Migrant Policies in Thailand in Light of the Universal Health Coverage: Evolution and Remaining Challenges

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Global Movements, Criticisms and Challenges on Migrant Health

At present, there exists a need to share responsibility and expectation of global support in addressing needs of international migrants. So far, there have been a number of global agreements in the past several years to facilitate the implementation of health policies towards migrants.

In 2016, the United Nations General Assembly unanimously adopted the ‘New York Declaration for Refugees and Migrants’. The declaration underlined a need for more cooperation among nations towards effective management of migration and negotiation on the ‘Global Compact for Safe, Orderly and Regular Migration’, which was later endorsed in 2018.

In 2017, the World Health Assembly (WHA) endorsed a resolution, ‘Promoting the Health of Refugees and Migrants’ (WHA 70.15), leading to the development of the ‘Draft Global Action Plan, 2019-2023’ in 2019. These agreements were supported by Thailand and many other countries. During negotiation of such agreements, there were debates and criticisms, particularly on issues of shared responsibility and ownership of countries, clarification of roles among key stakeholders, distinction between illegal and legal migrants, and commitment of member states to implement actions specified in the agreements while maintaining national sovereignty (Table 1).

Thailand and Universal Health Coverage at a Glance

Universal Health Coverage (UHC) is both path and principle to ensure that all people are able to access standard health services, without incurring financial hardship. It is now one of the global targets in the Sustainable Development Goals. Thailand has achieved UHC since 2002, which is attributed to continuous investment in health workforce and health care infrastructures for over 30 years, combined with a critical health financing reform.

At present, there are three main public insurance schemes in Thailand. First is Civil Servant Medical Benefit Scheme which covers Thai civil servants, constituting around 9% of total population. Second is Social Security Scheme (SSS) for private employees in the formal sector, numbering about 15% of total population. Third is Universal Coverage Scheme (UCS) for the majority of Thai citizens (75% of total population). All of the three schemes have been successful in improving health of Thai citizens and protecting them against catastrophic expenditures.

All of these accounts made Thailand gain remarkable achievement as one of the UHC champions in global health arena (Table 2).

Linkage between UHC and Migrants

Theoretically, UHC means ‘universal protection’ for all populations. Yet, practically, there is always a fundamental question, to what extent the term ‘population’ covers. Does it cover the native residents only? Does it include anyone living in the country border? This issue becomes more complex when dealing with non-Thai population. Most of them are migrant workers and their dependents, numbering around 3.1 million. This figure has not included undocumented migrants who are untraceable by the government.
Over 90% of them are from Cambodia, Lao PDR and Myanmar, so-called CLM migrants. The CLM migrants are mostly engaged in dirty, demeaning and dangerous jobs. The rest 10% is a group of well-off non-Thai, including professional workers and expatriates who are already covered by either private insurance or SSS. Low-skilled migrant workers working as employees in the formal sector have to be enrolled in SSS while those in the informal sector (such as fishermen, farmers, and housemaids) are to be insured with Health Insurance Card Scheme (HICS) of the Ministry of Public Health (MOPH).

Protecting health of migrants is not only a matter of health. In fact, it means a protection of the national macro-economy. Recent report by the International Labour Organization suggested that in 2010, migrant workers contributed around 4.3-6.6% of gross domestic product in Thailand. This figure represented 4.7% of the employed population.

Since CLM migrants constitute the greatest share of non-Thai population in Thailand, most policy dialogues on migrant health so far have been centered on CLM migrant workers and their dependents. One of the greatest complexities of this issue is that a large amount of CLM migrants are (and can be) undocumented at certain periods of their lives. Thus, the term ‘undocumented’ in this regard means that they once entered Thailand without legitimate travel documents, or dependents were born

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### Table 1. Key characteristics of selected important international agreements on migrant health

<table>
<thead>
<tr>
<th>Agreement</th>
<th>Key substance</th>
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<tbody>
<tr>
<td>New York declaration for refugees and migrants (Resolution 71/1)</td>
<td>Leading to 2 main concrete actions: (1) initiating the draft on Global Compact for Safe, Orderly and Regular Migration and (2) initiating guidelines on the treatment of migrants in vulnerable situations</td>
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<tr>
<td>Global compact for safe, orderly and regular migration</td>
<td>Support the development of evidence-based migration policy (ensuring proven identity, enhancing availability and flexibility for regular migration, access basic services, and making provisions for both full inclusion of migrants and social cohesion)</td>
</tr>
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<td></td>
<td>Emphasising principles of national sovereignty (reaffirming the sovereign rights of a country to determine its national migration policy and its prerogative to govern migration within their jurisdiction, in conformity with international laws)</td>
</tr>
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<td></td>
<td>Making no distinction between illegal and legal migrants</td>
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<tr>
<td>World Health (WHA) Assembly resolution 70.15, ‘Promoting the Health of Refugees and Migrants’</td>
<td>Focusing on strengthening international cooperation and partnerships on the health of refugees and migrants</td>
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<tr>
<td></td>
<td>Leading to the development of a Global Action Plan for consideration at the following WHA in 2019</td>
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<tr>
<td>Global Action Plan, 2019-2023</td>
<td>Following from the WHA resolution 70.15</td>
</tr>
<tr>
<td></td>
<td>Asserting health as an essential component of good migration governance</td>
</tr>
<tr>
<td></td>
<td>Key activities mainly confined in the WHO secretariat rather than the member states</td>
</tr>
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</table>

