

หลักประกันทางสุขภาพสำหรับประชากรข้ามชาติ ในประเทศไทย: เรามาถึง ณ จุดไหน?

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บทคัดย่อ

บทความนี้นำเสนอผลการทบทวนและสังเคราะห์นโยบาย รวมถึงการดำเนินงานของประเทศไทย เกี่ยวกับหลักประกันทางสุขภาพสำหรับกลุ่มประชากรข้ามชาติจากประเทศกัมพูชา ลาวและเมียนมา ในช่วงทศวรรษที่ผ่านมา (ปี 2547–2558) โดยมีจุดเน้นคือช่วงปี 2556–2558 ซึ่งมีการเปลี่ยนแปลงทางนโยบายที่เกี่ยวข้องในหลายด้าน แหล่งข้อมูลประกอบด้วยเอกสารทฤษฎีภูมิ รายงานตัวเลขสถิติและข้อค้นพบจากงานศึกษาในระดับพื้นที่และงานศึกษาที่เกี่ยวข้องซึ่งถูกรวบรวม ทบทวน และวิเคราะห์เพื่อสะท้อนสถานการณ์ในแต่ละช่วงเวลา และสรุปเป็นข้อพิจารณาที่จะเป็นประโยชน์ต่อการปรับปรุงการเข้าถึงหลักประกันทางสุขภาพและบริการสุขภาพที่จำเป็นของกลุ่มประชากรข้ามชาติ ผลการสังเคราะห์พบว่า ในทางนโยบาย ทิศทางการพัฒนาหลักประกันทางสุขภาพสำหรับกลุ่มประชากรข้ามชาติมีความชัดเจนและเปิดกว้างในด้านความครอบคลุมมากขึ้น โดยเฉพาะนโยบายของระบบประกันสุขภาพแรงงานต่างด้าวที่ดำเนินการโดยกระทรวงสาธารณสุข อย่างไรก็ตาม ในทางปฏิบัติ พบว่า ความครอบคลุมของระบบหลักประกันทางสุขภาพยังคงจำกัดและไม่ทั่วถึงประชากรข้ามชาติบางกลุ่ม ซึ่งมีสาเหตุหลักมาจากความล่าช้าในการดำเนินการพิสูจน์สัญชาติในกลุ่มประชากรข้ามชาติที่จดทะเบียนแล้วที่ศูนย์บริการจดทะเบียนแรงงานต่างด้าวแบบเบ็ดเสร็จ และการขาดประสิทธิภาพในการติดตาม รวมถึงการขาดแรงจูงใจในการขึ้นทะเบียนกับระบบประกันสังคมของกลุ่มที่ได้ดำเนินการพิสูจน์สัญชาติเสร็จสิ้นแล้ว

คำสำคัญ: ประชากรข้ามชาติ สุขภาพ หลักประกันทางสุขภาพ ประกันสุขภาพ ประเทศไทย

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Health Security for Cross–border Migrants in Thailand: Where Have We Been?

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Abstract

This article presents a review and synthesis on policies and practices of health security for migrant populations in Thailand over the past decade. The focus was placed on cross–border migrants from Cambodia, Lao PDR and Myanmar. The study period was 2004–2015 with an emphasis given to recent policy changes during 2013–2015. Secondary documents, statistics and findings from previous field studies on relevant topics and issues were compiled, reviewed and then synthesized to reflect the migrant health security situation in each period and provide considerations of the way forward in order to improve access to health security and services for migrant populations. From the synthesis, this study highlighted that Thailand’s policy toward health security for migrant populations, particularly the Migrant Health Insurance Scheme (MHIS), has become clearer in terms of direction and inclusivity for all migrant groups. However, in practice, the coverage of migrant health security is still incomplete, leaving some groups of migrants still uninsured. Gaps in coverage are caused by, firstly, the delayed completion of the nationality verification (NV) of migrants who registered at the OSSC (OSSC) and, secondly, the ineffective enforcement and disincentives for enrollment in the Social Security Scheme (SSS) among migrant workers who had completed the NV process. Given the persistence of these two problems, there will always be some groups of migrants left uncovered by the health security system.

Keywords: Migrant, Health, Health security, Health insurance, Thailand

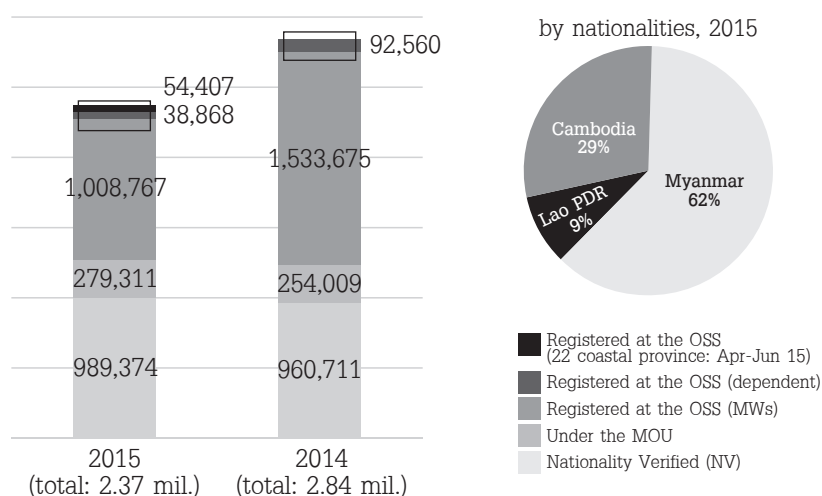
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Introduction

The focus of this paper is on migrants in Thailand from Cambodia, Lao PDR and Myanmar. The actual number of these migrants who are currently residing and working in the country is still unknown. Data for 2015 from the Department of Employment suggests the number of documented migrant workers (with a work permit) from these three countries living in Thailand was around 2.33 million. The majority—about 1.27 million—were those who had completed the nationality verification (NV) process and those who came to Thailand under the MOU between Thailand and the home country, totaling 0.99 million and 0.28 million as of December 2015 (Office of Foreign Workers Administration, 2016), respectively. Other migrants were workers who registered at a One-Stop Service Center (OSSC) operating nationwide from April to June 2015 (OSSC–Round 2) and workers in the fisheries sector who newly registered at the OSSC in 22 coastal provinces; one million and 50,000 migrants, respectively. This number, however, does not include the workers’ accompanying dependents who registered at a OSSC or 38,868 persons (Office of Foreign Workers Administration, 2015). Also, it is possible that some migrants were still left undocumented but there is no estimate for that total.

