



Financing Healthcare for Migrants:

A case study from Thailand



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Acronyms

BMA	Bangkok Metropolitan Administration Hospitals
CMHI	Compulsory Migrant Health Insurance Scheme
DRG	Diagnosis Related Group
EPI	Expanded Program for Immunization
GDP	Gross Domestic Product
IOM	International Organization for Migration
MOLSW	Ministry of Labour and Social Welfare
MOPH	Ministry of Public Health
MSF	Médecins Sans Frontières
NGO	Non-governmental Organization
NHSO	National Health Security Office
OOP	Out-of-pocket payment
PHO	Provincial Health office
SSS	Social Security Scheme
UC	Universal Health Coverage Scheme
US	United States
WHO	World Health Organization
WVFT	World Vision Foundation of Thailand

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Executive summary

Rationale of the study

Thailand has a relatively well established public health system featuring the launch of universal health care coverage in 2002. The development of the public health system and healthcare financing has contributed significantly to an equitable service provision and financial contribution of the health care system. However, in the absence of official Thai status, stateless / displaced persons are excluded from the Universal Health Coverage Scheme (UC), despite the fact that they were previously covered by the Low Income or Health Card Scheme prior to the introduction of the UC policy.

The increased number of migrant workers from Myanmar, Lao PDR, and Cambodia is considered a direct response to an increased demand for labour. However, the number of migrant workers who are registered has been significantly declining since 2005, and hence, the majority of current migrant workers are unregistered. The Ministry of Public Health (MOPH) have been implementing the Compulsory Migrant Health Insurance Scheme (CMHI) for registered migrant workers since the cabinet solution on 24 June 1997. The CMHI aims to provide migrant workers and their families with access to essential health care services, and to mobilize additional budgets for public hospitals. Nevertheless, an overall decline in the number of registered migrants has inevitably impacted on healthcare financing options for all migrant workers. The impact of CMHI's performance and its functions is of significant concern. Of additional concern is whether the CMHI can be financed in a more sustainable way.

Objectives and methodologies

The study aims to investigate the existing healthcare financing options for stateless / displaced persons and registered or unregistered migrant workers in order to provide recommendations to the MOPH and the National Health Security Office in relation to future healthcare financing for these population groups. The study was conducted in the provinces of Mae Sot, Sangklaburi, Samut Sakorn and Ranong. Both quantitative and qualitative approaches were employed to inform the study.

Results

Health care financing for stateless/ displaced persons and migrant workers

Stateless / displaced persons are excluded from the UC scheme. Normally, an out-of-pocket payment is required to access health care at public health facilities; yet, as a permanent resident, many stateless people know they can ask for an exemption and the expense will be shouldered by local public health facilities. Ranong is the only province amongst the studied areas implementing a voluntary health insurance system for this population group. However, being voluntary, the system has resulted in selection bias and subsequent financial instability. In 2006, the scheme documented 1,337 participants, the majority of which were reported to be experiencing chronic health conditions, resulting in incurred costs being double that of the collected revenue.

An unclear government policy towards the registration of migrant workers, in addition to the constraints of law enforcement, has resulted in a decrease in the total number of registered migrant workers, despite the fact that migrants continue to flow into Thailand. The decline in registered migrants has inevitably affected healthcare financing for migrant workers, for example, the waning of CMHI financing sources is counteracted by an increase in hospital exemptions and out-of-pocket payments. CMHI revenue accounted for 79% of all financing sources for migrant workers in 2005, dropping to 60% in 2006. Hospital exemptions and out-of-pocket payments each accounted for 20% of health care financing for migrant workers, predominantly unregistered migrants in 2006. The more hospital exemptions are given, the higher the financial burden on hospitals, particularly in border provinces where there are large clusters of stateless / displaced persons and unregistered migrants. There is no additional government budget to subsidize exempt services to both Thai and non-Thai populations who cannot afford to pay. As a result, hospital exemption is totally dependent on revenue collected from funding sources outside the hospital. In light of this fact, hospitals with limited revenue generating capacity are identified as those facilities that are less flexible with providing exemptions.

Performance of the CMHI

Access to health care under the CMHI scheme has demonstrated improvements for registered migrant workers. However, the utilization rate of outpatient care was still found to be far below that of the UC and Social Security Schemes. Self-medicating continues to be more common among stateless / displaced persons and migrants than their Thai counterparts. Language and cultural barriers partly explain the relatively low utilization of outpatient care, even though many hospitals provide translation services. The complexity of hospital service systems coupled with the limited number of translators is likely to impact on the quality and effectiveness of available assistance to migrant workers when receiving care in hospital.

However, the comparable inpatient utilization rate of migrant workers with that of the Social Security Scheme beneficiaries suggests that once seriously ill, migrants will take-up the benefits of the scheme. At present, the reinsurance policy also enables access to some high cost care and referrals. Health promotion and prevention services are provided to all migrant workers regardless of their registration status. Japanese Encephalitis vaccine and Hepatitis B vaccine are not generally provided in the four studied provinces even though they are included in the benefit package. This is probably due to the relatively high cost of these vaccines and a lack of clarity in regards to their impact on the epidemics. In order to achieve more effective control of the two diseases, both vaccines should be provided to migrant children. The active provision of health prevention and promotion services in migrant populated areas partly comes from funding supported by international organizations and various non-governmental organizations.

A relatively low service utilization rate has resulted in high cost recovery of the scheme due to the incurred costs being lower than the collected revenue. Costs of curative care services have increased in accordance with an increase in the service utilization rate of beneficiaries, despite being less than overall revenue. If exemption for unregistered migrants were assumed as expenses of the CMHI, overall costs of the scheme in 2006 would be greater than the curative budgets of the CMHI. Cost recovery of the scheme varied from province to province. Border provinces had relatively low cost recovery

due to the high number of unregistered patients in addition to cross-border patients. System administration, particularly governance of the scheme, is a further issue that needs to be addressed. A conflict of interest exists and active purchasing functions have not yet been performed since the MOPH acts as both the provider and purchaser of the scheme. Only one private hospital in Samut Sakhon province provides services to migrant workers under the CMHI. The exclusion of private providers limits the available choice and access to health services among migrant workers. In addition, monitoring and evaluation of the scheme's performance is limited as reflected by a decline in the number of provinces reporting to the MOPH. Therefore, active purchasing functions including monitoring, evaluation and information systems are identified as areas that could be strengthened.

Policy recommendations

1. Expansion of the UC scheme to cover stateless/ displaced persons is recommended as their contribution to society is equal to that of Thai people. In addition, given that the majority are poor and that they used to be covered by the Low Income Card, facilitating access to appropriate care is likely to provide positive outcomes to society in general. Expansion of the UC scheme requires an additional budget of 1,080 million Baht per year.
2. Improvements to the current CMHI scheme, and its management, are urgently required. Management Information Systems must be strengthened as a matter of priority. In addition, management boards should be established at both the central and provincial levels to develop coordinated strategies which aim to improve the overall performance of the scheme, to monitor, evaluate and enhance the scheme, and to facilitate collaboration amongst all related organizations and stakeholders.
3. Two healthcare financing options are proposed for unregistered migrant workers:
 - a. Additional budget allocations are required to support hospital exemption for migrant workers in communities where many unregistered migrants reside. Theoretically, health care costs incurred by migrant workers should be paid by those who benefit from the presence of migrant workers, including employers, local communities, the local and national economy, as well as local and national governments. Given that these groups already pay taxes, either directly or indirectly, a public subsidy scheme is recommended. According to the 2006 exemptions, this would require approximately 117 - 170 million Baht per year.
 - b. Health is a basic human right and to observe this on a national level, health security is recommended to include an expansion of the CMHI to cover all migrant workers and their dependents. Such an expansion would require all migrants identify themselves in order to pay their contribution. It is unlikely that all migrants could be covered on a voluntary basis, so it is therefore recommended as a compulsory scheme. In order to achieve this expansion, an explicit and liberal government policy is required to ensure a fair registration process, humane enforcement of the law, and improved coordination between various government organizations and stakeholders. There are no anticipated financial constraints should the government adopt this option.

1. Introduction

1.1 Background

Political instability and minimal economic growth in neighbouring countries continue to influence the movement of irregular migrants into Thailand. While there are more than 140,000 displaced persons from Myanmar living in temporary shelters along the Thai-Myanmar border, it is estimated that many more are living and working in Thailand outside of the shelters, either registered or unregistered, as temporary residents. The shelter residents receive assistance from numerous non-governmental organizations (NGOs) who have been providing food, basic health services and education for over 20 years. This is not the case for unregistered migrants residing outside the shelters who remain highly vulnerable and mostly underserved. Registered migrants on the other hand receive an annual physical check-up and basic health services through a Compulsory Migrant Health Insurance (CMHI).

Although access to primary health care is a basic human right, being stateless in remote areas excludes migrants from the relatively well established Thai public health system. Many migrants live in the same area or in close proximity to Thai communities, and improving health conditions among migrants will ultimately benefit and assist with maintaining the health security of host communities. While the Ministry of Public Health (MOPH) endorses the Healthy Thailand policy, and has clear intentions to deliver basic health services to all, the actual provision of services remains a significant challenge. Many migrants continue to have limited or no access to basic health care primarily due to: 1) their illegal status, poverty, and remoteness of their residence, all of which contribute to their marginalization; 2) limited knowledge and understanding about their rights to basic health care; 3) language and cultural barriers; 4) high levels of mobility amongst some migrant populations; 5) lack of cooperation from employers toward their employees; 6) negative perception and attitudes amongst health service providers; and 7) MOPH's limited financial and human resources to provide adequate health services to migrants.

It is difficult to anticipate any major change to the migration challenges facing Thailand in the near future. In light of this fact, it is critical that a systematic migrant health policy is established with an emphasis on long-term sustainability. In August 2005, the World Health Organization (WHO), International Organization for Migration (IOM), and Thailand's MOPH began implementing a joint Migrant Health Program for migrants from Myanmar in two priority provinces of Ranong and Samut Sakhon. The primary goal of the program was to improve the general health and well-being of migrants and their communities. The program strategies included: establishing and/or strengthening health infrastructure and health service delivery systems to enable appropriate and acceptable responses which better meet the needs of targeted populations; improving health related knowledge and awareness among targeted populations; increasing access to available public health services; enhancing human capacity of government, non-government, and private sectors in addressing the migrant health and rights issues as well as the capacity of migrant communities to conduct community and self care; and assisting the MOPH with developing sustainable mechanisms for migrant health systems and services.

As highlighted above, there are numerous international agencies that provide services and support to migrants residing in the shelters. CMHI is a crucial financing tool for registered migrants, however, the majority of unregistered migrants have to spend out-of-pocket money in order to receive health services. Alternatively, they might not be able to access services or may have to ask for an exemption from health care facilities. Financial sustainability is the key factor contributing to the continuation of migrant health systems and services once donor support ceases. In addition, it facilitates an expansion of the scale and scope of current systems and services in place. Therefore, the assessment of available health care financing options was conducted to investigate the local cost recovery schemes in order to present the macro - level policy options to the Royal Thai Government.

1.2 Objectives

The overall objective of this assessment is to investigate existing options for migrant health care financing in order to provide recommendations to the MOPH and the National Health Security Office (NHSO) in relation to future healthcare financing for migrants.

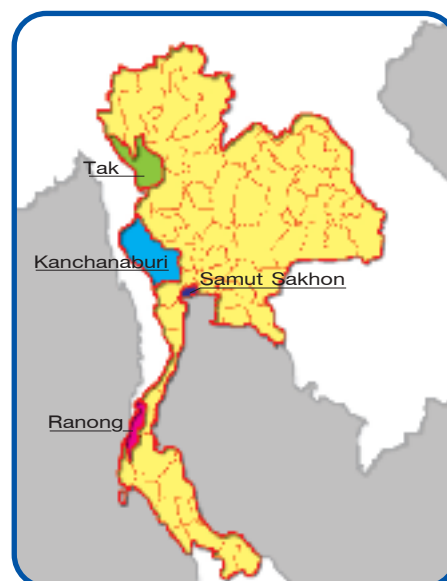
Specific objectives of this assessment include:

- 1) to investigate the existing health care financing options for both regular and irregular migrants, including stateless / displaced persons such as indigenous persons;
- 2) to gain a better understanding of how each option works, including pros and cons;
- 3) to determine the efficacy of cost recovery, health insurance schemes, and other available methods;
- 4) to identify alternative options for migrant healthcare financing; and
- 5) to provide MOPH, IOM and WHO with recommendations that will inform their future migrant health policy development, advocacy and action.



1.3 Study Sites

The study was conducted in the central MOPH office and selected cities in four provinces, namely; Muang district of Samut Sakhon province, Muang district of Ranong province, Sangklaburi district of Kanchanaburi province, and Mae Sot district of Tak province. A high concentration of migrants is the primary criteria for study site selection. In addition, Samut Sakhon and Ranong provinces are both implementation sites of the collaborative migrant health program between MOPH / IOM / WHO.



1.4 Populations and samples

The study focused on three main population groups from Myanmar, Lao PDR, and Cambodia; all of whom were categorised as either registered migrant workers, unregistered migrant workers or stateless / displaced persons.

1.5 Methodologies

Both quantitative and qualitative studies were employed for this assessment with the following methodologies.

- 1) Review of routine Provincial Health Office (PHO) reports from 2004 - 2006 were obtained to provide information at both local and national levels. The review covered the following issues:
 - Rationale and objective of different healthcare financing schemes,
 - Benefit package, actual services provided and access conditions of each scheme,
 - Management of benefits and funds at national and local level, and
 - Performance of the schemes.
- 2) Analysis of the 2005 - 2007 high cost care databases from the Health Financing Office to improve understanding of patient characteristics, patterns of illness, and cost of services provided to migrants and stateless / displaced persons with and without health insurance.
- 3) In - depth interviews with selected key informants from government and non - government agencies at both national and local levels. Ten key informants were interviewed: two at the national level (Director of Bureau of Health Policy and Strategy and Director of Bureau of Health Service System Development); four at the provincial level (Provincial Chief Medical Officer and / or the deputy in each province); and four at the provincial and / or district hospital level (director or deputy director of the hospital in each province). The list below is an example of issues discussed during the in - depth interviews:

- Attitudes toward migrants,
 - Perceptions about the impacts of migrant workers in Thailand,
 - Available health systems and services for migrants and the performance of such systems and services,
 - Perceptions about obstacles and concerns in relation to the implementation of the migrant health policy, and
 - Available financing options for the health care of migrants and the performance of each option.
- 4) Focus group discussions with migrants and stateless/ displaced persons were conducted in the four study sites.

