. What we observe between 1997 and 2007 is the emergence of strong partisan ties to groups of citizens divided along the national cleavages of region, class, and urban/rural residence.

How should these changes in Thailand’s institutional and political environments shape public policy? We draw on theories of electoral rules in relation to public goods provision that focus on the size of constituencies to which politicians are accountable (Persson and Tabellini 2004, 1999; Milesi-Ferretti, Perotti, and Rostagno 2002; Franzese and Nooruddin 2004; Rickard 2005; Edwards and Thames 2007). In the pre-1997 era, Thai constituencies were small and narrow due to geographically small electoral districts characterized by high levels of intraparty competition, weak links between parties and voters, and the absence of broad social cleavages with salience in the party system. As a result, there were few incentives for parties to develop policy platforms aimed at broad national constituencies and few incentives for voters to consider party labels or policy positions when casting their vote (Hicken 2006; Selway 2011). All three of these factors changed in the 1997–2007 era. The 1997 constitutional reforms effectively increased the size of constituencies to which politicians responded while increasing the importance of party labels. They did so by eliminating intraparty competition, adding a new national party list tier to the electoral system, and granting prime ministers new power over intraparty factions (Hicken 2006; Selway 2011). These institutional reforms, combined with the increasingly party-centered policies pursued by the Thaksin government, helped make broader social cleavages based on geography or class salient for the purposes of partisan competition. In short, during the 1997–2007 period, the constituencies to which politicians responded expanded, party labels become more important, and broadly based social cleavages became more salient.
When the 2006 coup makers tried to reengineer the political system, they discovered, to their dismay, that bringing back the pre-1997 electoral rules was not enough to reproduce the pre-1997 party and policymaking environment. New links between parties and broad groups of voters had been forged in the previous decade, which could not be quickly or easily reversed. Thus, by the time coup makers tried to turn back the institutional clock, the sociopolitical environment with which those institutions interact had changed. The effect of changing electoral rules in Thailand in 2007 can only be understood through the lens of this critical juncture, this sociopolitical realignment. In short, we argue that electoral rules matter but that their effect is conditional on the underlying social structure and the strength of partisan ties to shape the policymaking environment.3

The article proceeds as follows. We first briefly review the pre-1997 policymaking environment in Thailand and its manifestation in health policy. We then discuss the 1997 reforms and the way in which they reshaped the incentives and capabilities of policymakers in Thailand over health care. Finally, we review the 2007 reforms and discuss the implications of those reforms for politics and policymaking. We demonstrate how Thailand’s transformed political environment should alter our expectation as to the effects of these institutional reforms.

Policymaking in Pre-1997 Thailand

As Thailand began its transition to democracy in the 1980s, a pattern quickly emerged and remained in place through the 1997 reforms.4 A block vote,5 candidate-centered electoral system and a relatively weak prime minister combined to produce large, multiparty coalition governments that were notoriously short-lived. Political parties tended to be short-lived vehicles of electoral convenience, and party labels/party programs were relatively meaningless for both voters and party members themselves (Ockey 1994; Hicken 2008). Given the weakness of links between parties and voters, the latter took advantage of the opportunity that block vote provided to split their multiple vote across candidates from different parties. As a consequence, most districts returned representatives from more than one party. In this environment, characterized by short-time horizons, narrow constituencies, and multiple veto players, the development, passage, and implementation of broadly targeted policy reforms was nigh impossible (Hicken 2001, 2004; Selway 2007a). Instead, broadly targeted policies were undersupplied and other public policies were particularized or morselized,6 with parties and party fac-
tions having a relatively free hand in running their ministerial bailiwicks and individual politicians doing all they could to siphon personally attributable government goodies back to their individual constituencies.

The effect of this policymaking environment is clearly seen in the area of health policy. Despite impressive amounts of health spending, pre-1997 Thailand was a chronic underperformer when it came to health outcomes. Table 1 compares Thailand to its neighbors with similar levels of economic development in terms of health expenditures and outcomes in 1993.\(^7\) We see that Thai spending in 1992 on health care as a percentage of gross domestic product (GDP)—6.38 percent—was more than double that of most of its regional neighbors (World Health Organization 1993). Likewise, per capita expenditures in 1993 were US$73 per person in Thailand compared to $12 in Indonesia, $14 in the Philippines, $18 in Sri Lanka, and $67 in Malaysia. Yet, despite its higher health spending, Thailand’s “return” on the investment was much lower than that of neighboring countries. In terms of measurable outcomes, only 33 percent of births were attended by physicians in Thailand compared to 43 percent in Indonesia, 82 percent in Malaysia, and 87 percent in Sri Lanka. Thai infant mortality stood at 38 per 1,000 live-births, while the rates in Sri Lanka were 18 and Malaysia 15. Thais also had a shorter life span, an estimated 68 years, compared to 70.5 for Malaysians and 71.3 years for Sri Lankans.

A comparison with the Philippines is particularly enlightening. Despite being outspent by more than 400 percent, the Philippines managed to produce health outcomes that were on par with what Thailand produced. In short, as we look across the neighborhood, while Thailand is not always the worst on some indicators, it is also not the best on any—

<table>
<thead>
<tr>
<th>Country</th>
<th>Health Spending (percentage of GDP)</th>
<th>Per Capita Health Spending (in US$)</th>
<th>Infant Mortality (per 1,000 live births)</th>
<th>Life Expectancy (years)</th>
<th>Births Attended by Physician (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indonesia</td>
<td>2</td>
<td>12</td>
<td>74</td>
<td>60</td>
<td>43</td>
</tr>
<tr>
<td>Philippines</td>
<td>2</td>
<td>14</td>
<td>74</td>
<td>60</td>
<td>53</td>
</tr>
<tr>
<td>Malaysia</td>
<td>3</td>
<td>67</td>
<td>41</td>
<td>65</td>
<td>82</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>3.7</td>
<td>18</td>
<td>41</td>
<td>70.5</td>
<td>87</td>
</tr>
<tr>
<td>Thailand</td>
<td>6.4</td>
<td>73</td>
<td>38</td>
<td>68</td>
<td>33</td>
</tr>
</tbody>
</table>

*Source: World Health Organization (1993).*
surprising considering it dramatically outspent all its regional neighbors in percentage and nominal terms.

