Migration and Health Service System in Thailand: Situation, Responses and Challenges in a Context of AEC in 2015
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Migration and Health Service System in Thailand:
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The views expressed in this paper are the views of the authors and do not necessarily reflect those of WHO.

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Executive Summary

Thailand is evolving into a crossroads of regional migration given its central position in the Indochinese peninsula. Thailand shares a land border of over 5,000 kilometers with its four neighbors (Myanmar, Lao PDR, Cambodia and Malaysia) and this facilitates cross-border movement of migrants. Thailand’s increasing demand for lower-skilled labor and its relatively higher minimum daily wage has stimulated an influx of migrant workers (MWs) from its three lower-income neighbors (or 87.2% of all registered foreign MWs in Thailand). This demographic shift has certain implications for Thailand’s ability to provide essential services such as public health in the coming years.

This report presents the results of a study which had the following objectives: (1) To review trends in migration of MWs to Thailand; (2) To document the development and observations of measures and systems for health care for MWs from Myanmar, Lao PDR and Cambodia; (3) To review the health systems of the migrant countries of origin; and (4) To describe the health service system for labor-importing countries of ASEAN and the European Union (EU). These findings are synthesized into a set of challenges for further development of the Thai health care system to accommodate the growing population of migrants.

Thailand has been using a universal health insurance approach to extend coverage of health care to the migrant population from Myanmar, Lao PDR and Cambodia. In 1999, the Thai Ministry of Public Health (MOPH) implemented measures and guidelines for hospitals under the MOPH authority to provide health examinations and insurance for MWs in their catchment area. These measures were in force on a year-by-year basis, requiring annual Cabinet resolutions to renew it. In addition, during 2005-6, the MOPH formulated a draft strategy for migrant public health services, including a border health development master plan to address weaknesses of the health system to improve its ability to accommodate an increasing number of migrants.

Policy on registration of MWs has tended to fluctuate each year, and this results in artificial ups and downs in the official count of MWs. During 2005 to 2013, the lowest total of registered MWs was 589,646 while the highest total was 1,825,658, despite the probability that the de facto resident population of MWs did not vary that much from year to year.

At present, health care for MWs is covered under two insurance schemes: (1) Social Security, as managed by the Social Security Office of the Thai Ministry of Labor (MOL); and (2) Year-by-year health insurance program of the MOPH. The MOPH scheme is targeted to MWs who are not covered by Social Security, and unregistered MWs and their accompanying dependents. Data for 2013 show that the Social Security system covered less than half of eligible MWs, while the year-to-year scheme covered less than 63% (not including undocumented individuals, thus further reducing the coverage rate). Further, it is estimated...
that only 7.8% of eligible children are covered by health insurance. Even when the migrants do have health insurance, there are obstacles to obtaining health care due to lack of ability to communicate in Thai, fear of being arrested while seeking care, and the lack of community-based health care network such as Thai citizens enjoy. In August 2013, anti-retroviral therapy (ART) treatment for People Living with HIV (PLHIV) was added to the benefits package for those covered under the year-to-year insurance program, resulting in an increase of the annual premium from 1,300, to 2,200 Baht (39.5 USD to 66.8 USD), and a corresponding decrease in the number of migrants enrolled.

This study also documents the following deficiencies in the health care systems of countries of origin when compared with Thailand:

- **Myanmar:** The ministry of health plays a principal role in public health but lacks adequate budget and medical personnel. There is no national health insurance program. Burmese citizens can receive free examination and diagnosis from public sector outlets, but have to purchase medical supplies and medicines out-of-pocket from private pharmacies. Thus, the role of the private sector in health care is minor, and limited to out-patients. There are only a small number of specialist hospitals, and these are concentrated in large urban areas.

- **Cambodia:** For many years, Cambodia’s limited budget and infrastructure meant that international NGOs played a large role in health services, including health insurance schemes for the poor. Gradually, Cambodia has increased public expenditures for health so that it is now at the level of 16.5% of the entire government budget. Nevertheless, services are still not adequate to meet the demand and, thus, many Cambodians rely on the private sector for health care, despite the higher cost. The private hospital sector is expanding alongside the country’s economic development.

- **Lao PDR:** This country has a decentralized structure for health care that extends widely throughout the country at all levels. But Lao PDR still relies heavily on foreign aid, including aid from Thailand, to develop its health care services. Also, usage of the public health care system from the district on down is rather low due to logistical problems of access and staff shortages. Thus, as in Cambodia, the Lao population turns to the private clinic sector or drug stores to meet health care needs. Fully 63% of health care expenditures are made in the private sector.

Thailand has been collaborating with its neighbors in public health service development, but at different levels of intensity. At present, Thai-Cambodian collaboration is the furthest along. Collaboration between Thailand and Lao PDR is in terms of development of certain areas, while collaboration with Myanmar is accelerating now that the country is more open to outside involvement.
Experience of labor-importing countries, such as Malaysia and Singapore among ASEAN members, and Germany, Spain, Italy, U.K, and France in the EU, provides the following lessons in MW health care which can be applied by Thailand:

1) Each country clearly segregates the “health service system” from the “social welfare system”.

2) Each country clearly specifies the responsibility of the employer for participating in protecting the health and social welfare of its migrant labor force, with penalties for non-compliant businesses.

3) Singapore has a system for health and social welfare under the control and management of the government, arranged for the MWs before they enter the country.

4) In Malaysia, a private sector agency implements public relations outreach to market health insurance, and motivates MWs to enroll in the system, thus achieving high coverage rates.

5) The EU countries view the rights to health as emanating from the collection of direct and indirect taxes collected while the migrant is employed/resident in the country.

6) Countries of the EU extend health services to both documented and undocumented migrants, and documented migrant receive health services virtually equivalent to citizens of those countries. Undocumented migrant receive a basic minimum level of standard care which differs among member countries.

It cannot be denied that, as the region prepares to enter the era of the ASEAN Economic Community, Thailand will become an even more diverse society, with an increasing number of people from ethnic communities, with different languages and cultures, all thrown into the mix. This presents a challenge for Thailand’s health care system in how best to accommodate the certain increases in caseloads and diversity of clientele. Some of the more notable challenges are as follows:

1) Review other approaches to health for all, inclusive of the migrant population: This is because health insurance scheme is unlikely to be the single answer to universal, standard care. Relying solely on health insurance premiums can present problems.

2) Explore alternative guidelines for management and implementation of health promotion and disease control for migrants through integration with the routine services for Thais: This applies to sources of adequate budget which should not be segregated, with comprehensive monitoring and evaluation.
3) Establish guidelines related to laws, regulations, preliminary agreements, and controls in collaboration among related agencies: This should prompt the business owners who employ MWs to play a more direct role in providing health insurance coverage and health care for their workforce. There should be consideration of penalties for employers who do not comply with these regulations.

4) Reduce gaps or obstacles to multi-lingual communication and cross-cultural harmony: Additionally, efforts should be made to reduce the caseload burden and budget shortages of the public health providers. Consideration of health personnel exchange among ASEAN countries can be an option so that migrants can be seen by practitioners from their home country.

5) Review and consider the feasibility of a migrant registration for health system to improve access to health care without regard to legal status: This concept is derived from principles of health security which impact on national security.

6) Consider management strategies for a minimum package of health services, as applicable to all migrants living and working in Thailand, including those with or without health insurance.

7) Continue strengthening collaboration with countries of origin in the care and treatment of migrant living with HIV/AIDS, including other communicable diseases and chronic illnesses over the longer-term period, in the event that the migrant decides to return home for on-going care.

It can be asserted that the majority of the budget for health care of MWs in Thailand (at all levels) comes from migrants who pay into the health insurance system of the government, and this presents the following challenges for the near future:

1) The year-by-year health insurance approach is conditional upon registration of the migrants which makes it quasi-compulsory.

2) Coordination, methods, and strategies among public and private healthcare providers, business owners and employers, need to be mindful of the essential nature of health insurance. One approach might be to divide responsibility of the health insurance vendors, and provide incentives to enroll more uninsured migrants.

3) Mechanisms for control and monitoring of migrant health insurance policy to assess client-friendly health service outlets are needed as a means of learning about limitations, obstacles, and factors affecting the effort to meet client needs so that improvements can be made which are fact-based and feasible.

4) Alternative funds management to improve efficiency of the migrant health insurance system at the national, provincial and district levels is needed. This is especially important for the smaller service outlets to protect against a negative balance of funds.
5) There is a need for strengthening collaboration and exploring the feasibility of working more closely with the National Health Security Office and the Ministry of Labor to make social security and health insurance a “compulsory option” for migrants residing in Thailand.

6) There is a need for development of longer-term measures for securing budget for migrant health care in Thailand in ways that reduces dependence on migrant health insurance premiums as the only source of revenue.

The following are challenges for insuring children of migrants:
• If the government maintains the policy of a low health insurance premium for children of migrants, then the MOPH should consider providing a subsidy to make this policy feasible going forward.
• There should be consideration of adjusting the health insurance premium so that it is consistent with the actual cost of treating migrant children.

Finally, there is a need for more research on health systems for migrant populations. It is important that the investigators respect the migrant population and honor their basic human rights. The research needs to take into consideration the contextual factors that are relevant to the topic of study, so that the findings accurately reflect the genuine situation.
## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AEC</td>
<td>ASEAN Economic Community</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Treatment</td>
</tr>
<tr>
<td>ASC</td>
<td>ASEAN Security Community</td>
</tr>
<tr>
<td>ASCC</td>
<td>ASEAN Socio-Cultural Community</td>
</tr>
<tr>
<td>ASEAN</td>
<td>Association of South East Asia Nations</td>
</tr>
<tr>
<td>BMA</td>
<td>Bangkok Metropolitan Administration</td>
</tr>
<tr>
<td>CBHI</td>
<td>Community Based Health Insurance</td>
</tr>
<tr>
<td>CSS</td>
<td>Civil Servant Scheme</td>
</tr>
<tr>
<td>CPA</td>
<td>Complementary Package Activities</td>
</tr>
<tr>
<td>DHD</td>
<td>District Health Department</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>FWHIPS</td>
<td>Foreign Workers Health Insurance Protection Scheme</td>
</tr>
<tr>
<td>GFATM</td>
<td>Global Fund to Fight Aids Tuberculosis and Malaria</td>
</tr>
<tr>
<td>HCC</td>
<td>Health Care Centers</td>
</tr>
<tr>
<td>HP</td>
<td>Health Post</td>
</tr>
<tr>
<td>MOL</td>
<td>Ministry of Labor</td>
</tr>
<tr>
<td>MOM</td>
<td>Ministry of Manpower</td>
</tr>
<tr>
<td>MOPH</td>
<td>Ministry of Public Health</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>MPA</td>
<td>Minimum Package Activities</td>
</tr>
<tr>
<td>MW</td>
<td>Migrant Worker</td>
</tr>
<tr>
<td>NAPHA</td>
<td>National AIDS</td>
</tr>
<tr>
<td>NHSO</td>
<td>National Health Security Office</td>
</tr>
<tr>
<td>NV</td>
<td>Nationality Verification</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
</tr>
<tr>
<td>SEA</td>
<td>South East Asia</td>
</tr>
<tr>
<td>SKHPPA</td>
<td>Foreign Worker Hospitalization &amp; Surgical Insurance</td>
</tr>
<tr>
<td>SSO</td>
<td>Social Security Organization Scheme</td>
</tr>
<tr>
<td>THD</td>
<td>Township Health Department</td>
</tr>
<tr>
<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
</tr>
<tr>
<td>VAT</td>
<td>Value-Added Tax</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
Chapter 1

Introduction
Chapter 1

Introduction

1. Labor Migration into Thailand

Thailand is evolving into a regional hub for migrants, as destination and country of origin, or as a transit point to the third country. Thailand has one of the largest economies in Southeast Asia (SEA). The contrast in level of development among countries has given rise to a pattern of chain migration among unskilled laborers to Thailand from its lower-income neighbors. Similarly, higher-skilled Thai labor is migrating to other countries in SEA, Central Asia, and other regions of the world.¹

While other countries in Asia may have a larger number of foreign migrant workers (MWs), Thailand ranks third in SEA after Malaysia and Singapore as a destination country for MWs. Ever since 1978, Thailand has had a policy of attracting non-Thai professionals and skilled labor to assist with large projects, and programs with international funding. However, beginning around 1991, the expanding domestic Thai production sector required more low-skilled labor, as there were not enough Thais willing to take all the vacant positions. This created a strong “pull” factor for MWs from Thailand’s closest neighbors, resulting in significant increases of these MWs into expanding sectors of the Thai economy² during the subsequent two decades.

The geographic position of Thailand in the center of Indochina results in a land border extending 5,286 kilometers (kms) with its four neighbors (Lao PDR, Myanmar, Cambodia, and Malaysia). The longest shared land border is with Myanmar on the west, extending 2,202 kms from Thailand’s North region to the South. The next longest shared border is with Lao PDR covering 1,750 kms, followed by 758 kms with Cambodia, and 576 kms with Malaysia.³

The existence of such lengthy shared borders has meant that cross-border migration between Thailand and its neighbors has been occurring

¹ RosaliaSciortino and SureepornPunpuing, 2009
² Sakarin Niyomsipa, 2011
³ National Center for Technology and Electronics, accessed in November 2013
for generations. Travel to and from these countries is also relatively simple and convenient. The Thai Ministry of Interior for 2013 has classified the 89 official border-crossings into three types: (1) Permanent crossing points; (2) Temporary crossing points; and (3) temporarily permitted area for people along the border. The establishment of these sites is to facilitate the orderly transport of goods and people to and from Thailand.

<table>
<thead>
<tr>
<th>Thailand</th>
<th>Length of the shared border (km)</th>
<th>International Border Crossings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Permanent</td>
<td>Temporary</td>
</tr>
<tr>
<td>Myanmar</td>
<td>2,202</td>
<td>4</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>1,750</td>
<td>13</td>
</tr>
<tr>
<td>Cambodia</td>
<td>758</td>
<td>6</td>
</tr>
<tr>
<td>Malaysia</td>
<td>576</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: ASEAN Data Center, 2013

Thus, it is no surprise that, as demand for low-skilled labor in Thailand exceeded the availability of Thais willing to do that work; the labor vacuum has largely been filled by MWs from Thailand’s lower-income neighbors, especially given the higher minimum wage in Thailand. Myanmar, Lao PDR and Cambodia have the largest proportions of farmers of its labor force compared with the other countries in SEA. Thus, the rapid expansion of Thai agro-industry and manufacturing combined with the ease of crossing into Thailand and proceeding to provinces with labor shortages have helped fuel the rapid growth in cross-border migration during 1991-2010. (It is noteworthy that the minimum wage in Malaysia is higher than in Thailand and this, among other factors, limits the number of Malaysian MW in Thailand.) In the earlier stages of this migration evolution most of the MWs did not have authorized travel documents or work permits.
2. Efforts to Register Foreign Migrant Workers in Thailand

The large and increasing number of MWs from Myanmar, Lao PDR and Cambodia prompted the Thai government to develop clearer guidelines and regulations for labor in-migration starting in 1996. Initially, there was an amnesty for MWs who entered Thailand illegally, as long as they registered for employment, and processed an annual renewal of this registration. Then, in 2001, a new measure was enacted to require registered MW to have a physical exam and purchase health insurance before approving a renewal. These policies and measures were approved annually by Thai Cabinet resolutions during the period from 2002-2004. Next, Thailand processed bi-lateral Memoranda of Understanding (MOU), first with Lao PDR, then Cambodia, and Myanmar to initiate a process of verification of nationality of MWs already working in Thailand as a basis for providing a temporary travel document issued by the country of origin and authorization to work in Thailand.