Figure 1 Number of documented migrants from Cambodia, Lao PDR and Myanmar year 2014 and 2015



Sources and note: The data of the NV and MOU for migrant workers for 2015 was as of December 2015 and, for 2014, was as of November 2014 (Office of Foreign Workers Administration, 2016). The data of the OSSC for 2015 (round 2, operating during April to June 2015) was reported in July 2015 (Office of Foreign Workers Administration, 2015), and for 2014 (round 1, operating during June to October 2014) was reported in November 2014 (Office of Foreign Workers Administration, 2014).

Right to health and equal access to health services are considered as a basic human right that should be respected and secured for everybody in society, including migrants (WHO, 2010; Panitchpakdi, Pinyosinwat, & Suratchareonsuk, 2011). In the case of Thailand, due to irregular immigration and the undocumented status of a number of cross-border migrants from Cambodia, Lao PDR and Myanmar, this challenge is still not fully met (Achavanitkul, 2013). From different perspectives of the relevant policy makers, providing universal access to health security and services to all migrants, regardless of their legal status, was sometimes perceived as going against national security principles (Wareechananon, 2014). The undocumented status resulting in unavailable and incomplete information about migrant health status and determinants also made the policy planning and management of migrant health service delivery more burdensome. Health and health insurance policies towards migrant populations were, thus, mostly on a short-term basis of Cabinet Resolutions, and revised often (Limanond & Peungpossop, 2011).

This study presents a review and synthesis of migrant health insurance policies and practices in Thailand over the past decade (2004–2015). The chorological changes and consequences of the policy in each period in terms of insurance coverage and management performance are illustrated and discussed with consideration of the way forward. As mentioned, the review and discussion are focused on cross-border migrants from Cambodia, Lao PDR and Myanmar. Though the scope of the study period is from 2004 to the end of 2015, the emphasis is on key changes of the situation during 2013–2015. Literature and data employed in the synthesis review were gathered and compiled from various sources including policy announcements and related statistics of the government authorities (e.g., Office of Foreign Workers Administration, the Ministry of Public Health, the Cabinet Resolutions, and the National Council for Peace and Order), previous study reviews and research reports on relevant topics.

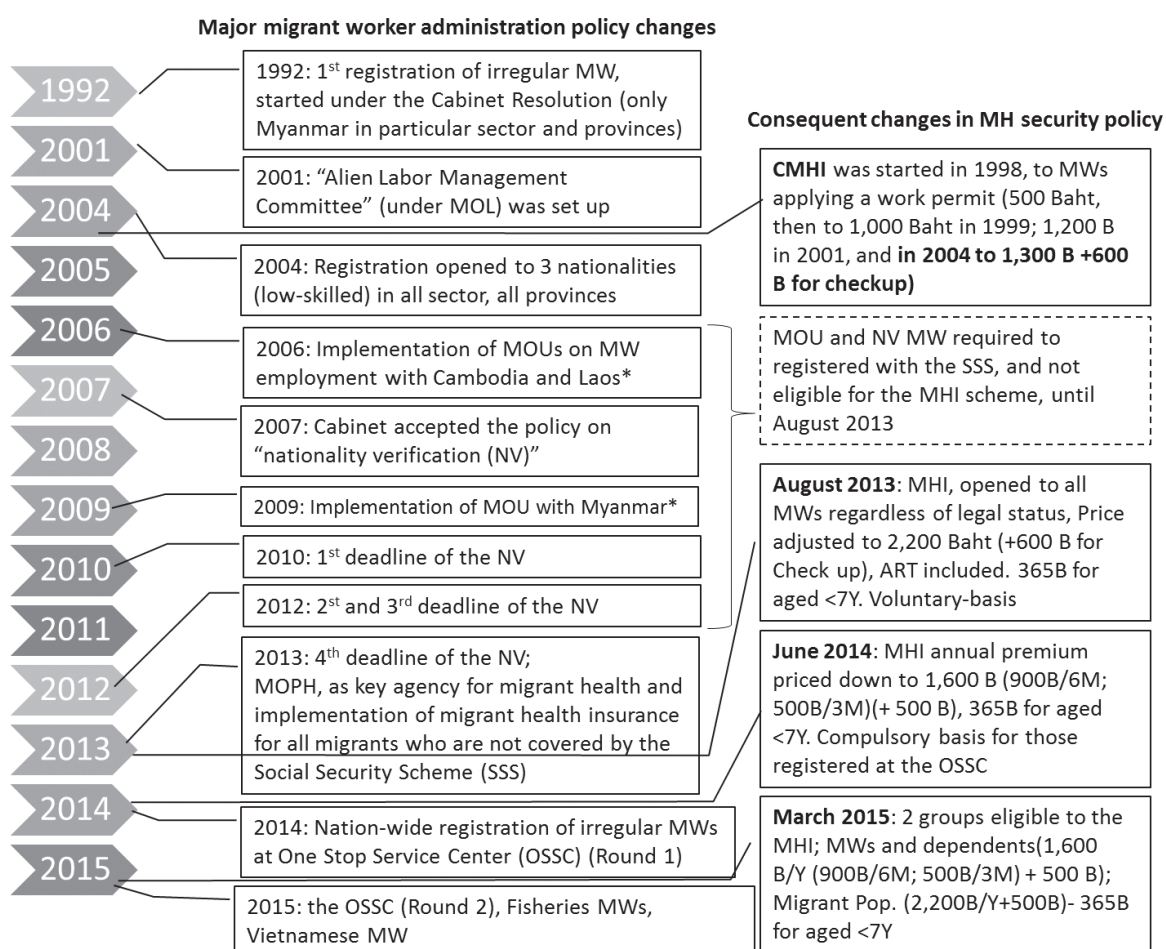
Major policy changes and existing health schemes for migrants

The direction of health security policy for migrants in Thailand is highly determined by the legal framework administration of the migrant worker population by the Thai government, and that has changed from time to time (Limanond & Peungpossop, 2011; Chamchan, 2014). Primarily, the administration of migrant workers in Thailand is conducted according to the Alien Employment Act 2008. The three guiding principles include, firstly, maintaining national security, secondly, protecting job opportunities for Thais, and thirdly, securing a level of labor migration that supports the growth and development of Thailand¹. The Act is supplemented by regulations which list the

¹ Alien Employment Act 2008, Section 7

occupations in which migrant workers are allowed to work². So far, the administration and management of migrant workers from Cambodia, Lao PDR and Myanmar has been mostly ad hoc (based on each Cabinet Resolution), and arbitrarily changed almost year-to-year. Major changes in the legal framework and policies in Thailand towards this group of migrants in the past decade are summarized in Figure 2.