Notably, these relatively poor outcomes run counter to the expectations of some of the leading health policy experts in the early 1980s. Given Thailand’s rapid economic growth and its relatively competent health bureaucracy, Thailand was expected to experience rapid improvements in health over the course of the 1980s and 1990s. For example, in 1984 the head of the World Health Organization (WHO) lauded Thailand’s health projects and heralded the country for being on the verge of Health For All by 2000. Indeed, in that same year, another WHO official said that Thailand had the best primary health care program of all WHO aid recipients—so much so that Thailand was the only country that was permitted to make its own decisions on what to do with WHO funding and was granted US$12 million in WHO commitments over the succeeding six years. Had the WHO known what changes Thailand’s newly elected politicians would bring in the allocation of health resources in Thailand, it might have thought twice about granting Thai policymakers complete autonomy over their funding.

The incentives generated by the pre-1997 institutional environment were such that political parties and politicians had few inducements to pursue broadly targeted policies, and even more limited capacity to do so. Not surprisingly, the pre-1997 era saw almost no policy initiatives emerging from political parties. Despite a fairly technocratic Ministry of Public Health (MOPH) that designed and tested numerous improvements to the health system, individual politicians and parties had no incentive to take these suggestions on board, either in legislative proposals or, surprisingly, even in party platforms, which all tended to be cardboard cutouts of the National Economic and Social Development Board (NESDB) five-year plans. Instead, the focus of policymaking was on targeted spending toward individual constituencies, again consistent with the institutional incentives. When the rare broadly targeted policy did make it through this unfavorable institutional environment, it was subsequently morselized by the governing coalition.

For example, the Free Medical Services for the Poor (FMSP) program, launched in 1980, was used as a means of rewarding political supporters. Through their political networks of chiefs and kamnans (subdistrict headmen) who were responsible for screening and distribution, Thai members of parliament (MPs) took direct credit for the program by issuing cards to their supporters. Several evaluations estimated that up to 45 percent of cardholders exceeded the means-test limits, while up to 72 percent of the poor did not even acquire the cards (Suksawat 1989; Tumkosit 1996).
However, it is not the case that the incentives toward pork and particularism dampened spending on health policy. As we have demonstrated, Thailand devoted a comparably disproportionate share of its budget to health spending. But funds tended to be allocated on the basis of narrow political calculations, flowing to projects and programs that might offer inferior returns of investment but for which politicians could easily claim credit. The composition of the health budget is a good indicator of the highly targeted nature of policy. The health budget can be broadly divided into three main categories: salaries, operating expenditures, and investment. Between 1979 and 1997, the investment portion of the budget almost doubled in size, from 22.6 percent to 38.7 percent. In addition, the size of the health budget as a percentage of the overall government budget was increasing during this era, almost doubling in size between 1987 (4.4 percent) and 1997 (7.8 percent). Where was all this investment going? The answer is hospital building, which accounted for almost all the increase in spending in the health budget. The nature of this flurry in construction is also telling, as the focus was on building hundreds of small (ten-bed) hospitals. Approximately one for every single electoral district was built by 1987, after which investment went toward upgrading them to thirty-bed hospitals (Selway 2009).

1997 Constitutional Reform

In 1997, Thailand adopted a new constitution aimed at fundamentally reforming elements of the Thai political system. Drafters set out to remake Thailand’s political environment through a series of reforms. These included establishing a series of new accountability and oversight institutions (e.g., the National Counter Corruption Commission and the Election Commission), turning the Senate into an elected body, and reforming the electoral and party systems. It is the latter set of reforms on which we wish to focus.

To begin with, drafters changed the electoral system from a block vote system with one to three seats per constituency, to an electoral system with 400 single-seat constituencies. This did two things: it reduced the effective number of parties per constituency (thereby putting downward pressure on the number of national parties), and it eliminated competition between copartisans that had helped feed the demand for candidate-centered and particularistic goods and services.

Drafters also added a second tier of 100 seats to the House of Representatives, selected via proportional representation (PR) from national party lists. The addition of the PR tier gave voters the opportunity to
select a party (as opposed to an individual) that they wanted to see form the government and that would represent the nation as a whole. It also gave voters an incentive to consider national issues. As a result, Thais in the provinces were now more empowered to affect politics in Bangkok. Parties responded to this change by seeking to build large, national parties and generate attractive programmatic platforms (discussed further in the next section).

Complementing the party list tier were new restrictions on party switching, which gave new leverage to the prime minister over members of his own party. Politicians now had to be registered with a political party ninety days before an election was called. In theory, this rule would prevent large-scale defections from within the government’s party. All the prime minister would have to do is call elections within ninety days and the defectors would be locked out of politics, potentially for up to four years.

These three reforms—the move to single-seat constituencies, the addition of a national party list, and new leverage for the prime minister—combined to reduce the number of parties post-1997, both at the constituency level and at the national level. One consequence of a smaller number of parties was the rise of majority party government—a novelty for democratic Thailand. The first election for the House of Representatives under the new constitution was held in 2001. For the first time since democratic elections were restored in 1979, a single party—the newly formed Thai Rak Thai (TRT) party—nearly captured a majority of the seats in the House. Shortly after the election, two parties agreed to merge with the TRT, giving it a majority of seats. In 2005, Thai Rak Thai was swept back into office with 75 percent of the seats. What had been a very fragmented political environment in Thailand became one in which power was concentrated within the ruling majority party, specifically around the office of the prime minister. As a coalition constructed around a majority party, post-reform governments proved more stable than their predecessors. Thaksin Shinawatra completed a full four-year term as prime minister in 2005—the first elected prime minister ever to do so.

In addition to reducing the size of the party system, constitutional reform also sought to strengthen political parties, broaden their vision (or induce them to acquire one in the first place), and create stronger attachments between parties and their candidates and voters. While attitudes and behaviors did not change overnight, these new incentives did induce a change in strategy on the part of parties, candidates and, ultimately, voters. Political parties, led by TRT, began to move away from relying solely on personal strategies in favor of coordinated party-centered strategies, party labels became valuable tools for candidates and voters, and
voters began to identify more strongly with particular political parties (Phatharathananunth 2008; Selway 2009).

What did these changes mean for the politics of policymaking? First, the changes to the electoral system increased the incentives of parties to invest in programmatic policies. Post-1997, we thus observe an increase in the development of serious and differentiable policies in issue areas such as social welfare, education, and health care. With regard to health, parties began investing in independent means to develop programmatic policies and come up with detailed plans to fund such policies (Selway 2009).

Second, the advent of majority party government enhanced the capabilities of policymakers, making it easier for a programmatic party to actually make good on its policy promises. Recall that the prereform environment was a system of fractured, short-lived coalition governments fraught with collective action problems. The fact that control of government policy was divided among a large number of parties and factions, each with different interests, made collective decisionmaking and policy coordination extremely difficult. The Democrat Party, for instance, had long been considered the most programmatic-minded of all Thai parties. However, each time they were in the governing coalition, the Democrats had to deal with a host of parties, each of which staked jurisdiction over a certain ministry. After 2001, in contrast, a single party at the helm of government—a party that itself was much more centralized than any of its predecessors—meant that a programmatic-minded party could more easily implement its policies.