These MOU with Thailand are still limited to MWs from Myanmar, Lao PDR and Cambodia, but not any other countries in ASEAN, since they comprise the majority of the MWs in Thailand in the current era. Despite the amnesty and MOU, there remains a significant number of unofficial (unregistered or undocumented) MWs in Thailand. The total for registered MWs during the period from 2005 to 2013 peaked in 2011 at 1,825,658 and was lowest in 2008 at 589,646. The main factor affecting the volume of registered MWs is the prevailing policy of a given year, and these totals do not include the dependents of the MWs and, of course, the many unofficial MWs.

The plan to launch the ASEAN Economic Community (AEC) in 2015 is bound to make the migration situation more complex, especially for labor migration to Thailand. The “Report on Changing Trends in Asian Migration in the Era of Regional Economic Cooperation” forecasts that a more liberal investment climate among ASEAN members will contribute to increased investment in Cambodia, Lao PDR, Myanmar and Vietnam, and this could motivate the unregistered MWs in Thailand to return to their home countries. Nevertheless, the significantly higher minimum wage in Thailand compared to its lower-income neighbors (by a factor of three to five-fold) combined with the health and social benefits of workers in Thailand will remain important “pull” factors for MWs to seek work in Thailand. What is more, the low Thai birth rate will contribute to greater Thai labor shortages in the coming decades as Thailand transitions to an aging society, further increasing the pressure to attract low-skilled foreign MWs.

The implication of the current and future increases of labor migration into Thailand is that the health system of Thailand will need to adapt and evolve in tandem with the changing demographic profile of the working-age population. The challenge is how to provide efficient and accessible prevention, health promotion, disease control as well as treatment and care for the expanding population of MWs in Thailand in the coming years.

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4 Office of Foreign Workers Administration, 2011
5 Office of Foreign Workers Administration, 2008
6 SakarinNiyomsilpa, 2011
3. Objectives and Methodology of the Study

This study had the following objectives:

1) To review the status and trends of foreign labor migration into Thailand in order to identify key target migrants to design the health service system;

2) To review the development of measures and systems of health care for migrants from Myanmar, Lao PDR, Cambodia and other groups, including health insurance coverage and remarks for future development;

3) To review and analyze the health system and access to health services in the ASEAN countries of origin, and linkages with the Thai health system;

4) To review examples of migrant health service delivery in other destination countries of ASEAN and elsewhere, including observations and potential for replication to Thailand.

5) To summarize the findings, challenges and recommendations for improving the health service system to accommodate migrants in Thailand.

This study report was prepared in an accelerated time-frame of 20 days during November to December 2013. The report presents data and information to help inform improvements in the 2014 health strategy for migrants in Thailand. This study relied, for the most part, on secondary sources of data and findings from research studies, program reports, statistics, Internet web pages of related government agencies, studies of the health service systems of other countries (both migrant origin and destination). The authors also conducted non-formal phone and personal interviews with administrators and individuals involved with health services for migrants. The findings from these primary and secondary sources were synthesized into challenges and recommendations for modifying the Thai health service system to accommodate MW in the coming years. Thus, taking these limitations into consideration, the reader may assume that not all aspects of the study objectives were comprehensively addressed. Nevertheless, the authors sincerely hope that these findings will be inputs to guide a direction of migrant health strategy development in Thailand.
Chapter 2

Migrants in Thailand
Chapter 2

Migrants in Thailand

Thailand is located in the middle of Southeast Asia (SEA) and has one of the leading economies in the region. The government is pro-investment and the country is a hub for commerce and tourism. Thus, it is no surprise that, each year, there is a significant influx of non-Thais entering Thailand. Immigration Law (1979) Article 4 uses the word “alien” to define foreign migrant as any ordinary person who does not have Thai citizenship. This definition also encompasses the many foreign migrant workers (MWs) who come to Thailand to work, their families, children and other accompanying dependents, whether their stay is short or long-term, and whether their entry, work and residence in Thailand is legally documented or not. Migrants also include undocumented persons who are waiting to verify their Thai nationality. The following describes these categories in more detail.

1. Who Are the Migrant Populations in Thailand and How Many Are There?

There are many different categories of migrants in Thailand, but determining the actual number by type is problematic, especially for those who entered illegally. In addition, different government agencies track different segments of the migrant population in Thailand, and there is no comprehensive database. Secondary data on the migrant population comes largely from three sources: (1) The Immigration Division of the National Police Headquarters; (2) The Office of Foreign Workers Administration of the Department of Employment of the Ministry of Labor (MOL); and (3) UNHCR (United Nations High Commissioner for Refugees) office for SEA. Additional secondary data on migrants come from technical reports of the National Health Security Office (NHSO) and other technical documents which tend to classify migrants into the following two groups:

1.1 Circular migrants and tourists

This group of migrants consists of non-Thais who enter and leave Thailand legally and may have temporary domicile in the country. This group can be further sub-divided into (1) Tourists; (2) Migrants with temporary work permits; (3) Transit visitors en route to a third country; and (4) Those granted temporary permission to stay in Thailand for various reasons such as living with family members, academic study, diplomatic service, retirement, etc. The number of migrant entries to Thailand in this category (excluding those transiting to a third country)

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7 Immigration Bureau, accessed on November 2013
8 Immigration Bureau, National Police Headquarters, 2012
toted 20 million per year; the majority is tourist and most of whom entered and left within the same year (see the Table below).

**Table 2 Number of Entries and Exits to Thailand and Balance Remaining**

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Entries and Annual Balance</th>
<th>Tourists</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Entry</td>
<td>Exit</td>
</tr>
<tr>
<td>2011</td>
<td>20,396,852</td>
<td>19,953,783</td>
</tr>
<tr>
<td>2012</td>
<td>23,820,906</td>
<td>23,335,174</td>
</tr>
<tr>
<td>2013</td>
<td>18,920,662</td>
<td>18,856,415</td>
</tr>
</tbody>
</table>

*Source: Bureau of Immigration for 2011, 2012, and 2013 (data through August 2013)*

It can be seen from the table that the balance of visitors to Thailand remaining in country at the end of the calendar year was about 4.4 hundred thousand in 2011 and 4.8 hundred thousand in 2012. Data from the Bureau of Immigration and the Ministry of Tourism and Sports indicate that Thailand needs to consider the different health coverage needs of both short-term visitors and those with extended stays.

**1.2 Foreign migrant workers in Thailand**

The proportion of the Thai population in the working-age years is declining as that in the dependency years is increasing. The Thai fertility rate continues to decline and this is translating into current and future Thai low-skilled labor shortages at the younger age groups. Thus, Thailand will become increasingly dependent on MWs in the years ahead. Over the past decade, demand for MWs has increased steadily in the wage labor sector, domestic helper, security guard, cleaner, etc. The MWs filling these positions enter Thailand both legally and illegally. The Study on Demand for Migrant Labor During 2010-14 conducted by the Department of Employment of the MOL determined that the trend is toward increased need for MWs given their importance for the continued expansion of the Thai economy. This is especially true for the construction and fisheries industries. The recent Report on the Status of Migrant Labor as of August 2013, issued by the Office of Foreign Workers Administration indicates that the number of MWs in Thailand totaled 1,237,679. These MWs can be further classified into the following groups as per the Foreign Labor Law (1968):

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10 Department of Tourism, Ministry of Tourism and Sports, 2013
1.2.1 MW who legally entered Thailand as per Article 9: These MWs are temporarily allowed to reside in Thailand for the purpose of employment. In August 2013, 1,217,829 MWs were in this category, and they had proper travel and work permit documents. These MWs can be further sub-divided as follows:

1) **Lifetime**: These MWs have authorization for permanent residence in Thailand according to 1978 Immigration Law, possess foreigner identification number and have been approved to work in Thailand indefinitely. Currently, Thailand no longer issues these permanent residence and work permits. Foreigners can apply for two-year work permits for general employment. Thus, the number of MW in this category declined from 14,423 to 983 in 2011, and remained constant at this level to the present time.

2) **General**: This includes MWs who have received temporary authorization to work in Thailand and mostly consists of skilled laborers. Some are sent from the headquarters of companies investing in Thailand, or have entered independently as professional workers in specialty areas and language skill requirements for which there are not yet enough Thais to perform. Some are independent investors or have a joint business with their wife or in collaboration with Thai nationals. The minimum threshold of investment for approval in this category is two million baht and applies to foundations, associations, international NGOs, etc. In the past, MWs in this category could work only for the duration of their visa. However current Thai law allows for up to two-year periods of work. The Office of Foreign Workers Administration reports that, as of August 2013, there were 95,824 MWs in this category, most of whom were Japanese, British, and Chinese citizens. Other less numerous nationalities in this category includes MW from the Philippines, India and the USA. The MWs in this category tends to have high-level positions such as manager, professor, chairman, and senior administrator.

3) **Nationality Verification (NV)**: This group includes those MWs who have entered Thailand illegally from Myanmar, Lao PDR and Cambodia. Initially, the Cabinet issued a resolution to provide amnesty for temporary stay prior to repatriation for those working as wage laborers or domestic helpers. Their status was regularized so they were no longer illegal MWs after completing a process of nationality verification, with documentation from their home country and issuing of a temporary passport or certificate of identity as a basis for application for employment. This resolution allowed these MWs to work for a period of two years with possibility of a single two-year extension, and not to exceed four years in total. Since 2007, the number of MWs in this category has increased due to improved NV processing. As of August 2013 there were 917,212 MWs in this category.

4) **MOU**: MWs in this category are allowed to enter Thailand for work under one of three bi-lateral memoranda of understanding which Thailand has signed with Myanmar, Lao PDR and Cambodia. These MWs are allowed to work in low-skilled occupations such as wage laborer and domestic helper for two years, with the possibility of a single two-year extension, and not to exceed four years total. As of August 2013, there was a total of 93,265 MWs in Thailand in this category.
1.2.2 MW legally entering Thailand under Article 12: This refers to MW allowed to work in Thailand under special authorizations such as the 1977 Investment Promotion Law, the Thailand Industrial Park Law of 1979, and other related laws. The registrar is required to issue a permit to the MW within seven days of being notified. Mostly, these MWs have special skills for work in industrial estates, large factories such as large truck manufacturers, food and beverage production, etc. These MWs tend to occupy high-level positions such as section manager, engineer, specialist, senior manager, etc. The Office of Foreign Workers Administration reported that MW in this group has been increasing steadily since 2006 from 22,741 in that year to 35,325 as of August 2013. Of these, half are from Japan, followed by China, India, Taiwan, and South Korea.

1.2.3 MW in Thailand illegally as per Article 13: Some MWs or non-Thais who are in country illegally are allowed to remain for work as per the following categories:

1) Ethnic minorities awaiting Thai nationality verification: In accordance with Task Force Resolution No. 337, dated December 13, 1972 and from the report of the Office of Foreign Workers Administration, the number of MW in this category has been declining steadily due to more efficient nationality verification. There were 45,029 MWs in this category in 2006 and only 19,850 as of August, 2013.

2) MW entering Thailand without documents: This group consists of MWs from Myanmar, Lao PDR and Cambodia who received temporary permission to stay while awaiting repatriation as per Immigration law. Most of these MWs are very low-income persons who cannot find employment in their home country or are trying to escape political insecurity in the homeland. Because of the extensive shared land border between Thailand and these three countries, there is a large and irregular flow MWs into Thailand for work in agriculture, industry, fisheries, and domestic help. The number of MWs in this category varies with national Thai policy and conditions of registration. Since 2004, the lowest number of legally registered MWs in country was 501,570 (in 2008) while the highest number was 1,314,382 (in 2012). Some of these MWs have gone through a process of nationality verification and have transitioned into the “NV” category of legal MW. As of August 2013 there was a balance of 19,850 MWs in this authorized category. However, there remain a large number who are not pursuing national verification and, as of 2013, Thailand had no policy to increase the number approved to stay and work in country. Thus, there probably continue to be a large number of undocumented MW remaining and working in Thailand in this category, but it is difficult to determine the actual number since they are somewhat “hidden” populations. Overall, the majority of MWs registered for work in Thailand is in the low-skilled category and come from Thailand’s three lower-income neighbors (see Figure 1).
Fully 87.2% of MWs are from Myanmar, Lao PDR and Cambodia (including the NV, MOU and undocumented entry groups). The remaining 12.8% of MWs come from 40 other countries. It is also noteworthy that the official data on registered MW does not include accompanying dependents and family members, and do not include the illegal, non-numerated MW which are probably quite a large number.

1.3 Cross-border Refugees

The UNHCR (The United Nations High Commissioner for Refugees: UNHCR) is the principle international agency which monitors the status of international refugees, and attempts to enumerate the number of refugees in different categories. As of June 2013, Thailand was reported to have a total of 129,019 cross-border refugees.\(^{11}\) These include persons who have been fleeing conflict in Myanmar over a period of 30 years, and mostly comprise ethnic minorities of the Karen and Red Karen groups. These persons reside in refugee camps or in one of nine temporary shelters in five provinces of Thailand including Mae Hong Son (3 sites), Tak (3), Chiang Mai (1), Kanchanburi (1) and Ratchaburi (1). A total of 129,019, only 81,177 are registered with UNHCR, with 13,000 requesting to enroll in refugee camp.\(^{12}\) In the past, there were camps for Lao and Cambodian refugees, but these were closed as the security situation in those two countries stabilized.

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11 The Border Consortium, 2013
12 The United Nations High Commissioner for Refugees (UNHCR), 2013
Table 3: Number of Refugees on the Thai-Myanmar Border

<table>
<thead>
<tr>
<th>Province</th>
<th>Refugee Camp</th>
<th>Number of Refugees</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Female</td>
<td>Male</td>
<td>Total</td>
<td>Registered with UNHCR</td>
</tr>
<tr>
<td>Chiang Mai</td>
<td>WiangHaeng</td>
<td>269</td>
<td>270</td>
<td>539</td>
<td>539</td>
</tr>
<tr>
<td>Mae Hong Son</td>
<td>Ban Mai Nai-Sawp</td>
<td>6,024</td>
<td>6,664</td>
<td>12,868</td>
<td>10,041</td>
</tr>
<tr>
<td></td>
<td>Ban Mae Surin</td>
<td>1,678</td>
<td>1,691</td>
<td>3,369</td>
<td>1,668</td>
</tr>
<tr>
<td></td>
<td>Mae La Awn</td>
<td>6,392</td>
<td>6,470</td>
<td>12,862</td>
<td>9,117</td>
</tr>
<tr>
<td></td>
<td>Mae La Ma Luang</td>
<td>7,383</td>
<td>7,183</td>
<td>14,566</td>
<td>8,982</td>
</tr>
<tr>
<td>Tak</td>
<td>Mae La</td>
<td>23,184</td>
<td>22,803</td>
<td>45,987</td>
<td>26,049</td>
</tr>
<tr>
<td></td>
<td>Um Biam</td>
<td>7,344</td>
<td>7,357</td>
<td>14,701</td>
<td>10,146</td>
</tr>
<tr>
<td></td>
<td>Nupo</td>
<td>7,065</td>
<td>6,823</td>
<td>13,888</td>
<td>8,250</td>
</tr>
<tr>
<td>Kanchanburi</td>
<td>Ban Don Yang</td>
<td>1,823</td>
<td>1,679</td>
<td>3,502</td>
<td>2,546</td>
</tr>
<tr>
<td>Ratchaburi</td>
<td>ThamHin</td>
<td>3,517</td>
<td>3,220</td>
<td>6,737</td>
<td>4,378</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>64,859</td>
<td>64,160</td>
<td>129,019</td>
<td>81,177</td>
</tr>
</tbody>
</table>

Source: Refugee and IDP camp population June 2013

Thailand provides oversight and support for these camps and shelters in collaboration with the UNHCR and international NGOs. Refugees are provided with essential nutrition, shelter, medicine, and education. Most of these services are implemented by NGOs.

