

Toward Equity in Oral Health: Thailand's 15-Year System-Level Initiative for People with Disabilities (2011 to 2025)

Nithimar Sermsuti-Anuwat¹, Yaowapa Chantaraboot²

¹Academic Affairs Division, Faculty of Dentistry, Chulalongkorn University, Pathumwan, Bangkok, Thailand; ²Department of Dentistry, Phon Thong Hospital, PhonThong, Roi Et, Thailand

Correspondence: Nithimar Sermsuti-Anuwat, Academic Affairs Division, Faculty of Dentistry, Chulalongkorn University, 34 Henri-Dunant Road, Wongmai, Pathumwan, Bangkok, 10330, Thailand, Email Nithimar.s@chula.ac.th

Background: People with disabilities experience disproportionate oral health burdens worldwide. In Thailand, despite universal health coverage (UHC), persistent barriers—including transportation, caregiver availability, distance, and costs—limit access to care. Since 2011, government and partners have pursued multilevel actions to improve equity for this population, yet no comprehensive synthesis of their evolution has been reported.

Objective: To describe the context and content of Thailand's 2011 to 2025 initiative for people with disabilities, summarize what was implemented across policy, workforce, curriculum, services, and governance, and identify observed results, limitations, and next steps for sustainability.

Methods: A national secondary synthesis aligned with SQUIRE 2.0 analyzed policy documents, program reports, and training materials (2011 to 2025) using document and thematic analyses with contribution analysis and triangulation. Eligibility required relevance to disability-inclusive oral health in Thailand; units were policies, curricula, service models, and financing/monitoring, and engagement mechanisms were extracted as reported; no human data were used, and ethics approval was not required.

Results: The initiative advanced through four overlapping phases: Phase 1 (2011 to 2014) comprised Thai Health Promotion Foundation (ThaiHealth) funded pilot projects to increase access, followed by increasingly explicit government policy in Phase 2 (curriculum integration and professional development, 2015 to 2017), Phase 3 (network expansion and digital knowledge sharing, 2017 to 2020), and Phase 4 (institutionalization and policy integration, 2021 to 2025). Actions were associated with expansion of dental service sites from 11 to 30 across 12 provinces, integration of special care dentistry into multiple dental curricula, establishment of specialty boards, and adoption of national strategic frameworks. Persistent barriers included workforce shortages, transportation difficulties, and gaps in national oral health data.

Conclusion: Thailand's phased, system-level strategy demonstrates how policy integration, curriculum reform, and network development can accelerate equity in oral health care for people with disabilities. Priorities for sustainability include a nationwide disability-focused oral health survey, rural workforce pipelines, integration of special care dentistry into UHC benefits, and expanded use of digital platforms. Lessons may inform similar reforms in other middle-income settings.

Keywords: disabled persons, dental care for disabled, health policy, health services accessibility, public health, health equity

Introduction

Oral health inequities remain a pressing public health issue worldwide, disproportionately affecting individuals living with disabilities. According to the World Health Organization (WHO), approximately 15% of the global population experiences some form of disability, and this group consistently demonstrates higher rates of dental caries, periodontal disease, and unmet oral health needs compared with the general population.^{1,2} These disparities reflect a combination of systemic, structural, and social barriers, including limited access to services, transportation difficulties, financial constraints, and reliance on caregivers.^{3–5}

Across Asia, research consistently highlights that children and adults with disabilities experience poorer oral health outcomes than their peers without disabilities.^{6–9} This pattern persists even in countries with established universal health coverage (UHC), underscoring the limitations of financing reforms alone in achieving equitable care.^{8–11} Workforce shortages, predominance of private dental services, uneven service distribution, and constrained funding for oral health within UHC frameworks continue to widen gaps in access to essential dental care. These challenges point to the urgent need for integrated and disability-inclusive health systems supported by robust policy measures.