Figure 2 Major policy changes in migrant worker administration and migrant health security, 1992–2015



Note: *The MOUs were signed in 2002 with Lao PDR and in 2003 with Cambodia and Myanmar.

Source: compiled from various sources by the authors

² Alien Employment Act 2008, Section 8

At the present, there are two health security schemes eligible for migrants from Cambodia, Lao PDR and Myanmar in Thailand: The Social Security Scheme (SSS) and the Migrant Health Insurance Scheme (MHIS). The SSS is administered by the Social Security Office, and eligible only for formal sector migrant workers who came to Thailand through the MOU channel and those who have completed the NV process with a valid work permit. Coverage does not include workers in agriculture, those on fishing boats and domestic workers. The scheme is a contribution-based scheme. Basically, a contribution at 5% of the monthly wage of the worker will be allocated to the Social Security Fund monthly from the worker and the employer. A partial subsidy is also provided by the government. The SSS provides seven types of benefits, including benefits for medical services, maternity, disability, death, children allowances, old-age, and unemployment. In terms of benefit utilization and requirements, migrant workers under the SSS are treated equivalently to Thai workers (Silanupap, 2014). Basically, eligibility for the benefits will be activated after at least three months of monthly premium payments or contribution from the registered worker to the fund.

The contribution which is co-paid by employers provides no incentive for both migrant workers and employers to register. In addition, in the migrants' view, the disadvantage of the SSS is that some aspects are not in line with the timeframe of the Thai work permit, e.g., the elderly and unemployment benefits. The monitoring process that enforces migrant workers going through the NV process to register with the Social Security Office was considered not to be effective enough (Chamchan, et al., 2016; Taweesit & Chamchan, 2014). As a result, a large number of those verified workers were not registered by their employers, and became uninsured workers being unable to take part in the health insurance scheme.

The other scheme, the Migrant Health Insurance Scheme (MHIS), is administered by the Health Insurance Unit (HIU), the Ministry of Public Health (MOPH). The scheme was established in 1998 with the initial purpose to provide health protection to irregular migrant workers who registered and applied for a work permit. According to regulations of the Thai Government at that time, all irregular migrant workers who were registered and received a temporary ID card (Tor. Ror. 38/1) and applied for a work permit in that year were required to buy a 500-baht health insurance card for a one-year period of coverage (plus an additional 600 baht for medical checkup). The premium was increased to 1,000 baht in 1999, to 1,200 baht in 2001 and then to 1,300 baht in 2004 (Srithamrongsawat, Wisessang, & Ratjaroenkhajorn, 2009). Starting in 2006, migrant workers who came to Thailand under the bilateral MOU between and completed the NV process were required to enroll in the SSS and were no longer eligible for the Migrant Health Insurance Scheme (Limanond & Peungpossop, 2011).

In 2013, the Cabinet designated the MOPH to be the key agency responsible for migrant health and implementation of migrant health insurance for all migrant workers who were non-SSS beneficiaries. Accordingly, in August 2013, the MOPH implemented a new migrant health insurance policy, allowing all migrant workers who were not covered by the SSS, regardless of the legal status, to buy a MHIS Card from registered public hospitals. The MHIS's premium was increased from 1,300 baht to 2,200 baht (plus an additional 600 baht for a medical checkup), of which the 900 baht increment was used to finance ARV treatment for those infected with the HIV/AIDS (which was not covered by the previous benefits package). This rate was for migrant workers aged seven years or over. For those aged less than seven years, the insurance premium was 365 baht. (Note: a medical checkup might be exempted upon the doctor's opinion). Those who were newly registered with the SSS, and on a three-month waiting period to be eligible for the SSS benefits, could also buy a 3-month card under this scheme at a 550 baht premium (plus 600 baht for a medical checkup) (Ministry of Public Health of Thailand, 2013).

In 2014, according to the announcement of the National Council for Peace and Order (NCPO) No. 67-68, 70 and 77/2557 (National Council for Peace and Order, 2014)³ measures in addressing and solving problems of migrant workers were announced and implemented by the NCPO with a key strategy to establish OSSC for the registration of migrant workers in all provinces. Migrant workers and dependents with irregular status were required to register at the OSSC at the to receive a temporary ID card, at which time the Ministry of Labor would issue the temporary work permit and the MOPH would do the medical checkup and enroll the worker in the Migrant Health Insurance Scheme. The OSSC (round 1) was operated from June 30, 2014 to the end of October 2014. The costs of medical examination and issuance of MHIS Card were priced down from 600 baht and 2,200 baht to 500 baht and 1,600 baht, respectively. The total expenses paid by the worker were, thus, decreased from 2,800 baht to 2,100 baht with the unchanged benefit packages provided by the MHIS. The budget allocation to the scheme was still the same as before, with the exception of ARV treatment for which the allocation was reduced from 900 baht to 300 baht. For migrant's accompanying dependents aged under seven years, the annual premium is 365 baht. Migrant workers from the three neighboring countries and their followers who did not have to register at the OSSC and their insurance had expired (or no insurance) could apply for insurance

³ Order No. 67: Temporary Measures in Addressing Migrant Workers; Order No. 68: Urgent Interim Measures to Prevent and Suppress Human Trafficking and Solve Problems Pertaining to Migrant Worker , Phase One; Order No. 70: Interim Measures in Solving the Problem of Migrant Workers and Human Trafficking; Order No. 77: Establishment of Additional and Measures for Orderly Management of Migrant Workers Working on Fishing Vessels in Provinces Bordering the Sea

cards at designated public hospitals. The health checkup and health insurance fees were charged at the same rate as the OSSC (500 baht for an examination and 1,600 baht for an insurance). Migrant workers classified as stateless and people having problems with their legal status could apply for health insurance at designated and near-by health facilities with a registration fee of 600 baht and a health insurance premium cost of 2,200 baht.