4.1 One focus group discussion session was conducted in each studied site including both registered and unregistered migrants. A local NGO working with migrants was approached to facilitate coordination at each site. The coordinator recruited migrants according to the criteria proposed by the researcher, i.e. including both registered and unregistered migrants, gender, those who had experienced accessing / receiving care. The meetings took place in the local NGO office. The discussions were facilitated by researchers, and a local translator was hired to translate group discussions.

The number of migrants who participated in focus group discussion sessions in each site:

Site	Male	Female
Muang, Samut Sakhon	8	5
Sangklaburi, Kanchanaburi	4	6
Mae Sot, Tak	3	4
Muang, Ranong	2	5

The following issues were discussed :

- Working and living conditions of migrants,
- Participants' length of stay in Thailand and their future plans,
- Participants' experience with health problems, their coping mechanisms and health care seeking behaviours,
- Problems or constraints the participants faced in accessing essential health care and how they overcome the problems or constraints,
- Participants' perception regarding locally managed migrant health insurance and prepayment scheme, and
- Suggestions to improve the current migrant health insurance systems.

4.2 A focus group session among stateless / displaced persons was conducted in each studied site of Mae Sot, Sangklaburi, and Ranong. The researchers directly approached communities where stateless / displaced persons reside and invited interested participants to meet and discuss issues in a group forum. Each participant spoke Thai; therefore, there was no need for a translator. The number of participants varied from three persons in Sangklaburi, seven persons in Mae Sot, and 20 persons in Ranong. The issues discussed were similar to those discussed amongst migrants including:

- Their background, length of stay in Thailand, obstacles in obtaining Thai citizenship and any difficulties experienced as stateless or displaced persons,
- Participants' experience with health problems, their coping mechanisms and health care seeking behaviours,
- Access to essential health care, any problems or constraints faced in accessing essential health care, and how these problems or constraints were overcome, and
- Participants' perceptions regarding locally managed prepayment health schemes and their suggestions to improve the current health insurance system.

1.6 Study period

The study began in January 2008 and was completed in August 2008. Field data collection took place between January - March 2008.



2. Migrant Workers and Stateless / Displaced Persons in Thailand

This section provides an overview of current circumstances amongst migrant workers and stateless / displaced persons in Thailand, the economic contribution of migrant workers, and the impact of migrant workers.

2.1 A summary of Thailand's policies towards migrant workers

Thailand's two-digit economic growth period in the 1980s created an expansion of the labour market and subsequently an acute labour shortage. This was particularly evident at the level of unskilled labour during the 1990s. The private sector expressed an eager demand for labour to fulfil production, however local Thais were not interested in joining the unskilled labour market. This was partly due to the extension of compulsory education to secondary school and partly due to a preference to work in the rapidly growing service sectors. As a result, the private sector placed pressure on the government to permit them to employ migrant workers. In 1992, Thailand began discussions about developing an immigration policy for unskilled foreign workers. As a result of these discussions, considerable barriers were identified within the existing legal framework, namely the Immigration Act 1979 and the Foreign Employment Act 1978. These Acts excluded clauses permitting foreign workers to be employed within Thailand. In light of this, the Thai government agreed to employ cabinet resolutions as a mechanism to develop new legal frameworks. The cabinet resolutions are considered to be more of an impromptu approach to policy formulation which, in this case, allowed greater flexibility than the strict immigration and foreign employment laws (Chantavanich, 2007).

Policies concerning migrants who are working illegally can be divided into four phases (Chantavanich, 2007). The first phase, 1992 - 1998, is classified as an area - based, non - quota system. In 1992, registration was limited to migrants from Myanmar border provinces; and later in 1996, was gradually extended to include Laotian and Cambodian workers in the low - skilled and domestic sectors. During phase 2, between 1999 - 2000, a further two registration periods were launched for illegal migrants. These periods were managed quite differently in that a quota system was imposed to limit the number of people who could register. During phase 3, 2001 - 2003, the government took a more liberal step by opening up registration for illegal workers without imposing any quotas. Phase 4 began in April 2004 when the Cabinet made the decision to develop a new registration system whereby migrant workers, their dependents and their employers were required to register themselves. A thirteen - digit identification number was allocated to each worker and their dependents. Details of Cabinet decisions in relation to the registration of migrant workers during 1992 - 2005 are summarized in Table 1.

Table 1. Thai cabinet decisions regarding registration of migrant workers from Myanmar, Lao PDR, and Cambodia, 1992-2005

	Date	Scope of the Registration	Fee	Note
Phase 1	17 March 1992	<ul style="list-style-type: none"> 10 border provinces 	<ul style="list-style-type: none"> 5,000 Baht for bound 1,000 Baht registration fee 	<ul style="list-style-type: none"> Myanmar migrants only 706 migrants registered
	22 June 1993	<ul style="list-style-type: none"> 22 coastal provinces Only those working in fishing industries are eligible 	As above	<ul style="list-style-type: none"> Not implemented until the 1939 Thai fisheries law was amended on 3 November 1993
	25 June 1996	<ul style="list-style-type: none"> 39 provinces (later extended to 43) Registration for 7 industries (later extended to 11) 	<ul style="list-style-type: none"> 1,000 Baht bound 1,000 Baht registration fee 500 Baht health insurance fee 	<ul style="list-style-type: none"> Two-year permits for those who registered between 1 September - 29 November 1996 34 job types open to migrants
	29 July 1997 19 January 1998	As above	As above	<ul style="list-style-type: none"> Set up border and interior enforcement Provincial committee established to deal with migrants, which encouraged factories in the border areas to hire migrant workers. Post 1997 financial crisis, the government deports 300,000 migrants and a further 300,000 in 1998
	28 April 1999 8 May 1998	<ul style="list-style-type: none"> 54 provinces with 47 employment options One year extension to work permits due to expire in August 1998 (to August 1999) 	<ul style="list-style-type: none"> 1,000 Baht for bound 700 Baht medical examination fee 500 - 1,200 Baht health insurance fee 	<ul style="list-style-type: none"> 158,000 posts were allowed, however only 90,911 migrants registered. In addition, a daily work permit was issued for migrants who commute from their country of origin on a daily basis.
Phase 2	3 August 1999 2 November 1999	<ul style="list-style-type: none"> 37 provinces 18 sectors in 5 industries 	<ul style="list-style-type: none"> 1,000 Baht for bound 700 Baht medical examination fee 1,000 Baht for health insurance 	<ul style="list-style-type: none"> 106,000 one year work permits available, to expire on 31 August 2000, however only 99,974 migrants registered
	29 August 2000	<ul style="list-style-type: none"> 37 provinces 18 sectors in 5 industries 	As above	<ul style="list-style-type: none"> 106,684 migrants eligible to work until 31 August 2001 across 18 sectors and 37 provinces
Phase 3	28 August 2001	<ul style="list-style-type: none"> For all sectors in all industries 	<ul style="list-style-type: none"> 3,250 Baht registration fee 1,200 Baht for six - month renewal 	<ul style="list-style-type: none"> Six-month permit Renewable for a further six months until September - October 2002
	24 September - 25 October 2002	As above	As above	<ul style="list-style-type: none"> 568,000 migrants registered for six months; of which, 430,074 renewed their registration.
	November 2003 - June 2004	As above	As above	<ul style="list-style-type: none"> 288,780 migrants registered
Phase 4	April 2004 - June 2005	<ul style="list-style-type: none"> As above However employers were also required to register with the Ministry of Labour 	<ul style="list-style-type: none"> 3,800 Baht (including 1,800 Baht for 1 year work permit, 1,300 Baht for health insurance, 600 Baht for medical examination and 100 Baht for registration fee) 	<ul style="list-style-type: none"> 1,284,920 migrants and dependents reported themselves to the authorities; of which 838,943 obtained one - year work permits. there were 705,293 migrants in the extension of work permit in 2005
	MOLSW 2006			<ul style="list-style-type: none"> There were 668,576 registered migrants in this year and 85% of them were Burmese,

Source: 1. Sontissakyothin (2000)154-62
3. Chantavanich (2007)

2. Caouette et al (2000)
4. Ministry of Labour and Social Welfare (MOLSW)

2.2 Number of irregular migrants in Thailand

Various sources of migrant related data provide different estimates of the total number of migrants residing in Thailand. It is generally agreed that the overall number of migrant workers from Myanmar, Lao PDR, and Cambodia has increased significantly since 2001, particularly following the more liberal, open registration phase (See Table 2). The number of registered migrants in each phase correlates with the government policy of the period. For example, there was a decline in the number of registered migrants during the period of economic recession in 1998-1999. The decline can be explained by a government policy at the time to deport migrants in order to open up employment opportunities for Thai citizens. The number of unregistered migrant workers decreased compared to registered migrants as shown in Table 2. The sharp decrease in the number of non-registered migrants can be explained by the open registration policy in 2001, and the opportunity for renewed registration in 2004. A decrease in registered migrant workers, post 2004, is thought to be a result of the limited registration policy of the time, which only allowed previously registered migrants to renew their work permits. In 2006, the estimated number of unregistered migrants exceeded one million, whereas registered migrants accounted for only 0.7 million. Furthermore, between 1995 and 2003 it was estimated that migrant workers accounted for 2-3% of the total labour force in Thailand. This increased to 4-5% by 2005 (Pholphirul, P. and Rukumnuaykit, P., 2007).

Estimates from 2005 reported that approximately 76% of migrant workers originated from Myanmar with the remaining (23%) originating from Lao PDR and Cambodia. Men (53%) account for slightly greater numbers than women (47%). Approximately 20% of migrants work in agricultural and animal farming industries, and distribute themselves almost equally (14-15%) in fishing and fishery processing industries, private households, and construction works.

Table 2. Number of migrant workers in Thailand originating from Myanmar, Lao PDR and Cambodia, 1995 - 2008

Year	Registered migrants ¹	Unregistered migrants ²	Total ²	Proportion of registered and unregistered migrants
1995	293,652	406,348	700,000	42
1996	293,652	424,037	717,689	41
1998	90,911	870,556	961,467	9
1999	99,974	886,915	986,889	10
2000	99,956	563,820	663,776	15
2001	562,527	287,473	850,000	66
2002	409,329	558,920	968,249	42
2003	288,780	711,220	1,000,000	29
2004	847,630	151,770	999,400	85
2005	705,293	807,294	1,512,587	47
2006	668,576	1,104,773	1,773,349	38
2007	532,305	1,267,695	1,800,000	30
2008	501,570	N/A	N/A	N/A

Source: 1. Number of migrants who renewed their work permits in 1996, 1998 - 2008 sourced from the Ministry of Labour
 2. Updated from Martin (2007)

2.3 Number of migrant workers in studied areas

Amongst the studied provinces, the number of registered migrants is reported to be highest in Samut Sakhon, with approximately 70,000 - 80,000 registered each year (Table 3). However, according to demands projected by private sectors in the province, the number of migrant workers is estimated to be three to four times higher than that of the total number registered. Samut Sakhon is a preferred destination of many Myanmar migrant workers due to its urban characteristics, proximate location to Bangkok and relatively high wage rate compared to other provinces. The majority of migrants in Samut Sakhon work in the fishing and seafood processing industries as these industries are often rejected by Thai labourers. As a primary destination of migrant workers, the number of registered migrants in Samut Sakhon has been relatively stable, meanwhile declining trends have been observed in other provinces. Another striking feature is that both public and private hospitals are recruited as 'authorized' providers to registered migrant workers. Approximately 60% of migrant workers in Samut Sakhon are registered with a private hospital and the remaining 40% are registered with any one of the three public hospitals auspiced under the MOPH.

In accordance with national figures, there has been a decrease over time of registered migrant workers in Kanchanaburi, Tak, and Ranong provinces. The numbers of registered migrant workers in Kanchanaburi and Tak provinces were noticeably lower than the estimated figure of migrant workers actually residing there. This is probably because both provinces are common entry points from Myanmar into Thailand, so people may temporarily work there before moving elsewhere. In addition, many migrant workers cross into Thailand to work in factories along the border and then return to Myanmar in the evening.

Table 3. Total population compared to number of migrant workers in studied areas, 2004 - 2007

Province	Year	Total population ¹	Number of migrants ²	
			Registered	Demand for migrant workers
Samut Sakhon	2004	442,687	78,794	137,080
	2005	452,017	73,896	184,960
	2006	462,510	50,713	201,497
	2007	469,934	74,531	250,000 ³
Kanchanaburi	2004	810,265	14,743	39,554
	2005	826,169	12,226	37,172
	2006	834,447	9,141	37,172
	2007	835,282	7,551	110,296 ³
Tak	2004	515,877	52,768	96,874
	2005	522,197	41,242	107,264
	2006	527,677	27,248	143,012
	2007	530,928	26,912	300,000 ³
Ranong	2004	176,372	31,962	49,704
	2005	178,122	23,312	45,690
	2006	179,850	19,099	48,517
	2007	180,787	17,809	68,199 ³

Source: 1 Total population figures sourced from the annual Ministry of Interior's Citizen Registration.
2 Total numbers of registered migrants in 2004 - 2007 - sourced from the Ministry of Labour
3 Total number of migrants - estimated from surveys, or approximate figures calculated by the studied province from Provincial Employment Office

2.4 Number of stateless / displaced persons

In 2004 there were reported to be 19 ethnic and indigenous groups composed of 514,424 people living in Thailand (Artvanichkul, K. and Prasartkul, P., 2005). The majority of these population groups are classified into three key indigenous groups who reside in the remote highland areas of the country (Artvanichkul, K. and Saisuthorn, P., 2005). The first group are categorised as those who are in the process of being granted Thai nationality. Most of this group are highlanders born in Thailand who have never been registered as citizens. Alternatively, members of this group were originally of Thai ethnicity, used to live in Myanmar or Cambodia and have migrated back to Thailand. The second group comprise of those who immigrated to Thailand prior to 1985, who married into a Thai family, or are identified as having contributed significantly to the country. They may also be in the process of being granted Thai nationality. The third group is comprised of those who were displaced from their homeland due to political insecurity between 1985 and 1992.

In general, the identified indigenous groups experience lower socioeconomic status when compared to Thais. In addition, most of these groups were previously eligible to receive the Low Income Card, or they could purchase the Health Card in order to access essential health care.

The Royal Thai Government introduced the Low Income Card in 1975 with the intention to improve access to health care for those living in poverty. Households and individuals eligible to receive this card were those whose monthly income fell below a defined 'poverty' level. Those who held the Low Income Card were eligible to receive free health care from the local government health facilities, with government allocated budgets subsidizing the costs of care provided. Once individuals or households were eligible for the Low Income Card, they could receive benefits for up to three years before being reassessed and potentially reissued a new card.

The Health Card Scheme was first implemented in 1978 as a community financing scheme, however, in 1994 it evolved into a publicly subsidized voluntary health insurance scheme. Households who were not eligible for the Low Income Card could purchase a Health Card for 500 Baht, which would enable them access to free health care at specified public health facilities on an annual basis. Only family cards were available and one card covered up to five members in a family. Both the Low Income and the Health Card schemes were provided to all individuals and/or households regardless of their nationality/ethnicity.