Existing condition of facilities and services in Thailand: within Thailand's mixed public–private system, disability-relevant oral health services are delivered through hospital dental departments, primary care clusters, community hospitals, and periodic outreach. Facility adaptations for accessibility (ramps, adjustable chairs, communication supports) are variable; referral pathways are inconsistently formalized; and capacity for advanced behavior support, sedation, or general anesthesia is largely concentrated in urban centers. Workforce distribution favors cities, and only a subset of providers report training or confidence in special care dentistry. These service characteristics contribute to fragmented pathways and delays in care.

Thailand illustrates this regional challenge. The National Statistical Office's 2022 Disability Survey, supported by UNICEF, estimated that 4.19 million people—approximately 6.0% of the population—live with disabilities.¹² The survey further revealed that 4.1% of individuals requiring medical attention did not receive necessary care. Transportation barriers, absence of a caregiver, long travel distances, and limited financial resources were the most frequently cited reasons for forgone care. Additionally, more than 90% of individuals with self-care limitations relied on caregivers, highlighting the magnitude of unmet oral health needs in this population.¹² Despite the availability of UHC, these findings demonstrate persistent service gaps and inequities. Importantly, Thailand lacks a comprehensive nationwide oral health survey specifically focusing on people with disabilities, limiting evidence to guide targeted policies and services.¹³

To address these gaps, the government of Thailand has pursued a series of multilevel initiatives since 2011 to improve oral health equity for people with disabilities. In line with this trajectory, Phase 1 (2011 to 2014) comprised Thai Health Promotion Foundation (ThaiHealth) funded pilot projects to increase access, including community engagement, inclusive health promotion, and capacity building. Phases 2 to 4 deepened the government response: formal curriculum integration and professional development (2015 to 2017), network expansion and digital knowledge sharing (2017 to 2020), and institutionalization and policy integration (2021 to 2025). Taken together, these actions represent a large-scale, system-level improvement initiative that has advanced access and coordination nationwide.

However, while individual projects and policies have been documented, there has been no secondary synthesis describing how interventions evolved across phases, interacted with system context, and produced intended or unintended outcomes.

To maintain conceptual clarity, this review synthesizes system and policy developments related to disability-inclusive oral health in Thailand between 2011 and 2025, including workforce, curriculum, service models, and strategic frameworks, and it does not appraise specific clinical biomaterials or regenerative procedures. We acknowledge broader determinants of oral health, including bidirectional links with psychological stress reported in recent literature; an in-depth treatment of these factors lies outside the present system-level focus.

This study therefore aimed to: (1) describe the context and content of Thailand's multi-phase oral health improvement initiative for people with disabilities between 2011 and 2025; (2) synthesize how interventions evolved and interacted with health system and social context; and (3) identify results, unintended consequences, limitations, and future directions for sustainability and spread.

Materials and Methods

Context

Thailand is an upper-middle-income country with universal health coverage (UHC), compulsory rural service for dentists, and mixed public–private service delivery.¹⁴ The oral health initiative for people with disabilities engaged multiple stakeholders, including universities, professional associations, primary care clusters, rehabilitation institutes, non-governmental organizations, and community partners. Provincial contexts varied considerably in terms of geography, capacity, and resources.

Interventions

For clarity, interventions were grouped into four overlapping phases:

Phase 1. Foundation and Early Networks (2011 to 2014)

Community engagement, inclusive oral health promotion, and capacity building for care of developmental and intellectual disabilities. Multi-site outreach models included facility-based, school-based, and home visits. Pilot projects to increase access were funded by the Thai Health Promotion Foundation (ThaiHealth). Pilot curricula and intersectoral partnerships were introduced.^{15–17}

Phase 2. Curriculum Integration and Professional Development (2015 to 2017)

Formal inclusion of special care dentistry in undergraduate curricula at leading dental schools. Innovations included community-based learning (home visits, accessibility mapping), interprofessional training, reflective practice, and family care team models.^{18–20}