According to the Cabinet Resolution on March 3, 2015, the OSSC was re-opened (round 2) nationwide from April to June 2015 for migrant workers and accompanying dependents who had registered in the first round but who had not completed the NV process. This registration allowed these migrants to stay in the country for an additional one year in order to complete the NV process. New migrants and dependents in the fisheries sector were permitted to register at a OSSC located in 22 coastal provinces during the same period. To accommodate the OSSC operations, the MOPH issued two new notifications revising the management of medical checkups and the MHIS. According to these notifications, migrants were classified into two categories—migrant workers and accompanying dependents (Myanmar, Lao PDR and Cambodia migrant workers who registered at the OSSC), and other migrants (who were not working and non-SSS beneficiaries) (Ministry of Public Health of Thailand, 2015). For the first group, the annual premium of the MHIS would be charged at 1,600 baht (or 900 baht for 6-month, and 500 baht for 3-month coverage), plus 500 baht medical checkup fee. For other migrants, the premium is higher at 2,200 baht per year (with no options for 6-or 3-month coverage), plus 500 baht medical checkup fee. The annual premium for those aged less than seven years is the same for both groups at 365 baht. In December 2015, Vietnamese unskilled workers who entered Thailand legally with a passport before August 10, 2015 and worked in specific sectors gained permission from the Cabinet Resolution and the MOPH's notification to register, apply for a 1-year work permit, and enroll in the MHIS with the same premium rate of migrant workers from Cambodia, Lao PDR and Myanmar (Ministry of Public Health of Thailand, 2015). Revisions of the MHIS during 2004 to 2015—regarding to eligibility and target group of migrants, premium rate and benefits covered are summarized in Table 1.

Table 1 Revisions of the MHIS by the MOPH during 2004–2015

Year	Eligible groups	Annual Premium	Benefits
2004– Aug. 2013	Registered migrant workers (on a semi-compulsory basis), not included under MOU, NV migrants	1,900 baht (1,300 baht plus 600 baht for medical checkup)	Equivalent to Thai Universal Coverage Scheme with some exceptions, not including ARV treatment
Aug. 2013– June 2014	All migrants who were Non-SSS beneficiaries (regardless of legal status–Voluntary basis), including dependents/children, the 3-month SSS-to-be	Aged 7 and over: 2,800 baht (2,200baht +600 baht) Less than 7: 365 baht 3-month SSS-to-be: 1,150 baht (550+600 baht)	ARV treatment was added in the package
June 2014– March 2015	All migrant workers and accompanying dependents registering at the OSSC + (Non-SSS migrants)	Aged 7 and over: 2,100 baht (1,600 baht +500 baht) (Note: 900baht/6 months and 500 baht/3 month + 500 baht) (same for other group)	Same as above
March 2015– December 2015	(1) Registered migrant workers (proceeding NV) and accompanying dependents, Workers in fisheries (*including migrant workers from Vietnam)	Same as above	Same as above
	(2) Migrant populations (non-SSS beneficiaries)	Aged 7 and over: 2,700 baht (2,200 baht + 500 baht) Less than 7: 365 baht	Same as above

Source: Compiled from various sources by the authors

Securing health of migrants: Where have we been? (2004–2015)

By immigrant status, migrants from Cambodia, Lao PDR and Myanmar who came to Thailand under the bilateral MOUs (with a passport, a valid visa and a work permit) are the only group that possess legal immigrant status when entering Thailand. The other group consists of those who irregularly entered the country. According to changes of the migrant administrative policies in Thailand over the past ten years, the immigration status of migrants can range from being “irregular (undocumented)”, to “registered with a temporary ID card (under the amnesty or the OSSC registration)”, to “Nationality Verified with a passport” (through the NV process). By employment status, there are two groups: Migrant workers with legal status (possessing a valid work permit) and those without a legal status or a valid work permit.

Statuses of migrants, both immigration and employment, are considered as a key underlying factor having direct implications on their health protection entitlement. In the past, regular immigrant status did not always indicate legal employment status or receiving migrant health insurance. Legal employment status also did not always guarantee access to the existing health security scheme. Receiving health protections (either under the SSS or the MHIS) also did not guarantee physical access to necessary health services (at the registered health facility) for the migrant. Further, physical access to a health facility also did not guarantee receiving quality services from the service provider (Boonchalaksi & Chamratrithirong, 2007; Jitthai, 2009; Tharathep, Thamroj, & Jaritake, 2013).

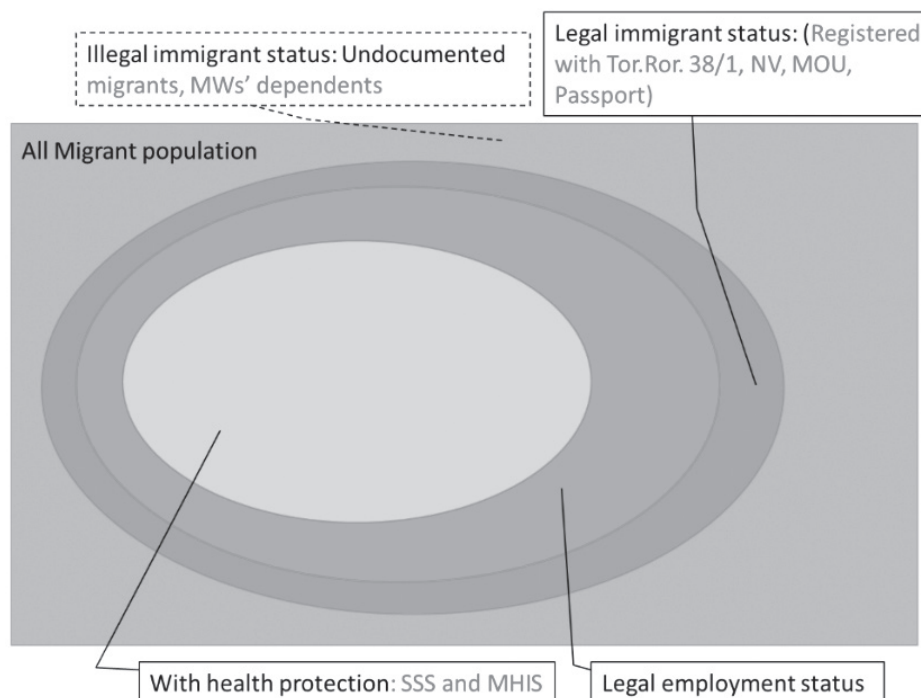
Taking the status of migrants into account, the consequences of the policy changes on migrant health security coverage and its performance are analyzed next. The discussion is in reference to four policy periods: Before August 2013, August 2014 to June 2014, June 2014 to March 2015, and March to December 2015.