**Policymaking Under Thai Rak Thai**

The various accounts of the evolution of the policymaking environment under Thai Rak Thai all tell a similar story. Parties began to develop serious and distinguishable platforms. Thaksin, through a variety of reforms, worked to centralize power and authority within Thai Rak Thai, and specifically within the office of the prime minister. Measures such as bureaucratic restructuring, reform of the armed forces, new duties for provincial governors, and the marginalization of semiautonomous supervisory agencies reduced political fragmentation while strengthening the position of the TRT vis-à-vis bureaucratic and partisan rivals (Phongpachit and Baker 2004; Painter 2006).

The story is no different in the area of health policy. First, party platforms became more programmatic and differentiated. Second, power over health policy was centralized around the Office of the Prime Minister. This resulted in significant changes to the composition of the health budget and in real changes to the pocketbooks of the Thai electorate. Fi-
nally, although actual health outcomes are hard to gauge during this period, hospital utilization increased significantly and infant mortality declined much more rapidly than previously.

The 2001 electoral campaigns of the two major parties (Democrats and TRT) entailed detailed health policies aimed at decreasing the number of Thais without health insurance. The then largest party, the Democrats, appointed Harvard School of Public Health graduate Burunaj Samutharaks to direct their health policy. Burunaj, who spearheaded the National Health Act, formulated a detailed party policy that centered on expanding the Voluntary Health Card program to cover all Thais within three years. In addition, their platform targeted preventive medicine, including free physical checkups and vaccinations. Other parties also distinguished themselves on health policy. The Thai Motherland Party’s platform promoted healthy cities, while the National Development Party (Chat Pattana) aimed to develop health centers all over the country. Unlike previously, when health policies were cardboard cutouts of the NESDB, the 2001 party platforms were quite detailed (some more than others), and parties even engaged in a public debate at the Ramathibodhi Hospital.

TRT began researching universal coverage in mid-1999. TRT counseled with health reformists to study how to “effectively utilize the existing healthcare resources,” gain “cooperation from both the public and private sectors,” and determine the appropriate user contribution (Pitayarangsarit 2004, 16). The party’s vision entailed a complete overhaul of the health system—hospital accreditation, methods of financing hospitals, preventive care, and, at the end of its regime, even doctor shortages. Indeed, TRT’s health policy was much more detailed than any other party’s. TRT appointed Dr. Surapong Suebwonglee to head its health research team. Like Democrat Burunaj Sumutharaks, Dr. Surapong was a technical expert, and it was he who devised the copay amount based on lengthy research, only afterwards coming up with the catchy slogan sahm-sip baht raksar tuk rohk (30 baht cures every ailment). In addition to their more detailed research and more daring proposals, TRT also trumped the Democrats in the use of public opinion surveys to gauge the popularity of its policies, which TRT did on a weekly basis. While the Democrats also organized some telephone polls, focus groups, and surveys, they were not as extensive as TRT’s. Accordingly, we see that TRT emerged as a new type of political party—one with independent means to formulate and assess public policies and determined to forge strong links to voters.

A second major change in the policymaking environment was the centralization of power around the Office of the Prime Minister. In order to wrestle power away from the strong bureaucracies in Thailand, TRT...
had to be creative. With health policy they acted early and swiftly, creating the National Health Security Office (NHSO) and diverting funds away from the Office of the Permanent Secretary in the Ministry of Health. The NHSO, directed by the innovator of the 30-baht scheme, Dr. Sanguan Nittyarampong, would be crucial to the success of universal health care in Thailand. In the NHSO, TRT had not only an ally but also a direct link to implementation. In addition, because the NHSO was created from scratch, it had no ties or loyalties to existing bureaucratic institutions—it was wholly and entirely the product of and responsive to Thaksin and the ruling party. Thaksin took advantage of this new institution and regularly consulted with it. He was very hands-on in the early stages, holding frequent meetings in what was dubbed the “war room” to discuss the 30-baht scheme.

A third shift in the nature of policymaking was manifested in the allocation of health funds. In particular, we witness a dramatic decrease in hospital building after 1997. Compared to a furious construction rate in the previous era—16,000 beds added in just two years (1995–1996)—only 150 beds (five hospitals) were added in the first three years after 2001 (MOPH 2004). Although part of this decline can be understood in light of the financial crisis, the low rate of building continued even after the economy rebounded and overall government spending surged. Table 2 shows that after 1997, the percentage of funds dedicated to the investment portion of the health budget dropped to its lowest levels ever—as low as 1.6 percent in 2005, compared to a previous low of 11.3 percent in 1987 (a reflection of the mid-1980s financial crisis), a high of 38.7 percent in 1997, and an average of 21.8 percent between 1979 and 1997. TRT simply set different priorities and sought to more efficiently use funds to finance the 30-baht scheme. Since the financing of the 30-baht scheme was constantly under pressure, with study after study calling for an increase in the per capita amount, belt tightening in all areas was imposed. There simply was not any room for pork-driven construction projects, and corruption was much less tolerated; the 30-baht scheme dominated the agenda.

But the 30-baht scheme was not the only broadly targeted programmatic policy to emerge after 1997. The Democrat Party, in power between 1997 and 2001, focused on resuscitating two existing health programs. By drastically increasing funding to the Free Medical Services for the Poor and the Voluntary Health Card (VHC) programs (quadrupling), the Democrats were the first to strategically respond to the new institutional environment. Specifically, by 2001, the percentage of those without health insurance had dropped from 54.5 percent in 1996 to 29
Table 2 MOPH Budget, by Allocation Category

<table>
<thead>
<tr>
<th>Year</th>
<th>Salaries</th>
<th>Operating</th>
<th>Investment</th>
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<tr>
<td>1979-1997</td>
<td>43.9</td>
<td>34.3</td>
<td>21.8</td>
</tr>
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<td>1998</td>
<td>38.5</td>
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<tr>
<td>2006</td>
<td>46.4</td>
<td>51.7</td>
<td>1.8</td>
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percent (Tancharoensathien 2004). This had been achieved by increasing those participating in the VHC scheme from 15.3 percent to 20.8 percent of the population and also increasing those on medical welfare from 12.6 percent in 1996 to 31.5 percent.