Phase 3. Network Expansion and Knowledge Sharing (2017 to 2020)

Growth of a national network, diversification of care delivery models (hospital, primary care, outreach), and use of digital platforms and social media for rapid dissemination of training materials and policy updates.^{21,22}

Phase 4. Institutionalization and Policy Integration (2021 to 2025)

Adoption of national oral health strategic frameworks, recognition of specialties (Geriatric and Special Care Dentistry, Family Dentistry), establishment of specialty boards, and introduction of modular postgraduate training pathways.^{23,24}

Study Design

We conducted a secondary evaluation of a national oral health improvement initiative, reported in accordance with the Standards for Quality Improvement Reporting Excellence, version 2.0 (SQUIRE 2.0) framework.

Study Setting and Scope

The analysis covered national policies and programs implemented across all regions of Thailand. Where available, we referred to regional or provincial examples to illustrate implementation differences.

Data Sources and Selection

Sources included government strategies and plans, program guidelines, training materials, surveillance and administrative summaries, and peer-reviewed publications. Inclusion criteria were: (1) relevance to disability-inclusive oral health in Thailand, and (2) coverage between 2011 and 2025. Exclusion criteria were documents not specific to oral health, or clinical studies on materials or procedures without system-level implications.

Units of Analysis

The primary units of analysis were policies, governance arrangements, financing mechanisms, curricula and training initiatives, service models, and monitoring indicators. We organized the narrative synthesis into four sequential phases (foundation and early networks; curriculum integration and professional development; network expansion and knowledge sharing; institutionalization and policy integration).

Stakeholder Engagement

Where documents described participation, we noted mechanisms to engage people with disabilities, families, disabled people's organizations, providers, and local government partners, including advisory groups, community-based networks, and feedback channels. Evidence of engagement was used to contextualize problem signals, implementation strategies, and reported outcomes.

Synthesis Approach

- Document analysis: Documents were screened for relevance, authenticity, and completeness.²⁵
- Thematic analysis: Codes were developed inductively and deductively to identify drivers, strategies, outputs, outcomes, contextual moderators, and unintended consequences.²⁶
- Contribution analysis: Temporal associations between interventions and outcomes were mapped, triangulated across sources, and rival explanations examined.^{27,28}

Measures

- Process measures: Network size (sites, provinces), training activities, integration into curricula, issuance of policy documents, establishment of specialty boards.
- Outcome measures: Workforce milestones (specialty recognition, postgraduate programs), integration of disability content into standards of education and care and reported service reach.
- Context assessment: Workforce distribution, transport barriers, financing, and data infrastructure as described in surveys and policy documents.

Ethics and Data Governance

This study synthesized publicly available and institutional documents and de-identified administrative summaries. No individual-level identifiable data were accessed. Consistent with this design, human-subjects ethics approval was not required. We followed good practice for secondary analysis of policy documents and respected the confidentiality provisions stated in source materials.

Results

Results are presented by phase. The synthesis identified a progressive evolution of Thailand's oral health system for people with disabilities across four overlapping phases (Table 1).

Table 1 Phase-by-Phase Logic Model of Problem, Strategy, Outputs, and Reach/Lessons (2011 to 2025)

Phase	Problem Signals and Drivers	Strategies / Actions	Policy or System Outputs	Reach / Lessons
Phase 1: Foundation and Early Networks (2011 to 2014)	Low visibility of needs; fragmented services	ThaiHealth funded pilots; national recognition; community engagement; capacity building	Initial guidance and pilot pathways; early data elements; basic referral records	Early adopters in selected provinces; increased awareness; barriers identified
Phase 2: Curriculum Integration and Professional Development (2015 to 2017)	Workforce skills and confidence gaps	Undergraduate curriculum updates; targeted CPD; interprofessional training; family care team mo policy advocacy	Standardized training modules; faculty development; institutionalized competencies	More trained providers; holistic, collaborative care; logistical/practitioner gaps persist
Phase 3: Network Expansion and Knowledge Sharing (2017 to 2020)	Uneven access and referrals; need for scale	Expansion of community- and facility-based models; intersectoral referral; digital platforms for rapid dissemination	Referral protocols; coordination mechanisms; strengthened policy support	Wider geographic coverage; better knowledge sharing; resource/access gaps remain
Phase 4: Institutionalization and Policy Integration (2021 to 2025)	Need for sustainability and accountability	Inclusion of disability indicators in monitoring/financing; alignment with national strategies; specialty recognition; modular postgraduate training	Routine reporting; budget lines or incentives; specialty boards; formal standards and pathways	National scale with routine monitoring; resilient, adaptive system; uneven provincial implementation persists