1.4 Persons Awaiting Verification of Thai Nationality

Stateless persons in Thailand refer to those awaiting verification of Thai nationality since they have no documentation of being a citizen of any other country, either now or in the past. Without documentation, these persons have difficulty accessing some of their basic rights in society. These persons may be the child of Thai parents but who had not been entered into the Civil Registration system. The number of stateless persons in Thailand in 2010 was estimated to be 457,409. They are now living in Thailand, got the identity card with a special series of number in order to wait for National Verification process.

13 Thailand Burma Border Consortium (TBBC), 2013
14 Sudaporn Jiamjurai, 2013
15 Phongsatorn Pawkpermpon, 2013
This group of persons had the basic rights of registering a child born in Thailand, with the birth certificate as a principle means of establishing one’s identity. They also had the rights to education as stipulated in the Cabinet Resolution dated July 5, 2005 mandating access to schooling for everyone listed in the Civil Registration system, despite not having fully legal status. Schools could receive a per capita subsidy for each child in this category, as with Thai children. Stateless persons in Thailand can work, as mandated by the Foreign Employment Act of 2008, however, for health care; these individuals are only eligible for welfare in accordance with basic human rights.

2. Which Group of Resident Foreigners Should Thailand Give Priority To?

Historically, movement among MWs of ASEAN countries was usually from the more densely populated countries with higher levels of unemployment. The destination countries tended to be those with declining birth rates coupled with increasing labor-intensive industrialization. This created a shortage of labor at the low-skilled level. ASEAN countries which have a large number of its citizens seeking work in other countries include Indonesia, the Philippines, Vietnam, Myanmar, Cambodia, and Lao PDR. The popular destination countries in ASEAN include Brunei, Singapore, Malaysia and Thailand. Some countries, such as Thailand, have large numbers of incoming MWs as well as Thai MWs seeking work in other countries of the region such as in Taiwan, Japan, South Korea and countries of the Middle East. Cambodia is also a destination country for MWs from Vietnam.

The population of the ten ASEAN countries is 600 million. Of these, 307 million are in the working ages while 148 million have a daily income of less than 64 baht (2 USD), and 28.8 million make less than 32 baht (1 USD) per day. At the country level, Indonesia has the largest absolute number of population in the working age groups (120 million), followed by Vietnam (52 million), the Philippines and Thailand (about 40 million), Myanmar (28 million), Malaysia (12 million), Cambodia (8 million), Lao PDR (3 million), Singapore (2.9 million), and Brunei (0.2 million). The 1.8 million MW in Thailand (not counting the undocumented MW) represent 0.6% of the entire working age population of ASEAN countries. Most of this migration is temporary with employment contracts of two years, and the MWs mostly for work in factories. It is noteworthy however, that a significant proportion of the de facto populations of MWs in Thailand are undocumented migrants.

At present, citizens of ASEAN countries can travel within ASEAN without the need for a visa (though they still need to pass through immigration, and the duration of stay varies by country). This has a boosting effect for intra-regional tourism, business trips and technical exchange visits. The following table presents data for ASEAN population movements within the region for 2011:

16 Department of ASEAN, Ministry of Foreign Affair, 2013
17 NerumonNiratha, 2013
Table 4 Migration among ASEAN Member Countries (number of migrants)

<table>
<thead>
<tr>
<th>Country of origin</th>
<th>Brunei</th>
<th>Cambodia</th>
<th>Indonesia</th>
<th>Lao PDR</th>
<th>Malaysia</th>
<th>Myanmar</th>
<th>The Philippines</th>
<th>Singapore</th>
<th>Thailand</th>
<th>Vietnam</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brunei</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7,905</td>
<td>0</td>
<td>1,003</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>8,908</td>
</tr>
<tr>
<td>Cambodia</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>909</td>
<td>0</td>
<td>0</td>
<td>232</td>
<td>0</td>
<td>124,761</td>
<td>0</td>
<td>125,902</td>
</tr>
<tr>
<td>Indonesia</td>
<td>6,727</td>
<td>505</td>
<td>0</td>
<td>0</td>
<td>1,397,684</td>
<td>0</td>
<td>5,865</td>
<td>102,323</td>
<td>586</td>
<td>0</td>
<td>1,513,698</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>0</td>
<td>1,235</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>110,854</td>
<td>0</td>
<td>112,089</td>
</tr>
<tr>
<td>Malaysia</td>
<td>81,576</td>
<td>816</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>394</td>
<td>1,060,628</td>
<td>2,251</td>
<td>0</td>
<td>1,145,664</td>
</tr>
<tr>
<td>Myanmar</td>
<td>0</td>
<td>247</td>
<td>0</td>
<td>143</td>
<td>17,034</td>
<td>0</td>
<td>415</td>
<td>0</td>
<td>1,078,767</td>
<td>0</td>
<td>1,096,606</td>
</tr>
<tr>
<td>The Philippines</td>
<td>15,861</td>
<td>728</td>
<td>0</td>
<td>277,444</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>6,778</td>
<td>0</td>
<td>300,811</td>
</tr>
<tr>
<td>Singapore</td>
<td>3,033</td>
<td>581</td>
<td>0</td>
<td>0</td>
<td>103,318</td>
<td>0</td>
<td>288</td>
<td>0</td>
<td>1,617</td>
<td>0</td>
<td>108,837</td>
</tr>
<tr>
<td>Thailand</td>
<td>3,855</td>
<td>50</td>
<td>506</td>
<td>734</td>
<td>3,880</td>
<td>226</td>
<td>145</td>
<td>13,919</td>
<td>0</td>
<td>536</td>
<td>23,851</td>
</tr>
<tr>
<td>Vietnam</td>
<td>0</td>
<td>173,694</td>
<td>0</td>
<td>8,167</td>
<td>0</td>
<td>0</td>
<td>748</td>
<td>0</td>
<td>301</td>
<td>0</td>
<td>182,911</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>111,052</td>
<td>177,856</td>
<td>506</td>
<td>9,953</td>
<td>1,807,264</td>
<td>2,26</td>
<td>9,091</td>
<td>1,176,879</td>
<td>1,325,915</td>
<td>536</td>
<td>4,619,277</td>
</tr>
</tbody>
</table>

Source: Preparation of Manpower in the Era of Free Labor Migration and Markets in Nine Sectors as per the AEC Framework

The launching of the AEC (ASEAN Economic Community) in 2015 will accelerate the cross-border movement of skilled MW and professionals such as doctors, dentists, nurses, engineers, accountants, architects, and survey researchers. ASEAN countries have processed Mutual Recognition Agreements (MARs) to more clearly define the job skills needed to be filled by professional MW in the different sectors in the era of freer labor exchange. ASEAN countries have also processed MOU to establish a common proportional ownership of business investment of 70% by all member countries. As a consequence, it is also expected that there will be an increase in investment among ASEAN countries and expansion in production which, in turn, will stimulate more MW migration, both skilled and unskilled. While some may be concerned that some portion of Thailand’s investment and production base will shift to other countries in the AEC era (e.g., to Myanmar, Vietnam and Cambodia), the comparatively higher wages in Thailand will continue to be a magnet for MWs. In addition to Thailand’s immediate neighbors, citizens of other countries such as Vietnam might be interested in migrating to Thailand because of the higher average incomes (see Table 5). Currently, there is an evidence of Vietnamese who work in Thailand but lack of official record.

18 Suwanna Tunyawainpongse, 2011
19 Economic Intelligence Center. Siam Commercial Bank, accessed in November, 2013
**Table 5 Comparison of the Minimum Daily Wage, Daily Expenses, and Balance**

<table>
<thead>
<tr>
<th>Country</th>
<th>Minimum Wage (baht/day)</th>
<th>Cost per meal (baht per day)</th>
<th>Cost of 3 meals a day (baht)</th>
<th>Balance (baht)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Singapore</td>
<td>1,851</td>
<td>80-100</td>
<td>240-300</td>
<td>1,611-1,551</td>
</tr>
<tr>
<td>The Philippines</td>
<td>300</td>
<td>30-40</td>
<td>90-120</td>
<td>210-180</td>
</tr>
<tr>
<td>Thailand</td>
<td>300</td>
<td>30-50</td>
<td>90-150</td>
<td>210-150</td>
</tr>
<tr>
<td>Malaysia</td>
<td>300</td>
<td>50-60</td>
<td>150-180</td>
<td>150-120</td>
</tr>
<tr>
<td>Indonesia</td>
<td>169</td>
<td>40</td>
<td>120</td>
<td>149</td>
</tr>
<tr>
<td>Vietnam</td>
<td>95</td>
<td>25-30</td>
<td>75-105</td>
<td>15 - not enough</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>90</td>
<td>25-35</td>
<td>75-105</td>
<td>15 – not enough</td>
</tr>
<tr>
<td>Cambodia</td>
<td>66</td>
<td>30-40</td>
<td>90-120</td>
<td>Not enough</td>
</tr>
<tr>
<td>Myanmar</td>
<td>66</td>
<td>20</td>
<td>60</td>
<td>6</td>
</tr>
</tbody>
</table>

Source: http://www.uasean.com/kerobow01/201

*Comparison of the Minimum Wage Rate among ASEAN Countries*

If Thailand increases its proportional investment from 49% to 70% in 2015, it is forecast that there will be a significant expansion of the economy as a result. Thailand’s strengths are its base as a center of manufacturing and agro-industry on a global scale. It has the infrastructure to serve as a communications hub for regional networking and for delivering efficient public utilities. Thailand has a strong banking and financial services sector. Thus, Thailand will continue to rely on MW for years to come.

Given the anticipated trends in the expanding ASEAN economy and movement of migrant labor, one issue is which group of MW should Thailand give priority consideration to? Currently, skilled and professional MW represents only 12.8% of the registered MW labor force in Thailand. These MWs are well taken care by their employers and have international compensation packages, including health and social insurance which often covers family members and education costs for children. These MWs have no difficulty accessing their basic service needs. By contrast, the 87.2% of MWs who are low-skilled and mostly come from Myanmar, Lao PDR and Cambodia, still face challenges in accessing the basic service systems, especially in the health sector. Despite the government measures to provide health coverage for MWs through the social security system to be on par with Thai nationals, but not all MWs are covered.

The greater freedom of movement and investment in the AEC era is certain to increase the influx of MW to Thailand. This demographic shift will strain Thailand’s public health system, the schools, and social welfare. Thus, the government needs to consider policy improvements to provide quality coverage for all. In the near future, it is also likely that there will be more cross-migration among professional occupations e.g., doctors and
nurses among ASEAN countries, and Thailand should be more proactive involving/hiring health providers from Myanmar, Laos PDR and Cambodia to work for the Thai hospitals to take care of MWs from these countries. This will help to reduce health care service burden for MWs, deriving from communication barriers and different culture. This aims to balance a health service standard between Thais and non-Thais living in the country.
Chapter 3

Health Care Measures and Systems for Migrants in Thailand
Chapter 3

Health Care Measures and Systems for Migrants in Thailand

1. Health Care System for Thais in Thailand

In the past, most Thais sought standard health services at government hospitals, and they had to pay for the service out-of-pocket. Since 1975, the government subsidized the cost of care for very low-income patients using social welfare funds. Other forms of welfare for medical care were also available such as the Medical Care for the Elderly Program (launched in 1991), and Health Insurance for Children from Birth to Age 12 Years Program (also begun in 1991) as an outgrowth of the Student Health Insurance Project. Government civil servants, full-time contract hires and state enterprise workers have their separate health insurance program which covers the parents, spouse and children of the insured. Finally, there are targeted medical care welfare programs for the disabled, veterans, Sub-district executive officers, village headmen and various groups of volunteers.

In 2002, Thailand passed the National Health Insurance Act, including the establishment of the National Health Security Office (NHSO) under the administration of the Minister of Health, in the Minister’s role as Chairperson of the National Health Insurance Committee. The NHSO functions as the secretariat of this Committee. In addition, the NHSO manages the national health insurance fund with the goal of providing full access for the population to standard and quality health care. The fund has the mandate to maximize efficiency of operations, to operate transparently and to be subject to periodic audits. All Thais holding a national ID card can present their card at their local, registered health outlet to obtain free service. After ten years of implementing this national health insurance scheme, it can be concluded that there is greater coverage of health care of the population, and only about one percent were not able to access subsidized health care (as per a 2010 survey).

In addition to the national health insurance, there are various compulsory and voluntary-participation health funds for different groups as described below:

1) The 1972 Workers’ Compensation Fund for laborers experiencing job-related hazards, injuries or illness. This fund covers treatment and direct compensation.


20 National Health Security Office, retrieved on November 2013
21 Health Systems Research Institute, 2012
3) Vehicle accident insurance (1992) covering medical care and disability due to traffic accidents, and is mandatory for vehicle owners, and purchased from private insurers.

4) Voluntary health insurance issued by the Ministry of Public Health (MOPH) was launched in 1983 and is referred to as the “health care” scheme. This program was the government’s attempt to cover the lower-income and those who were not eligible for other health care subsidy programs. The user paid an annual fee of 500 baht (about 16 USD) for coverage. After the introduction of the national health insurance scheme in 2002, the MOPH health card was provided on a limited basis to those not covered by the national program such as undocumented persons or foreign MWs (prior to the proclamation for MW health insurance).

5) Private health insurance is elective coverage by individuals willing to purchase the insurance from a private provider. There are both individual and group insurance programs in the private sector.

2. Developments in Health Care for Burmese, Lao and Cambodians in Thailand

Thailand’s national health insurance programs are part of a larger effort toward the goal of health for all Thais. However, to achieve health for all requires providing full access to health care for all residents of the country. As the number of MWs from Myanmar, Lao PDR and Cambodia living and working in Thailand increased, the MOPH introduced a year-by-year health insurance program for MWs under the administration of the Bureau of Health Service System Development of the Department of Health Service Support. In 2009, the MOPH conducted an internal reorganization, and management of this insurance program was transferred to the Bureau of Health Administration under the Office of the Permanent Secretary for Health. This change benefits in a way that the new bureau have a supervising and monitoring roles toward all hospital-based care in the MOPH system rather than just technical support.