### Table 2. Key characteristics of the main three insurance schemes for Thai citizens at present

<table>
<thead>
<tr>
<th>Insurance scheme</th>
<th>Population coverage</th>
<th>Source of revenue</th>
<th>Mode of provider payment</th>
<th>Access to service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Civil Servant Medical Benefit Scheme (CSMBS)</td>
<td>~9%, government employees plus dependents (parents, spouse, and up to 2 children)</td>
<td>General tax, noncontributory scheme</td>
<td>Fee for service, direct disbursement to mostly public providers and Diagnostic Related Groups (DRG) for inpatient treatment</td>
<td>Free choice of public providers</td>
</tr>
<tr>
<td>Social Security Scheme (SSS)</td>
<td>~16%, private sector employees, excluding dependents</td>
<td>Tripartite contribution, equally shared by employer, employee and the government</td>
<td>Inclusive capitation for both outpatient and inpatient plus additional adjusted payments for accident and emergency and high-cost care</td>
<td>Registered public and private contractors</td>
</tr>
<tr>
<td>Universal Coverage Scheme (UCS)</td>
<td>~75%, the rest of the &quot;Thai&quot; population not covered by SSS and CSMBS</td>
<td>General tax</td>
<td>Capitation for outpatients and global budget plus DRG for inpatients</td>
<td>Registered contractors, notably the network of public hospitals (Contracting Unit for Primary Care)</td>
</tr>
</tbody>
</table>
in Thailand without registering for a birth certificate. Therefore, a provision of health care cannot be functioned effectively unless measures to remedy the precarious legal status of migrants are in place.

**Health Insurance Card Scheme - One of the Most Remarkable Policies on Migrant Health in Thailand**

The health-protection policy for migrants started in early 1990s. During that period, the government proclaimed public health insurance for migrants in certain industrialized provinces until 2004 when there was an establishment of public insurance for migrants, namely, HICS, for the whole country. The benefit package of HICS is quite similar to UCS, including out-patient, in-patient and emergency care, and high-cost treatments. HICS is financed by annual premium paid by migrants. Note that during the start-up period, the HICS benefit still excluded HIV/AIDS treatment with an annual at 1,300 Baht (USD 39) plus 600 Baht (USD 18) for a pre-enrollment health check. In 2013, HICS faced the important milestone in its evolution. The cabinet at that time approved to include HIV/AIDS treatment in the HICS benefit package. Besides, HICS extended its enrollment eligibility to cover undocumented migrants’ dependents, aged below seven years. However, to be insured with HICS, these undocumented migrants were obliged to register with the government to undertake the ‘nationality verification’ (NV) and acquire ‘work permit’ from the Ministry of Labour first. In other words, NV serves as a legalization process for undocumented migrants. Before enrolling in HICS and obtaining a work permit, applicants must undertake health screening for detect serious communicable diseases that can pose public health threats such as active tuberculosis, syphilis, leprosy and filariasis.

In 2014, the HICS premium reduced to, 365 Baht (USD 11) per year for a migrant child, and 1,600 Baht (USD 49) a migrant adult plus 500 Baht (USD 15.2) for the preconditioned health check. Moreover, HICS for a migrant adult is classified into several subtypes with a less-then-one-year validity period. This sub-arrangement is made so as to cover migrants working in private enterprises who will be soon be enrolled in SSS, but have not completed the SSS contribution requirement. Normally, a SSS beneficiary requires to have his/her wage deducted to SSS for at least three months as a precondition in activating the rights to enjoy services. In 2010, the cabinet proclaimed the insurance policy specifically for this population, so-called, ‘Health Insurance for People with Citizenship Problems’ (HIS-PCP). The insurance is financed by central budget of MOPH, with the benefit package almost comparable to UCS. However, HIS-PCP is beyond the scope of this paper and it needs more space to discuss further in detail on its operational constraints and remaining challenges.

**Direction of the Government to Address the Health of Migrants**

Aside from the insurance policy, MOPH has launched the Border Health Plan as a guideline for all public facilities to provide care for migrants. The plan emphasizes the importance and benefit of migrant friendly service. To this end, migrant health workers
Table 3. Chronological evolution and key characteristics of several subtypes of the insurance card for migrants