Phased System Development

Phase 1: Foundation and Early Networks (2011 to 2014)

Low visibility of oral health needs among people with disabilities and fragmented services prompted national recognition of disability-inclusive oral health as a priority and pilot networks, supported by ThaiHealth funded pilot projects to increase access. This period established structures and practices that guided subsequent reforms. A multidimensional approach to oral health promotion emphasized education, prevention, clinical care, and rehabilitation, grounded in humanistic and inclusive values. Dental professionals were encouraged to advocate for dignity and respect for people with disabilities, setting new ethical and operational standards in Thailand.^{15–17} Capacity building focused on preparing dental professionals to care for individuals with developmental and intellectual disabilities. Institutional partnerships supported the creation of specialized curricula integrated into professional training, laying the foundation for later phases.^{15,16}

The service network expanded from 11 sites in 8 provinces to 30 sites in 12 provinces. Nearly 4000 individuals were screened, with about 10% receiving follow-up treatment. Facility- and community-based models—including school and home visits—broadened preventive services and strengthened community engagement. Interprofessional teamwork further facilitated best practice sharing.^{15,16}

Key challenges included workforce shortages, limited community-level networks, and weak policy support. Recommendations emphasized public awareness campaigns, policy development, workforce expansion, accessible educational materials, and promotion of self-care and local leadership.^{15–17} These lessons directly informed curriculum integration and professional development in Phase 2.

Phase 2: Curriculum Integration and Professional Development (2015 to 2017)

Building on Phase 1, skills and confidence gaps in the workforce led to undergraduate curriculum updates and targeted continuing professional development (CPD). This phase emphasized formal integration of special care dentistry into undergraduate curricula at several dental schools, including Chiang Mai, Naresuan, and Khon Kaen.¹⁸ Training approaches included community-based learning such as home visits, accessibility mapping, volunteering, and reflective practice. These activities helped students and professionals gain competencies in patient management, communication, and inclusive care.^{18–20}

Structured workshops and interprofessional training with nurses and allied health professionals encouraged collaborative, holistic care and helped reduce stigma. Policy advocacy and models such as the family care team reinforced integration of disability services within primary care frameworks.^{29–31}

Despite these advances, persistent barriers included limited practitioner awareness, uneven exposure to special care dentistry, and logistical constraints in service delivery. These insights highlighted the need for broader curriculum innovation and stronger institutional support, which laid the groundwork for national network expansion in Phase 3.

Phase 3: Network Expansion and Knowledge Sharing (2017 to 2020)

Based on curriculum advancements and collaborations in Phase 2, Phase 3 focused on expanding and strengthening a national network that unites dental professionals, community organizations, and academic partners. However, uneven access and referral patterns remained; these were addressed through expansion of community-based and facility-based service models and intersectoral referral arrangements, supporting innovation dissemination and peer support.²¹

Service delivery models (hospital-based, primary care, and community outreach) were tested and improved through multidisciplinary teamwork. Targeted oral health programs, new professional training curricula, digital platforms, and social media facilitated the rapid dissemination of resources and knowledge sharing.²¹ Published studies have contributed important data to Thailand.^{22,32–35}

Although policy support strengthened substantially, persistent challenges, such as workforce shortages, resource disparities, and access barriers, remained.^{29–31,36–40} Local adaptation and collaborative problem-solving are critical for effective policy translation. Lessons from this phase highlighted the importance of ongoing professional development, institutionalization of disability oral health education, enhancement of digital knowledge-sharing platforms, and sustained advocacy—guiding the institutionalization and policy advancements in phase 4.