In 2002, the government launched a Universal Health Coverage (UC) Policy aiming to provide universal access to essential health care for all Thais. It achieves this by providing insurance to those who are not covered by any other public health insurance scheme. In implementing the UC policy, the government withdrew the Low Income and Health Card Schemes and extended coverage to previously uninsured Thais regardless of income levels. However, it has become apparent, since the launch of the UC Policy, that Thai citizens are the only eligible beneficiaries to the UC scheme. In light of this, the UC policy has negatively impacted on stateless/ displaced persons who have

been formally excluded from government health coverage since this time (Artvanichkul, K. and Saisuthorn, P., 2005).

Stateless persons are reported to be mainly residing in border provinces including three of the four studied provinces. Samut Sakhon is the only province who report having no record of stateless persons residing there. Kanchanaburi and Tak provinces are most populated with stateless persons, with figures recorded at 70,399 and 48,786 individuals respectively. The majority of those on record in Kanchanaburi province are classified as highlanders or displaced persons from Myanmar who reside in one of three main districts in Sangklaburi, Tongpapum and Saiyok. Similarly, those residing in Tak province are mostly classified as highlanders or displaced persons from Myanmar who live in Tasongyang, Pobpra, Mae Sot, and Mae Ramad districts. In Ranong, there are approximately 5,425 ethnic Thais who migrated from Myanmar over time. The majority of populations are concentrated in Kraburi and Suksamran districts.

2.5 Economic contribution of migrant workers to Thailand

Historically, Thailand has not had any specific policies concerning migrant workers. However, there have been policies regulating registration numbers external to the 36 employment categories within which migrants can work (Artvanichkul et al, 1997). Many concerns related to illegal migrant workers have come to light since 1988 following a period of severe political instability in Myanmar which caused an exodus of migrants into Thailand. Simultaneously, Thailand's economic boom resulted in an increased demand for labour forces. The private sector subsequently used this demand for labour as a catalyst to campaign the Thai government to open up the country to migrant workers.

By 2005, migrant workers accounted for 5% of all labour forces within Thailand (Martin, P., 2007). The migrant workforce is estimated to contribute a total of two billion US dollars per year. The estimate is based on an average earning of 1,125 US dollars per worker per year. Even if migrant workers remit one billion US dollars to their countries of origin, the potential impact of consumption would raise the Thai Gross Domestic Product (GDP) by about two billion US dollars; assuming an expenditure-to-GDP ratio of two (Martin, P., 2007). Furthermore, Martin, P (2007) estimated that if migrants were as productive as Thai workers in each sector, their total contribution to output would be in order of 11 billion US dollars or about 6.2% of Thailand's GDP. If migrant workers were less productive than Thai workers, even at a maximum output of 75% of Thai workers, their contribution would still be in the order of eight billion US dollars or 5% of the GDP. Overall, migrants generate between 7-10% of the value contributed in industry, and 4-5% of value contributed to agriculture (Martin, P., 2007).

In addition, migrant workers generally receive lower wages than Thai workers. A 2003 study conducted in Tak province found the average wage of migrants to be 50-70 Baht, or half of the minimum Thai wage that year (Arnold, D., 2004). Migrant construction workers in Bangkok receive slightly higher than the minimum wage of Bangkok, however, it is still relatively low and makes up just 82% of the average Thai wage.

It has been identified that an increase in migrants leads to an increase in consumption of goods and services within Thailand, which ultimately raises government revenue from value added taxes. Furthermore, an increased demand for social services, including health care and education, is a natural consequence of population growth within Thailand. The Thai government currently provides some basic essential services to registered migrants, for example, education and health services via the migrant health insurance scheme. However, many migrants, particularly those who are unregistered, are not eligible for tax-supported benefits. This suggests that migrants receive nominal benefits when they are likely to pay more in taxes than they consume in tax-supported services.

2.6 Impacts of migrant workers on health and social aspects

Migration can have various consequences on the social environment as a result of social and economic exclusion. Of particular concern is an increased risk of crimes such as murder, drug trafficking and human trafficking (Saisilp, A, 2009; Wongviriyaphan, K, 2009). Media and news broadcasts often report migrant abuse, assault and homicide. Similarly, there is media coverage of employer homicide. Discrimination, exploitation and hardship related to exclusion and having an illegal status can often influence migrant workers to engage in illegal activities (Balbo, M and Marconi, G, 2006).

Migrating workers from Myanmar, Lao PDR and Cambodia are also linked to a re-emergence of communicable diseases (Nitchanet, 2008). Malaria, filariasis, leprosy and poliomyelitis are some examples of diseases that were previously well controlled in Thailand. Managing communicable diseases amongst migrant workers is an ongoing challenge. Addressing the challenge is complicated due to the fact that the majority of migrant workers are unregistered and also highly mobile. In addition, the lack of documented and consistent information makes it difficult to keep track and follow-up on their health status.

Access to health care is a further challenge among migrants, specifically unregistered migrants. Registered migrants are covered by the prepaid migrant health insurance scheme, and therefore, access to necessary health care is of less concern than for unregistered migrants. However, barriers in accessing health care continue to exist amongst registered migrants. Language and culture are considerable barriers as are health beliefs, long distances to designated health facilities and long working hours (Isarabhakdi, P., 2004; Khruemanee, T., 2007). In addition, some employers seize migrants' work permits to prevent them from leaving their jobs. Such instances of exploitation cause additional obstacles for migrant workers access to health facilities.

3. Financing Health Care for Migrant Workers and Stateless / Displaced Persons

This chapter provides an overview of current health care financing options for migrant workers and stateless/ displaced persons in Thailand. All registered migrant workers are covered by the CMHI which is managed by the MOPH. Unregistered migrants, their dependents, and stateless / displaced persons must pay out of their own pocket to receive health care. However, hospital exemption plays a vital role in bridging the financial gap for those who cannot afford to pay. Some provinces have established a voluntary health insurance scheme for stateless / displaced persons. In addition, migrant health programs supported by international donors exist in most migrant populated areas and subsequently play a primary role in subsidizing financing of migrant health care.

3.1 Overview of healthcare financing

Health care financing refers to the means in which health care is funded. The process includes three basic functions: 1) revenue collection, 2) risk pooling, and 3) purchasing health services and payment methods. Major concerns in relation to revenue collection include how, and from which sources, to collect money that will sufficiently finance health care in an equitable and sustainable way. Health services can be financed directly, at the time of service utilization, by out-of-pocket payment or through a prepaid system.

Out-of-pocket payments are common in most developing countries and often finance health services in the private sector. Out-of-pocket payments provide freedom of choice for clients, and therefore, people often become more cost conscious when seeking care. However, Out-of-pocket payments make it difficult to achieve equity within the health system because access is often determined by a person's ability to pay. Furthermore, there are no safety net mechanisms to prevent or reduce any negative consequences impacting on the poor. Many advanced and middle-income countries have established prepayment systems or health insurance as an alternative to paying out-of-pocket. Such approaches include community financing schemes, voluntary health insurance, compulsory health insurance, and financing health care through general revenue.

Risk pooling is a mechanism employed to distribute the financial risks and to cross subsidize health care amongst members of a prepayment or health insurance scheme. Health insurance provides two primary functions; enabling access to health care when needed, and protecting individuals from hardship due to medical expenses. Prepayment mechanisms appear to be more rational than out-of-pocket payments in financing health care as they separate payments from service utilization. However, the extent to which health insurance or prepayment schemes can distribute risks and cross subsidize amongst

members is dependent on progressivity¹. Progressivity influences premiums, contribution rates, pooling of funds, breadth of population covered, and the balance of mechanisms between funds.

Purchasing and payment methods are equally important financing functions. They can ensure the provision of efficient, high quality services to beneficiaries. There are four primary objectives associated with purchasing; 1) to ensure the good health of beneficiaries, 2) to resolve health problems, 3) to be responsive to social expectations, and 4) to control costs. Purchasing can be passive, i.e. by simply paying bills as they are presented, or active by researching means to maximize health system performance. For example, researching options may enable one to be in a better position to make informed decisions about which treatment to purchase, how and from whom. Provider payment promotes financial incentives, and the range of payment methods supports a controlling of costs and a variety of service provision incentives. Fee-for-service² payments provide good service provision incentives and responsiveness to clients; however, there is less incentive in controlling costs since all incurred costs are covered by payers. Close-end payment methods, i.e. capitation³ or global budget⁴, provide the opposite effect, greater incentive to controlling costs but less incentive in providing services. All payment methods have strengths and weaknesses, and hence, incorporating more than one approach would be beneficial. Doing so is likely to simultaneously maintain strengths and prevent negative consequences, i.e. point system and/or Diagnosis Related Group (DRG)⁵ weight global budget.

In summary, equity and efficiency are two major concerns in relation to financing health care. Equitable access to health care should be fostered by focusing on responding to health needs rather than the client's ability to pay. For example, bankruptcy is a devastating consequence of paying medical bills. In order to achieve equity and efficiency, health assessments should be made according to one's ability to pay. The wealthy should pay more than the poor, and collected revenues should be pooled in order to distribute health financing risks. This will allow revenue collected from the wealthy to be cross subsidized to the poor. The above information demonstrates that out-of-pocket payments are the most inequitable method of financing health because they are directly related to health service utilization, rather than an ability to pay. In light of this, any prepayment method - either taxes, insurance or security - is considered a more beneficial and preferable means for financing health care (WHO, 2000).

¹ Progressivity refers to payments being made as a result of individual affordability. The wealthy should therefore pay according to their financial status, i.e. they should pay a greater proportion of their contribution than the poor.

² Fee-for-service is a retrospective payment method that is made according to itemized charge. Providers charge all inputs made in service provision.

³ Capitation refers to a fixed payment per beneficiary to a provider responsible for delivering a range of services for a certain period of time, usually for a year.

⁴ Global budget refers to a prospective payment where the unit of service is either an administrative entity or health facility. Total payment is fixed to cover a specific time period. Some end-of-year adjustment may be allowed.

⁵ Diagnosis Related Group (DRG) is a system to classify hospital cases with similar severity and resources used into the same group. There are approximately 500 classified groups. It is a case-based prospective payment system for inpatient care. DRG has been adopted in Thailand to pay hospitals in various health insurance schemes for more than a decade. When incorporated with global budget, then the accumulative relative weight of each hospital will be used to calculate payments under global budgets.

3.2 Current healthcare financing sources for migrant workers in Thailand

Major health concerns amongst migrant workers include the re-emergence of certain communicable diseases, stress and skeletal or muscular illnesses due to heavy workloads and poor occupational health and safety standards. Of additional concern is the financial burden carried by public hospitals in migrant populated areas, particularly when there is no third party payer. The acquisition of pharmaceutical drugs to self-medicate is common amongst migrant workers, more so than amongst Thai populations. This is likely to be a response to the various barriers to accessing health care (Isarabhakdi, 2004). Many migrant workers receive acute health care from public hospitals when they are severely ill and requiring hospitalization. However, in general, in-patient services are more expensive than out-patient services. When migrants are unable to pay, exemption is the most common and, often the only available option, particularly when employers refuse to take responsibility for any payment.

As highlighted, there are several mechanisms to financing healthcare for migrants in Thailand. It is noted that most of the options available to migrants have been explored in this study, apart from the Social Security Scheme (SSS). The existing SSS was created for Thai employees more than a decade ago. It has been expanded in recent years to include regular migrant workers from Cambodia and Lao PDR. These particular migrants work in Thailand via the bilateral Memorandum of Understanding between governments of Thailand and neighbouring countries. However, the present permitted number of migrant workers is very limited, and therefore, for this reason, the SSS concerning migrant workers was excluded from this study.

3.2.1. Compulsory Migrant Health Insurance (CMHI)

A health insurance program for migrant workers was first introduced in 1997, following a cabinet resolution permitting the MOPH to provide health insurance to migrant workers at no less than 500 Baht per person per year. In 2001, an additional cabinet resolution was passed which required that all registered migrant workers comply with annual health screening at a cost of 300 Baht and annual CMHI membership at a cost of 1,200 Baht. In addition, a co-payment of 30 Baht per visit is required when receiving care from health facilities. In 2004, the price of annual screening and health insurance cards increased to 600 Baht and 1,300 Baht respectively. The CMHI scheme primarily targets migrant workers; however it only applies on a voluntary basis for their dependents.

The CMHI program aims to provide health screening, curative care, health promotion, and disease surveillance and prevention services. Health screening includes:

- Chest x-ray and sputum examination to investigate suspected cases of tuberculosis,
- Blood examination to investigate syphilis and microfilaria infections,
- Urine examination to monitor for narcotic drug use and pregnancy tests (for women),
- The provision of Diethylcarbamazine (300 mg DEC) for all, and every six months for those who test positive to microfilaria,
- Leprosy screening, and
- The provision of a single dose of Albendazole 400 mg to control parasite infections.

Migrants who report having the following conditions are not granted a work permit:

- Active tuberculosis,
- Obvious leprosy or filariasis,
- Stage 3 syphilis,
- Narcotic drug addiction,
- Alcoholism, and
- Psychosis or mental disorder.

Benefit package

Registered migrant workers are eligible to access the benefit package health services at the same hospital in which they received the health screening. The following list details the benefit packages of the CMHI scheme:

General illness

- Physical examination, diagnosis, treatment, child delivery - including neonate medical, rehabilitation and approved alternative medicine,
- Dental care including tooth extraction, filling and scaling,
- Board and meals in the common inpatient ward,
- Medicine and medical products covered by the National Drug List, and
- Medical referral

Treatment of high cost care

The CMHI scheme provides a comprehensive package including both outpatient and inpatient care as well as high cost services. The MOPH reserves a portion of the budget, 50 Baht per person, to reimburse hospitals providing high cost care to migrant workers. The reserve is a mechanism to redistribute financial risks among MOPH hospitals, particularly for hospitals with small numbers of registered migrants. In addition, it ensures that migrant workers will have access to high cost services as required, and health care providers will be reimbursed for costs of service provision.

Accident and emergency conditions

Access to accident and emergency services is slightly different to the design of the UC scheme. This is because migrant workers are only permitted to work and reside in the province in which they are registered. Therefore, access to emergency and accident services is limited to hospitals within the registered province and dependent on the terms and conditions created by each province. However, provisions are made due to the nature of mobility within the fishing industry, and as such migrant seafarers can access designated hospitals in 22 coastal provinces. Registered migrants in Bangkok can access accident and emergency care in all designated hospitals under the administration of the MOPH and Bangkok Metropolitan and Medical Schools.