The number of uninsured, however, dropped even further after the introduction of the 30-baht scheme. The number of uninsured fell to just over 5 percent of the population within the program’s first year (Tancharoensathien 2004). Out-of-pocket expenditures also plummeted; the poorest 10 percent of the population paid an average of 7.1 percent prior to 1997, but only 1.2 percent by 2002. As such, it is difficult to assess improvements in health since the implementation of the 30-baht scheme improved detection of many illnesses. Infant mortality, however, is a good indicator of how access to health facilities affects health because it is less affected by poverty and nutrition than other indicators—the two biggest causes of infant deaths (under one year of age) are dehydration (due to diarrhea) and pneumonia, both of which depend heavily on rapid access to health services. And, in fact, we see that from a rate of nineteen deaths per 1,000 live births in the 1990–1995 period, the infant mortality rate (IMR) for Thailand dropped to seven for the 2005–2010 period (United Nations 2009). Compare this rate of decrease to Malaysia’s, which had an IMR of fifteen for the 1990–1995 period, but only nine for 2005–2010. One explanation for Thailand’s more rapid decrease in infant mortality is the increase in the percentage of births attended by skilled personnel, from just 85 percent in 1995 to 97 percent in 2006 (World Health Organization 2010).
2007 Constitutional Reforms

The centralization of power around Thaksin eventually generated a backlash from certain segments of the public and, ultimately, from Thailand’s conservative forces. There is no need to detail here the events surrounding the September 2006 coup and its aftermath—this has been done elsewhere (Supalak 2006; Ungpakorn 2007). For our purposes it is sufficient to note that constitutional reform was immediately put forward as one of the central planks of the coup leaders’ (and interim government’s) reform agenda. Their stated goal was to use constitutional reform to correct some of the perceived shortcomings of the 1997 constitution and the excesses of the Thaksin era (Hicken 2010).

The motives of the coup leaders were fairly transparent. Officials in the Council for National Security (CNS) managed the selection of a constitutional drafting assembly/committee and then made their preferences for the new constitution clearly known. While it is important to note they did not get everything they wanted, they did succeed in drafting and then passing via referendum a constitution designed to purge the body politic of “Thaksinization” and prevent the return of Thaksin or another figure like him. In short, the 2007 constitution is explicitly crafted to undermine the capacity of political parties and elected leaders to challenge Thailand’s conservative forces in the future. Specifically, they sought to make it much more difficult for large, nationally oriented parties backed by large swaths of the electorate to win elections, control a majority of seats in the legislature, and hold all the reins of power. They did so by (re)adopting institutions designed to refragment the party system and undermine the importance of parties to voters and politicians.

Weaker Prime Minister

A variety of reforms combine to diffuse power and undermine the authority of the prime minister vis-à-vis other actors in the political system. There are new checks on the authority of the prime minister in the form of a now partially appointed Senate—with the prime minister playing no direct role in the selection process (a change from past constitutions). The new constitution also makes it easier to launch a no-confidence debate. One of the frustrations of Thaksin’s opponents was that his party’s super majority in effect shielded him from the threat of no-confidence motions. Now governments will essentially have to capture all of the seats in the legislature to prevent a censure debate.

The 2007 charter also removed much of the prime minister’s leverage over party members by effectively eliminating the stringent party-switching restrictions rules that had kept would-be party switchers loyal
under Thaksin. Under previous rules, party switchers had to be members of a party for ninety days to be eligible for election. The 2007 constitution maintains the ninety-day rule but provides a key exception: in the case of an unexpected house dissolution the rule is waived and politicians need be party members for only thirty days in order to stand for election.

Finally, the new constitution places a two-term limit on the office. Thailand is one of only a few parliamentary systems to have adopted term limits for its prime minister. This is a measure designed to make it impossible for Thaksin to return and also to prevent the rise of a future Thaksin. Going forward it will be impossible for politicians to directly dominate the political scene for years as Thaksin seemed poised to do. At most, even very popular prime ministers will be eligible to serve only eight years in office before being forced to step down.

Return to the Pre-1997 Party System
A weaker prime minister is also part of an engineered effort to return Thailand to an earlier era of multiple weak, narrowly focused parties and large, unstable governments and in the process protect the power of the coup makers and their supporters. The 2007 constitution contains a series of reforms designed to undermine the importance of parties and party labels and discourage the creation of large national parties. In addition to the effective lifting of party-switching restrictions, there are two other key reforms. First, the single-seat electoral constituencies were replaced with the old multiseat, block vote system. This means that once again candidates from the same party had to compete against each other for election—generating stronger incentives for particularism.

Second, the single national party list election was scrapped and replaced with eight regional party lists. Moreover, the proportional representation area boundaries were deliberately designed to break down regional identity, indicating that the drafters understood that a new social environment had emerged under the 1997 constitution (see Figure 1). Area 1 contained eleven of the sixteen provinces from the Northern region. The remaining five regions from the North were lumped together with two provinces from each of the traditional Central and Northeastern regions into Area 2. Indeed, the Northeastern region was divided into four areas. Areas 3 and 4 contained ten and six provinces, respectively, from the Northeast. The final Northeastern provinces were joined to Area 5, which also contained nine provinces from Central Thailand. Area 7 was an attempt to take a couple of provinces from the South and adjoin them to thirteen provinces from Central Thailand. Area 6 was Bangkok. The consequence of this reform was that the party list campaign no
Figure 1 Map of New Proportional Representation Areas, 2007 Constitution

Note: Dotted lines represent regional boundaries.
Forcing the Genie Back in the Bottle

longer served as a national referendum on each party’s platform and prospective prime minister since each region voted on a separate slate of party list candidates and, potentially, a different set of parties.

Thailand’s conservative forces also hoped that the return to the block vote electoral system and the watering down of the party list election would be enough to refragment the party system, thus ensuring an end to majority party government and a restoration of relatively anemic, short-lived coalition governments. Bolstering these changes are the dramatically reduced powers of the prime minister, as discussed earlier. This means future prime ministers will find it more difficult to build and maintain a large, cohesive national party—precisely the drafters’ intent. A final change that was designed to reduce the possibility of large parties going forward is a new restriction on party mergers. Thai Rak Thai became a dominant party in part by bringing other parties under its tent after the 2001 election. The new charter prohibits parties with members in the House of Representatives from merging during the parliamentary term. Table 3 summarizes the electoral rules over the three periods.