Phase 4: Institutionalization and Policy Integration (2021 to 2025)

The need for sustainability and accountability drove inclusion of disability indicators in monitoring and financing and alignment with national strategies. In Phase 4, reforms were decisively anchored in national policy. Strategic frameworks such as the Bangkok Declaration (2024) and Thailand's Strategic Plan for Oral Health (2023 to 2037) prioritized equity and sustainability for vulnerable groups.^{23,24} Key milestones included the Royal College of Dental Surgeons of Thailand recognition of two specialty boards (Geriatric and Special Care Dentistry; Family Dentistry). The boards were established to set professional standards and guide policy.^{23,24} Modular postgraduate programs and flexible training pathways were also introduced, aligning workforce development with regional needs.³⁸

Board examinations were reformed to include flexible tracks and greater emphasis on technical knowledge, ethics, and social/legal competencies. These measures strengthened specialist training, improved workforce distribution, and embedded disability-inclusive care within national systems. While these reforms systematized progress and established a model for the region, challenges remain, including uneven provincial implementation and continuing gaps in national oral health data for disability populations.

Discussion

Evolution Toward a Sustainable, Integrated System

Over the past 15 years, Thailand's oral health initiatives for people with disabilities have evolved from small, fragmented projects into a coordinated, policy-supported system. Each phase built on the lessons of the previous one: establishing foundational networks, integrating special care dentistry into curricula, expanding national networks with digital platforms, and institutionalizing reforms through specialty recognition and strategic planning. This adaptive, phased development demonstrates how long-term investment and policy integration can embed disability-inclusive oral health within broader health and education systems. Phase 1 used ThaiHealth funded pilot projects to increase access, which set conditions for government policy expansion in Phases 2 to 4; these linkages are summarized in Table 1.

Barriers and Gaps

Despite progress, major barriers persist. The 2022 National Disability Survey found that 4.1% of individuals with disabilities did not receive needed medical care, mainly due to transport, caregiver shortages, distance, and costs.¹² Workforce shortages and unequal rural distribution remain critical barriers, while gaps in national oral health data hinder evidence-based policy.⁴¹ Social and attitudinal barriers—including low awareness, stigma, and weak prioritization of inclusive care—further limit services. Integration of special care dentistry within UHC frameworks also faces logistical challenges.^{8–11} A Southeast Asian scoping review highlighted persistent problems such as uneven workforce distribution, poor health information systems, predominance of the private sector, and limited outpatient funding.⁹ Even in countries with strong UHC, such as Thailand and Sri Lanka, oral health gaps remain.^{9,10} Across Asia, recurring obstacles include policy implementation gaps, specialist shortages, and insufficient data.^{6–9} Studies and meta-analyses confirm that children and adults with special needs consistently have poorer oral health than peers without disability,^{4,5,7} largely due to systemic inequities, limited caregiver support, and inadequate professional training.^{7,8} Providers struggle with scarce training and weak policy integration,⁸ while families face low oral health literacy, financial constraints, transport barriers, and stigma.^{7,32,42}

Lessons for Policy and Practice

Thailand's experience illustrates the effectiveness of integrated approaches—combining capacity building, curriculum reform, interprofessional collaboration, and targeted advocacy. Strategic partnerships among governmental agencies, academic institutions, professional bodies, and communities have been essential for achieving sustainable and scalable improvements.⁴³ Institutionalization through formal specialty recognition, regulatory reforms, and continuous professional development guarantees that these advancements are integrated into the broader health system, boosting resilience and sustainability. Emphasizing clinical excellence, empathetic patient care, robust knowledge dissemination, and ongoing evaluation has fostered a responsive and adaptable oral health system.⁴⁴