Before August 2013

Migrant health security coverage, is illustrated by Figure 3. Though the total number of migrants in Thailand at that time was unknown, a significant number were believed residing illegally (without a passport or a temporary ID card). According to the legal framework at that time, only legal migrant workers were eligible to apply for a work permit. Due to ineffective enforcement, some migrant workers with legal immigrant status were left without a work permit (Taweessit & Chamchan, 2014). Prior to August 2013, the access to health protection for the migrants (either registering with the SSS or enrolling in the MHIS) was attached to (or conditional by) their immigrant and employment statuses. However, due to ineffective enforcement and low compliance, only

a subset of migrant workers with a work permit actually had access or entitlement to a health insurance scheme.

Figure 3 Migrant health security coverage, before August 2013



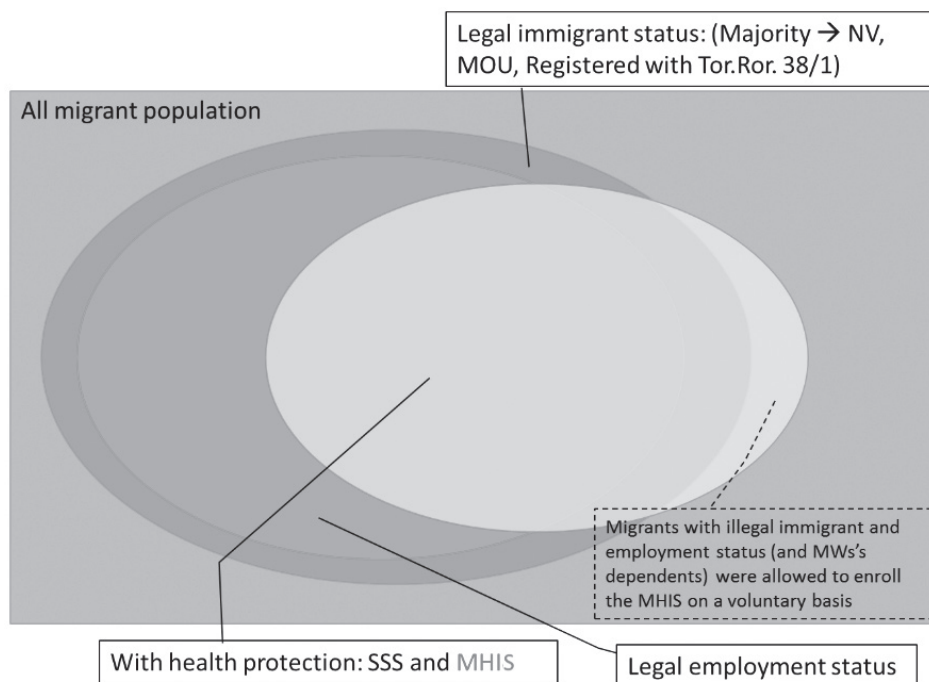
According to a study by Chamchan & Apipornchaisakul (2012), migrants who were unable to access health protections or left unprotected from catastrophic health expenditure included irregular and undocumented migrant workers, migrant workers' accompanying dependents (e.g., children, spouse and parents), and some migrant workers under the MOU or with NV status who failed to register with the SSS. In June 2013, the number of MOU-based migrant workers and those with NV status was around one million but the number of those who actively enrolled in the SSS was much lower, at only 320,000 (Huguet, 2014, p. 37).

The low coverage and compliance rate of the SSS were mostly due to poor cooperation from the migrant worker's employer and disincentives to register by the migrant workers themselves. Aspects of the SSS that discouraged enrollment of migrant workers include, for example, exclusion of some groups of migrant workers from the fund (e.g., agricultural and domestic workers), the minimum 3-month waiting period to activate the benefits, and some impractical benefits for migrant workers' conditions. In the migrant's view, old-age and unemployment benefits were not relevant to their needs. Also, the monitoring process that enforced migrant workers to go through the NV process to register with the SSS was considered not to be effective enough.

The major problems with the MHIS were limited health coverage and financing capacity, and fluctuating viability. Eligibility to enroll in the MHIS was attached to migrant workers' registration, year-to-year changes of terms, and unclear policy on migrant worker administration. Some felt that the premium of 1,300 baht was too expensive. Some registered migrants who had completed the NV opted out of the SSS. Because of the limited coverage of the SSS and the MHIS, health financing for service provision to migrants was relying less on the pre-paid health security system and more on out-of-pocket payments by the migrants, and hospital exemptions. This caused considerable financial burden to the hospitals and service providers, especially in the border areas.

August 2013 to June 2014

Figure 4 Migrant health security coverage, during August 2013 to June 2014



According to the revision of the MHIS by the MOPH in August 2013, eligibility to the scheme was opened to all migrant workers not covered by the SSS, regardless of legal status. It is worth noting that the enrollment of the irregular migrant population (including accompanying dependents) was on a voluntary basis. Thus, the situation regarding migrant health security coverage during this time changed and became not fully attached to immigrant and employment status of the migrant. The policy intention of the MOPH was to expand the coverage of health protection to all migrants with additional benefits that covered ARV treatment. However, according the field studies (Taweessit & Chamchan, 2014; Chamratrithirong, Boonchalaksi, Holumyoung, Chamchan, & Apipornchaisakul, 2016; Chamchan, et al., 2016) in 2013–2014, migrants' access to health security and services was