<table>
<thead>
<tr>
<th>Card</th>
<th>Premium</th>
<th>Coverage length</th>
<th>Beneficiary</th>
<th>Stating year</th>
<th>Benefit package</th>
<th>Legal basis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Insurance Card for 'migrant'</td>
<td>1,300 Baht + 600 Baht for health check</td>
<td>1 Year</td>
<td>Migrant workers</td>
<td>2004</td>
<td>Out-patient, in-patient, and health promotion, disease prevention services but excluding HIV/AIDS treatment, mental diseases and drug dependence, and chronic dialysis</td>
<td>Cabinet Resolution</td>
</tr>
<tr>
<td>Health Insurance Card for 'migrant'</td>
<td>2,200 Baht + 500 Baht for health check</td>
<td>1 Year</td>
<td>All non-Thai populations, except for tourists, and Caucasian foreigners</td>
<td>2013</td>
<td>Out-patient, in-patient, and health promotion, disease prevention services but excluding HIV/AIDS treatment, mental diseases and drug dependence, and chronic dialysis</td>
<td>Cabinet Resolution</td>
</tr>
<tr>
<td>Health Insurance Card for 'migrant child'</td>
<td>365 Baht</td>
<td>1 Year</td>
<td>Migrant child aged less than 7</td>
<td>2013</td>
<td>Out-patient, in-patient, and health promotion, disease prevention services but excluding HIV/AIDS treatment, mental diseases and drug dependence, and chronic dialysis</td>
<td>Cabinet Resolution</td>
</tr>
<tr>
<td>Health Insurance Card for 'migrant worker'</td>
<td>1,600 Baht + 500 Baht for health check</td>
<td>1 Year</td>
<td>Migrants who registered with the One Stop Service by 31 October 2014</td>
<td>2014</td>
<td>Same as 2013</td>
<td>National Council for Peace and Order</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6 months</td>
<td>Migrants who registered with the One Stop Service by 31 October 2014</td>
<td>2014</td>
<td>Same as 2013</td>
<td>National Council for Peace and Order</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 months</td>
<td>Migrants who registered with the One Stop Service by 31 October 2014</td>
<td>2014</td>
<td>Same as 2013</td>
<td>National Council for Peace and Order</td>
</tr>
<tr>
<td>Health Insurance Card for 'a child of migrant workers'</td>
<td>365 Baht</td>
<td>1 Year</td>
<td>Child of migrant workers, aged less than 7, registered with the One Stop Service by 31 October 2014</td>
<td>2014</td>
<td>Same as 2013</td>
<td>National Council for Peace and Order</td>
</tr>
</tbody>
</table>

Source: adapted from the Health Insurance Group, Ministry of Public Health, Thailand\(^6\)
(MHWs) and migrant health volunteers (MHVs) are promoted. The functions of MHWs and MHVs include not only being a translator for migrant patients in the Thai public facilities, but also providing outreach health education to migrant communities.20,21

The attempt to include migrants in the public insurance arrangement became more materialized in 2017, when the Thai government endorsed a 20-year Master Plan for Integration of Health Insurance Systems Development (2018-2037).22 The plan is chaired by the Deputy Prime Minister, with a purpose to ensure that everybody in Thailand is covered by at least one of the public insurance schemes and is able to maximize their health potentials. Such a political momentum coincides with the Vision of the National Health Security Office, the governing body of UCS, which clearly emphasizes that everybody on the Thai soil, regardless of their ethnic status, should be insured for their health by any of public insurance arrangements.23

Besides, Thailand has supported the ASEAN Declaration on the ‘Protection and Promotion of the Rights of Migrant Workers’ since 2017.24 The declaration reflects a political commitment and progress towards better protection for health of migrants not only in Thailand, but also in the whole Southeast Asia region.

Remaining Challenges and Future Ahead

Despite several initiatives on migrant health, challenges still remain as presented in the following examples. First, the NV process is a longish task and cannot be achieved without seamless coordination between sending and receiving countries, which hardly happen in reality.

Second, though the HICS in intended to be a compulsory scheme for all migrants, in practice there are some migrants failing or refusing to register with HICS or OSS. The number of these migrants remains in question. In addition, so far, there have not been any laws or regulations that indicate penalty on migrants who refuse to buy HICS or employers of migrants who leave their migrant employees uninsured. In other words, HICS is not truly compulsory as intended; its status is rather ‘semi-compulsory’.25 Third, the employment status of a migrant is never static. Portability of one scheme to another, SSS to HICS and vice versa, is still a critical challenge. Fourth, the unsynchronized data management systems across authorities always hamper effective implementation of migrant health policies.

Fifth, there remains a small, but significant discrepancy between HICS and UCS benefit packages, which is treatment for mental health diseases and drug dependence. Strictly speaking, psychiatric diseases are amongst diseases in the negative list specified in the immigration law. Migrants suffering from the negative-list diseases are prohibited from entering the country.26 However, the process of deporting these migrants is unclear and beyond the authority of the health sector. Thus, it is very likely that these migrants are neither able to enjoy services, nor deported back to their homeland. Last but not least is a variety of societal attitudes and diverse legal interpretations towards migrants, which definitely shape how migrants receive service in reality.25

Conclusion

Thailand has travelled far in the quest towards universal protection for ‘everybody’ on its land. Lessons from Thailand show that protecting health of migrants must come alongside a proper remedy on precarious legal status of migrants, especially the undocumented ones. Promoting health and well-being of migrants should be viewed as a sensible investment for the society rather than service burden. Finally, the synergistic effort and policy coherence from all relevant stakeholders are extremely indispensable to ensure health of the whole nation.

Suggested Citation


References


of policy implementation within a complex health system. BMC Health Services Research. 2014 Jul 7;14(2):P121.