Organized compulsory health insurance for the Burmese, Lao and Cambodian MW in Thailand began in 1999 when the MOPH issued the “Measures and Guidelines for Health Exams and Insurance for Foreign Migrant Workers.” These guidelines were provided to MOPH hospitals throughout the country, including provincial and district hospitals in provinces outside of Bangkok. For Bangkok public hospitals, the MOPH assigned responsibility for this program to the Department for Medical Services in collaboration with the Bangkok Metropolitan Administration (BMA). Two private hospitals (in Samut Sakorn Province and Bangkok) also participate in the program in view of the large number of MWs in their catchment areas.

It is noteworthy that, during 2004-11, this health exam and insurance program for MWs had to be reviewed and re-authorized by the Cabinet each year. Thus, the Board for Illegal
Foreign Workers Administration (Kaw Baw Raw) under the Ministry of Labor has the principle role in implementing the Cabinet authorization. Other agencies, including the MOPH issue their own guidelines that are consistent with the Cabinet resolution and the prevailing Kaw Raw Baw guidelines for that year. For example, in 2004 and 2006, the Cabinet resolution gave priority to the registration of dependents and family members of the MWs under the Civil Registration system (Thaw Raw 38/1). Accordingly, the MOPH expanded its guidelines to include dependents and family members of the MWs.

During the 2005-08 period of migrant health insurance, the MOPH attempted to maximize coverage for MWs and their dependents, without regard to their legal status. This measure stimulated extensive debate along the following two viewpoints:

1) The MOPH should adhere strictly to the Cabinet resolutions. Health insurance should be provided only for those registered MWs from Myanmar, Lao PDR and Cambodia. This position is consistent with the position of the National Security Council which has stated that health insurance should not be provided to those migrants in Thailand illegally.23

2) The MOPH, in its role as overseer for the health of the country, should expand health insurance coverage to include all MWs and their family members without restriction by legal status, as health is a basic human rights and because “providing health insurance for documented MWs does not stop infectious disease, as the disease do not infected only documented, but all migrants” This standpoint is endorsed by NGOs, technical academics and human rights activists, who continue to advocate for it.

During 2005-2006 the MOPH worked with other stakeholders in society, including public, private, NGO, academics and the business sector to develop a comprehensive health strategy for migrants, in which migrants was defined as foreign workers in Thailand including their dependents. The strategic vision was “To promote the health of MW through collaboration with government agencies, local administrative organizations, the private sector, NGOs and the affected communities through an integrated process.” The strategy has five strategic themes as follows:

1) To develop the public health system for migrants to provide full coverage and access to standard services;

2) To provide health insurance for all;

3) To promote participation of migrant populations and the community to care for themselves and their family members with collaboration and participation of all sectors;

4) To develop a database and information system; and

5) To manage health services for migrants.

22 Bureau of Public Health Administration. MOPH, 2004-2008
23 Result of a meeting to review Migrant Health Strategic Plan by MoPH, August 2006
The pursuit of this strategic vision is a sensitive issue for the country in view of the significance of the target beneficiaries for the Thai economy and the potential future need to expand coverage to include migrants of other countries than just these three neighbors of Thailand. Thus, the strategy has remained in draft form since it was first developed in 2006.

For a decade, the Bureau of Policy and Strategy, in collaboration with the World Health Organization (WHO), have been working with key stakeholders to develop a master plan to address the problems and health needs of the four border areas, with an emphasis on Thailand’s borders with Myanmar due to its complexity. More momentum has been gained for Lao PDR and Cambodia borders. The plan and strategies aiming to cover all the populations living in the border area (including Thais, those waiting for verification of nationality, refugees from conflict in Myanmar, documented and undocumented MW, and family members). Four components of this master plan include: (1) Developing health service system; (2) Access to basic health services; (3) Strengthening collaboration and participation of all sectors; and (4) Administration. A second cycle of the Border Health Development Master Plan has been developed for the period of 2012-2016.

In 2009, responsibility for overseeing migrant health issues in the MOPH was shifted from the Department for Health Service Support to the Office of the Permanent Secretary. The strategy for migrant health services was modified to be more strictly consistent with the Cabinet resolution and the Kaw Baw Raw, meaning that health insurance was now restricted only to those registered MWs in Thailand and their accompanying children up to age 15 years.24

The three MOUs enacted between Thailand and Lao PDR on October 18, 2002, with Cambodia on May 31, 2003, and with Myanmar on June 21, 2003, meant that MWs in Thailand would have to provide nationality verification by their home country and process proper entry permits, after which they would be eligible for social security under the regulations of the Social Security Office of the Ministry of Labor. This coverage would include social benefits, medical care, and other benefits, equivalent to what Thai workers enjoy. Lao PDR and Cambodia began sending MWs to Thailand under the MOUs beginning in 2005. However, it wasn’t until 2010 when Myanmar started implementing the MOU.

3. Types of Registration of Burmese, Lao and Cambodians in Thailand

The steady flow of irregular migrant workers into Thailand, primarily from Myanmar, Lao PDR and Cambodia, prompted the Thai government to implement a policy in 1992 to allow MW in-country to apply for a temporary work permit, and formal registration began in 1996.25 The Cabinet issued a resolution providing the framework for an annual registration

24 Bureau of Public Health Administration, MOPH, 2009
25 Krittaya Achawknitkul, 2012
process because the labor shortage situation by type of employment was evolving, with fewer and fewer Thais willing to take on low-wage, difficult labor. This transition was exacerbated by the continuing fertility decline of the Thai population. The aging of the Thai population translates into fewer Thais in the working-age years and increased labor shortages in the low-skilled, wage-labor sector. Thus, it cannot be denied that, in the past three decades of economic growth, MWs in Thailand have been a major factor contributing to this economic expansion.

The Office of Foreign Workers Administration of the Department of Employment of the Ministry of Labor has data on the number or MWs registered for work in Thailand, dating back to the initial relaxation of requirements in 2004. These data show that MWs from Myanmar comprise the largest number workers from Thailand’s three lower-income neighbors, with similar, though lower, numbers for MWs from Lao PDR and Cambodia.

Registered MWs are classified into the following categories:

1) **MW registering on an annual basis**: Also referred to as the “Wavier Group” this category includes MW who registered to obtain temporary residence permits (Thaw Raw 38/1) and 13-digit ID numbers from the Thai Ministry of Interior. Registration in this category began in 2004, and allows temporary residence for aliens while their nationality is being verified. The number of MW in this group varies by year depending on policy. In 2013, the Thai government had no policy to approve MW in this category. So, if they did not have proof of nationality, they became undocumented MW.

2) **MW who has received nationality verification**: This group is also referred to as “Nationality Verification or NV.” Since 2006, Thailand has put forth measures to regularize the status of “waived” MW to be fully legal through a process of nationality verification. The NV process began with Lao PDR and Cambodia in 2004, while Myanmar started verifying the nationality of its MWs in 2009.

3) **Imported MW**: This group of imported labor enters Thailand under the bi-lateral MOUs between Thailand and Myanmar, Lao PDR and Cambodia. The MOUs allowed MWs to enter Thailand legally. However, complications of processing in the countries of origin (e.g., rather high processing fees, many steps in the process, etc.) has limited the number of MWs entering Thailand through this mean.

4) **Unregistered MW**: This group of undocumented MWs includes those illegally entering Thailand for work and not registering under the waiver or NV systems, and tends to be a somewhat hidden population due to fear of being arrested and deported. Some of these persons could be dependents of the MWs and may engage in temporary work but without work permits.
The following tables show the number of MWs who were registered during 2005-13, categorized by type of registration. It can be seen that, during 2005-2006, the data for registered MWs only include those approved under the waiver system. By 2007 however, there begin to be MWs in the “NV” category for Lao and Cambodians. There was a sharp increase of MWs in this category in 2010 due to the addition of Myanmar in the process of nationality verification. The total continued to increase through 2013. Since many of the NV MWs came from the waiver system group, the totals for the latter category decline proportionately. However, if MWs in the annual waiver system cannot verify their nationality, then they will eventually be lost to the registration system (i.e., becoming undocumented MWs) due to Cabinet policy, which became effective at the end of 2012 as noted above.

### Table 6 Number of MW from Myanmar, Lao PDR and Cambodia during 2005-13 by Registration Category

<table>
<thead>
<tr>
<th>Cabinet Resolution Year</th>
<th>Number of registered MW</th>
<th>Type of Registration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Annual Waiver</td>
</tr>
<tr>
<td>2005</td>
<td>849,552</td>
<td>849,552</td>
</tr>
<tr>
<td>2006</td>
<td>668,576</td>
<td>668,576</td>
</tr>
<tr>
<td>2007</td>
<td>632,920</td>
<td>546,272</td>
</tr>
<tr>
<td>2008</td>
<td>589,646</td>
<td>501,570</td>
</tr>
<tr>
<td>2009*</td>
<td>1,419,743</td>
<td>1,314,382</td>
</tr>
<tr>
<td>2010</td>
<td>1,200,698</td>
<td>932,225</td>
</tr>
<tr>
<td>2011*</td>
<td>1,825,658</td>
<td>1,248,064</td>
</tr>
<tr>
<td>2012</td>
<td>994,749</td>
<td>167,881</td>
</tr>
<tr>
<td>2013</td>
<td>1,105,528</td>
<td>19,850</td>
</tr>
</tbody>
</table>

* Refers to the year of the Cabinet resolution relaxing the registration requirements for MW on an annual basis, and which allows undocumented MW to

### Sources of data:
2. All totals refer to the balance of MW authorized to work in Thailand as of December of the year, except for 2013 for which the data are for August.

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26 Office of Foreign Workers Administration, Ministry of Labor, 2005-2013
The data from the above table reflect important limitations in the countries of origin in processing MWs to Thailand. During 2007-13, the cumulative total of MWs under the MOU (imported MW) does not reach 200,000 despite the bi-lateral agreements to promote this legal transfer of labor. Costs of processing fees, employment broker fees and complexity of the process retard the flow of MWs in this category.

The annual waiver system was supposed to be phased out by the end of 2012. But because of delays in the nationality verification process, there have been temporary extensions of waived MWs. The latest extension is until December 2013.27

Overall, the number of registered MWs depends on Cabinet resolutions and may go up or down in a given year depending on the resolution. In fact, the actual number of de facto MW in-country may not have decreased, or actually increased as the Thai economy expands. The increase of the minimum wage to 300 baht (less than 10 USD) per day in 2012 is another “pull” factor for MWs travel to Thailand.

**Figure 2 Number of Registered MW from Myanmar, Lao PDR and Cambodia during 2005-13**

![Bar chart showing the number of registered MWs from Myanmar, Lao PDR, and Cambodia during 2005-13.](source)

*Source of data: Total balance of MW authorized to work in Thailand: Annual summary for 2005-12 as of December of each year, and through August 2013.*
4. Current Status of Health Care for MW from Myanmar, Lao PDR and Cambodia

In 2013, the Cabinet resolution dated January 15 appointed the MOPH as the lead agency for managing public health care for all migrants who are not already covered in the social security system. The resolution advised the MOPH to explore means and mechanisms to motivate those without health insurance to join the MOPH migrant health insurance system. A key feature of the resolution was the authorization for the MOPH to establish a health insurance scheme for MWs without regard to legal status, including the dependents, family members and children of the MWs. In March, 2013, the MOPH issued measures and guidelines for providing health exams and insurance to MWs (from Myanmar, Lao PDR, and Cambodia). It was noted that these measures referred to “migrant” rather than “migrant worker” as in the past.

The 2013 Cabinet resolution resulted MW from Myanmar, Lao PDR and Cambodia were covered by health insurance in one system or another (see below):

1) Social security scheme of the Social Security Office of the Ministry of Labor, including:
   • Imported labor through the MOU process
   • MW who had their nationality verified

2) Year-to-year health insurance administered by the MOPH, including:
   • MWs approved to work under the MOU or NV process, and working in the fisheries and seafood processing industry, agro-industry, animal husbandry, construction, or domestic help, who are otherwise not covered in the social security system
   • MWs approved to work under the MOU or NV process, and who are eligible for social security but are awaiting the rights to medical care (since three months of payments need to have been made before medical coverage begins). This insurance covers health services for three months aiming to fill this gap.
   • Undocumented MWs working in Thailand
   • Accompanying dependents, family members and children of the MWs up to age 15 years

4.1 Social Security System

The Social Security Office mandates that MWs from Myanmar, Lao PDR and Cambodia, both those entering from their home countries and those registered via NV, be insured in accordance with the 1990 Social Security Law. There are three contributors to the social security fund: The government, the employer and the employee. Those workers in the fisheries, agro-industry, and domestic help sectors, which are occupations excluded from social security benefits, are to be included in the system on a year-to-year basis. The Social

28 Office of the Secretariat of the Cabinet, 2013
29 Bureau for Public Health Administration, MOPH, 2013
Security Office has set the following conditions for exception: Those MWs working in agricultural cultivation, fisheries, forestry or animal husbandry and whose employment is not continuous through the year, and who do not have secondary occupations; MWs working on an ad hoc basis as required by the employer; itinerant or seasonal workers. MWs working for an itinerant vendor or trade-stall merchant; or working as a domestic helper not involved in the employer’s business.\(^{30}\)

MWs who are eligible for social security need to contribute 5% of their monthly income (not less than 1,650 baht (50 USD) or over 15,000 baht (456 USD)) at the time of registration for social security. The insurance covers the following: (1) Injury or illness; (2) Disability; (3) Death; (4) Child delivery; (5) Child welfare; (6) Conditions of aging; and (7) Unemployment. Despite the opening of the social security system to MWs, there remain numerous obstacles to accessibility. Lack of knowledge about Social Welfare benefits is an important barrier. Also, the insurance premium is higher than that for year-to-year MOPH health insurance. For the minimum daily wage of 300 baht and 25 routine work-days per month, the premium is 375 baht (11.4 USD) per month or 4,500 baht (136.7 USD) per year. The fact that employers must contribute to the fund on behalf of the MWs increases the cost to the employer. In 2013, less than half of the MWs who were eligible for social security were enrolled (see table below).

**Table 7 Number of MW and Number of MW Enrolled in the Social Security System**

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Target Population</th>
<th>Estimate number eligibility for social security</th>
<th>Number enrolled in the social security</th>
<th>Coverage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NV group</td>
<td>MOU group</td>
<td>Total</td>
<td>Not eligible*</td>
</tr>
<tr>
<td>Feb. 2013</td>
<td>848,443</td>
<td>111,295</td>
<td>959,738</td>
<td>308,855</td>
</tr>
<tr>
<td>Aug. 2013</td>
<td>917,212</td>
<td>168,486</td>
<td>1,085,698</td>
<td>349,594</td>
</tr>
</tbody>
</table>

* Calculated as the proportion of MW registered to work in Thailand by type of work eligibility for social security (data in February 2013). About one-third (32.2%) of MW were non-eligible to enroll the social security fund.
** As of September 2013

Source:
1. MW approved for employment as of February and August, 2013\(^{31}\)
2. Number of insured MW by nationality; Social Security Office, obtained from MoPH

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\(^{30}\) Social Security Office, Rayong Province, 2013
\(^{31}\) Bureau of Foreign Worker’s Administration, Ministry of Labor, 2013
Even though the range of benefits under the social security scheme extends beyond health care, social security is designed more for long-term coverage and is not appropriate for MWs who are authorized to work in Thailand for no more than four years. Thus, the children’s and elderly welfare provisions are somewhat irrelevant for the MWs population, and there are limitations of access to the subsidy for child birth. For instance, male MWs must show a marriage certificate or birth certificate to access welfare for child delivery. Unemployment compensation is also impractical for MWs since they are required to return to their country of origin after termination of employment. Thus, MWs are required to pay into a system whose benefits they cannot fully access when needed.