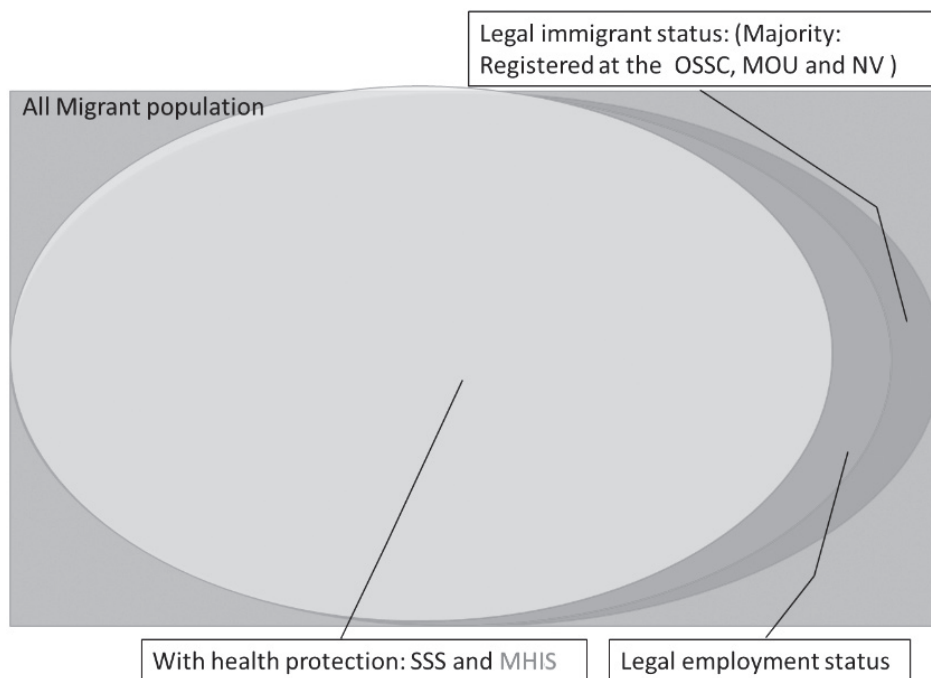
still limited and had, in fact, worsened. According to a survey during the first half of 2014 among 3,555 migrant workers in eleven provinces of Thailand, the coverage of MHIS and the SSS were 42.8 and 5.6 percent, respectively. About half of the respondents were uncovered by any health scheme (Chamratrithirong, Boonchalaksi, Holumyoung, Chamchan, & Apipornchaisakul, 2016).

An important problem was that some contracted hospitals did not allow migrants to enroll in the MHIS unless they could present some identity documentation or were guaranteed by their employers. This practice was not consistent with the announced policy by the MOPH. From the service providers' point of view, there were three key limitations that prevented them from implementing the new policy. Firstly, many hospitals lacked confidence in the new MHIS policy due to unclear operational guidelines relayed by the MOPH, as well as several issues emerging from the management of health insurance. For example, there was a controversial definition of migrant workers who were eligible for the MHIS (whether it included only the low-skilled workers from Cambodia, Lao PDR and Myanmar or included also Western migrants and high-skilled workers). Also, there were problems with the service reporting system to claim reimbursement for high medical costs (i.e. ARV treatment); up to June 2014, local hospitals that could not report the result of patients' treatment did not get reimbursement. Secondly, the enrollment in the MHIS was not compulsory. It should be noted that, to apply for a work permit from the Department of Employment, Ministry of Labor, registration or enrollment in the SSS or the MHIS was not required. This led some groups of the migrant workers (especially the healthy) to avoid registration. Also, employers who saw no benefits or the importance of enrolling in a health insurance scheme did not comply with policy. Migrant workers and their accompanying dependents who voluntarily registered with the MHIS were largely at-risk patients or the chronically-ill and, thus, there would be no risk diversification of the pool of the insured, which is necessary for a health insurance system to be viable. As the insurance fee was increased from 1,300 to 2,200 baht in August 2013 this only further deterred healthy migrant workers and their dependents from buying into the MHIS. Consequently, the policy became an added financial risk for the public hospitals. Thirdly, there were problems with the database system and data linkages among other related databases used for personal verification in order to prevent the duplicate registration of migrants. MOPH hospitals agreed to use the newly-created 13-digit numbers to manage undocumented migrants. However, monitoring, migrant verification, follow-up and prevention of duplication were still difficult to manage. This was one of the reasons that hospitals began requiring documental proof or address and employer confirmation, rather than using the 13-digit ID numbers.

As noted, some migrants chose not to join a health insurance scheme. Some felt that the annual premium was too expensive, especially for those who perceived themselves as healthy and with low risk of illness. Others felt the inclusion of the ARV treatment benefit was not relevant, or

unfair to have the uninfected subsidize the HIV+ migrants. Also, there was lack of confidence that they could really access the health services included in the MHIS benefit package. Some said that they had negative experience in seeking health services at the public health facilities. Indeed, most migrants chose not to go to the public health facilities if not seriously ill. Therefore, they perceived that having the insurance would not reduce their families' expenditures, in particular in the case of minor illness. The migrants suggested the need for improvements in awareness, understanding and attitudes among service providers toward migrant clients in order to provide migrant-friendly services.

Figure 5 Migrant health security coverage, during June 2014 to March 2015



June 2014 to March 2015

According to the strategy in addressing and solving problems of migrant workers of the NCPO, the OSSC (Round 1) were set up for the registration of irregular migrant workers, and operated in all provinces during June to October 2014. At the OSSC, all migrants and accompanying dependents from Cambodia, Lao PDR and Myanmar who had no valid documentation were allowed to register for a temporary ID card, apply for a work permit, and then required to enroll in the MHIS. The MHIS's premium for migrants aged seven years or over was priced down from 2,200 baht (plus 600 baht for medical checkup) to 1,600 baht (plus 500 baht for the checkup). The benefit packages remained unchanged. The situation in terms of immigrant status, employment status and

entitlement to health protection improved somewhat. The number of migrants who had irregular or undocumented status and were not covered by a health security system declined significantly. As presented in Figure 1, the number of documented migrant workers with a work permit in December 2014 was 2.71 million (excluding dependents), of which 1.53 were registered migrants at the OSSC and all supposedly covered by the MHIS.