Medical referral

In cases where the designated hospital is unable to provide suitable treatment and care, the patient becomes eligible for medical referral to appropriate hospitals within or outside of the registered province. However, it depends on the nature of the referral, and as seen in the SSS and UC schemes, there are fourteen conditions⁶ excluded from the benefit package:

- Psychosis
- Treatment and rehabilitation of narcotic drug dependency
- Traffic accident injury
- Infertility
- In vitro fertilization
- Sexual reassignment surgery
- Plastic surgery without medical indication
- Treatment without medical indication
- Hospitalization beyond 180 days, except those with complications or medical indication
- Treatment linked to clinical trials and research
- Chronic renal failure
- Organ transplants
- Dentures
- Antiretroviral therapy for Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS), except in preventing mother-to-child transmission

Health promotion and prevention services

The list below identifies health promotion and prevention services covered in the benefit package:

- Individual health examination book
- Perinatal care
- Health examination
- Antiretroviral therapy in pregnant women for prevention of mother-to-child transmission of HIV
- Contraception for male and female, including tubal ligation
- Home visit and home health care
- Health education and consultation

⁶ Even though the UC and SSS schemes already cover treatment of chronic renal failure and ARV in HIV and AIDS patient, these are still not covered by the CMHI. Traffic accident injuries are already covered by a separate Traffic Accident Insurance scheme.

- Oral health prevention and promotion services, i.e. oral health examination, oral health education, fluoride supplement in high risk group
- Disease prevention and control

3.2.2. Public voluntary health insurance

Public voluntary health insurance is another financing mean for unregistered migrants and stateless / displaced persons. In 1997, when the Thai government commenced a period of open registration and health insurance for migrant workers, the MOPH did not have specific policy guidelines, and therefore, each province had greater flexibility to implement their own migrant health programs. Some provinces, as approved by the Provincial Governor, piloted a health insurance program for both registered and unregistered migrants. Following the introduction of the CMHI, some locations, for example, Sangklaburi district in Kanchanaburi province, continued to implement local health insurance for unregistered migrant workers with the approval of the Provincial and District Governors. However, the absence of a legal framework concerning unregistered migrants inevitably resulted in a lack of sustainability and therefore termination of this model. This is primarily because the program could not be implemented without permission from the Provincial and District Governors.

For stateless / displaced persons, there is at least one province, namely Ranong that provides Public Voluntary Health Insurance to stateless / displaced persons with identification numbers previously assigned by the Ministry of Interior. Fees and benefit packages are similar to those found in the CMHI and locally managed by the Provincial Health Office. However, because it operates under a voluntary basis, the province is confronted by poor risk sharing and financial instability. This is due to the majority of members having chronic health conditions at the time they joined the scheme. In addition, those who are in better health are more likely to avoid paying for unforeseen health care needs. In 2006, 1,337 or 25% of displaced persons residing in Ranong purchased the Public Voluntary Health Insurance. An average of 2.95 outpatient visits and 0.30 admissions were recorded per person per year. As a result, revenue collected from selling insurance cards to displaced persons could only cover 44% of expenses, the rest was covered by hospital exemption.

As identified, there is no Public Voluntary Health Insurance available for unregistered migrants. This is due to their illegal status and the lack of legal framework in place to enable the MOPH and PHO to implement such a program. However, for stateless/ displaced persons with temporary identification numbers, and thus a potential to receive legal Thai status, the Public Voluntary Health Insurance would only be appropriate if the member is able to pay a premium. In view of the above, the Public Voluntary Health Insurance and Private Health Insurance schemes are not viable options for unregistered migrants as they have no legal status in Thailand.

3.2.3 Out-of-pocket payment (OPP)

Out-of-pocket payments are the primary health care financing method for both unregistered migrant workers and stateless/ displaced persons. This is particularly the

case when purchasing drugs to self-medicate or when accessing low cost outpatient services. However, when hospitalized, the majority are not able to afford the fees, resulting in reliance on hospital exemption.

3.2.4 Hospital exemptions

Prior to the introduction of the UC policy, the government allocated some of the health budget to all public hospitals. The allocation was made in order to support service provision and subsidize those who were not covered by public insurance or welfare schemes, including those who were unable to afford medical costs. The budget allocation was terminated following the introduction of the UC policy. An assumption was made by the government that all Thai people were covered by one of the health insurance schemes, for example, the Civil Servant Medical Benefit Scheme and SSS.

Even though Thailand has achieved universal health care coverage, hospital exemptions continue to play an important role to meet the needs of uninsured populations, e.g. stateless / displaced persons, unregistered migrants, and those who do not comply with the access conditions of health insurance schemes. Hospital exemption is found to be more common within inpatient services than outpatient services due to the higher cost of inpatient services. Given that the government no longer allocates additional budgets to support public hospitals, the hospitals are required to cross-subsidize any expenses incurred by patients falling within the category of uninsured populations. Surplus budgets gained from public insurance schemes, such as the Civil Servant Medical Benefit Scheme, SSS, CMHI or private health insurance schemes, could be used to subsidize those who request hospital exemption due to an inability to pay. However, it is noted that cross-subsidizing would be difficult to implement in hospitals with few patients holding certain health insurance such as registered migrants or members of the Civil Servant Medical Benefit Scheme or SSS.

3.2.5 International donors

Various NGOs deliver both health and other social programs in the migrant populated provinces of Samut Sakhon, Ranong, Tak and Kanchanaburi. The majority of these programs receive financial support from international donors and organizations. All international financial support comes with specific objectives and a core set of activities. Health programs operated by NGOs include the provision of basic health services, particularly the prevention and treatment of communicable diseases such as tuberculosis and HIV / AIDS.

The Mae Toa Clinic located in Mae Sot district of Tak province is operated by volunteer doctors from Myanmar and several other countries. The clinic plays a critical role in providing care to unregistered migrant workers and cross-border patients from Myanmar. The clinic has been relieving the enormous burden of service overloads from Mae Sot General Hospital. This is demonstrated by the 79,096 caseloads registered in 2006, including 8,876 admissions to inpatient departments and 107,137 consultations registered in all Mae Tao Clinic departments (Mae Toa Clinic, 2006). The caseload of Mae Toa Clinic was half that of registered caseload in Mae Sot General

Hospital in 2006. However, if services provided to migrant workers were the only factor considered, the registered caseload of Mae Toa Clinic was found to be greater than the 6,613 inpatient admissions and 33,934 outpatient visits of Mae Sot Hospital. It must be noted that approximately half of Mae Tao Clinic's caseload are categorized as cross-border patients. Mae Tao Clinic's total expenditure recorded for 2006 was 54.89 million Baht. This figure is significantly higher than exemptions (to the value of 44.5 million Baht) sought from migrant workers attending Mae Sot Hospital in the same year.

Médecins Sans Frontières (MSF) and World Vision Foundation of Thailand (WVFT) are prominent NGOs operating in provinces with large communities of migrant workers. MSF provides health care and training to health workers to enable them to treat migrants and stateless / displaced persons in border areas and in Myanmar. WVFT has established a clinic in Ranong which provides health care to migrant workers. Both NGOs place an emphasis on treatment and control of communicable diseases including tuberculosis and HIV and AIDS. The financial and caseload capacity of these two NGOs is much smaller scale than that of Mae Toa Clinic.

In addition, there are quite a few other international organizations and NGOs who provide a vast amount of basic health care such as first aid, family planning, perinatal care, child immunization and growth monitoring, as well as a variety of health education and health promotion activities to migrant rich communities.

3.3 Trends in healthcare financing for migrant workers

The three primary financing sources for curative care of migrant workers are Compulsory Migrant Health Insurance (CMHI), hospital exemptions, and out-of-pocket payments (OOP) (Figure 1). Revenue and expenditure of each scheme was calculated based on data and available reports⁷ from all provinces. In 2004, 65 provinces reported to the MOPH on service provision, cost and utilization to migrants. By 2005, the number of provinces reporting on service provision decreased to 46, and 47 in 2006. CMHI revenue was calculated by multiplying the number of registered migrant workers with per capita budget for curative care, at 964 Baht per person⁸. Revenue from OOP was extracted from the same reports. In relation to hospital exemptions, figures were calculated by subtracting the total hospital exemption for unregistered migrants from the excess revenue of CMHI⁹.

The CMHI scheme plays a major role in financing health care for migrant workers; however, a decline in the number of registered migrants has reduced its role. CMHI revenue accounted for 75% and 79% of all financing sources in 2004 and 2005 respectively, but this figure reduced to 60 % in 2006.

Hospital exemption plays an important and growing role in financing health care for unregistered migrant workers who are unable to afford medical services. In 2004 and

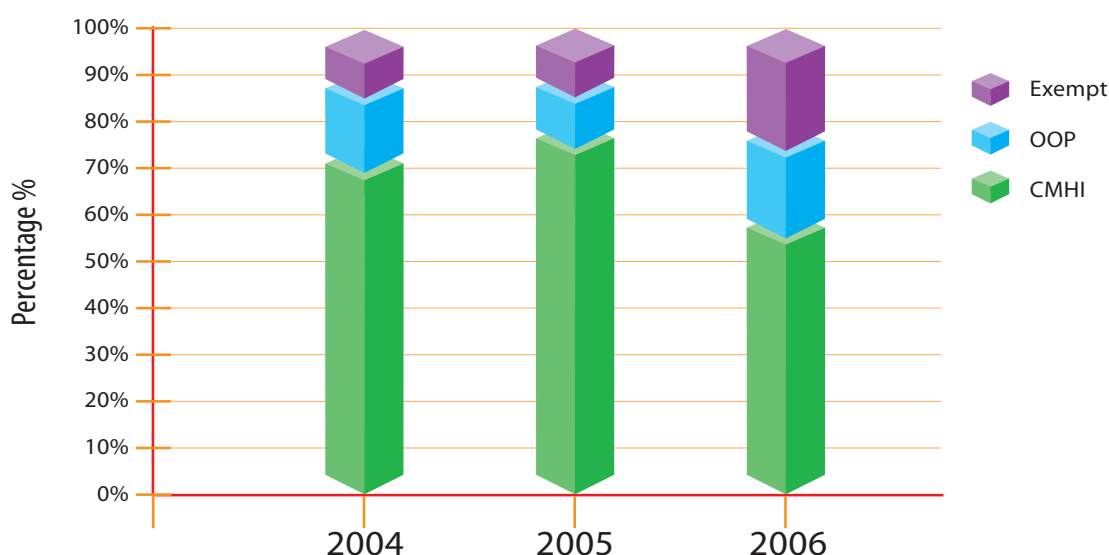
⁷ The routine report on migrant worker service provision includes number of registered migrants; number of outpatient visits and expenses; and number of inpatient admissions, duration of stay and expenses for registered migrants. For unregistered migrants, both out-of-pocket payment and hospital exemptions were included.

⁸ The remainder of the 1,300 Baht is 206 Baht for prevention and promotion services and 130 Baht for administrative cost.

⁹ Excess revenue of CMHI = CMHI revenue ÷ total charge of services provided to registered migrant workers.

2005, the hospital exemption accounted for only 8-9% of all financing sources, but increased to 21 % in 2006. It should be noted that all hospitals provide an exemption for uninsured migrant workers who are unable to pay¹⁰; however, only those hospitals with expenses greater than revenue - when providing services to both registered and unregistered migrant workers¹¹ - were included in the calculation for total magnitude of hospital exemption. This approach was used because all public hospitals are not-for-profit organizations, and therefore, excess revenue collected from registered migrant workers should be used to subsidize the costs of services being exempt for the unregistered migrants. Underutilization of services among the CMHI members results in many hospitals collecting excess revenue from members. If the cost of services exempt by each hospital exceeds the revenue collected from registered migrant workers, such costs would be documented as exemption provided by sources other than the hospital. In light of this, it is likely that these calculations underestimate the magnitude of hospital exemptions.

Figure 1. Financing sources for curative care of migrant workers, 2004 - 2006



Note: Calculations were made based on available reports on migrant health services from 65 provinces in 2004, 46 provinces in 2005 and 47 provinces in 2006. The data in 2007 was not included in this figure since there are only reports from nine provinces available.

The OOP accounted for 17% of health care financing for unregistered migrant workers in 2004, and reduced to 12% in 2005, however increased to 20% in 2006. The increased role of OOP and hospital exemptions could be best explained by a reduction in the number of registered migrants, which is reflected by the increase in unregistered migrants.

Public Voluntary Health Insurance has a minimal role in financing health care for migrant workers and in fact potentially faces financial risk due to the classic problem of

¹⁰ Total exemptions reported hospitals each year were 96.38, 132.65, and 170.17 million Baht in 2004, 2005 and 2006, respectively.

¹¹ This equates to revenue from CMHI subtracting expenses of service provision to both registered and unregistered migrants of each province which reduced the amount of exemptions to 46.55, 64.31 and 125.89 million Baht in subsequent years.

selection bias. This refers to the selection process of each member to participate in Public Voluntary Health Insurance, whereby it is more likely that people with serious or chronic diseases will join the voluntary insurance scheme rather than people with good health status.

The actual role of international support varies from province to province though it is clearly significant in border areas such as Mae Sot district of Tak province. International support is, however, usually accompanied by specific objectives and activities, and for this reason, the extent of international agency contribution across the country, as well as in the four studied provinces, was not explored in detail.

3.4 Summary

Compulsory Migrant Health Insurance (CMHI) is a primary financial source of migrant workers' health care. However, its role has been declining as a result of the decreased number of registered migrant workers. Dependence on hospital exemptions financing health care for migrant workers has increased significantly as have OOP expenses.

The CMHI was established through the MOPH's effort to relieve the financial burden of public hospitals. This is partly achieved by providing curative care to migrant workers as well as supporting public hospitals to provide active health prevention and promotion services. In general, however, some of the major issues of concern raised among policy makers have focused on locating and securing sufficient budgets to finance hospitals, rather than focusing on equitable financing of health care for migrant workers.

At present, Thailand delivers universal health care coverage to Thai people. The government considers that all Thai people are covered by one of the various public health insurance schemes and that it is not necessary to allocate extra budgets apart from the insurance funds. In light of this, exemption must be supported by the hospitals' own revenue sources. As a consequence, hospitals with limited revenue generating capacity outside the existing health insurance schemes inevitably face obstacles when subsidizing health service costs for migrant workers.



4. Policy Implementation: Healthcare financing for migrant workers and stateless / displaced persons

This section describes the perceptions of health sector personnel in relation to migrant workers and stateless / displaced persons. It also considers how migrant workers and stateless / displaced persons cope with their health problems and financial difficulties, how the CMHI scheme has been implemented and what other possible financing options are available for these sub-populations. Data informing this section is from in-depth interviews with health managers and administrators, focus group discussions with migrant workers and related literature reviews.

4.1 Attitude towards migrant workers

A variety of attitudes toward migrant workers were identified from health administrators and managers in the four studied provinces and the MOPH.