<table>
<thead>
<tr>
<th>Table 3 Constitutional Reforms</th>
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<tr>
<td></td>
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<tr>
<td>House of Representatives</td>
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<tr>
<td>Block vote</td>
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<td>Senate</td>
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<tr>
<td>Party switching</td>
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<td></td>
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<tr>
<td>Prime minister</td>
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</tbody>
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Source: Adapted from Hicken (2006).
Putting the Genie Back in the Bottle

Were we looking at the institutions in isolation, we would expect a return of the pre-1997 policymaking environment characterized by short-lived, multiparty governments, ministries run as the bailiwick’s of individual politicians or factions, and strong incentives for pork and particularism over policy. However, despite the hopes and intents embodied in the 2007 charter, resurrecting the political environment of the 1980s and 1990s was not a straightforward matter of resurrecting a few institutional rules. Institutions do not exist or operate in a vacuum. They interact with the broader social and political context, and in the Thai case, there is evidence that the 1997 reforms helped bring about a substantial change to that context. The tools and incentives produced by the 1997 constitution, combined with the talents and resources of Thaksin and the resulting policies of his government, invigorated what had been largely latent cleavages in Thailand—class (wealthy and middle classes versus the poor) and region (Bangkok and the South versus the North and Northeast). The class cleavage especially has long existed under the surface of Thai politics. Only moderately politicized, it at times helped shape politics and policymaking, but under Thaksin this cleavage not only becomes more politicized (Selway 2011), but it also becomes particized. We thus witness poor rural voters becoming partisan in ways they had not been before (Hicken 2010).

These newly partisan cleavages are grounded in, though not completely coincident to, long-standing sociocultural differences across Thailand’s regions. Charles Keyes (1997), for example, argues that Southern and Central Thai cultures are the most closely related of all the regions. The North and Northeast also are closely related, both speaking a dialect of Thai more closely related to Laotian. Class and region are also somewhat reinforcing: Bangkok and the South (bar the Malay provinces in the deep South) have long been the wealthiest regions in Thailand, while the North and Northeast have trailed behind, especially outside of the North’s capital of Chiang Mai (Selway 2007b). Thus, despite there being fair numbers of rural poor in the Central and Southern regions, and populations of urban middle class in the North and Northeast, the cultural and economic divides are pronounced enough in objective terms to explain why they might have emerged as a serious political divide.

These nominal differences, however, had stayed relatively dormant in terms of providing a base for political divisions. What caused them to form the basis of partisan identity in the post-2007 era? We have already discussed in detail the 1997 reforms to the electoral and party system, which helped ignite an interest in national-level, programmatic...
policies among Thai voters. Growing out of and reinforcing these macrochanges was the development of new collective identities in response to new government policies. As parties responded to the increased demand from the electorate for collective goods, we have seen the policymaking environment change significantly.

These changes greatly affected who the recipients of government resources were. Indeed, the 30-baht scheme was just one of numerous policies created by TRT that fashioned a new and large constituency with important “commitments” to these new policies. More importantly, this new constituency, consisting mostly of the rural poor in the North and Northeast, saw TRT as the guarantor of these policies. Historical institutionalists use the term commitments to refer to long-term investment decisions that individuals make in response to policy changes (Pierson 2004). For example, poor Thais were now spending only 1 percent of their income on out-of-pocket health expenditures (as opposed to 7 percent pre-2001), allocating the extra 6 percent to other expenses. This reallocation, then, gave them a vested interest in the status quo, attaching them more deeply to a particular policy preference and, if parties take positions on that policy, a partisan identity. TRT introduced many such policies, such as rural credit schemes, a debt moratorium for farmers, the One Tambon One Product (OTOP) program (aimed at developing rural small and medium-sized enterprises), and a slew of education policies, all of which contributed to the positive feedback of the new policy environment.

Just as these new commitments would serve to lock in the 30-baht scheme, previous health policies had generated their own constituencies that worked to fiercely protect their commitments. In the battle over competing visions for health care policy, we can see some of the first salvos being fired between two increasingly contentious constituencies. On the one side was the constituency supportive of the 30-baht health scheme. On the other side, we had the civil servants and middle- and upper-class employees who already benefited from either public or private health care schemes and increasingly worried that the 30-baht scheme would put those benefits in jeopardy or require higher taxation to pay for the new program. For example, the 15 million people covered by the Civil Servant Medical Benefits (CSMB) and Social Security Insurance Program (SSIP) not only failed to gain from the 30-baht scheme but also feared that their long-standing and more generous programs would be dissolved. Those fears were not unwarranted. Thaksin’s original plan was to merge both programs into the 30-baht scheme. However, fierce opposition from civil servants quickly ended efforts to fold the CSMB, and not long thereafter talk about the SSIP merger fizzled out as well.
One of the messiest parts of the 30-baht scheme’s implementation, and one that would further increase the salience of the cleavage divide, was the method of financing. The 30-baht scheme explicitly sought to benefit rural areas by allocating funds to hospitals in keeping with the number of patients rather than the size of the hospital (Phromporn et al. 2002). The new financing method allocated funding to hospitals in keeping with the number of patients (demand driven) rather than the size of the hospital (supply driven). The change in budget allocation resulted in increased funding for most community (rural) hospitals around the country. Conversely, more than half of the larger hospitals (over 150 beds) received less money than before. Accordingly, the Northeast region was the biggest winner in this regional redistribution, while the Central and Southern regions tended to face financial shortages. The idea behind the new financing scheme was to force large hospitals to adjust aspects of their management, especially staffing decisions; the vision was a redistribution of doctors to rural areas. However, after extreme pressure from urban forces (hospital administrators, doctors, patients, and other groups) that had made commitments under the old financing system, the TRT government backtracked, reverting to a financing system much closer to the old method.

In the end, the 30-baht scheme produced some impressive results. Research shows that the introduction of universal health care was responsible for reducing poverty in Thailand by 15 percent, or 1 million people, “surely the most effective anti-poverty program ever in the history of our country” (Panyarachun 2006). Yet the program’s success further fed the regional/class divide. Poorer voters became increasingly aware of the inequality in redistribution of government resources and invested in protecting this new program. The reversal of the hospital financing method and the failure to merge the CMSB and SSIP were seen less as TRT failures and more as greed on behalf of the urban middle class. For their part, middle- and upper-income groups viewed the program as an anti–upper/middle class redistribution scheme, and they were increasingly incensed at the perceived attack on their benefits and programs. TRT constantly had to defend itself against claims that it was trying to exclude the rich from the scheme. In short, health policy became a central arena for regional/class disputes.