According to a qualitative study by Chamchan, et al. (2016) in six provinces, the view of service providers toward the MHIS situation improved compared to before June 2014. Overall, the health insurance enrollment of migrants was improving, except in some OSSC with low up-take. As health insurance was required as part of the registration process, this significantly increased the number of insured migrants, both healthy and unhealthy persons. Even though the insurance premium was decreased from 2,200 to 1,600 baht, the larger number of migrants under the MHIS significantly improved the financial situation of most contracted hospitals. Also, because all migrants who enrolled in the MHIS were those who registered for a temporary ID card at the OSSC, this helped populate the database of the insured migrants. The 13-digit ID numbers was now used as a standardized reference number for the central database and all relevant organizations. This helped management and cross-checking.

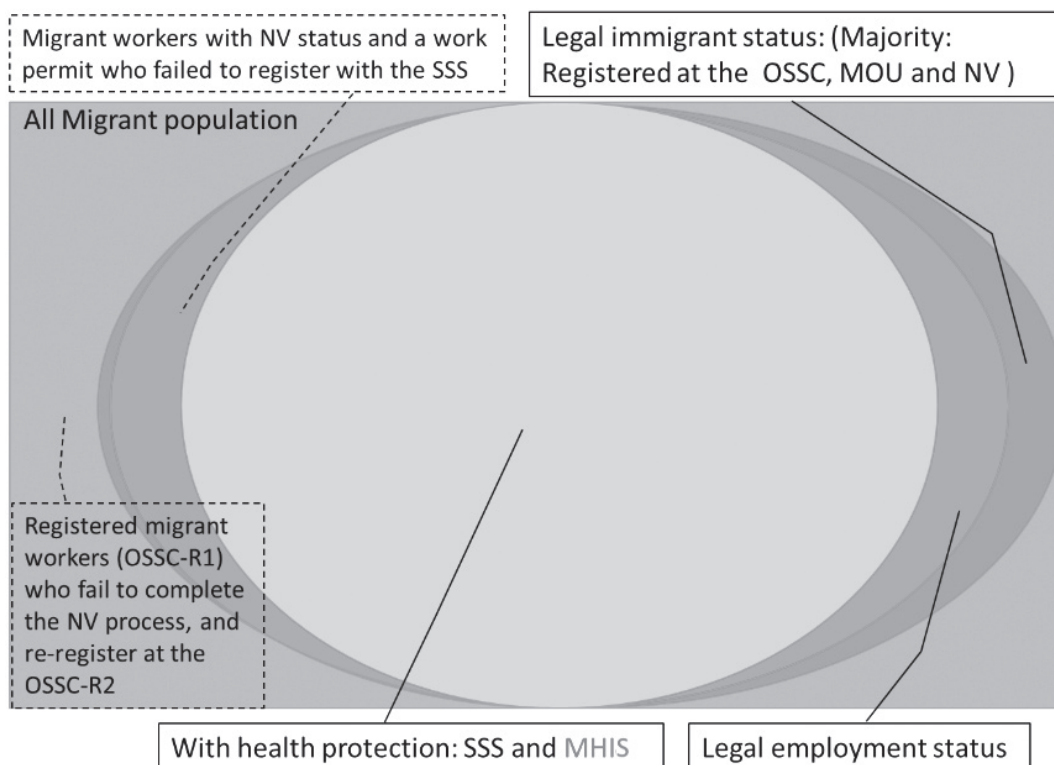
Remaining concerns among service providers include reporting of patients' treatment outcomes, and claiming reimbursement for high-cost care, including the provision of ARV treatment. Also, the situation after March 2015 (with expiry of registration validity and deadline for all registered migrants to complete the NV process) was unclear, and there was uncertainty whether the policies regarding the MHIS would be changed from the central administration and in which direction.

March to December 2015

Following the Cabinet's resolution in the beginning of 2015, the guidelines of migrant worker management was announced for the period after March 2015. For Group One, i.e., registered migrants who had completed the NV process and obtained a work permit which was initially valid until March 31, 2016, the work permit's expiry date was extended for an additional two years. Group Two, i.e., registered migrants who had not yet completed the NV process, were required to re-register at the OSSC (Round 2) by the end of June 2015 and re-apply for a work permit for an additional year (valid till the end of March 2016), then complete the NV process to get an additional two-year work permit. Group Three, i.e., irregular migrant workers in the fisheries or related businesses (in 22 coastal provinces), were required to register at the OSSC during April–June 2015 to get the one-year work permit (valid till the end of March 2016), go for a medical checkup and enroll in the MHIS.

In managing migrant health insurance, the MOPH required all migrant workers and dependents who registered at the OSSC (Round 2) to enroll in the MHIS. The medical checkup was exempted for migrants who had proceeded within the past year, and migrant's accompanying dependents aged not over seven years. The MHIS premium remained unchanged at 1,600 baht for one-year coverage, 900 baht for a half-year coverage and 500 baht for three-month coverage. After the closing of the OSSC, these rates were also applied to all migrant workers and accompanying dependents (who were not registered with the SSS), including the Vietnamese migrant workers who were recently allowed to register with Thai authorities and obtain a temporarily work permit in December 2015. For other migrant populations (who were not registered with the SSS), the annual premium was set at 2,200 baht plus 500 baht for a medical checkup. The premium for migrants aged less than seven years was the same, at 365 baht per year.

Figure 6 Migrant health security coverage, March to December 2015



As presented in Figure 1, the number of migrant workers and accompanying dependents who registered at the OSSC (Round 2) in 2015 was 1.1 million, or lower than the number in Round 1 (about 0.61 million). The migrants who registered at the OSSC–Round 1 but did not re-register in Round 2 were expected to have completed the NV process. Thus, it would not be surprising if the number of migrants with NV status increased at a similar rate. From the records, however, the

number of migrants with NV status in December 2015 was 0.99 million, an increase of only around 30,000 from November 2014. Considering the MHIS, the number of registered migrants also decreased by nearly half a million from 1.78 million in 2014 to only 1.34 million in October 2015 (Ministry of Public Health, Thailand, 2015; Ministry of Public Health, Thailand, 2015; Akksilp, 2015). Information about the number of migrants registering with the SSS revealed an increase from around 412,000 persons in May 2014 to 489,914 persons in July 2015 (Tantrakul, 2015; Thanaisawanyangkul, 2015; Silanupap, 2014). Accordingly, the coverage of migrant health security, under the MHIS and the SSS, at the end of 2015 is expected to be at around 1.8–2.0 millions.