"Migrant workers are inevitable and are needed in the current economic system".

It was well recognized by all interviewed health managers and administrators that the presence of migrant workers is inevitable due to the disparity in economic development between Thailand and its neighbouring countries. Thailand's economy has grown significantly faster than other countries in the region; attracting many people from neighbouring countries to migrate and fill particular gaps in the labour force. Fishing and fishery industries - frequently classified as '3D jobs' difficult, dangerous and dirty - are examples of the type of employment generally refused by Thai workers. Nevertheless, this is one of the largest industries in Thailand, demanding enormous labour force, and therefore, calling out for labour sources from neighbouring countries. Even though the government attempts to restrict incoming migrant workers, it is recognized that inappropriate regulation and porous borders between Thailand and neighbouring countries inhibit the restriction and as such the number of migrant workers continue to increase.

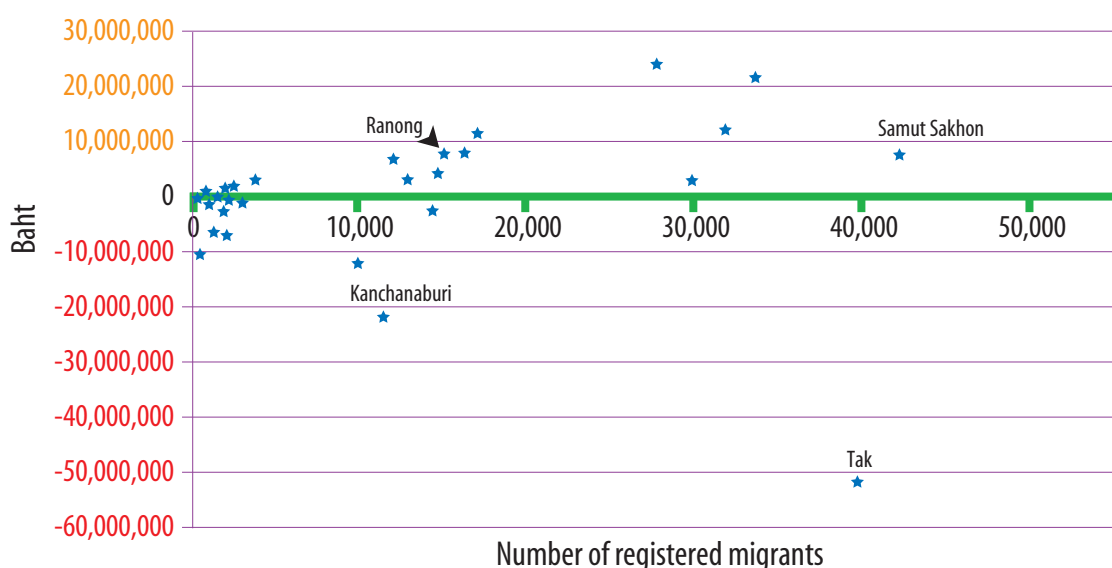
"Deporting all migrant workers back to their countries may collapse our local economy".

Local economies of the studied provinces are dependent on migrant workers, particularly in relation to production and consumption. Local industries and businesses employ considerable numbers of migrant workers who are visible in local retail shops, restaurants and hotels of the studied provinces; in addition to those in general households doing domestic work. Furthermore, it was found that migrant workers in the studied provinces make up between 10% and 50% of the local populations; evidently contributing to a substantial part of the consumer market.

"Migrant workers are income generators for some hospitals".

Due to the relatively low member service utilization of the CMHI scheme, provinces with large numbers of registered migrants benefit financially from the scheme, even when taking into account the financial loss experienced through hospital exemptions (as shown in Figure 2). This is particularly the case in areas where there are over 10,000 registered migrants. One health administrator asserted that the CMHI scheme is an additional income generator for hospitals to subsidize any deficits from the UC scheme, particularly for those with greater numbers of registered migrant workers. Samut Sakhon province is a good example of this. The province continues to attain financial surplus, even when hospital exemptions are taken into account. However, a very different scenario can be found in hospitals along border areas, i.e. in Tak, Kanchanaburi, Trad, and Chaing Rai provinces. Significant hospital exemptions explain the various deficits in these provinces. In 2006, Tak province recorded a deficit of over 50 million Baht in providing health care services to migrant workers while Kanchanaburi province recorded a 22 million Baht deficit in the same year.

Figure 2. Financial status of selected provinces providing services to migrant workers by number of registered migrant workers in 2006



Source: MOPH reports from 47 provinces on health services for registered and unregistered migrant workers in 2006

Note: Financial status represents the balance between revenue from CMHI and expenses of providing services to registered migrants and hospital exemption to unregistered migrants (Financial status = CMHI revenue - (CMHI expense + hospital exemption)).

"Access to basic health services among migrants is crucial".

All interviewed health administrators and managers recognized the need to provide basic health services to migrant workers. However, their primary concerns were focused on controlling communicable diseases rather than the provision of accessible

care for migrants. All health administrators and managers advised the view that migrant worker registration is vital to providing essential and preventative services in order to control various communicable diseases. A major obstacle to registration and effective service provision is the fact that unregistered migrants regularly change work and place of residence.

4.2 Coping with health problems and medical expenses

Self-medication remains a common method of treatment when migrant workers are ill, even when they have CMHI coverage. Such practices result in relatively low utilization of the scheme, particularly the use of outpatient care. Language and cultural barriers are reported by migrants to be major problems, even though translators are available in many hospitals. Health system service provision in public hospitals can be complex and is often divided into various stages and departments, for example registration, outpatient, laboratory, radiology, pharmacy and accounting. It is unlikely that the few translators who work at the hospital will be able to assist with translation throughout the various stages. In addition, the absence of legal status causes migrants to feel insecure and estranged, and as such they try to avoid leaving their living and/or working environments to seek health care and other services. Furthermore, many migrants are not familiar or aware of their rights to access basic health care.

Obtaining care from Mae Tao Clinic for those residing in Mae Sot District is also common. The clinic is a preferred destination to receive care, even for those with CMHI, due to reports that there are less language and cultural barriers;

"...I usually go to get care from Mae Tao Clinic. ...because I can easily communicate with people in there in my language and I feel it is friendlier".

A migrant who participated in a focus group discussion in Mae Sot District

Both registered and unregistered migrant workers who require services which are not covered by the CMHI, for example work-related injuries, must spend OOP when receiving care. Hospital exemptions come into play when migrant workers are unable to pay. In addition, many migrants residing in Mae Sot district prefer to receive health care from Mae Toa Clinic, mostly because the clinic charges a relatively small fee which is more affordable and beneficial for patients who pay out of their own pockets.

Stateless/ displaced persons, who were previously covered by the Low Income Scheme prior to the introduction of the UC scheme, are no longer covered by any public insurance scheme. Despite this, stateless / displaced persons often receive free health care from public health centres because local health personnel know that they are poor, and therefore exemptions are often provided to them. The payment of medical bills is required when receiving hospital care; however, many stateless / displaced persons have learnt that after paying only a portion of the bill, the rest of the fee is often exempt as one person describes below.

"...when my mother was admitted in Mae Sot hospital, a medical bill was delivered to me every one - two days and I learnt that I have to pay some of it first before asking for an exemption. So, I reserved my money to pay a part of the bills so that I could ask the hospital to exempt the rest for me without difficulty".

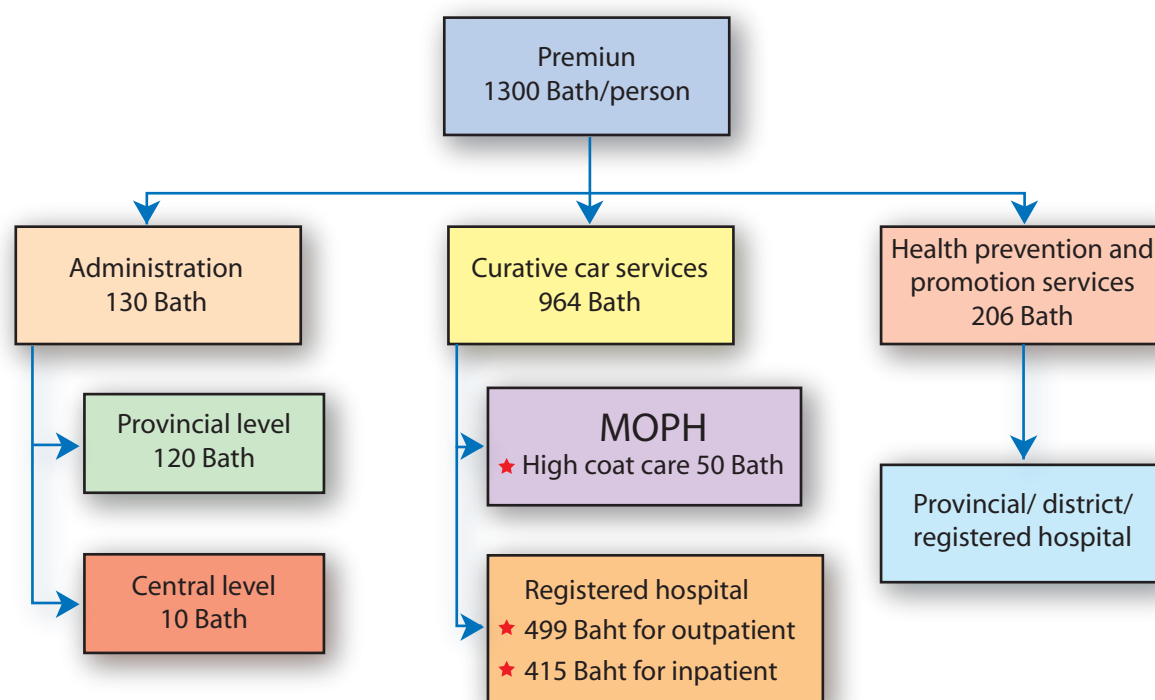
A stateless woman who participated in a focus group discussion in Mae Sot District

There were no issues raised in relation to exorbitant expenditure or inaccessibility to adequate care by any focus group participants.

4.3 Management of the CMHI funds

The MOPH's Bureau of Health Service System Development and Department of Disease Control provide guidelines to the provinces to implement the CMHI program. For example, the type of services covered by the scheme and fund allocation and management. In addition, the Health Financing Office, under the Permanent Secretary Office of the MOPH, manages high cost care funds. CMHI funds are mainly managed by the Provincial Health Office. The Provincial Universal Health Coverage Committee has been established to avoid duplication of work, set criteria and to administer the program. Funds are allocated according to principles of the UC scheme, as shown in Figure 3.

Figure 3. Allocation of the Compulsory Migrant Health Insurance Funds



Source: MOPH financial management guidelines

Ten percent of the budget, or 130 Baht per card, is allocated to administration. The majority of this (120 Baht) is distributed to the Provincial Health Office and the remainder, 10 Baht, is allocated to the Department of Medical Services at the MOPH in Bangkok. The remaining 10 Baht per card is allocated to the Bureau of Health Service System Development at the MOPH. The Provincial Health Office is able to use this budget allocation to strengthen the existing system, for example a migrant health unit could be established, a migrant health information system could be developed, or more personnel and translators could be employed to support hospitals.

Nine hundred and sixty four (964) Baht is allocated to curative services with 50 Baht being reserved at the central level for high cost care. The remainder of the funds is allocated to hospitals where migrants are registered for their outpatient and inpatient care. The Diagnosis Related Group (DRG) system is adopted for referral cases across provinces to pay for inpatient care at the flat rate of 10,300 Baht per weight of DRG. A fee-for-service system is adopted to pay for outpatient care according to the actual charges of the hospital providing care. However, payment within the province is subjected to the agreement made by the provincial committee.

Two hundred and six (206) Baht is allocated to health promotion and prevention services for migrant workers within the province. In 2004, the first year of its implementation, most Provincial Health Offices who administer this portion of the budget requested hospitals and District Health Offices to submit proposals in order to receive budgets for health promotion and prevention in their catchment areas. Later, the Provincial Health Offices allocated most of these budgets to registered hospitals to provide the health promotion and prevention services in both the health facility and in the community and reserved the remaining budget at provincial level. For example, Samut Sakhon Provincial Health Office allocates 80 Baht per card to hospitals for prevention and promotion services in health facilities, a further 96 Baht per card for the same services in the community, and reserves 30 Baht per card at the Provincial Health Office. To use the reserved budgets at the Provincial Health Office, hospitals or District Health Offices must submit proposals for approval. Tak Provincial Health Office directly allocates 50% of the budget to registered hospitals and the remaining budget requires a proposal from those who would like to access the funds.

Hospitals that provide outpatient and inpatient care that meets the criteria of high cost care to CMHI beneficiaries can be directly reimbursed from the reserved high cost care budgets. This mechanism acts as a reinsurance policy to protect hospitals from financial bankruptcy when providing high cost services. It also provides incentives to facilitate necessary high cost services to migrant workers by reducing the hospitals' financial risks.

The criteria of high cost care has been adopted from that of the UC and SSS schemes. The criteria of high cost care include:

- Inpatient cases with relative weight of DRG equal to or greater than four (reimbursement by DRG with a flat rate of 10,300 Baht per weight),
- Specific inpatient case regardless of the relative weight of DRG - for example

cancer patients receiving chemo or radio therapy, head injuries requiring craniotomy, open heart surgery, coronary artery bypass, percutaneous balloon vulvuloplasty, unhealthy newborn babies (reimbursement by DRG with a flat rate of 10,300 Baht per weight),

- Specific treatments such as chemo or radio therapy, treatment of cryptococcus meningitis in AIDS patients and peritoneal or hemodialysis in acute renal failure patients (reimbursement according to a price list set by the MOPH), and
- Apparatus and prosthesis (reimbursement according to a price list set by the MOPH).

There were 366, 502, and 914 high cost cases in 2005, 2006 and 2007 respectively. The number of cases and high cost care amount reimbursed in 2005 was far below actual revenue. However, the amount has been steadily increasing since then, as shown in Table 4. In 2005, only 5% of high cost budgets were reimbursed, but this increased to 30% and 73% in 2006 and 2007 respectively, despite the decrease in the recorded number of CMHI members.

Table 4. Revenue and reimbursements of the high cost care funds, 2005 - 2007

Category	2005	2006	2007
Revenue (Baht)	44,159,340	30,411,900	21,721,478
Number of patients approved for high cost care	366	502	914
- Outpatient	NA	91	222
- Inpatient	NA	411	692
Cost reimbursements (Baht)	2,294,277	8,958,417	15,796,429
Percentage of high cost reimbursement to revenue	5.2%	29.5%	72.7%

Source: Health Financing Office, MOPH

The 2005 data framework demonstrated that details of high cost services were recorded differently to the data frameworks of 2006 and 2007, and therefore they could not be analyzed in detail. Accordingly, this section primarily explores details of high cost services provided to migrant workers in 2006 and 2007. There were 631 and 974 claims submitted to the MOPH for this matter in 2006 and 2007. However, only 80% and 90% were approved in the subsequent year to meet the high cost care criteria for reimbursement. The majority of reimbursements, 75-80%, were for inpatient care.