**Consequences of the 2007 Reforms**

This change in the sociopolitical landscape helps explain why the 2007 constitutional changes aimed at reverting Thailand to pre-1997 politics were less successful than conservative forces had hoped. The fact that the
2007 reforms did not completely revert Thai politics to pre-1997 dynamics gives us amazing insight into the context conditionality of political institutions. We see that the block vote electoral system failed to induce the same level of intraparty competition post-2007 as it had done previously. Why? First, the rise of partisanship, described previously, muted the effect of the block vote within constituencies. Post-1997, many voters, notably those in the North and Northeast, began to develop partisan attachments and exhibit partisan loyalty across elected offices and across elections (Hicken 2010). The block vote only generates intraparty competition where voters are willing to split their multiple votes between different parties. Pre-1997, given the opportunity, most voters chose to split their votes. When the block vote returned in 2007, voters had changed. Despite the opportunity to split their vote, a majority now chose to cast a straight ticket for a single party. As a result, candidates suddenly had a strong incentive to campaign as party teams rather than engage in the every-man-for-himself free-for-all that was the standard in earlier elections.

Second, the major social divisions in Thai society had switched from competition among local cliques—phak phuak—to partisan-based competition between two major cultural-economic regions: Bangkok/South and North/Northeast (Nelson 1998). This divide is easy to see. For example, the UN has a Human Achievement Index that ranks all Thai provinces by their human development. In 2007, most of the Democrat-voting provinces appeared in the top half of the UN’s Human Achievement Index, with an average position of twenty-second. By contrast, most of the People Power Party (PPP)—voting provinces ranked in the bottom half, at an average forty-fifth. According to another study, the average family income in provinces voting Democrat was 2.5 times the average income in provinces voting for the PPP. In the twenty-five Democrat-voting provinces, average yearly income was 750,000 baht, compared to 300,000 baht in the thirty-two PPP-voting provinces. Only a handful of “poor” provinces voted Democrat, and only four provinces with income above the national average voted PPP. These figures underscore the regional/class cleavage that played such a big role in the 2007 elections. When social divisions are broad in nature, they provide the glue that connects politicians from the same party both within and across constituencies. Thus, even electoral systems that tend to be highly candidate-centered can result in party-centered political dynamics (Selway 2009).

By 2007, then, voters were much more interested in national-level policies than they had been a decade earlier and now evaluated candidates largely on the basis of party affinity (Hicken 2010). Moreover, a clear regional preference for TRT and its successor party had emerged, while Bangkok joined the South in its support for the Democrats.
The most dramatic change occurred among voters in the North and Northeast. Long known for their lack of attachment to any particular party, post-1997 voters in much of the North and Northeast began to vote as a block for a single party, Thai Rak Thai. As a result, elections in 2001 and 2008 began to approach a two-party contest between Democrats in the South and parts of Bangkok and Central Thailand, and Thai Rak Thai in the North and Northeast. Even after the fall of Thaksin and the banning of TRT, voters in the North and Northeast continued to vote as a block—voting “no” on the 2007 constitutional referendum and casting all their votes for the TRT successor party, PPP, in the 2007 general election (Hicken 2010).

In short, voters in much of the North and Northeast have exhibited an impressive degree of party loyalty—first to Thai Rak Thai, then to Palang Prachachon, and then, in the most recent election, to Puea Thai. As a result, the potentially fragmentary and inflationary effects of the 2007 reforms to the party system have been muted. We have seen a modest increase in the number of parties nationally (from 2.4 in 2005 to 3.7 in 2007), but the stronger party loyalties (and perhaps greater polarization) have kept the number of parties well below the pre-1997 average of 7.2 parties. The strong and collective support of North and Northeast voters enabled the PPP to win the 2007 election in a very difficult political environment, even though it fell just short of a majority with 40 percent of the seats.

Policymaking Post-2007
Given the turbulent nature of recent politics in Thailand, it is a challenge to test hypotheses about policymaking patterns. Nonetheless, we endeavor to do so here. Our general presumption is that we should see significant policy continuity in the area of health policy post-Thaksin for three reasons. First, the newly salient cleavages and stronger party ties mean that voter interest in party policy positions remains strong, while incentives for individual candidates to try and cultivate personal votes via pork and particularism remain relatively weaker than in the pre-1997 era. Second, many of the health-related policies adopted by the Thai Rak Thai government are overwhelmingly popular (e.g., the 30-baht health scheme)—so much so that meddling with these policies is politically dangerous. Broadly targeted health policies now have a place on the agenda and will not easily be removed. These policies have, in effect, created a broad constituency (even the virulently anti-Thaksin military government elected to leave the 30-baht program in place, although renaming it and eliminating the 30-baht copay). Third, while the 2007 constitution did not produce the level of fragmentation some had hoped for, it did result
in an end of majority party government and a return of multiparty coalitions. This, combined with the political polarization and political instability that has existed since 2006, produced a bias against major reforms and toward the policy status quo. All together then, we expect the patterns of health spending and the emphasis on universal health care to not change dramatically post-2007.

However, while we expect to see continuity in the large, publicly visible policy areas, we do expect to see changes to policy and policymaking on the margins. Specifically, the end of majority government coupled with weaker powers for the prime minister vis-à-vis coalition and faction rivals should correspond with less coordinated/centralized policymaking and a return to a large degree of discretion for ministries (in this case, the health ministry) over spending and allocation decisions. In the past, such arrangements produced policies that tracked closely with the interests of whatever party, faction, or individual who controlled the health ministry, resulting in regular allegations of corruption and impropriety.

The Continuity of High-Profile Policies
Consistent with our expectations, since 2007 the major parties have maintained a focus on differentiable policy programs, including health policies. In the 2007 elections, the Democrat Party expanded on its 2005 election campaign with a package of high-profile, publicly visible policies intended to differentiate the party from the PPP. Indeed, all parties devised a package of policies attempting to differentiate themselves from competitors, advertising their major policies on billboards and commercials. Political parties launched websites with detailed policies in numerous policy areas. One PPP poster, satirizing this universal trend among political parties, even read “Everyone can make up good policies, but the people who keep their word are in the People Power Party.”

There have been two governing coalitions since the 2007 elections. The first coalition was led by the PPP and was replaced by a Democrat-led coalition before a year had passed. Both governments have pressed for high-profile, publicly visible policies. Not long after the PPP came into power, it began resuscitating old TRT “grassroots consumption” (Thaksinomics) policies such as debt suspension for farmers, village funds, tax breaks for low-income earners, low-cost computers, and student loans and scholarships for poor students upcountry. A year later when the Democrats took control, the Abhisit Vejjajiva administration immediately announced a new policy of fifteen years of free education and reignited the village funds program.
Both governments have also strongly supported the universal health care (UHC) program. No longer called the 30-baht scheme, UHC was made completely free shortly after the 2006 coup. There was not much left for parties to do in this policy area, then, other than improve the system, which mostly entailed increasing its funding. We begin with a look at the overall size of the health budget, which has reached record proportions vis-à-vis other budget areas. The health budget now makes up over 10 percent of the government’s budget (Table 4), its most ever. In keeping with our expectations that these broadly targeted, publicly visible policies would continue, we see that the investment portion of the MOPH budget has also continued to stay low (Table 5). There has not been a return to the outlandish construction building of the pre-1997 era. And we see that both governments continued to increase funding for the universal health care program. Indeed, the revolving fund for health care now composes over half of the health budget (Table 6). This money goes directly to the NHSO, a highly technocratized and professional office that oversees the implementation of universal health care.