A research study on “How much social protection MW in Thailand should receive?” conducted by the former high level administrators of the Ministry of Labor. The study recommends that the Social Security Office should have a special category of coverage for MW in the following situations: 1) Costs for treating non-work-related injury and worker’s compensation during periods of missed work; (2) Child-birth costs except for wage compensation during maternity leave to promote contraceptive use; (3) Costs for work-related disability and travel to return to country of origin; (4) Death; (5) Conditions of aging; payment of lump sum pension instead of installments; and (6) Children’s welfare, including health care, education, and day care during parents’ employment in Thailand. (7) The compensation due to termination of employment should be waived.

The view of Civil Society on this issue is that Thailand already has favorable social insurance laws compared to other countries in SEA which do not discriminate by nationality. Thus, they do not see the need for a separate category of insurance for MWs. Instead, it would be preferable to make minor modifications in existing social security law to better address the needs of MWs, improve access and reduce obstacles to access due to communication or language barriers.

### 4.2 MOPH Year-to-year Health Insurance System

The MOPH and participating hospitals provide health exams for 600 baht (18.2 USD) a person and health insurance for 1,300 baht (39.5 USD), so the total amount to be paid by migrants is 1900 baht (57.7 USD) per year. Those covered by social security must be enrolled in the system for three months before they are eligible for benefits. The cost for the health exam is 600 baht and health insurance is 447 baht (13.6 USD) for a total of 1,047 baht (31.8 USD). Children not over 15 years do not need to have health exams, with the combined health insurance cost of 365 baht (11 USD).

The benefits for migrants under this health insurance scheme are similar to the “Health for All” program except for dialysis and treatment for end-stage kidney disease, and anti-retro-
viral therapy (ART) for AIDS. However, the insurance does cover prevention of mother-to-child transmission of HIV. Each treatment encounter requires a co-pay of 30 baht (0.9 USD) for adult insurer. And it should be noted that the MOPH health Insurance is not a central pooling fund. The fund is not purely managed by a single unit. Health Insurance Group under Permanent Secretary Office is managing high cost care, while big portion of the fund is remained at provincial level; some with provincial health office for disease prevention and control and administration and the main part on health care services are kept and managed by contracted hospitals. This current system has a greater risk for a small pooling fund at the hospital where participation of migrants on HI is low.

However the latest MOPH policy on migrant HI has clearly showed that Thailand’s intention to improve coverage of health insurance to all migrants in the country, regardless of legal status. The challenge is how to inform and motivate eligible migrants to participate in the HI scheme. Factors that hinder their decision include their view on health insurance as well as their willingness to pay annual health insurance premium. The data in the table below shows that the number of Burmese, Lao and Cambodian migrants joining the MOPH health insurance scheme is still low.

Table 8  Number and Coverage of MW Enrolled for Health Insurance
(Dec. 15, 2012 –Aug. 11, 2013)

<table>
<thead>
<tr>
<th>Social Security</th>
<th>Number enrolled in health insurance</th>
<th>Waiting for NV</th>
<th>MW ineligible for social security</th>
<th>MW without work permits</th>
<th>MW dependents and family members</th>
<th>Number enrolled in health insurance</th>
<th>Number of Children of MW age 0-15 years</th>
<th>Number enrolled in health insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 months Health Insurance Program</td>
<td>Year-to-Year Health Insurance Program</td>
<td>Adult</td>
<td>Children</td>
<td>Adult</td>
<td>Children</td>
<td>Adult</td>
<td>Children</td>
<td>Adult</td>
</tr>
<tr>
<td>736,104</td>
<td>23,065</td>
<td>19,850</td>
<td>349,594</td>
<td>No data</td>
<td>No data</td>
<td>234,284</td>
<td>No data</td>
<td>2,306</td>
</tr>
<tr>
<td>Coverage = 3.1%</td>
<td>Total = 369,444++</td>
<td>Estimate * 63,015++</td>
<td>Coverage = 63.4%</td>
<td>Coverage = 3.7%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Medium estimate from a Bangkok research study in 2011 which found that children of migrants age 0-15 years comprised 5.7% of the survey migrant population. This figure is applied as a minimum estimate since those undocumented dependents and family members are not enumerated.

Sources of data:
1. Results of health exams for aliens during December 15, 2012 to August 11, 2013
2. Balance of the total number of aliens authorized to work in Thailand as of August 2013
3. Number of MW with social security by nationality (Burmese, Lao, Cambodian)

35 HCC and PATH, the Institute for Population and Social Research of Mahidol University and Faculty of Archaeology, Silapakorn University, 2011
The Samut Sakorn Hospital is a health insurance service provider for a large number of migrants. A senior administrator of this hospital explained that, since the health exam and insurance are not mandatory as part of the MWs registration process as same as it was in the past, the number of MWs enrolling in any health insurance schemes (SSS and MOPH HI) has declined significantly. In addition, those migrants who are insured into MOPH HI are more likely to be those with chronic or serious health problems. Thus, without a proper balance of healthy and infirm in the insurance pool there is a shortage of funds to treat those in need (a 54 million baht or 1.6 million USD deficit in the case of this hospital). Some of the MWs in this province have social security and use that to cover health care at the Samut Sakorn Hospital. But the social security fund does not cover prevention or disease control. Plus, because a large number of MWs use social insurance programs of private hospitals in the province, this makes it difficult to conduct comprehensive disease control and prevention activities for the migrant population.

Even those MWs who are covered by health insurance still face obstacles in access to services, for example, they need support from their employer to provide transportation to the health service provider, there are long waits for service which cause a loss of wages, there is difficulty in communication with the health staff due to not enough bi-lingual interpreters in the hospital, and harassment by officials during the commute to and from the health outlet. In addition, there is no referral network among participating health service outlets, as there is with the Health Insurance Program for the Thai people. Thus, MWs can only obtain service at the facility to which they are registered, and which might be more remote from the worksite or domicile than local health centers. Thus, if their health problem is not serious, MWs will go to nearby outlets, even if they have to pay out of pocket, and only go to their assigned hospital when they have a serious condition, and this increases the per-patient cost for the hospital. Besides, the negative attitude of health providers towards migrants based on different in ethnicity, nationality, language, believe and culture remains a key barrier of migrant friendly services.

To make health services more foreigner-friendly, some hospitals have migrant health volunteers (MHVs) to facilitate communication between patient and provider and to reduce the burden on health staff for both passive and outreach services. Hospitals with large migrant caseloads have arranged separate out-patient departments for those MWs with health insurance, and this has improved access and convenience.

In August 2013, the MOPH made modifications to the measures and guidelines for health exams and insurance for aliens, resulting in the following significant changes:

1) Expansion of coverage for all migrants, not just Burmese, Lao and Cambodians

2) De-linkage of insurance enrollment with labor registration

3) Inclusion of ART as part of the benefits

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36 Interview with Dr. Moli Wanichsuwan, November 29, 2013
4) Increase of the health insurance premium by 900 baht (27.2 USD) from 1,300 to 2,200 baht (39.5 to 66.8 USD) per year

5) Migrant youth age seven years or more pay the adult rate for insurance coverage

6) Participating providers must meet the criteria of NHSO, which disqualifies a number of private hospitals from providing insured care for MWs as they had in the past

7) Redesign of the central and provincial management structure for health insurance to be in the form of a committee

8) At the central level, the Health Insurance Group of the Office of the Permanent Secretary will have a greater oversight role for health insurance in collaboration with the Bureau for Health Administration.

The addition of ART to the benefits package was a feature which Civil Society and NGOs had lobbied for since 2004. In order to achieve parity with Thais covered under the Health for All program, the Global Fund to Fight AIDS, Tuberculosis and Malaria has been providing financial support to Thailand to provide ART to 2,518 undocumented persons under the NAPHA project (National Antiretroviral for People Living with HIV/AIDS), consisting Burmese, Lao and Cambodians 82.7 %, ethnic group 14.7% and a small proportion of persons awaiting verification of Thai nationality 2.6%. NAPHA project will be ended in September 2014 and it is anticipated that there will be at least 1,000 migrants who will require ART. So the addition of ART to health insurance benefits will provide one option for continuing care among this population.

The NAPHA Project provides ART through 400 service outlets. The hospitals with large migrant caseloads (e.g., Ranong and Samut Sakorn Provincial Hospitals) have good service models. Key factors contributing to such a model include existence of Migrant Health Volunteers (MHVs) who assist health service providers and on-going support to the hospitals by NGOs. Through NAPHA Extension Project, the guidelines for providing ART for migrants enroiling in MOPH health insurance is drafted. It covers three core components: (1) HIV Voluntary Counseling and Testing (VCT); (2) ART; and (3) Laboratory monitoring of ART results. Additionally the guidelines also recommend providing condoms to ART clients to prevent infection and transmission of ARV-resistant virus as a part of insurance benefit.

Efficient management of ART requires experienced service outlets and personnel. From interviews with technical officer of NAPHA project it was found that 80% of Thai government outlets could provide standard ART for Thais under the Health for All programs. However, providing the same standard of treatment for migrants might be more difficult because of the communication barrier and complexity of follow-up due to higher mobility migrants. Therefore improving ART service system for migrants is needed. A concept of

37 The Global Fund to Fight AIDS, Tuberculosis and Malaria, 2013
38 Interview with KhunPornthipYuktanon, Bureau of AIDS, Tuberculosis and STIs, on November 11, 2013
having one to three outlets per province equipped to standard of care to migrants is proposed.

At the time of this study, there were 883 hospitals participating as providers for insured migrants. Among these, four are under the BMA, and one is a public organization (Ban Phaew Hospital). Based on estimates of the carrying capacity of the insurance fund with an increased fee of 900 baht (27.3 USD) per 200,000 MWs expected to enroll in the MOPH migrant HI, this would enable MOPH to continue ART for migrants to be transferred from NAPHA extension project.39
Chapter 4

Health Service Systems of Migrants’ Countries of Origin
Chapter 4

Health Service Systems of Migrants’ Countries of Origin

The ten member countries of ASEAN comprise 600 million people who represent a diverse range of ethnicities, religions, cultures, customs, economies and societies. They also share similarities such as policies to expand their economies through increased production and agro-industry, an abundance of natural resources which attract tourists, the possession of international sea ports (except for Lao PDR), and a nexus with surrounding regions of the world. The ASEAN countries have a large number of unskilled laborers who are willing to work for relatively low wages when compared with industrialized countries. Thus, this region is an important center for global industrial production.

ASEAN collaboration in the arenas of politics, security, socio-economy and culture has the aim to increase quality of life for its citizens, promote adequate livelihoods, social security, rights, justice, environmental conservation, highlight unique positive attributes, and reduce inequality. Health and public health services are an area of development in the ASEAN region as well. Thailand, in its role as a destination country for MWs from its lower-income neighbors of Myanmar, Lao PDR and Cambodia, is formulating policies and plans for implementing public health services for mobile populations, including migrants. To help inform the Thai policy in this area, it is important to understand the health systems of the countries of origin of the migrants.

1. Health Systems in the Countries of Origin

1.1 Myanmar

Public health development in Myanmar has been slow in accordance with political policy and administration. The Myanmar Ministry of Health (MOH) has responsibility for administration and development of public health systems for the population, including health promotion, disease prevention, medical care, and rehabilitation. The MOH has the goal to raise the health status of the entire population as per the national policy and development plan. The MOH has a Department of Health (DOH) as one of seven departments. The DOH administers the health service system for the 14 states, inclusive of border populations and those in remote areas. Other ministries have independent health systems for their employees and their families, but the emphasis is mostly on clinical care. The Ministry of Labor (MOL) has three hospitals under it administration (two in Yangon, and one in Mandalay). These three

40 World Health Organization, 2012
hospitals serve workers who have social security. Because of the limitations of the public health system, as well as budget and staff, the private sector is rather active in health care, but most of the private outlets only provide out-patient services.

The DOH is the central agency for health planning in accordance with national policy. The DOH organizes training, technical support, supervision and evaluation. At the district level, there is the District Health Department (DHD) which conducts management, control and health activities in its area of jurisdiction. Each DHD has about three to seven townships, each with a Township Health Department (THD). The typical THD has a catchment population of 100,000 – 200,000 population. At the peripheral level there are Health Care Centers (HCC) which provide primary health care to communities. For more complicated cases, the HCC refers clients to station hospitals or the township or district hospital. Some of these hospitals have areas of specialty, as follows:

1) 29 district hospitals provide special secondary care;

2) 302 township hospitals have capacity in proportion to the size of their catchment populations and range in size from 16 to 50 beds;

3) There is an average of two station hospitals per township, with one or two physicians on staff;

4) There are four to seven HCCs in the catchment area of the station hospital and primarily serve the rural population. The HCC oversee health posts with midwives, lady health visitors, and village health volunteers. In towns, the municipal health center provides school health and MCH services.

In addition to the formal system, there is a linked network of traditional healers who play an important role in caring for the health needs of the Burmese population. The government has recognized the importance of this sector by creating a Department of Traditional Medicine in the MOPH which provides oversight, and controls standards of care given by the traditional healers. There are 14 traditional medicine hospitals in the country.

Myanmar has 35 reference hospitals which provide specialized, tertiary care. Of these, 25 are located in Yangon, seven in Mandalay, two in Kachin State, and one in Shan State.

1.2 Cambodia

As of 2012, Cambodia had an official population of 14.8 million, 80% of who resided in rural areas. Following the end of civil conflict in Cambodia, public health improved rapidly. As of

41 My Media Power, accessed in December 2013
42 World Health Organization, 2012
1993 the Cambodian Ministry of Health had developed policies and administered a public health system which covered the entire country. However, limited government health budget resulted in the active participation of international NGOs, and an integrated, multi-sectoral approach to health issues. Traditional healers played an important role in health care at the community level. During 1990-96, Cambodia implemented a structural reform of health service outlets by dividing the 24 provinces of the country into 73 operational health districts. Currently, that number has increased to 77, and each health district has a catchment population of 100,000 – 200,000. There are two categories of health service at the district level: Minimum Package Activities (MPA) and a Complementary Package Activities (CPA). The district can provide health care across multiple dimensions and is a crossroads for referral for specialized care. The private care outlets are not able to provide the MPA and CPA services at the same level as the government. The health service outlets of Cambodia can be classified as follows:

1) The 1,049 HCC and Health Posts (HPs) are primary care outlets, each with a catchment population ranging from 10,000 – 20,000 persons. Services include counseling, preliminary diagnostics, emergency care, care for chronic illness, MCH, delivery (for uncomplicated pregnancies), contraception, immunization, health education and referral. However, due to staff shortages, only 43% of the HCC can provide the full range of services. The focus of the services is on contraception, ante-natal care (ANC) and pre-natal tetanus toxoid.