The average reimbursement per outpatient visit was almost 3,000 Baht in 2006 but only about 1,650 Baht in 2007 (Table 5). The relatively high reimbursement payment per outpatient care visit in 2006 was due to highly skewed reimbursements. During this period there were a few cases with extremely high reimbursement figures. This accounted for a high standard deviation of mean reimbursement per visit. Reimbursement per outpatient visit ranged from 153 - 71,700 Baht in 2006 as compared with 200 - 4,000 Baht in 2007.



Both average reimbursement of inpatient cases and the adjusted relative weight of DRG¹² in 2007 were slightly greater than that of 2006. The average reimbursement per inpatient admission in 2006 was 21,135 Baht as compared to 22,297 Baht in 2007, while the adjusted relative weight of DRG in 2006 was 2.52 as compared to 2.64 in 2007. The average duration of high cost hospital stay cases in 2006 and 2007 was 11.7 and 11.4 days respectively. Changes in the disease profile, DRG groups, and management of the hospitals are possible explanations of the slight decline in the number of hospital stays.

Table 5. Average reimbursement, average adjusted relative weight, and average days of hospital stay per high cost case, 2006 - 2007

Category	Per outpatient visit		Per inpatient admission	
	2006	2007	2006	2007
Average reimbursement (Baht)	2,988 (SD=7,374)	1,651 (SD=1,244)	21,135 (SD=32,630)	22,297 (SD=36,463)
Average adjusted relative weight	Not applicable	Not applicable	2.52 (SD=2.46)	2.64 (SD=2.84)
Average number of admission days	Not applicable	Not applicable	11.7 (SD=17.1)	11.4 (SD=18.9)

Source: Health Financing Office, MOPH

The disease profile of high cost cases for nearly all outpatient reimbursements were for the treatment of malignant neoplasm (79% in 2006 and 99% in 2007) and several types of cancers e.g. breast, cervix and larynx. The majority of inpatient high cost cases were injuries as shown in Table 6. Seventy percent of high cost reimbursements of inpatient care were for those with injuries in 2006, but this figure declined to 65% in 2007. Neoplasm was the second most common reimbursement disease category which accounted for 10% of high cost inpatient cases in 2006, and 16% in 2007.

¹² The relative weight of DRG which has been adjusted by number of admission days

Table 6. Number and percentage of high cost inpatient cases by disease group, 2006 - 2007

Category	2006		2007	
	Number	Percent	Number	Percent
Infectious diseases	8	1.9	12	1.7
Neoplasm	41	10.0	113	16.3
Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	1	0.2	0	0.0
Endocrine, nutritional and metabolic diseases	1	0.2	0	0.0
Diseases of the nervous system	2	0.5	1	0.1
Diseases of the eye and adnexa	19	4.6	34	4.9
Diseases of the circulatory system	14	3.4	31	4.5
Diseases of the respiratory system	0	0.0	1	0.1
Diseases of the digestive system	10	2.4	14	2.0
Diseases of the musculoskeletal system and connective tissue	19	4.6	23	3.3
Diseases of the genitourinary system	1	0.2	2	0.3
Pregnancy, childbirth and the puerperium	1	0.2	0	0.0
Congenital malformations, deformations and chromosomal abnormalities	2	0.5	6	0.9
Injuries, poisoning and certain other consequences of external causes	285	69.3	451	65.2
Factors influencing health status and contact with health services	7	1.7	4	0.6
Total	411	100	692	100

Source: Health Financing Office, MOPH

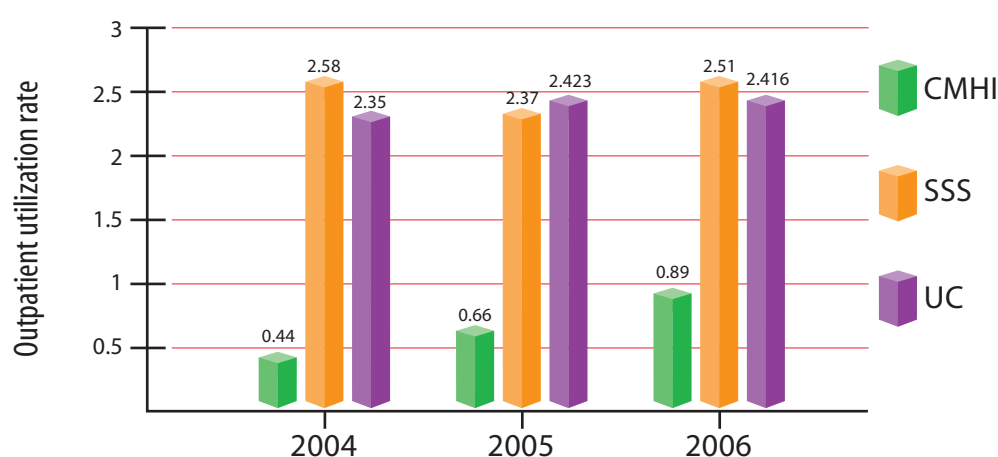
5. Performance of Compulsory Migrant Health Insurance

This chapter explores service utilization and cost of services provided to migrant workers; compulsory migrant health insurance (CMHI), hospital exemption, and out-of-pocket payment (OOP). The national database informed the analysis by representing national figures. The data is based on regular reports from hospitals and provincial health offices to the Bureau of Health Service System Development of the MOPH. It should be noted that the number of provinces reporting to the MOPH has declined over time from 65 to 46, 47, and 9 provinces between 2004 and 2007. Since the available data from 2007 is very limited, only the 2004 - 2006 databases were analysed and discussed in this study.

5.1 Utilization and costs of outpatient and inpatient services

The utilization of outpatient services by CMHI members was still far below that of the SSS¹³ and UC members. However, an improvement in access and uptake of benefits under the CMHI scheme is observed as shown in Figure 4. Outpatient service utilization by registered migrant workers increased from 0.44 visits / person / year in 2004 to 0.66, and 0.89 visits / person / year in 2005 and 2006 respectively. These figures were still less than half of the national figures detailing members of SSS and UC schemes in the same report years.

Figure 4. Outpatient utilization rate under different health insurance schemes, 2004 - 2006

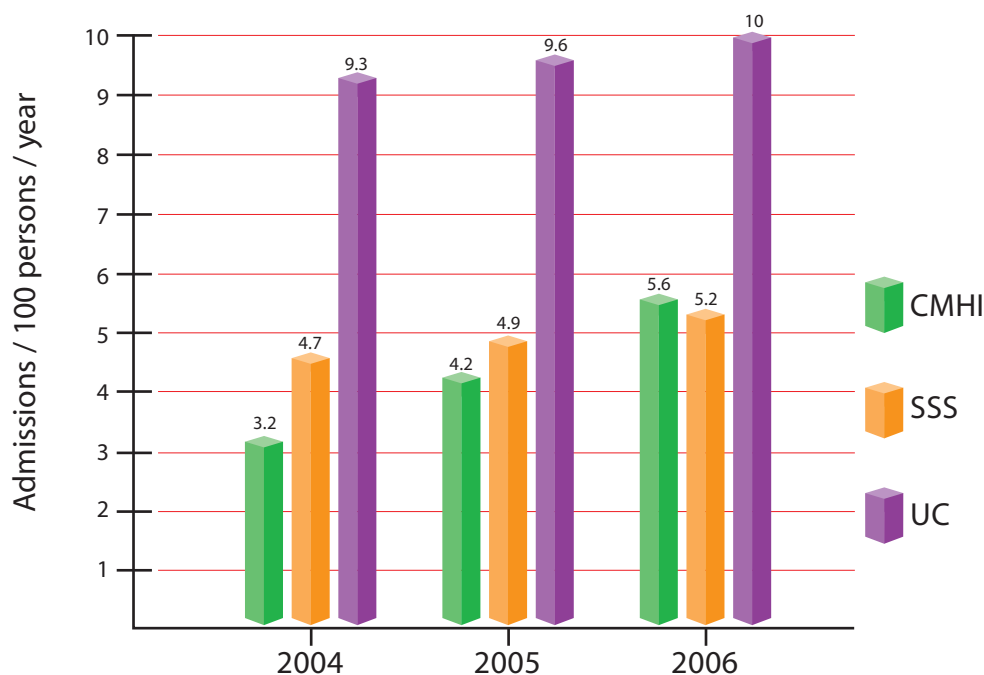


Source: MOPH, Social Security Office and National Health Security Office

¹³ These figures represent overall utilization rate of SSS members including both Thais and non-Thais workers.

Improvements in access to inpatient care among registered migrant workers are also observed. Hospitalization rates of the registered migrants holding CMHI cards were only 3.2 admissions / 100 persons / year in 2004, and increased to 4.2 and 5.6 admissions / 100 persons / year in 2005 and 2006 respectively (Figure 5). As identified in the outpatient case, the hospitalization rate of CMHI members was lowest when compared with that of the UC and SSS schemes. Nevertheless in 2006, the increase in benefit uptake among CMHI card holders resulted in a greater hospitalization rate of CMHI compared to that of SSS. The hospitalization rate of SSS members in 2006 was only 5.2, compared to 5.6 admissions / 100 persons / year among the CMHI members. UC scheme members have always had the highest admission rate of 9.3 - 10 admissions / 100 persons / year between 2004 and 2006.

Figure 5. Hospitalization rate (admissions / 100 persons / year) under the different health insurance schemes, 2004 - 2006



Source: MOPH, Social Security Office and National Health Security Office

Health services provided to migrants who are members of the CMHI scheme are not limited to those within the province they are registered. Migrant patients who require advanced medical care and cannot be treated in their registered hospitals are referred to hospitals at a higher level either within or outside the province. By law, registered migrant workers must stay and work within the province they are registered; however, the hospital can request permission from the Provincial Governor to refer the patient to a hospital outside the province. Cases which meet the criteria of high cost care can be reimbursed by the MOPH from the high cost budget. An increase in the number and expense of high cost services was observed during 2005 - 2007, as shown in Table 4 of the previous chapter. This suggests an improvement in access to most needed health services.

5.2 Health promotion and prevention services

Compared to curative care, health workers are more active in providing health promotion and prevention services to both registered and unregistered migrant workers. This is primarily because they are particularly concerned with controlling communicable diseases. All registered migrant workers receive health screening and treatment of communicable diseases such as malaria, tuberculosis, leprosy, and microfilaria. Antenatal care is also provided to all migrant pregnant women regardless of their registration status, in addition to the immunization of children aged below five years. In migrant populated provinces such as Samut Sakhon, a migrant health unit has been established in collaboration with IOM to address the health issues of migrants, as well as to collect and record information on migrant health. Many provinces also train and hire migrant community health workers and volunteers to assist care providers in delivering appropriate and acceptable health information and care to migrants. Some provinces also conduct community outreach to provide health prevention and promotion services such as perinatal care, vaccination campaigns, and health education/communications. In addition, international organizations such as IOM provide additional funding and technical support to local public health staff for health promotion and prevention services. A variety of NGOs also provide these services in migrant populated areas.

More than 10,000 babies were born to both registered and unregistered migrants as shown in Table 7, and the majority, (over 90%) were delivered by health personnel within health facilities. Analysing the number of migrant children under five who have received immunization suggests there are a significant number of dependents residing in Thailand without insurance.

Table 7. Number of migrant live births, safe deliveries, and children receiving vaccination, 2004 - 2006

Category	2004	2005	2006
Number of live births	10,012	11,836	11,545
Number of deliveries attended by health personnel	9,145	11,081	10,455
Number of children aged under five years received vaccination through the Expanded Program for Immunization (EPI)	11,880	12,870	11,608
Number of children aged under five years received Polio vaccines (2 doses) during the national campaigns	45,521	51,720	59,334

Source: Migrant health reports of MOPH which cover 65 provinces in 2004, 46, and 47 provinces in 2005 and 2006 respectively.

Information gathered during interviews with health managers in the four provinces consistently indicated that the CMHI prevention and promotion benefit package is similar to that of the UC scheme, apart from the provision of vaccines against Hepatitis B and Japanese Encephalitis viruses. According to information provided by key informants in the four studied sites, the Hepatitis B virus vaccine is only administered to migrant children born to maternal carriers. The Japanese Encephalitis virus vaccine is provided in very rare circumstances. This is the case even though both types of vaccine are covered by the national Expanded Program for Immunization, which aims to

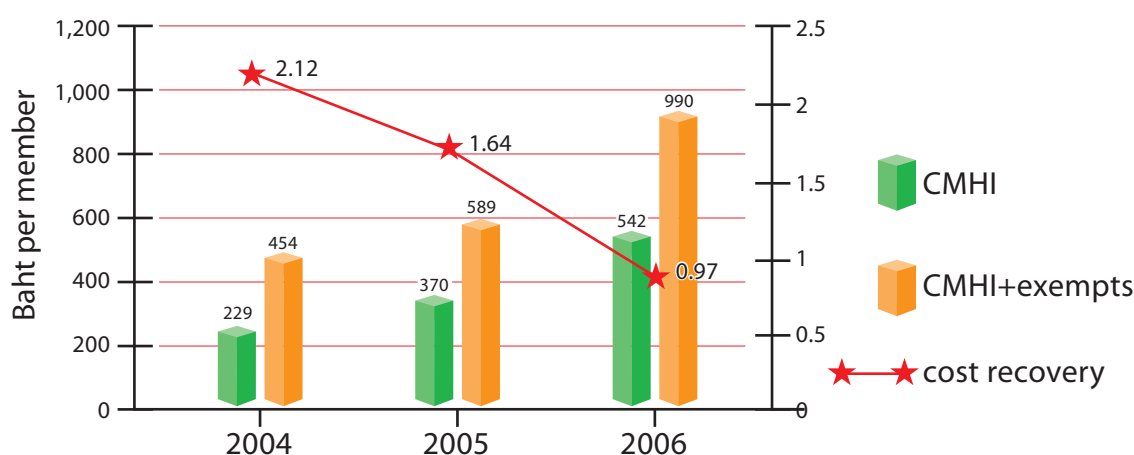
provide basic essential vaccinations to all children in Thailand regardless of their status. Additionally, antiretroviral therapy is provided by CMHI to expectant migrant women who are HIV positive in order to prevent mother-to-child transmission.