Other improvements to the system that have been discussed include the right to select any hospital to receive medical treatment. Interestingly, the health minister, rather than career bureaucrats, has been at the heart of these proposals, demonstrating the increased programmatic style of Thai political parties.

A Return to Past Patterns?
Despite these clear commitments to continuing universal health care, some of the unsavory elements of pre-1997 health policy have returned.

Table 4 Proportion of Government Budget by Allocation Functional Classification

<table>
<thead>
<tr>
<th>Year</th>
<th>Security</th>
<th>Education</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>1980s</td>
<td>24.5</td>
<td>19.1</td>
<td>4.6</td>
</tr>
<tr>
<td>1990–1997</td>
<td>19.0</td>
<td>20.1</td>
<td>6.8</td>
</tr>
<tr>
<td>2001–2006</td>
<td>13.3</td>
<td>22.8</td>
<td>7.5</td>
</tr>
<tr>
<td>2007</td>
<td>12.9</td>
<td>22.7</td>
<td>9.5</td>
</tr>
<tr>
<td>2008</td>
<td>14.2</td>
<td>22.0</td>
<td>9.3</td>
</tr>
<tr>
<td>2009</td>
<td>15.4</td>
<td>21.8</td>
<td>9</td>
</tr>
<tr>
<td>2010</td>
<td>15.5</td>
<td>22.3</td>
<td>10.5</td>
</tr>
<tr>
<td>2011</td>
<td>14.0</td>
<td>20.4</td>
<td>10.1</td>
</tr>
</tbody>
</table>

Source: Thailand Budget Bureau.
Consistent with our expectations, except for the commitment to universal health care, health policy appears to have become much more unstable and prone to capture by politicians helming the Ministry of Health. The first post-2007 government led by the PPP cycled through three health ministers in less than a year—reflecting an increase in intraparty and intracoalitional conflict. In addition, two of the three ministers were accused of political interference, nepotism, or corruption.38

Returning to the budget, we see in Table 5 that the investment portion of the budget stayed fairly low, even dipping below 1 percent in 2010. However, in 2011 we see the highest post-2001 investment portion of 7.4 percent. This high number still does not reach anywhere near the pre-1997 average of 21.8 percent but could be indicative of an increase in particularistic politics. The circumstantial evidence, while preliminary in nature, tends to support this view.
At the end of 2008, the Constitutional Court ordered the dissolution of the ruling PPP over allegations of election violations and a new government was formed headed by the Democrat Party and Prime Minister Abhisit Vejjajiva. The health ministry soon found itself mired in scandal and corruption allegations that hearkened back to pre-1997-style politics. For example, a government probe found “little necessity” for 681 million baht to be spent on a planned expansion of the Ratchaburi Regional Hospital. Ratchaburi province, with a population of just 720,000, has three other similar treatment centers. The government’s report explicitly highlighted the likely conflict of interest in the then deputy public health minister Manit Nopamornbodi, who played an active part in increasing the budget for the hospital. Manit not only had background in the construction business, but also happened to be an MP for the Ratchaburi province. The ministry was also caught up in an 86 billion baht medical procurement scandal which led to the resignation of both the minister and deputy minister. A government fact-finding commission found that the two ministers were directly involved in the irregularities. In short, members of the again necessary multiparty government coalitions are staking out unfettered control of their jurisdictions, as anticipated. It is too early to tell whether these scandals and inefficiencies are indicative of a broader trend, but the pattern of greater cabinet instability, increased politization of policymaking, and an uptick in corruption is consistent with the incentives generated by the new policymaking environment.

Conclusion
We have seen that attempts by the 2006 coup makers to turn back the clock have been only partially successful in eliminating a powerful and broadly appealing TRT-style party. In the 2007 constitutional era, we do see a modest increase in the number of parties, with governments being composed of multiple coalition members. However, the fragmentation is much less than the pre-1997 era, and TRT’s successor parties seem to have a stable party base in the poorer North and Northeastern provinces. We explain this phenomenon by analyzing the change in the Thai sociopolitical structure under the 1997 constitution, namely the strengthening of partisan identity among the Thai electorate. We also examine the change in the nature of Thai parties, which are now more rooted in class/regional identities than ever before and face voter demands for broadly targeted, highly visible policies. As such, we continue to see an attempt by parties to differentiate themselves by proposing and implementing high-profile, publicly visible policies.
We also detail preliminary evidence in the area of health policy that the broad outlines of health policy have been remarkably stable since 2007, consistent with our expectations. However, there is also some preliminary evidence that since 2007, as parties have enjoyed increased jurisdiction over their ministries, unregulated by a strong prime minister, we are perhaps also witnessing a return to some of the more inefficient and corrupt aspects of policymaking that so defined the pre-1997 era.

More broadly, the Thai case powerfully illustrates the interaction of institutions and social structure. The same institutions can have very different effects, depending on the nature of the broader sociopolitical context. It is necessary to take this context conditionality into consideration if we are to understand the predictable and observable implications of institutional reform for policymaking.

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Notes

This article is based on a paper originally prepared for the annual conference of the Asian Studies Association, March 25–27, 2010, in Philadelphia.

1. The latter two of these processes have often been ignored in the literature that emerged from Western European politics, which has tended to treat cleavages and party identity as relatively “frozen” (Lipset and Rokkan 1967). Studies of the developing world, by contrast, have noted that both the salience of certain cleavages (Posner 2004; Chandra 2004) and the strength of party identity are much more in flux (Bielasiak 2002; McAllister and White 2007; Levitsky 2007). And even the recent literature on the party systems in Europe has been much concerned with the partisan realignment and dealignment in those cases.
2. Regional and class cleavages at times had important political salience, but this rarely manifested itself in partisan differences (Hicken 2010). Arguably, the cleavage with the most salience for the party system during the pre-1997 period was local patron-client groupings (phak phuak). By definition, the constituencies involved in such groupings were also small in nature.