2) Referral hospitals are located at the national, provincial, and district levels, and can be classified according to the number of beds, staff, medicines and medical supplies available, as follows:
   - 33 primary care facilities, or CPA 1, can perform uncomplicated child delivery but cannot perform surgery requiring general anesthesia;
   - 31 secondary care facilities, or CPA 2, can perform emergency care, surgery requiring general anesthesia, have an ICU and physicians with specialty in ear, eye, nose and throat conditions, orthopedics, etc.
   - 29 tertiary care facilities, or CPA 3, can perform technical procedures and have more medical equipment than CPA 2 hospitals. The services include a wider range than the CPA 2 facilities. There are eight tertiary care hospitals at the national level and in 21 of the 24 provinces.

Cambodia has elevated the priority of health care for the population, and has increased the health budget each year. The proportion of health expenditures of all government expenditures in 2004 was 16.5% (compared to 12.4% in Thailand for the same year). At the same time, as the economic status of Cambodia has accelerated, the private sector health and medical services have expanded accordingly, especially in the larger cities. Staff shortages and lower quality and access to health care in public facilities have led a significant

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43 World Health Organization and Ministry of Health, Cambodia, 2012
44 National Health Security Office, 2012
45 World Health Organization and Ministry of Health, Cambodia, 2012
46 Bureau of Health Economic and Financing, Cambodia, 2013
percentage of the population to seek care in the private sector, despite the higher cost. In recent years, the proportion of the health care bill which the patient pays out of pocket has averaged 70%.

1.3 Lao PDR

In 2012, Lao PDR had an official population of 6.4 million, of whom 37.3% were under age 15 and 3.7% were over age 65 years. Most of the population lives in rural areas of the country’s 17 provinces. The capital of Vientiane is considered a special administrative area. The relatively low income of the Lao population limits its population’s access to health care, formal education, and social services.

Ever since 1975, the Lao government has had a policy for health development to improve equal access to public sector health services throughout the country. Since that time, Lao PDR has attempted to rehabilitate the country and society from decades of war through a policy of economic stimulus, expanded markets, and decentralization of administration. Nevertheless, as of 2012, Lao PDR was still ranked as a lower-middle-income economy. Lao PDR has set the goal of emerging from less-developed status by the year 2017.

The current health development strategy has three components: (1) Medical care; (2) Disease prevention; and (3) Administration. Large segments of the Lao population still prefer traditional healers, based on India’s Ayurvedic principles. The Lao government has established an Institute of Traditional Medicine which has developed standards of care and safety in treatment. Indeed, the traditional care movement is expanding through practices such as acupuncture, herbal medicines, and traditional Chinese healing methods, among others.

There are three levels in the Lao public health system: (1) Central level, with the Ministry of Health responsible for policy, support, and control of services; (2) Provincial level, with the Provincial Health Office responsible for applying national health policy; and (3) District level, with the District Health Office responsible for implementing health activities as per official policy.

There are both public and private health service outlets, which can be classified by level of service as follows:

1) 5,000 community health outposts provide primary care such as MCH, health education, family planning, outreach vaccination in the community, parasite control, vitamin supplementation, nutrition, and birth attendance at the community level. Each outpost has a catchment population of about 7,000 persons.

47 World Health Organization, Service Delivery Profile Lao PDR, 2012
2) 894 health centers also provide primary care with an emphasis on health promotion, MCH and nutrition.

3) 130 district hospitals provide medical care in addition to health promotion and disease prevention.

4) 12 provincial hospitals provide clinical care at the primary and secondary levels, and rehabilitation.

5) 4 regional hospitals provide clinical care and referral.

6) 4 reference hospitals are located in Vientiane and provide tertiary care and referral.

7) 3 specialty health centers serve as centers of excellence in such areas as skin disease, eye infections, and health rehabilitation.

While there are no private hospitals in Lao PDR, there are 222 private clinics, mostly in urban areas. Some clinics have a bed for recovery from treatment. In addition, there are 1,993 pharmacies, also concentrated in urban areas.

While the Lao public health infrastructure extends to all communities, usage at the district level and below is rather low due to limited access and staff shortages. Thus, the majority of the Lao population prefers to visit private clinics or to self-treat with medicine bought from private outlets. Fully 63% of total health care expenditures are in the private sector.48

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### 2. Health Insurance Systems of Countries of Origin

#### 2.1 Myanmar

Myanmar has no health insurance for all, and offers free clinical care to patients, but the patient has to pay for medical supplies and drugs from private pharmacies. Annual government health expenditure is rather low. During the 2010-12 Fiscal Years, health expenditure was about 2% of the GDP49. This low level of investment results in clinical staff shortages, low salaries, work overload, and shortage of medicines and medical supplies at all levels. Thus, the private sector health and medical services are often a more attractive option for patients. Myanmar has a total of 17,476 physicians, and 11,145 (or 68.8%) work in private clinics50.

Myanmar has a social security scheme (SSS) which covers laborers injured on the job. This scheme is managed under the administration of the MOL and is required for all businesses.

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49 World Health organization, 2012
50 My Media Power, accessed in December 2013
with five or more employees. The funds for the SSS come from a portion of the employee’s salary (1.5%), plus 2.5% from the employer, and the government. The government’s contribution is not a portion of the income but is calculated based on the business investment. The SSS covers medical care and other social benefits.

In the past, Myanmar did not allow private health insurance to be sold. However, in preparation for the ASEAN Economic Community in 2015, the government has put forth a policy to allow private health insurance companies to sell insurance.

2.2 Cambodia

In Cambodia, there is both compulsory health insurance as mandated by government, and voluntary health insurance as described below:

• Government-mandated health insurance
  1) The National Social Security Fund (NSSF): The NSSF provides coverage for workers under the protection of the Ministry of Labor to receive health and medical care for job-related conditions, and a pension after retirement. The funds for the NSSF come from 0.8% of the employee’s wages, a co-pay by the employer in the amount of 0.5% and 0.3% counterpart funding from the government. In 2010, a total of 480,446 workers were enrolled in the NSSF, 80% of whom were female.
  2) The National Social Security Fund for Civil Servants (NSSFC) is administered by the Ministry of Social Welfare. In 2012, the NSSFC covered 175,000 civil servants and 465,000 family members.
  3) The National Fund for Veterans (NFV) provides coverage for discharged military and police, including health, social welfare, and pension. In 2010, a total of 199,000 persons were enrolled, including 28,000 veterans and 162,000 battle survivors.

• Other health insurance schemes
  1) Community Based Health Insurance (CBHI): This fund was established with contributions from international NGOs, and targets the lower-income groups of the population in 18 districts of ten provinces. The insurance covers members and their family for health and medical care, and transportation to and from the service outlet. In 2010, there were 170,000 persons enrolled in the CBHI.
  2) Sokapheap Krousat Yeugn (SKY) is a large project under the CBHI and was launched in 2007. The target population for SKY is those at risk of poverty, and participating families must contribute a monthly membership fee ranging from 15 to 57 baht depending on the number of family members. SKY also builds capacity of government health outlets so that they can provide standard care to program members. SKY is supported by the French Groupe de Rechersce et d’ Échanges Techologique.

51 International Labor Organization, 2013
52 Center for Health Market Innovation, accessed in December 2013
53 SKY Health Insurance, accessed in December 2013
3) The Health Equity Fund (HEF)\(^{54}\) covers care for the destitute and impoverished, and is a pilot project with support from the University Research Co., LLC. Members can receive free health care. The project is implemented in 25 of the nation’s 76 districts and has three million enrollees.\(^{55}\) The government intends to expand coverage nationwide by 2014.

4) A number of companies are selling private health, accident and life insurance. This sector is expanding rapidly in pace with the country’s economic development. However, private insurance is still not very popular with the population since the benefits are narrow, coverage is limited to certain groups, and some companies have had difficulty paying for claims. Nevertheless, it is expected that this sector will continue to grow in the coming years.

2.3 Lao PDR\(^{56}\)

Lao PDR has health insurance programs for government civil servants and laborers, and insurance through community revolving funds. However, important segments of the population are not yet covered.

1) Civil Servant Scheme (CSS): The CSS is administered by the Lao Ministry of Labor and Social Welfare, and covers civil servants and their families. In 1997, the CSS was only able to reimburse members for 30% to 50% of their health care expenses. In 2006, the CSS was reformed with support from the ILO, with a pilot project in Vientiane, covering the military, civil servants and their family members.

2) Social Security Organization Scheme (SSO): The SSO provides coverage for workers in the public and private sector, with contributions from both the employee and employer. The employee pays 4.5% of wages and the employer pays 5.0%. Of the total 9.5%, 2.2% is set aside for health insurance (both in- and out-patient care but not including injury from traffic accidents, or beautification procedures). The Lao PDR Social Security Research Report (2012) found that 370 worksites were enrolled in the SSO, covering 40,000 workers and 40,000 family members.

3) Community Based Health Insurance (CBHI): The CBHI was set up under the Bureau of the Budget and Planning of the Ministry of Health, with technical support from the WHO, and financial support from the United Nation Human Security Fun (UNHSF). This is a voluntary insurance program for care of the whole family, and participation fees range from 40 to 100 baht (1.2 to 3.0 USD) per month depending on family size. Members receive reimbursement for medical care (in- and out-patient) and health promotion expenditures. District hospitals are the primary point of contact and

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54 University Research Co., LLC (URC), accessed in December 2013  
55 As previously referenced in 51  
56 International Labor Organization, accessed in December 2013
provide referral as needed. The Lao PDR Social Security Research Report (2012) found that the CBHI covered seven districts in four provinces, with enrollment of 18,730 persons from 3,979 families, representing from 6% to 20% of the target population in the area. Delinquent payment of membership fees was reported for 2% to 19% of members, while from 1% to 4% dropped out of the program. Having the CBHI improves access to health care as judged by the proportion seeking care when needed, and is greater than the national average.

3. Linkages between the Public Health Systems of Thailand and its Neighbors

There are different levels of collaboration between Thailand and its lower-income neighbors. The collaboration is both political and for internal security, and is also influenced by the differential levels of health care available. In the past, the collaboration between Thailand and Cambodia has progressed the fastest, both in terms of infectious disease control and in health system development. Collaboration between Thailand and Lao PDR has been in terms of capacity building. Now that Myanmar has become a more open society, collaboration with Thailand is increasing.

3.1 Myanmar

In the past, Myanmar has given priority to national security, and this has had the effect of extending central control to all parts of the country, including border areas with Thailand. This central control has retarded cross-border health service development and left a vacuum in terms of guidance on how to collaborate. Myanmar still has deficiencies in its health system and access to health care of its citizens. Thus, Burmese living on the Thai border often prefer to seek care at Thai health and medical outlets. This is especially clear in Mae Sot District of Tak Province which has a long land border with Myanmar. The Mae Sot hospital sees a large number of Burmese patients throughout the year. The Thai-based Mae Tao Clinic provides free care to a large caseload of Burmese who live on the Myanmar side of the border, and receives financial support from international organizations.

Nevertheless, Thailand and Myanmar are making efforts toward more effective and sustainable collaboration in the area of public health. The length of the land border between these two countries makes it imperative that they work together on areas of communicable diseases such as malaria, HIV, and tuberculosis. On September 20, 2013 an accord was signed by the two countries to collaborate on disease control, health promotion, food and drug control, and traditional medicine.

57 Regional Cooperation Section, Bureau of International Health, Office of the Permanent Secretary for Health, 2013
3.2 Cambodia

The Ministries of Public Health of Thailand and Cambodia signed a Memorandum of Understanding (MOU) to develop border health services by establishing a national task force to address the issue. There is a bi-lateral plan which covers disease prevention and control, human capacity development, detection of fake drugs, and strengthening health services management. The focus of the MOU is on the seven Thai border provinces of Srisaket, Ubon Ratchatani, Surin, Buriram, Sra Keo, Chantaburi, and Trat. Thailand also provides support to Cambodia for development of health centers and hospitals, medical equipment and supplies, clinical staff capacity building, ambulances, etc. Most recently, on July 22, 2013, a bi-lateral consultative meeting was held on human resource development in border locations and improving communication linkages. There was an agreement at the meeting on the care for emergency medical cases and improving the referral system for critically injured patients, as well as non-critical cases between hospitals at or near the international border. The proposal is for the establishment of “sister hospital” relationships to provide a continuum of care under a single standard. For example, the larger hospital of Sra Keo Province is teamed with the Cambodian Banteay Meanchay Provincial Hospital. The Phrapokklao Hospital in Chanthaburi is paired with the Battambang Hospital of Cambodia. Trad Provincial Hospital is the sister hospital with Koh Kong Provincial Hospital. For other Cambodians who seek treatment in Thailand, the Thai MOPH has a policy to care for these persons based on human rights, and collects a service fee from those with the ability to pay. But the caseload is high. In 2012, the Klong Yai District Hospital in Trad Province reported that 70% of its maternity patients were from Cambodia, many of whom were unable to pay the routine fee for this care, and this places a considerable burden on the hospital’s budgeting system.

3.3 Lao PDR

The Thai MOPH and its Lao counterpart have been collaborating for a long time. There is regular exchange of knowledge, experience, and expertise. In most cases, Thailand is providing the expertise and assistance to Lao PDR, for example, in the area of hospital development, support for medicines and medical supplies and equipment, capacity building for physicians, and prevention of communicable disease. Thailand and Lao PDR have implemented a large number of joint public health projects such as construction of the Pone Hong Hospital in Vientiane, improvement of the Bo Keo Provincial Hospital, refurbishment of the drug rehabilitation center of Champassak Province, collaborative disease control between Saiyaburi and Nan Province, and prevention of smuggling of pharmaceuticals and trade in fake medicines.

58 Regional Cooperation Section, Bureau of International Health, Office of the Permanent Secretary for Health, 2013
59 Thai Rath Newspaper, Public Health Page, accessed in December 2013
60 Regional Cooperation Section, Bureau of International Health, Office of the Permanent Secretary for Health, 2013
Despite the history of close collaboration, there still is no clear policy on how to link the health systems of the two countries in a more formal way. The Lao health service system still has problems and obstacles of access to care due in part to difficult commuting, low education and illiteracy of the populace, lack of health care information and risk prevention campaigns for the public, low per capita income, rising cost of living, and persistent attitudes that treatment on the Thai side is always superior. The main reasons are the higher capacity to provide care, and the more modern equipment, and cost-effectiveness of Thai medical care, even when compared with Lao PDR.

4. Care for Persons Living with HIV (PLHIV) in the Countries of Origin

4.1 Myanmar

HIV/AIDS can have a serious impact on the socio-economic condition of a country. In 2011, the WHO estimated that the HIV infection rate for Burmese age 15 years or older was 0.5% (The rates were higher for populations in higher-risk categories such as 9.6% for sex workers, 7.8% for men who have sex with men, and 21.9% for injection drug users). In the same year, it was estimated that there were 216,000 People Living with HIV (PLHIV) throughout the country, of whom one-third were women.