It is not clear as to why Hepatitis B virus and Japanese Encephalitis vaccinations, although included on the MOPH's basic essential vaccine list, are not provided to all children of migrant workers. It could be that, instead of purchasing the vaccines, the provinces use vaccines provided by the MOPH under the UC policy to vaccinate all children in the provinces. If this is the case, it indicates that there is a cross-subsidy from the UC scheme to migrant populations. However, due to the relatively high cost of both vaccines, they may be limited in quantity and cannot, therefore, be provided to all¹⁴.

5.3 Cost of health services provided to migrants and cost recovery¹⁵

Outpatient and inpatient service utilization and costs identified that on average the expense of curative services provided per registered migrant in all three years remained less than total collected revenue¹⁶. Average expense per person per year in 2004 - 2006 was only 229, 370, and 517 Baht respectively whilst the per capita budget for curative care per person per year was 964 Baht. If all exemptions per unregistered migrants were assumed as expenses of the scheme, average expense per member per year would increase to 454, 589, and 966 Baht respectively. In relation to the latter, the cost recovery¹⁷ ratio of the program was greater than 1 in 2004 and 2005 but consistently dropped to only 0.97 in 2006 as shown in Figure 6.

Figure 6. Curative care cost per member and cost recovery of migrant health insurance, 2004 - 2006



Source: MOPH

Note: Cost recovery = Curative care budget (964 Baht / person) - (CMHI expenses + total hospital exemption for unregistered migrant workers)

¹⁴ Prior to the introduction of the UC policy, the EPI budget was fixed under the MOPH to include all children regardless of their nationality; however, following to the UC policy, the budget has been fixed under the UC scheme. This is interpreted as involving organizations that only cover Thais, hence the quantity of vaccines are calculated based on the number of Thai children.

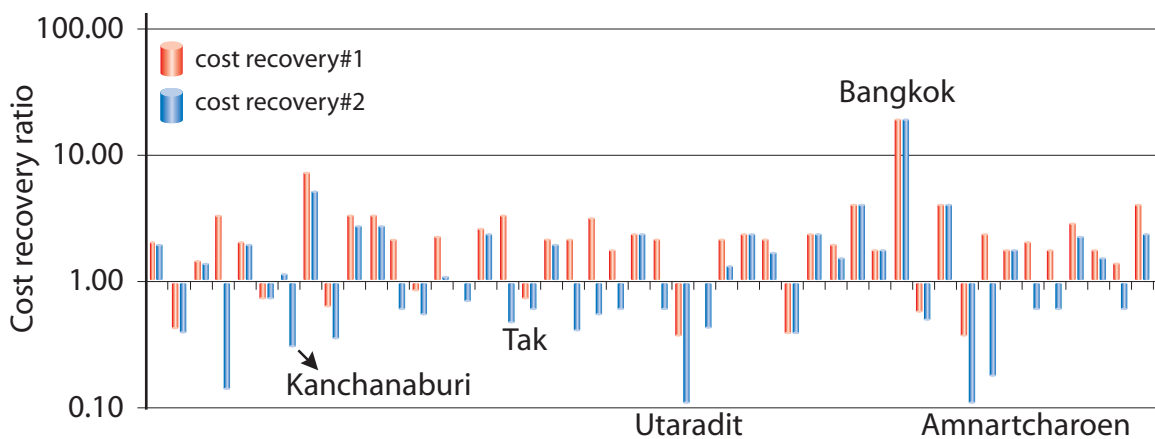
¹⁵ Charges of services provided to migrant workers are assumed to represent costs. In addition, the analysis is limited to expense incurred from health care utilization of both registered and unregistered migrant workers. This is because reporting on service utilization and charges for stateless / displaced persons are not available.

¹⁶ Only 964 Baht per member was taken in the calculation for revenue of curative care.

¹⁷ Cost recovery is calculated by dividing curative revenues of the scheme by costs of services provided to both registered and unregistered migrants who received hospital exemption.

However, cost recovery of service provision to migrant workers varies from province to province, depending on their local context. For example, the number of registered migrants workers, location of the hospital particularly its proximity from the border area and the migrant's ability to pay. When including the expense of services provided to registered migrants (cost recovery#1), 10 out of 47 provinces had a cost recovery ratio of less than 1 in 2006. The cost recovery ratio of another 14 provinces was less than 1 in 2006 when expense of services exempted for unregistered migrants were also included in the calculation (cost recovery#2). Among those with cost recovery#1 of less than 1, eight provinces were registered with less than 1,000 migrant workers. Among the 14 provinces with a cost recovery#2 of less than 1, five were registered with less than 1,000 migrants, three were registered with migrants greater than 10,000 persons but located in border areas, i.e. Tak, Kanchanaburi, and Chiang Rai. Therefore, the provinces with smaller numbers of registered migrants are more likely to result in a deficit. However, the three provinces had over 10,000 registered migrants thereby attracting a deficit due to being located in border areas.

Figure 7. Cost recovery ratio of services provision to migrant workers by province, 2006

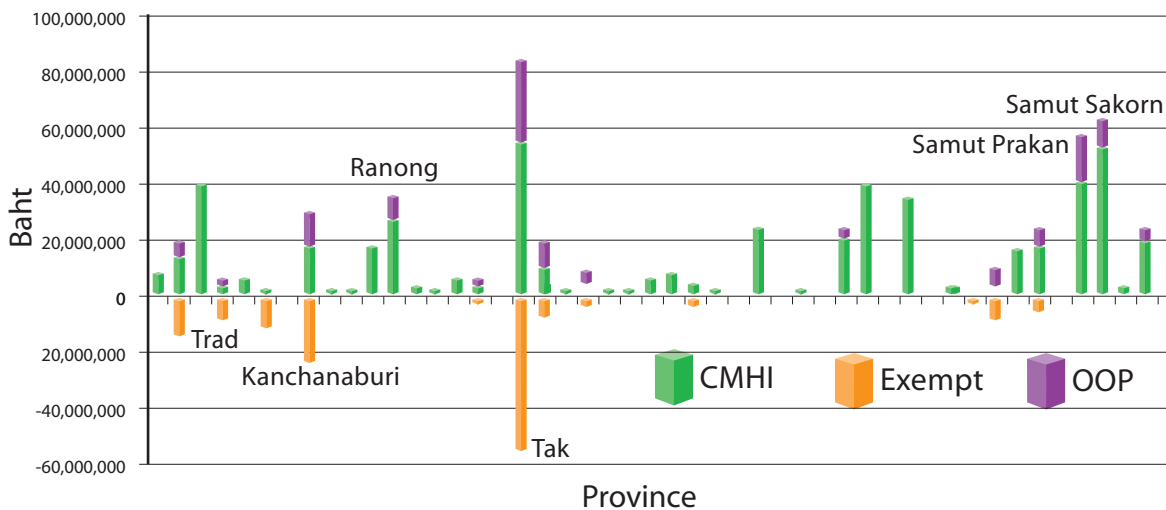


Note: Cost recovery#1 = revenues of CMHI (964 Baht/ person) / expenses on services provided to CMHI members
 Cost recovery#2 = revenues of CMHI (964 Baht/ person) / (expenses on services provided to CMHI members + exemptions for unregistered migrant workers of all hospitals in the province)

5.4 Financing health care for migrant workers by province

When balancing hospital exemption with excess revenue of the CMHI, there were three provinces Tak, Kanchanaburi, and Trad which were spending more than 10 million Baht to support services for unregistered migrants in 2006. Hospitals in Tak province spent the most compared to other provinces, reporting more than 50 million Baht in 2006. Hospitals in Kanchanaburi province faced the second greatest loss; spending about 22 million Baht in the same year. Trad province spent 12 million Baht in exempt medical expenses for unregistered migrants.

Figure 8. Financing health care for migrant workers by province, 2006



Source: MOPH

5.5 Summary

Following are major findings from this study:

- Access to health care for registered migrant workers under the CMHI has improved over time for both outpatient and inpatient services.
- However, outpatient service utilization rates by CMHI members were still far below those of the SSS and UC schemes. Self-medicating is common amongst migrant workers despite being in possession of a CMHI card.
- In relation to inpatient services, hospitalization rates of registered migrant workers were comparable with that of SSS. CMHI members also accessed medical referrals and high cost health services.
- Health promotion and prevention services are provided to both registered and unregistered migrant workers including their dependents. However, some expensive vaccines such as Japanese Encephalitis and Hepatitis B virus are not universally provided to migrant children.
- An increased health care utilization rate by CMHI members resulted in an increase in the cost of curative services provided to members, however the rate remains below that of the collected premium. If exemption for unregistered migrants were assumed as expenses of the scheme, overall costs of the scheme were greater than the curative budget in 2006.
- Cost recovery of the scheme varied from province to province, border provinces were more likely to experience a significant burden from exemptions for unregistered migrants as well as cross-country cases.

6. Health Care Financing Options for Migrant Workers and Stateless / Displaced Persons

This section begins with a discussion about current healthcare financing options for migrant workers and stateless/ displaced persons and concludes with recommendations.

6.1 Discussion

An increase in the number of migrant workers has resulted in both positive and negative consequences for Thailand. The influx of migrant workers provides an indispensable labour force to unfavourable industries in which Thai citizens prefer not to engage. Furthermore, migrant workers are estimated to contribute approximately 5% of total Thai GDP in addition to consuming a large proportion of the goods and services market. It is recognized by many health administrators and managers in the studied provinces that their local economies are dependent on migrant populations. Employers, business owners, local markets, government, by way of consumption taxes, and the Thai economy, are clearly all benefitting from the presence of migrant workers. Conversely, due to difficulties relating to social and economical exclusion, migrants can also be accountable for a variety of negative consequences including the re-emergence of communicable diseases and subsequent impacts on the social environment. An explicit registration policy would assist with addressing any negative consequences and facilitate efficient management of the migrant registration process, particularly when compared to the current practice of annual cabinet resolutions as a means to manage migrant registration.

However, due to an unstable migrant registration policy, in addition to an obstructed enforcement of the law, there has been an overall decrease in the number of registered migrant workers and an increase in unregistered migrant workers. Varying numbers of registered and unregistered migrants inevitably impacts on health care financing options for migrant workers. For example, a decrease in registered migrants results in reduced CMHI financing sources and subsequently a greater dependence on hospital exemption places which increases the financial burden on hospitals, particularly in border areas. Furthermore, the introduction of the CMHI scheme may result in improved attitudes of health administrators and managers toward migrant workers. This is particularly the case in provinces with large clusters of registered migrant workers, resulting in an increased potential for revenue to be collected from them. This study has confirmed that health administrators and managers recognise the need to provide basic essential health services to all migrant workers even though their primary concern is to control communicable diseases rather than to protect the basic health rights of migrants.

Access to health care under the CMHI scheme has improved over time among registered migrant workers. However, the utilization of outpatient care under the scheme is still

significantly lower than that of the UC and SSS schemes. Self-medicating is still more common among migrant workers compared to their Thai counterparts. The percentage of migrant workers choosing to purchase pharmaceuticals over the counter was recorded at 32% in 2003, compared to 12% of Thais in the same period (Isarabkakdi, P., 2004). Language and cultural barriers are possible explanations, although many hospitals provide a limited translation service. The complexity of service systems in large hospitals coupled with the few available translators is unlikely to effectively assist migrant workers throughout all stages of accessing and receiving care.

The comparable inpatient utilization rate of migrant workers against SSS beneficiaries suggests that once seriously ill, migrants are likely to take-up benefits from the CMHI scheme. The presence of a 'reinsurance policy' enables access to high cost care and referral to advanced medical services. Additionally, health promotion and prevention services are provided to all migrant workers regardless of their legal status. This is primarily due to concerns about preventing health problems, particularly infectious diseases. However, vaccines such as Hepatitis B virus and Japanese Encephalitis are not provided to migrants, even though they are part of the benefit package. This may be due to the high cost of the vaccines, and the lack of clarity around their impacts on the epidemic of the disease. In order to effectively control the two diseases, both vaccines should be provided to migrant children. Furthermore, it must be noted that the provision of health prevention and promotion services in migrant populated areas partly comes from funding supported by international organizations and various NGOs.

Stateless / displaced persons, on the other hand, have been living and working in Thailand for some time, notwithstanding the fact that many were actually born in Thailand. Stateless / displaced persons were previously covered by the Low Income Scheme on the basis that the majority are poor and usually reside in remote areas. Excluding this population group from the UC scheme because they do not have legal Thai status has resulted in much worse conditions today than in the past. Fortunately, many hospitals and health facilities recognize the issues and provide exemptions despite the fact there is no additional government budget allocated. Unfortunately, there is no reporting system in place which documents data relating to service provision or related costs, particularly in relation to the provision of health services to this population group. Ranong Province, for instance, administers voluntary health insurance with the same benefit package and price as the CMHI. This is an alternative for non-Thai populations who have been assigned a temporary identification number by the government; for example indigenous persons. However, it is identified this is a challenging scheme with low cost recovery due to selection bias as a result of it being voluntary membership.

Management and administration of the scheme is a further issue that must be addressed. There is no separation between health service provision and purchasing functions which may result in a conflict of interest. Hospitals retain the majority of curative budgets and distribute the budget for high cost care, health prevention, promotion and administration to the MOPH and the Provincial Health Office. There is no division between health service purchasing and health service provision under this scheme. Providers under CMHI are limited to those who are registered as service providers under the UC scheme. This is because the scheme is seen as an income generator for

hospitals, and therefore hospitals who contribute to the public system should benefit from this opportunity first. In practice, the majority of providers are MOPH hospitals and Bangkok Metropolitan Administration (BMA) hospitals. University hospitals do not enrol as main contracting providers and provide services to referred migrant patients only. A private hospital in Samut Sakhon province was the only private contracting provider of the scheme at the time the study was conducted; however, an additional private hospital in Bangkok has been recruited as a primary contractor in 2009. Limiting the scheme to MOPH and BMA hospitals almost certainly limits the choice and access to migrant workers, particularly within vicinity of Bangkok.

Given that the CMHI is an interim mechanism to support the impromptu labour migrant management policy, long term monitoring and evaluation of the scheme's performance for policy development may not be possible. A reduction in provincial reporting to the MOPH is a primary barrier to effective and informative monitoring and evaluation of the scheme. However, there is room for improvement, and it must be emphasized that monitoring and evaluation should be utilized to inform and strengthen planning around future migrant healthcare financing. Therefore all hospitals joining the scheme, both public and private, should be required to submit any CMHI related information to the MOPH. Moreover, although there is no data relating to service provision and associated costs incurred by private hospitals, it can be assumed that the hospital profits from this scheme on the basis of its for-profit business model. Therefore, there is potential for the active purchasing function to be strengthened as a whole.

6.2 Recommendations

Basic essential health services should be made universally accessible to individuals and families of Thais and non-Thais in order to improve the health and health security of the nation. Access to essential health care should be available according to an individual's needs rather than their ability to pay. To achieve this objective, all prepayment financing mechanisms should be prioritized over out-of-pocket payments.