3. In other work, Selway (2009) further develops the “social structure” premise of this argument by systematically considering the effect of electoral rules conditional on the number of social groups, the salience of the group divides along class lines, and the geographic distribution of those groups.

4. The 1991 coup briefly interrupted this pattern, while the elevation of Chatchai in 1988 accelerated the movement of elected politicians into control of the government.

5. Under a block vote system, voters are given as many votes as there are seats in a constituency, and they cast their votes for the individual candidates of their choice. The seats are awarded to the top vote-getting candidates in the constituency.

6. We borrow this term from Cox and McCubbins (2001), which refers to the tendency of politicians to transform nominally nationally oriented public goods into particularized private goods.

7. The year 1993 has been selected more or less at random. Selecting any other year in the late 1980s or early-to-mid-1990s would reveal a similar story.


9. The provincial disparity was equally alarming. In Nan province, from where the secretary to the MOPH minister hailed, 61.3 percent of the population was issued a free medical card compared to only 2.5 percent in Suphanburi; none of the five MPs from Suphanburi held a position in the MOPH (Selway 2007a).

10. The 5 percent threshold on the PR tier gave further disincentives for small, local parties to compete.

11. We see a decline in the average number of parties per constituency from the prereform average of 3.2 to 2 in the 2005 election—driven by adoption of single-seat constituencies. However, we see an even bigger decline in the number of parties nationally (from over 7 to 2.3) along with a narrowing of the gap between the constituency and national party system. In effect, what this gap tells us is that prereform there was a lot of variation in the strongest party from constituency to constituency, province to province, and region to region. Postreform, by contrast, the same parties tended to be the front-runners in most constituencies nationwide (Thai Rak Thai and the Democrats). This reflects new incentives to form national parties from the national party list tier and stronger powers for the prime minister (Hicken 2008).

12. This section draws heavily on Selway (2011).


14. In the following 2005 elections, the Democrats brought on Tarradon Pi-amphongsant to direct their research center. Tarradon’s center identified several refinements to the universal health care program, which became the foundation of their health platform in the elections. These refinements included abolishing the 30-baht co-pay as the most desired policy preference, raising the per capita payment from 1,300 baht to 1,700 baht paid for by earmarking taxes from the alcohol excise, providing extra services through the private sector, focusing on
prevention (free annual checkups), introducing a quality and accreditation program to tackle problems with quality of service, setting up an emergency fund for hospitals, and implementing a hospital emergency medical program (Democrat Party 2005). This was clearly a very different type of party than one that simply spouted off NESDB platitudes.

15. By 2006, approximately 40 percent of all health care funds were going to the NHSO.

16. Moreover, the poor paid 5.8 times as much (in salary percentage terms) as the rich: the Index for Fairness of Financial Contribution ranked Thailand 128 out of 130 countries (World Health Organization 2000).

17. The official figures show increases in the rates of many diseases/illnesses. Our interpretation is based on interviews with numerous doctors and MOPH officials.

18. Many indicators related to poor nutrition had worsened significantly by 2001 due to the financial crisis—for example, child mortality rates, life expectancy. Using these indicators would not show the true impact of the 30-baht scheme.

19. Measures to allow for an unelected PM, to completely eliminate the party list, or to establish a new “crisis council” were defeated after much debate and public criticism.

20. Prior to the 2011 election, the rules were changed yet again.

21. This cultural affinity has not manifested itself historically. For an excellent account of the history of the Northeast of Thailand see Rogers (1996).

22. Previously, student activism in the 1970s had come closest to igniting this divide, but this was quelled as the Left came under attack from a US-backed crackdown (Ungpakorn 2006).

23. Examples include the One Tambon One Dream School program, the One Child One Bicycle program, and the One Child One Laptop program.

24. Only 19 percent of beneficiaries had a monthly income higher than 15,000 baht in 2003 (Pannarunothai 2003).

25. The CSMB was notorious for its exorbitant benefits. Prior to the 30-baht scheme, CSMB benefits were over ten times greater than those in the FMSP. Following 2001, although CSMB benefits were “only” just under three times greater than 30-baht participants, the overall CSMB budget rose from 18 billion baht in 2001 to 25 billion baht in 2003 (Thailand Budget Bureau 2002).

26. Previously, hospitals were allocated lump sums determined by such factors as size of hospital, location and associated cost of living, and political favoritism. Under this system, Kantaralak District Hospital (Northeast), responsible for a population of 250,000, could only afford to employ three doctors. In contrast, two other provincial hospitals, in the Central and Southern regions, responsible for similar numbers of people, employed more than fifty doctors each. Under the new method, Kantaralak District Hospital was better financed, allowing it to provide better care and employ more doctors (The Nation, April 17, 2002).

27. Based on anonymous interviews with various members of Thaksin’s “war room” responsible for implementing the 30-baht scheme.

28. This is despite the introduction of extra co-pays for VIP treatment, which was heavily criticized for funding the rich seeking nonbasic, high-cost treatment in areas such as heart or brain surgery (The Nation, August 31, 2002).
29. Based on anonymous interviews with various members of Thaksin’s “war room” responsible for implementing the 30-baht scheme.

30. Authors’ own calculations based on election results and UN’s Human Achievement Index.

31. *The Nation*, June 1, 2009. A party is defined as “winning” a province if it got more seats than any other party. Taking Bangkok out of the equation, the Democrat-voting provinces still had around twice the average income per head as the PPP-voting provinces.

32. The provinces with the worst record on malnutrition are all in the outer Northeast. Those provinces all voted PPP in 2007. The provinces with the next-worse record are in the inner Northeast and upper North. All but one of these provinces voted PPP. None of them voted Democrat. In the provinces that voted Democrat, there are around twice as many doctors per head as in the provinces that voted PPP. On average, children stay in school for about a year and a half longer. In the PPP-voting provinces, a far larger proportion of schools are rated poor quality.

33. The websites of the two current major parties are: Democrat Party, www.democrat.or.th/th/policies/index.php; and the successor to PPP, Peua Thai (For Thais Party), www.ptp.or.th/policy/policy.htm.


36. Government officials began erasing TRT’s stamp on the numerous policies it had created. Some programs were altogether abandoned, while others were simply renamed. Attempts were made to improve on these policies, presumably to demonstrate that the coup leaders would not endanger the commitments of a sizable portion of Thai society. This conclusion is based on interviews with MOPH and Ministry of Education officials in 2007.

37. *The Nation*, December 30, 2008. That the health minister should involve himself with such policies is a big change from most individuals who occupied the position in the pre-1997 era (Selway 2009).


References


Stephan Haggard and Mathew D. McCubbins. Cambridge: Cambridge University Press.