Myanmar has received funding from the Global Fund to Fight Aids Tuberculosis and Malaria (GFATM) to improve the system of care for PLHIV, including provision of free ART. The three sectors of the MOH, UN agencies and international NGOs have collaborated to set up a comprehensive system of care for PLHIV. However, the government still lacks the personnel, budget and technical capacity to provide adequate care. Thus, NGOs still play an important role in PLHIV care in this country.

4.2 Cambodia

Cambodia has experienced a considerable level of success in combatting HIV/AIDS. From a prevalence level of 1.7% of the population age 15 years or older in 1998, Cambodia was able to reduce HIV prevalence to 0.8% as of 2010. The GFATM provided support to Cambodia in this effort in addition to other international donor agencies. Cambodia established the National Center for HIV/AIDS, Dermatology and Sexual Transmitted Infections in 1997 to take responsibility for managing and implementing programs to achieve the HIV control targets and expand treatment for PLHIV. As of 2012, Cambodia had enrolled 44,318 PLHIV in ART with the collaboration of international NGOs and the volunteer support network.

63 Kaiser Family Foundation, accessed in December 2013
4.3 Lao PDR

Compared to its neighbors, Lao PDR has a relatively low prevalence of HIV. As of 2011, the HIV prevalence among the population age 15-49 years was 0.2% or approximately 9,600 PLHIV. The most common route of transmission for these individuals was vaginal sex (87%), followed by mother-to-child transmission (4.6%) and anal sex (1.3%). As of December 2011, there were 3,650 registered PLHIV of the cumulative total of 4,942 registered cases recorded, or approximately one-third of the total estimated infections in the country. There were two waves of the HIV epidemic in Lao PDR. The first wave consisted of Lao MW who had become infected while working in neighboring countries and then infected their wives and infants upon their return. This wave was confined mostly to rural areas of the country and was self-limiting. The second wave of the epidemic occurred among those with high-risk behaviors such as selling sex, having receptive anal sex, and sharing of needles to inject drugs. Incidence of HIV among the population age 15 to 49 years increased from 0.2% in 2006 to 0.3% in 2012.

As the countries of ASEAN enter the era of the AEC, Lao PDR will become a more active cross-road for regional migrants seeking economic opportunity in the region. The projected increase in migrant populations to and through this country will bring with it corresponding public health challenges.

64 United Nations Programme on HIV/AIDS (UNAIDS), 2012
65 World Health Organization, 2012
Chapter 5

Models of Health Services Systems for Migrants in Other Countries
Chapter 5
Models of Health Services Systems for Migrants in Other Countries

Countries of the world have different levels of development, socio-political and economic stability, and this leads to international migration in search of better quality of life. When the number of immigrants reaches a certain threshold, the host country will recognize the need to issue measures and systems to manage this population influx. These systems include registration, settlement, and improving access to essential services. Health care is one of these essentials and is a key factor in maximizing the contribution of the migrants in the destination country. Better health is a benefit that accrues to the migrants directly, while their labor contributes to the host country economy by filling labor gaps in key industries effectively. Without good health however, the migrant population could become a burden on the host and home country health systems. Thus, it is important for countries with a large number of immigrants to implement prevention, health promotion, disease control and treatment, and this concept is recognized internationally as a cross-border imperative.

Migrant destination countries are attempting to improve their health systems so that service is equivalent for nationals and migrants alike. The significant difference between the health system in Thailand and its lower-income neighbors makes it a challenge for Thailand to expand health services for migrants in a way that does not strain the budget while overcoming barriers of language, culture, beliefs and prejudices. This chapter looks at models of health systems for migrants in ASEAN as well as European countries which have large populations of migrants. Much of the information in this chapter comes from the 2012 report of WHO\(^\text{66}\) and from review of additional literature.

1. ASEAN Member Countries

The Association of Southeast Asian Nations (ASEAN) was established on August 8, 1967 by five founding member countries (Thailand, Indonesia, Malaysia, Philippines, and Singapore). In 1974, Brunei joined ASEAN, followed by Vietnam in 1985. Myanmar and Lao PDR joined ASEAN in 1997, while Cambodia was admitted in 1999. Historically, there has been population movement among these ten countries, especially between those sharing land and sea borders. The 2009-2015 ASEAN plan to implement a higher level of collaboration was endorsed by leaders in the Hua Hin ASEAN Summit and includes three main components: (1) ASEAN Security Community (ASC); (2) ASEAN Economic Community (AEC); and (3) ASEAN Socio-Cultural Community (ASCC). The top three destination countries for

\(^{66}\) Shravyan Kidambi, August 2012
MW in ASEAN are Malaysia, Singapore and Thailand, respectively. Next follows a review of the health services for MW in Malaysia and Singapore.

1.1 Malaysia

Malaysia is host to a large number of MW from countries within and outside of ASEAN. The Malaysian Ministry of Home Affairs estimated that, in 2010, there were 2 million legally registered MW in country. The MWs mostly work in industry followed by construction, and agriculture. Half the MWs are from Indonesia followed by Bangladesh, Nepal, Myanmar and India in similar proportions. Other sending countries include Vietnam, the Philippines, Pakistan and Thailand (with 7,102 registered Thais in the 2010 estimate).

The Malaysian health system involves a low co-payment to access care at government health outlets. Ethnic Malays pay 1 ringgit (about 0.3 USD) while non-Malays (e.g., ethnic East or South Asians) pay 15 ringgit (4.7 USD), with a ceiling of 500 ringgit or 155 USD of health service. This system covers 100% of the Malaysian population. Social welfare is available for all Malaysians but not for MWs, even if they are registered. Prior to 2011, the Malaysian government provided insurance coverage for MWs only for accident and death (Foreign Worker Compensation Scheme or FWCS), and MWs had to pay an annual premium of 86 ringgit (about 26.7 USD). Employers whose workers were not insured were fined 20,000 ringgit (about 6,202.5 USD). In most cases, the MWs had to pay for the insurance themselves. In-patient health insurance is available on an elective basis through the Foreign Worker Hospitalization & Surgical Insurance (SKHPPA) and covers all costs of the stay and treatment, including lodging, clinical fees, drugs, surgery, and ambulance service up to a total of 10,000 (or 3,101.3 USD) ringgit per year. The premium for SKHPPA is 150 ringgit (46.5 USD) per year.

Then, in 2011, Malaysia introduced compulsory health insurance through the Foreign Workers Health Insurance Protection Scheme (FWHIPS). The premium for FWHIPS is 120 ringgit (37.2 USD) per year and only covers services at government health outlets up to a maximum of 10,000 ringgit (or 3,201.3 USD) per year. There are 25 government-approved companies in Malaysia which sell this insurance. Approximately 70% of registered MWs are covered by this insurance. However, it is estimated that there are one million undocumented MWs in country who cannot access any of these government-subsidized health insurance schemes, let alone social security.

1.2 Singapore

There has been a steady increase of MWs into Singapore since 1964. The Ministry of Manpower (MOM) reported that approximately 1.3 million MW entered Singapore in the 2012-13 periods. Of these, one-fourth were professionals or semi-skilled while the

67 Foreign Worker Hospitalization & Surgical Insurance: SKHPPA, retrieved on December 2013
68 MGCC Block, 2011
69 Borneo online, 2013
remainder were unskilled laborers. Half of the unskilled MWs worked in construction or as a domestic helper.\textsuperscript{70} Compared to other countries of ASEAN, Singapore has the most complete legal registration of its MWs, partly because of its being an island state, but also because of its system of strict and efficient immigration controls.

The health service system of Singapore is shaped by market strategies and consumer purchasing power. There is a range of schemes available at different prices depending on income level. Singapore has an estimated 10\% low-income population and these individuals can access a subsidized fund to cover costs of care in case of inability to pay. In 2012, this program was expanded to include the middle-income population.

The Singapore Ministry of Manpower imports the MWs with an effective management system. The MOM ensures that MWs have signed employment contracts, physical exams, health and accident insurance prior to travelling to Singapore for work. The employer must place a security bond with the government in the amount of 5,000 Singapore dollars (About 3,987 USD). The bond is to guarantee that the employer pays the MWs on schedule, provides appropriate accommodations and a minimum level of health insurance ($15,000 Singapore or 11,961 USD) and accident insurance ($40,000 Singapore or 31,895 USD). There must be advance notice of termination of employment of the MWs, and the employer covers the cost of repatriation (or funeral rights and repatriation of the body in case of death). If the MW leaves the country independently before the end of the employment contract, then government refunds only 50\% of the security bond to the employer.\textsuperscript{71} It can be seen that Singapore guarantees health insurance and adequate living conditions for MWs, but it does not provide social welfare to the MWs in any form.

\section*{2. Countries of the European Union (EU)}

The 28 countries of the EU comprised 505.7 million persons as of 2013. Of these, 33.5 million were migrants, 20.5 million of whom were from non-EU countries.\textsuperscript{72} The EU member countries with the largest populations of migrants are, in order, Germany, Spain, Italy, United Kingdom (UK), and France. Persons residing in EU countries are able to access subsidized health services (free or small co-pay) or can apply for the European Health Insurance Card from their country of residence, and this card can be used to access health care in other EU countries and in Iceland, Switzerland and Norway. Most of the labor migration in EU countries is for professional/skilled positions and which are covered under the European Health Insurance scheme. As with many advanced developing countries, countries in the EU have a shortage of indigenous labor for low-skilled or unskilled jobs and this drives their demand for MWs. These countries have established laws, guidelines and MOU with sending countries outside the EU. Data from 2011\textsuperscript{73} show that Germany had 7.2 million migrants, followed by Spain’s 5.7 million, Italy’s 4.6 million, the

\begin{flushleft}
\textsuperscript{70} Ministry of Manpower, Singapore, retrieved on December 2013
\textsuperscript{71} Cited in 44
\textsuperscript{72} Eurostat Newsrelease, 2013
\textsuperscript{73} Cited in 46
\end{flushleft}
UK’s 4.5 million and France’s 3.8 million. As a percent of the host country population, Spain had the highest proportion of migrants at 12.3% compared to France with 5.9% at the low end. By comparison, the two million registered MWs in Thailand was only 3% of the total population of 65 million.

The health care systems for MWs in the five EU countries with the highest number of MWs can be classified into two: (1) Those for registered MW; and (2) Those for undocumented migrants. These EU countries have a similar goal as Thailand in providing universal and equivalent health care coverage for all residents in the country. But the approaches differ among countries as described below:

- **Germany**: Health insurance options vary by income. In 2009, the German government stipulated that citizens and long-term residents with monthly income less that 3,938 Euro would have to join the government health insurance program called GKV (Gesetzliche Krankenversicherung). The premium fee is deducted from the employee’s pay, with the employer making an equal contribution on the worker’s behalf as well at the rate of 15.5%. This insurance covers both the employee and family members. The GKV system covers most of the population of Germany. Those of higher income can choose the GKV program or purchase another plan on the private market. Health insurance policy is set by the national government. The management of the program is a joint responsibility of the central government and states.

- **Spain**: has a national health insurance system for all, including migrant residents. Participants can receive care at government outlets for free, though there is a 40% co-payment for some medicines for patients less than 65 years of age. Since 2002, Spain has shifted to a decentralized management system of governance across 17 sub-national divisions. This includes decentralization of budget, expenditures, resource mobilization, and health expenditures. The funds come from direct and indirect taxation, which mostly consists of a value-added tax (VAT).

- **Italy**: There is universal health insurance, including migrant residents, covering free medical care for all in-patient costs. For out-patient and dental care, the patients pay 25% of the cost and the government covers the balance. The health insurance scheme in Italy is managed by the SSN (Servizio Sanitario Nazionale) using funds raised from direct and indirect taxation (VAT) and excise taxes on petrol.

- **United Kingdom**: The UK has implemented the National Health Service (NHS) since 1948. Health services are provided through a diverse array of channels including standardized quality public and private providers. A patient’s first point of contact is their primary care physician, dentist, optometrist, or pharmacist. If the health problem....

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74 How to Germany, retrieved on December 2013
75 Emily Clarke and Elliot Bidgood, 2013
76 European observatory in health system and policies, 2010
77 Angloinfo: the global expat network Italy, Retrieved on December 2013
78 The NHS constitution, 2013
cannot be resolved at this level, then the patient is referred to a hospital-based specialist. The exception is in case of medical emergency in which any participating NHS provider can provide emergency care. The NHS is funded by direct and indirect taxation through fixed rates for each year. Thailand has modeled its Health for All program after the UK-NHS.

- **France:** France has an integrated network for health care by public and private hospitals, physicians, and other independent clinicians to provide National Health Security Service (Sécurité Sociale). Services cover citizen and all migrants stayed in-country over a period of three months. The benefits come in different packages including the general package (most common) and occupation-specific (such as farmer, self-employed). Patients pay 100% of costs at time of care and then receive reimbursement for up to 80% of the services. Treatment for chronic conditions, AIDS, ante-natal care, disabled children, and veterans get a free of charge service without a co-pay. The fund for this system comes from a payroll tax, employer contribution, funds from local government, a tobacco tax, and a pollution tax.

It can be seen from the above that these health insurance systems by MW-importing countries of the EU are funded by direct, indirect and other taxes, including contributions from the insured and employer. In some countries, registered MWs have deductions from their monthly pay; other programs are funded by taxes so that MWs can enjoy the same access to health care as citizens of the host country. But access to social welfare benefits differs among countries as shown in the Table 9:

<table>
<thead>
<tr>
<th>Country</th>
<th>Health Service</th>
<th>Social Welfare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Germany</td>
<td>Employer purchases health insurance for the MW employee</td>
<td>Not provided</td>
</tr>
<tr>
<td>Spain</td>
<td>Registration with the local government office to access medical care, equivalent to citizens</td>
<td>Employer contribution</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>Registration with the local primary care physician; access for MW is equivalent to citizens</td>
<td>n/a</td>
</tr>
<tr>
<td>Italy</td>
<td>Equivalent rights to health services as citizens</td>
<td>Social welfare for MW is equivalent to citizens</td>
</tr>
<tr>
<td>France</td>
<td>Equivalent rights to health services as citizens</td>
<td>Social welfare for MW is equivalent to citizens</td>
</tr>
</tbody>
</table>
It is noteworthy that the health insurance systems in these EU countries differ from those in Malaysia and Singapore in that they provide access to care for undocumented migrants. Also, if emergency care is needed, that care will be provided immediately without charge, except in Germany. Care for pregnancy and early childhood is mostly free. For the very low-income, no fees are charged at all. The benefits for undocumented migrants differ as described in the table below.