Based on this information, there are a few questions worth considering. Firstly, where were the half million registered migrants (OSSC–Round 1) who did not re-register at the OSSC–Round 2 and had not completed the NV process? (Unless they had returned home or died, these migrants were still in (and working in) Thailand with illegal status.) Secondly, how many of NV migrants who failed to register with the SSS (approximately 989,374 minus 489,914, or 0.5 million) had enrolled in the MHIS voluntarily? (Assuming that all migrants and dependents registered at the OSSC–Round 2 enrolled in the MHIS, the rest of MHIS’s beneficiaries 0.23 million, or 1.34 minus 1.1 million, was the maximum number of those in question.) These questions remind us to think carefully about how to improve the NV process, the enforcement of enrollment in the SSS among migrant workers with NV status, and incentives to voluntarily enroll in the MHIS of migrants who were not covered by the SSS. Unless all irregular migrants (at the OSSC) could complete the NV process, all those with the NV status registered with the SSS, and all those not covered by the SSS enrolled in the MHIS, then the situation about migrant health security would revert back to the same as it was before June 2014. In the future, if the next round of the OSSC is not re-opened, many migrants would return to undocumented status. The MHIS coverage would then be smaller as the enrollment would be mostly on a voluntary basis. Also, a number of migrants, especially those with irregular or undocumented status, would be left unprotected and not covered by either the SSS nor the MHIS.

Concluding remarks

Up to the end of 2015, Thailand’s policy toward health security for migrant populations, particularly migrant workers and accompanying dependents from Myanmar, Lao and Cambodia; has become clearer in terms of the direction and more inclusivity for all migrant groups. Regular (and regularized) migrant workers with legal immigrant and employment status, i.e., those with MOU and NV verified status, are eligible and required to register with the SSS which is generally equivalent to what their Thai counterparts receive in terms of contribution to the fund and benefit

packages⁴. Irregular migrants (and accompanying dependents) who registered at the OSSC (including Vietnamese migrant workers) who received a temporary legal status to live and work in the country must enroll in the MHIS. The MHIS premium was reduced to be more affordable to migrants while the benefits package (including the ARV treatment) was unchanged. Undocumented migrants—the irregular migrants who did not have a registered status—are eligible to enroll in the MHIS on a voluntary basis. The annual premium was 600 baht higher than that of the migrant worker group, with the same benefits package.

In sum, it could be said that access to health security, in terms of policy, was opened to and eligible for all migrant population groups. In practice, however, the coverage of migrant health security was still incomplete leaving some groups of migrants uninsured. Though the undocumented migrants were the most likely group to be left out, the status of the documented migrants could not be ignored. Based on findings in the previous section, there were two causes of coverage gap among documented migrant. Firstly, the delayed completion of the NV process of the registered migrants left most uncovered. The number of migrants registering at the OSSC Round 1 in 2014 was 1.6 million, and all were supposed to complete the NV process by the end of March 2015. However, looking at the statistics, the number of migrants with NV status comparing between December 2014 and 2015 increased by only around 30,000 persons. Due to the limitations of the information, this study could not identify what were the causes of this gap. However, the delay is the key explanation of why the OSSC needed to re-operate (Round 2) in 2015. Unless this is improved, and the number of the registered migrants at OSSC Round 2 could not complete the NV process by the deadline in March 2016, their regular status would become invalid. If there is not a new round of the OSSC in the future, the enrollment in the MHIS of these migrants would be on a voluntary basis which was less likely and mostly adverse-selective (i.e., mainly those with high health risk would enroll in the health scheme).

The second gap in coverage is related to the ineffective enforcement of the enrollment in the SSS among migrant workers who had completed the NV process and some shortcomings of the scheme. By regulation, all workers with the NV status and those under the MOU are mandated to register with and enroll in the SSS. In practice, as revealed by the most recent statistics in 2015, the compliance rate was still very low (around 0.5 million out of 1.2 million NV and MOU workers). Although those who failed to enroll in the SSS were able to enroll in the MHIS instead, the likelihood was low as it was voluntary⁵. According to the migrant regularization policy, all registered

⁴ Except for retirement and unemployment benefits that migrant workers, in practice, seem not eligible to claim.

⁵ From a previous study, it was recommended that enrolment in either the Social Security Scheme or the Migrant Health Insurance Scheme should be compulsory to all migrant workers before receiving a work permit from the

migrants (about one million at the OSSC Round 2) were expected to complete the NV process. Unless the enforcement and compliance rate of registration with the SSS of migrant workers with the NV status is improved, the number of uninsured migrant workers not enrolling in either the SSS or the MHIS would be higher. This would also be a problem for MHIS management. Its coverage (the number of beneficiaries) is likely to be smaller as most of the enrollment will be on a voluntary basis. The scheme's risk pooling will also be negatively affected due to the "adverse selection" problem as most of those who enroll in the scheme are likely to be the group with high health risk. The low compliance rate with the SSS of migrant workers with the NV status should not be construed as only a problem of weak enforcement, but also due to some shortcomings of the scheme's features (in terms of contribution and benefit packages) which some migrant workers and employers feel are not accommodating their needs and the employment context in Thailand (Hall, 2012; Chamchan & Apipornchaisakul, 2012; Taweessit & Chamchan, 2014). Also, another major shortcoming is the fact that the scheme only covers formal-sector workers and, thus, excludes those in agriculture, those on fishing boats and domestic workers, who together comprise a significant percentage of migrant workers.

If these two gaps in coverage could not be reduced, despite the policy guideline that all migrants are eligible to health protection in Thailand, the situation would be likely regress to the situation before the implementation of the OSSC Round 1 in 2014. The number of migrants with irregular status (both immigrant and employment statuses) and not protected by any health scheme (either the SSS or the MHIS) would increase. Management of the MHIS would again face the problem of too small coverage and poor risk pooling. In the end, all these factors would pressure the government to recommence the registration of irregular migrants (similar to the OSSC). Thus, a more sustainable solution is needed. Otherwise migrant health insurance enrollment campaigns and drop-outs will continue in an unending cycle.

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