Future Directions

Translating these findings into actionable strategies requires building on past successes while systematically addressing persistent gaps. Prioritizing comprehensive national surveys of individuals with disabilities is essential for developing targeted, evidence-based policy and service frameworks. Expanding the oral health workforce and integrating special care dentistry into UHC remain critical for advancing equity. Moreover, leveraging digital technologies may hasten knowledge sharing and enhance service responsiveness.⁴⁵ Sustaining community engagement and multisectoral collaboration is key to ensuring inclusive and resilient progress.⁴⁶ Through these actions, Thailand can serve as a regional model, while other Asian countries can adapt these elements to advance equitable and accessible oral healthcare for individuals with disabilities. Related domains that influence oral health, such as the interaction between psychological stress and oral conditions, are important for comprehensive planning. These determinants were outside our predefined scope, which centered on system architecture and implementation. Future work could integrate mental–oral health models and cross-sectoral supports into disability-inclusive oral health planning to complement the system reforms described here.

Limitations of the Study

First, as a system-level synthesis, the review did not evaluate clinical materials or regenerative procedures. We drew on documentary and administrative sources that vary in detail across regions, which may under-represent local innovations not captured in national reporting. We also did not examine psychosocial determinants in depth because they were outside our predefined scope. This study is based exclusively on secondary data obtained from existing reports, project documents, and published literature. Thus, the findings may be affected by reporting bias, incomplete documentation, or inconsistencies that are inherent in the original sources. Second, the lack of recent, comprehensive national oral health survey data specific to individuals living with disabilities in Thailand limits the depth and representativeness of the analysis. Third, the lack of primary data collection also hinders the ability to capture current contextual nuances, stakeholder perspectives, or unreported developments at the local level. Thus, these limitations should be considered when interpreting the findings and their generalizability to broader contexts. Future studies incorporating primary data collection and stakeholder engagement may provide a more comprehensive understanding of oral healthcare for individuals with disabilities in Thailand.

Generalizability of the Study

Although Thailand's phased approach to improving the oral healthcare system for individuals with disabilities offers valuable insights, direct application of these findings to other settings should be approached with caution. The relevance and effectiveness of specific strategies may vary depending on health system structures, policy landscapes, workforce capacity, and cultural contexts. Nevertheless, the emphasis on collaboration, capacity building, and policy integration highlighted in this study may serve as a useful framework for other low- and middle-income countries aiming to advance special care dentistry. Adapting Thailand's experiences to align with local needs and circumstances is critical for achieving meaningful and sustainable improvements in oral health equity for individuals with disabilities.

Conclusion

Thailand's 15-year oral health improvement initiative for people with disabilities demonstrates how phased, system-level reforms can transform fragmented projects into a sustainable, policy-anchored system. Through curriculum integration, workforce development, network expansion, and specialty recognition, the country has embedded disability-inclusive oral health within both education and health service frameworks.

Yet persistent barriers remain, including unequal workforce distribution, transportation and financial constraints, and the absence of comprehensive national oral health data for disability populations. Addressing these gaps will require sustained investment, targeted surveys, rural workforce pipelines, and integration of special care dentistry into UHC benefit packages.

Thailand's experience provides a valuable model for other low- and middle-income countries seeking to strengthen equity in oral health. By adapting its lessons on phased reform, curriculum integration, community partnerships, and policy anchoring, similar settings can advance toward more inclusive and resilient oral health systems.

Abbreviations

CPD, continuing professional development; ThaiHealth, Thai Health Promotion Foundation; SQUIRE 2.0, Standards for Quality Improvement Reporting Excellence, version 2.0; UHC, Universal health coverage; UNICEF, United Nations Children's Fund; WHO, World Health Organization.

Disclosure

The authors report no conflicts of interest in this work.

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