### Table 10 Health Care for Undocumented Migrants

<table>
<thead>
<tr>
<th>Country</th>
<th>Emergency medical care</th>
<th>Primary and secondary care</th>
<th>Pregnancy and early child care</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Germany</td>
<td>Patient pays unless destitute</td>
<td>Patient pays unless destitute</td>
<td>free</td>
<td>Requires registration with the Social Security Office to request prior approval for service</td>
</tr>
<tr>
<td>Spain</td>
<td>Free</td>
<td>Co-pay</td>
<td>free (no registration necessary)</td>
<td>Requires registration with the local government before granted access to health care</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>Free</td>
<td>Free for primary care and treatment for 35 infectious diseases (includes HIV VCT, but not including AIDS therapy)</td>
<td>Patient pays unless destitute</td>
<td>Requires registration with the NIS and primary care physician before accessing service</td>
</tr>
<tr>
<td>Italy</td>
<td>Free (without the need for a STP code)</td>
<td>Free except for chronic illness; co-pay with government subsidy for some costs related to opportunistic infections due to AIDS</td>
<td>Free</td>
<td>Requires registration to receive an STP code (Stranieri Temporaneamente Presenti) in order to access services</td>
</tr>
<tr>
<td>France</td>
<td>Free (no need for AME)</td>
<td>Free (for children; no need for AME)</td>
<td>Free</td>
<td>Need to apply for AME (Aide Medicale de L’Etat); fee is 30 Euro per year</td>
</tr>
</tbody>
</table>

Despite these attempts to extend access to health care for undocumented migrants, there remain obstacles to services such as the following:

- **Germany**: The requirement to register with the social security office before being eligible for service might cause some undocumented migrants to fear deportation. There is access to emergency care since no government report is required.

- **Spain**: The requirement to register with the local government requires presentation of some form of identification and address. This could be difficult for some groups of undocumented migrants who do not want to disclose their identity or residence.
• **United Kingdom**: Registering with the NIS and primary care physician requires proof of residence, personal identification, and history of treatment. The attending physician may refuse to register the migrants due to their foreign citizenship. Also, some physicians report the residence of the migrants to the police, even though they are not required to do so.

• **Italy**: The advantage of the STP registration system is that it does not require a name or fee. But it does require an address of the migrants and evidence of inability to afford medical care.

• **France**: Registration with the AME requires evidence of inability to afford medical care, address, and paying of a fee. AME registration is rather difficult with the result that about 90% of migrants are not registered.

### 3. Considerations and Application to the Thai Context

1) In Singapore, Malaysia and the EU, there is a separation of systems for health care and social welfare. In Thailand, the year-to-year health insurance scheme of the MOPH does not include social welfare, but those who receive social security, even when it includes social welfare, have coverage only for medical care and not for prevention and disease control.

2) Countries like Singapore have systems for health care under the control and management of the government arranged for the MW before they enter the country. An island state with strict immigration can do this, but it is impractical for Thailand with over 5,000 km of land borders with its neighbors.

3) There is rather clear designation of employers as responsible for ensuring their workers have health care. Some countries fine employers who do not arrange for these benefits. In Thailand, however, even though there may be penalties for employers using uninsured MWs, it is difficult to enforce these laws since MWs are unlikely to press charges.

4) Having private insurers selling insurance, as in Malaysia, is an approach that Thailand should consider, since health insurance is no longer linked to registration process of the MWs. This has reduced the proportion of MWs who are covered. Also, government hospitals with high migrant caseloads do not have marketing offices or public relations outreach to motivate migrants to join the health insurance pool.
5) The EU countries view the right to health as emanating from the collection of various taxes, but these rates are much higher than what Thailand collects. The lowest tax rate in those countries starts at 20-33% and peak at 45%81 (whereas Thai tax rates range from 5-35%) with VAT ranging from 19-21% (compared to only 7% VAT tax in Thailand). The minimum wage of 300 baht per day at 30 days per month is equivalent to 108,000 baht per year, which is lower than the minimum annual income for income tax. Thus, MW making the minimum wage do not pay into the income tax pool, but all migrants do pay VAT when purchasing goods. This applies to both documented and undocumented migrants. There should be some consideration of tapping into the VAT resources to provide basic health care service for migrants.

6) Malaysia and Singapore do not provide subsidized health services for undocumented MW, whereas countries in the EU do provide access to health care for these group. Thailand also has a policy to extend government health insurance to even the undocumented migrants. These concepts and service system to provide care for undocumented migrants (that may need different approach/method than the documented MWs) could be applied in the Thai context, with a differentiation between emergency, primary and secondary care, care for pregnancy and early childhood, care for chronic illness and various infectious diseases.

81 Wikipedia, retrieved in November, 2013
Chapter 6

Summary and Challenges for Health System Development
Chapter 6

Summary and Challenges for Health System Development

Many lessons have been learned during the past decade of health system development for the migrant populations from Myanmar, Lao PDR and Cambodia. These developments did not occur in a vacuum but evolved in the different context of the migrant populations and services. External influences include MW registration policies and laws, bi-lateral MOU between origin and destination countries, economic development and demand for labor, national security policy, and attitudes of health administrators to design management guidelines. The knowledge that has been gained is considerable and provides an important foundation for Thai health system development in the coming years. It is increasingly apparent that important segments of the Thailand labor force are not just Thai citizens, but come from a wide range of countries with different cultures and languages.

In this summary chapter, first is presented a case study of the Samut Sakorn Provincial Hospital as an example of “good practice” which portrays the broad picture of health service development for migrant population at the present time. This case example also serves as a preamble to the discussion of challenges for health system development in the future.

Case Study of Samut Sakorn

Samut Sakorn (SSK) Province has been host to a large number of migrant populations for quite some time. The SSK Provincial Hospital is, therefore, rather experienced in providing health care to this population. One key feature is its disease control strategy which has a target coverage of all migrants, regardless of whether they have health insurance or not, and whether or not they are legal or illegal. Implementation of services is integrated with the routine disease control activities in the local Thai communities. The outreach activity is implemented in tandem with clinical care. Representatives of the migrant community have been recruited and trained to serve as Migrant Health Workers (MHW) as a liaison between the migrant population and the formal health system. The role of the MHW evolved from “Translation Centers” in the hospital into “migrant health insurance OPD” which operate alongside the regular out-patient department for National Health Insurance and Social Security members. The different funds pool their resources to provide an inclusive service to accommodate the migrant population as well as local citizens. The open and inclusive approach of the SSK Hospital has created a strong and broad level of acceptance among the population, and has attracted the interest of other health providers and managers who visit this hospital often as part of study tours.
However, a success story of SSK hospital in the past has weakened due to the shifting on health insurance policy. Some MWs who had national verification documentation could be enrolled in the Social Security System; others are eligible for the annually-renewed health insurance which is no longer linked with legal registration status. Though the 2013 health insurance measure authorized hospitals to offer health insurance to MWs who did not qualify for Social Security, including accompanying unregistered adults and children, but this comes on the same time that health insurance is no longer compulsory. This reduced the population of the insured from hundreds of thousands to tens of thousands. What is more, most of those who sought insurance were the ill or infirm and this severely strained the budget of the hospital which relied only on insurance premiums. The SSK Hospital went further into debt (peaking at over 50 million baht or 1.5 million USD at one stage). The increase of the health insurance premium to cover ART for AIDS further exacerbated the situation since it became harder to sell.

“If our goal is to provide wide access to health care, if we want the disease control to work well, then we must find ways to motivate the uninsured to join the program... if the premium remains too expensive, then the public hospitals like ours have to bare the financial burden. Further, the more people who are enrolled in the program enable us to know where they are, and this helps in controlling disease spread...”

The SSK Hospital administrator has accepted the role of the public hospital in providing health care to all residents in Thailand. Though illness seems to be an individual condition, when there is epidemic of communicable diseases, it suffers the entire SSK communities. The current financial limitation brings in a negative effect on prevention and disease control activities. The hospital significantly reduces number of Thai staff and migrant outreach workers to reach migrant communities.

“The budget is there to improve the efficacy of the health work, not to build up a balance of funds. The benefit comes from disease control and caring for patients. However, if the budget declines, then health services suffer...”

Despite these formidable challenges, the SSK Hospital team continues to strive to provide an acceptable level of static and outreach services to meet the target, even though the goal of full coverage seems more remote each day...
1. Challenges for Health System Development

Over the years, the attitude of Thai society toward the migrant population has gradually become more positive and constructive. Thai society has progressed from an obstructive stance toward migrants, toward an approach of peaceful co-existence and sharing of opportunity. This has led to a favorable mutual understanding among the cultures. In the area of health care, Thai service providers have become more accepting of migrants, rather than viewing them as a burden as they did initially. At the policy level, there have been improvements in strategies, implementation guidelines, and innovation of services to adapt to the evolving external environment. It cannot be denied that, as the region prepares to enter the era of the ASEAN Economic Community, Thailand will become an even more diverse society, with an increasing number of people from ethnic communities, with different languages and cultures, all thrown into the mix. This presents a challenge for Thailand’s health care system in how best to accommodate the certain increases in caseloads and diversity of clientele. Some of the more notable challenges are as follows:

1) Review other approaches to reach health for all goal, inclusive of the migrant population: This is because insurance scheme is unlikely to be the single answer to universal care. As when there is low insurance coverage for migrants, it depletes the insurance fund. This results a negative effect to the health service delivery.

2) Explore alternative guidelines for management and implementation of health promotion and disease control for migrants through integration with the routine services for Thais: This applies to sources of adequate budget which should not be segregated, with comprehensive monitoring and evaluation.

3) Establish guidelines related to laws, regulations, preliminary agreements, and controls in collaboration among related agencies: This should prompt the business owners who employ MWs to play a more direct role in providing health insurance and health care for their workforce. There should be consideration of penalties for employers who do not comply with these regulations.

4) Reduce gaps or obstacles to multi-lingual communication and cross-cultural harmony: Efforts should be made to reduce the caseload burden and budget shortages of the public health providers. Consideration of health personnel exchange among ASEAN countries can be an option so that migrants can be seen by practitioners from their home country. The use of MHW is one stop-gap approach, and provides empirical evidence that cross-national sharing of health personnel can reduce the workload burden for Thai health providers, and elevate the level of care for migrants.

5) Review and consider the feasibility of a migrant registration for a health system: This effort is needed to protect against the larger risk of communicable disease spread and need for care and treatment (without regard for legal status as in the case of Italy’s approach). This concept is derived from principles of health security which impact on
national security. If it is accomplished, then the benefits will accrue to both Thais and the migrant populations with improved access to services, better follow-up of treatment, and evaluation of service coverage.

6) Consider management strategies for a minimum package of health services, as applicable to all migrants living and working in Thailand, including those with or without health insurance: One strategy is to apply the concept of indirect taxes paid by migrants (as is practiced by European models in dealing with illegal migrants) which should have positive benefits in improving migrant access to primary health services, reduce the cost burden of treating acute and chronic illnesses, and in implementing essential disease control programs.

7) Continue strengthening collaboration with countries of origin in the care and treatment of migrant living with HIV/AIDS, including other communicable diseases and chronic illnesses over the longer-term period, in the event that the migrant decides to return home for on-going care: This would include an assessment of the capacity of the clinical care facilities in the countries of origin, as MoPH is currently being done with Cambodia.

2. Challenges for the Health Insurance System

It can be asserted that the majority of the budget for health care of migrants in Thailand (at all levels) comes from migrant who pay into the health insurance system of the government on an annual basis. The 2013 policy to expand coverage of health insurance to migrant population without discrimination based on legal status has been advocated by all sectors for quite some time. However, an unanticipated consequence of this policy is when some MW enrolled to the Social Security and the annual health insurance system becomes no longer compulsory. This is resulting in reduce number of annual insured migrants, and places a financial burden on the public sector health system. The situation presents several challenges to increasing insurance coverage as follows:

1) The year-by-year health insurance approach is conditional upon registration of the migrants which makes it quasi-compulsory by other mechanism.

2) Coordination, methods, and strategies among public and private health care providers, business owners and employers, need to be mindful of the essential nature of health insurance. One approach might be to divide responsibility of the health insurance vendors, and provide incentives to enroll more uninsured migrants.

3) Mechanisms for control and monitoring of migrant health insurance policy to assess client-friendly health service outlets are needed as a means of learning about limitations, obstacles, and factors affecting the effort to meet client needs so that improvements can be made which are fact-based and feasible.
4) Alternative funds management to improve efficiency of the migrant health insurance system at the national, provincial and district levels is needed. This is especially important for the smaller service outlets which provide services to migrant, which operate under protections from central agencies to protect against a negative balance of funds.

5) There is a need for strengthening collaboration and exploring the feasibility of working more closely with the National Health Security Office and the Ministry of Labor to make social security and health insurance a “compulsory option” for migrants residing in Thailand. Currently, coverage of social security is only 50% and this results in a disproportionate burden on the public hospitals which have large migrant caseloads.

6) There is a need for development of longer-term measures for securing budget for migrant health care in Thailand which covers health promotion, disease prevention, care, treatment and rehabilitation in ways that reduces dependence on migrant health insurance premiums as the only source of revenue.

Case of Health Insurance for Children of Migrant

Thai Ministry of Public Health (MOPH) policy regarding health insurance for children from Myanmar, Lao PDR and Cambodia has been positively received because of its benefit toward prevention and control of disease, improving access to primary care, and reducing the need for secondary and tertiary care. Data for 2013\(^\text{82}\) show that 53% of pediatric hospital beds were occupied by foreign children, whereas only 47% by Thai children. The annual health insurance premium was at the very low level of 365 baht for children of migrant age 0-5 years. The effect has been for hospitals to refuse to sell health insurance for children since the premium is not in balance with the average cost of care. In addition, research conducted in Bangkok on MCH\(^\text{83}\) is consistent with the experience of Samut Sakorn Hospital, and found that migrant women who deliver their child in Thailand were willing to purchase health insurance for their child on an annual basis at the adult rate (1,300 Baht per year). This presents the following challenges for insuring children of migrants:

1) If the government maintains the policy of a low health insurance premium for children of migrants, then the MOPH should consider providing a subsidy to make this policy feasible going forward.

2) There should be consideration of adjusting the health insurance premium so that it is consistent with the actual cost of treating migrant children so that the system is sustainable.

\(^{82}\) Health Education Division, Department of Health Promotion, 2013

\(^{83}\) HCC and PATH, in collaboration with the Institute for Population and Social Research of Mahidol University, and the Faculty of Humanities and Archaeological Studies of Silapakorn University, 2011.
3. Recommendations for Research

Health service development for migrants is a relatively new area for study, and presents several challenges. First, the migrant health system needs to be flexible enough to adapt with the changing demographics and population movements in the region and the world as a whole. Thus, there is a need for evidence-based policy formulation and decision-making based on solid knowledge and research results in the different socio-economic contexts such as policies affecting migration, international relations and other evolving areas. The process of study may start from making inquiries of the current situation and future challenges to look forward for future development. There should be an assessment of the process of implementation from various angles and viewpoints. The current database can be mined to allow an analysis of outcomes which can further inform areas of needed study.

Examples of research questions or study topics include investigation of clinical, health staff and health managers about attitudes and readiness, as well as obstacles for providing health services and planning to a growing population of migrants. Another topic of interest is migrant knowledge, understanding and the decision-making process in purchasing health insurance. There should be projections of indirect tax revenue collected from migrant living in Thailand which can be used to underwrite a minimum, essential package of health services, and which would be acceptable to all migrants and in accordance with their human rights. A study should be conducted among other government agencies, including national security, about their viewpoint about migrants and tap their attitudes about the MOPH providing health services to MW regardless of legal status. Another study might look at the feasibility of removing MW from the Social Security system and covering them through the year-by-year health insurance approach.

Whatever research topic is chosen, it is imperative that the investigators respect the migrant population and honor their basic human rights. The research should be comprehensive, with relevant context analysis, so that the findings can address the actual situation in society-at-large.
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