In acknowledgment of the distinction between issues faced by stateless / displaced persons compared to unregistered migrant workers, separate healthcare financing options are proposed for each group.

6.2.1 Improving current CMHI and its management

Major concerns regarding CMHI include the institutional arrangements of the scheme and its management capacity, particularly the monitoring and evaluation component of the Management Information System. A reduction in provinces who regularly submit CMHI related reports to the MOPH suggests there is an urgent need to strengthen management and administration mechanisms. Furthermore, available data should be strategically organized to facilitate the extraction of information to enhance future performance. This should be a matter of priority as the absence of essential baseline data and documentation is likely to influence capacity to develop evidence-based policy.

Provincial Health Offices and the MOPH are responsible for both service provision and financing. This fact could potentially impair the accountability of the scheme. At the time of the study, there was neither mechanism in place to monitor migrant workers' access to essential health services nor any measure as to how the system responds to their expectations. In addition, the marginalized status of migrant workers limits their capacity to voice an opinion on the matter, despite their financial contribution to the scheme. Although the scheme's current level of expenditure is still far below the level of contribution, it must be highlighted that this is due to the under utilization of its beneficiaries. It is anticipated that, if there were mechanisms to monitor the scheme's performance, the utilization rate would increase to a similar level of the SSS scheme, particularly for outpatient care. Systemic accountability and transparency should be strengthened as a matter of priority. For example, a similar structure to the SSS scheme could be adopted to establish systemic management at both central and provincial levels.

Various departments within the MOPH are involved with issues relating to migrant health. Key departments include; the Bureau of Health Policy and Strategy who is responsible for migrant health policy development; the Health Financing Office who manages high cost care budgets; the Bureau of Health Service System Development who provides guidelines and collects reports from the Provincial Health Offices; and the Department of Disease Control who provides guidelines for disease control. A committee on migrant health has existed for more than five years; however, the committee acts as a coordinating body and there are only occasional meetings on the matter. This identifies the importance of establishing an official management board with representatives from relevant organizations. Such a board could facilitate coordination and policy development to address issues relating to migrant health. Consultation with health economists would also support future planning and implementation of the scheme.

A major priority in relation to the development of CMHI is to improve access to outpatient services in response to the low utilization rate. Providing adequate and acceptable information about; the benefit package, improving service conditions, and the provision of outreach services, would more than likely increase access to essential health services. In relation to costs, if utilization rates increase to the level that incurred costs exceed in revenue, then an increase in collected revenue and / or price of health services is required.

6.2.2 Healthcare financing for migrant workers

Of primary concern is healthcare financing for unregistered migrant workers and the unregistered dependents of both registered and unregistered migrants. However, it should be noted that the current CMHI indirectly subsidizes services provided to unregistered migrants and their dependents (and possibly other groups), particularly in provinces with large communities of registered migrant workers. The current system is totally dependent on individual hospital policies. Therefore, how well a hospital performs its functions depends on both their financial capacity and hospital policy. Instead of shifting all responsibility to hospitals, relevant government agencies and

the MOPH should take a stronger policy guiding and development role. Three recommendations are proposed to improve healthcare financing for migrant workers.

6.2.2.1 Allocating additional budgets to support hospitals

A lack of additional budgets for hospitals with negative financial balance¹⁸ will deter hospitals from assisting unregistered migrants who are unable to pay. Therefore, additional budget allowances are required to support hospital exemptions. The fundamental question is who should pay for the health care of unregistered migrant workers.

According to the current system, revenue collected from registered migrant workers and hospital revenue collected from alternative sources are the two primary service subsidizing funds for people who are unable to pay. The presence of migrant workers is enormously beneficial to Thailand's economy as well as various components of the community including employers, locals and local economies. Theoretically, those who benefit most from the presence of migrants should pay for their healthcare. In light of this, it is recommended that; employers who profit from employing low-paid workers; local communities who profit from expanding local economies through migrant worker contributions and consumption; local government who benefit from profits made in local taxes; and the central government who benefits significantly from general revenue raising as a result of value added taxes and export taxes all fall within the category of constituents who should redistribute their profits to the community to finance migrant healthcare. Furthermore, given that some of the components of exemption derive from foreign patients who have crossed the border, the responsibility of neighbouring countries and perhaps international organizations should also be taken into consideration.

In light of the above information, additional healthcare financing budgets are required from both government and employers to facilitate access to appropriate healthcare for unregistered migrant workers. In fact, given that those who benefit from the presence of migrant workers already pay taxes either directly or indirectly; a simple approach to support this recommendation could be through general government revenue.

A feasible source of financing healthcare for unregistered migrants could be revenue collected from government registration fees. One thousand eight hundred Baht is collected per person, half of which is allocated to government revenue and the other half is distributed to a fund to send illegal migrants back to their countries. A second potential source of finance is within local government reserves. Local government, in provinces with large migrant populations, profit significantly from migrant generated revenue. Therefore, it is logical for local government to assume some responsibility to finance migrant healthcare. An additional revenue raising channel to support healthcare for migrant workers could be to increase local industry taxes for businesses that employ migrant workers.

¹⁸ This commonly occurs when revenue collected from registered migrant workers is not enough to subsidize exemption for unregistered migrant patients.

In 2006, 47 provinces reported a total exemption of 170 million Baht for unregistered migrant patients. However, if exemptions from provinces with a negative financial balance are taken into consideration, only 117 million Baht was required in 2006. The strengths and weaknesses of this alternative are summarized below.

Table 8. Strengths and weaknesses of allocating additional budgets for hospital exemptions

Strengths	Weaknesses
1. Those who gain benefits from the presence of migrant workers are encouraged to take responsibility.	1. Increased financial accountability of up to 170 million Baht per year for governments and employers.
2. Increasing a hospital's ability, particularly those with negative financial balance, to provide exemptions for unregistered migrants who contribute to the Thai economy.	2. This may not increase access to health care for migrants since it primarily aims to support hospitals.
3. The actual amount required is relatively small.	

6.2.2.2 Expanding the CMHI to cover all migrant workers and their dependents

Health as a human right has been promoted and supported by various international organizations including the MOPH. The fundamental objective of the health system is to ensure all migrant workers and their dependents are registered and therefore covered by the CMHI. Poor migration management results in many unregistered migrants who may increase the potential for negative impacts on the health and well-being of society. An explicit registration policy with effective enforcement could address this concern, and would be a more efficient alternative to relying on the conclusions of an annual cabinet resolution.

The division of registration and health protection to provide health insurance to all, regardless of their registration status, is an additional approach that could potentially be adopted. In order to effectively protect migrant workers and maintain health security, compulsory health insurance is required and demands greater cooperation between provincial governors. Ultimately the goal is to ensure government establishes a more explicit and liberal policy regarding the registration of migrant workers.

There would be no additional pressure on government budget reserves since all revenue comes from migrants themselves. Current costs incurred from service utilization remain lower than revenue due to an under utilization of health services among registered migrant workers. It is anticipated that utilization rates will increase if efforts are made to improve access to health services amongst registered migrant workers. In addition, current contribution rates may not be able to be maintained, and therefore, an increase to the premium is inevitable. Expanding the scheme to cover a further two-thirds of migrant workers will generate a bigger pool of funds making it easier to distribute financial risks. There is some concern however that migrant workers may not be willing or able to pay for the contributions. In light of this fact, it is unlikely that universal coverage

of migrants will be achieved on a voluntary basis, and therefore, coverage should be compulsory. Moreover, in order to relieve any financial burden experienced by migrant workers, contribution payments may be split into two or three allotments rather than collecting the full fee at once. Strengths and weaknesses of this option are summarized below in Table 9.

Table 9. Strengths and weaknesses of expansion of CMHI to cover all migrants

Strengths	Weaknesses
1. Pursues health as a basic human right.	1. Explicit and liberal government policy is required.
2. Improvement of financial sustainability in financing healthcare for migrant workers.	2. Effective enforcement of law is required.
3. There are no additional pressures on government budget reserves in order to implement this option.	3. Effective coordination among various government organizations is required.

Finally, an additional government budget is recommended during the transition phase, prior to implementing universal healthcare coverage for migrants. The additional budget should be prioritized in order to subsidize hospital exemptions, particularly for hospitals with negative financial balances as a result of service provision to migrants and stateless / displaced persons.

6.2.3 Healthcare financing for stateless/ displaced persons

Universal coverage of health care should include stateless / displaced persons since they are in fact permanent residents who used to be covered by the Low Income Scheme or Health Card prior to the introduction of the UC policy. As permanent residents, they contribute to both society and Thailand in the same way that Thai people contribute; therefore, excluding them from the UC scheme is significantly unjust. In light of this, the question remains as to whether government should only protect the poorest of the poor. One potential solution could be to develop a policy to ensure those with sufficient financial means pay their own healthcare costs. This could be one measure to minimize the potential outlay of the national health budget.

Targeting is the least preferred option for various reasons. First of all, it is difficult to efficiently and effectively identify beneficiaries as was demonstrated in previous government interventions, including the Low Income Card scheme itself. Evidence from an evaluation of the effectiveness of issuing a Low Income Card suggested that, instead of improving coverage and validity of Low Income Cards issued for the poor, it had the opposite effect and deteriorated over time (NIDA, 1990; Kongsawat et al, 2000). Technical difficulties identifying where the majority of low-income populations reside within the informal sector is one explanation for failure of this intervention. Secondly, the consideration of specific local contexts, for example, culture, politics and kinship among community members must be taken into consideration. Thirdly, stigmatization is a major issue of concern in relation to holding a card, specifically for the poor.

Fourthly, a publicly subsidized voluntary health insurance scheme, similar to the previous Health Card project or other schemes, will be required to prevent exorbitant expenditure among stateless / displaced persons who are not eligible for the Low Income Card. Fifth, the establishment of two additional programs will inevitably increase the financial burden via administration and costs. Finally, since the majority of stateless / displaced persons are poor, the estimated cost of implementing this option is evidently not going to be a more economical option than including this population in the UC scheme.

Accordingly, it is proposed that stateless / displaced persons are included in the UC scheme on the basis that stateless / displaced persons should be officially recognized as permanent residents who contribute to the country in a similar manner to Thai people. The financial burden on the government is estimated to be approximately 1,080 million Baht annually to cover 514,424 stateless / displaced persons at the capitation rate of 2,100 Baht. This is similar to that of the UC scheme. The strengths and weaknesses of this option are summarized below in Table 10.

Table 10. Strengths and weaknesses of implementing the Universal Health Coverage Scheme for stateless/ displaced persons

Strengths	Weaknesses
1. Observes the MOPH's policy on "Healthy Thailand" which aims to provide equitable, quality health services to all individuals in Thai society therefore recognising health as a human right	1. Increased financial burden of approximately 1,080 million Baht per year on the government
2. The majority of beneficiaries are poor and, therefore, including them in the UC scheme acknowledges the pro poor policy objective.	
3. It is easily implemented and does not require additional capacity to reach target groups.	
4. Facilitating access to essential care will improve the health conditions of beneficiaries, which in turn will contribute to the health of Thai society as a whole. In addition, productivity will improve and ultimately contribute to the Thailand's economy.	

In conclusion, an expansion of the UC scheme to include stateless / displaced persons is recommended. An expansion will facilitate greater access to essential health care and protect this population group from financial misfortune as a result of paying medical expenses. It is essential to recognize the contribution of migrant workers to Thailand, and important to enhance their health and wellbeing whilst maintaining the health security of Thailand. In expanding the scheme, an additional 1,080 million Baht is required per year.

6.4 Conclusion

Enhancing the current CMHI and its management is essential to increasing migrant workers access to appropriate health services. Improvements to the current CMHI are particularly necessary in relation to information management systems, including the development of monitoring and evaluation mechanisms that regulate the scheme's performance. Such regulation mechanisms will facilitate improved responses to meeting public health demands. In addition, the establishment of a CMHI management board at both the central and provincial levels will increase capacity to effectively coordinate and collaborate for increased access to health and therefore better health outcomes. Additionally, an expansion of the CMHI scheme to cover all migrant workers and dependents will promote the rights of migrant workers and their dependents access to essential health care. Such an expansion will require an explicit and liberal government policy for all existing migrant workers and dependents as well as effective, fair and humane enforcement of the policy. A definite government policy addressing better migrant registration processes will ultimately benefit the health security of local communities and Thailand as a whole.



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Appendix 1. Number of migrant workers and service utilization

Category	2004	2005	2006	2007
Number of provinces who submitted CMHI reports to MOPH	65	46	47	9
Number of registered migrants who participated in the CMHI	427,739	605,570	379,299	56,201
Revenue collected from CMHI	556,060,700	787,241,000	493,088,700	73,061,300
Allocation of CMHI premium				
- Curative care (946 Baht)	412,340,396	583,769,480	365,644,236	54,177,764
- General care (914 Baht)	390,953,446	553,490,980	346,679,286	51,367,714
- High cost care (50 Baht)	21,386,950	30,278,500	18,964,950	2,810,050
- Health prevention and Promotion (203Baht)	88,114,234	124,747,420	78,135,594	11,577,406
- Administration (130 Baht)	55,606,070	78,724,100	49,308,870	7,306,130
Utilization and costs of healthcare provided to registered migrants (CMHI members)				
- Number of outpatient visits	187,202	402,201	335,850	61,342
- Expenditure	36,309,471	83,285,965	67,927,919	10,264,007
- Number of inpatient admissions	13,498	25,650	21,238	5,231
- Hospital admission days	84,280	91,642	71,256	17,871
- Expenditure	61,703,348	140,666,452	137,574,518	28,473,825
- Total expenditure	98,012,819	223,952,416	205,502,437	38,737,832
- Average expenditure per member	229.14	369.82	541.80	689.27
Hospital exemption for unregistered migrants				
- Number of outpatient visits	184,815	147,115	161,007	51,140
- Expenditure	15,336,065	17,775,545	23,078,642	4,609,482
- Number of inpatient admissions	28,746	16,554	18,865	4,269
- Number of admission days	93,368	82,743	88,908	29,022
- Expenditure	81,043,544	114,873,174	147,093,104	33,917,399
Total expenditure	96,379,609	132,648,719	170,171,746	38,526,881
Out-of-pocket payment among unregistered migrants				
- Number of outpatient visits	184,022	152,608	190,495	56,391
- Expenditure	44,558,539	54,531,831	34,932,550	13,876,922
- Number of inpatient admissions	23,657	13,234	19,090	8,601
- Number of admission days	117,458	40,734	74,258	31,846
- Expenditure	48,469,879	39,618,402	84,961,148	27,226,319
Total expenditure	93,028,418	94,150,232	119,893,698	41,103,241

Note: Data on service utilization and expenses of stateless/ displaced persons are not available.

