ISSN: 2690 - 0688

Research Article

Journal of Humanities and Social Sciences

Universal Health Coverage for Undocumented Migrant Workers in Thailand: Challenges in Policy Implementation

Orawan Tawaytibhongs[*1], Joris Michielsen[2]

[1]*MD, MHSc, MSc, Khaoyoi Hospital, Ministry of Public Health, Thailand*

[2]*Ph.D. in Sociology, MA in Health Law and Ethics, MA in Development Evaluation and Management, and MSc in Sociology ,Institute of Tropical Medicine, Antwerp, Belgium*

[*]Corresponding author

Orawan Tawaytibhongs, MD, MHSc, MSc, Khaoyoi Hospital Ministry of Public Health, Thailand

Submitted: 23 Jun 2022; **Accepted:** 30 Jun 2022; **Published:** 05 Aug 2022

Citation: *Orawan Tawaytibhongs, Joris Michielsen.(2022). Universal Health Coverage for Undocumented Migrant Workers in Thailand: Challenges in Policy Implementation J Huma Soci Scie, 5(3): 206-214.*

Abstract

Background: *According to the Thai migration report in 2019, almost 5 million non-Thai are residing in Thailand. A majority are low-skilled migrant workers (LSMW) from neighbouring countries including Cambodia, Laos, and Myanmar (CLM). Although the progress in Universal Health Coverage (UCH) Thailand made during the last decade, only half of the LSMW were covered by public health insurance in 2018. A significant number remain deprived from any entitlement to any health insurance due to various barriers. In this paper we review the gaps and challenges in health policies related to migrant workers.*

Methods: *Literature review from PubMed, Biomed Central, and Google Scholar and discussion using WHO Universal Health Coverage cube as a framework*

Results: *Gaps in migrant health policy implementation persist due to the restrictive nature of migrant policies. The processes of providing social protection in health (SPH) to UMW are more of legalizing than protecting of human rights. The discourse that migrants are a burden to the health system still prevails. The accessibility to basic health services remained limited. Additionally, little was achieved regarding the promotion of equal rights and working opportunities.*

Conclusion: *To reduce gaps in health policy implementation, the migrant-friendly service is proposed to provide ease of access to care among migrant workers.*

Keywords: Universal Health Coverage, UHC, Migrant Workers, Healthy Policy, Health System, Health system management

Introduction

In mid-2020, approximately 3.6% of world population migrated across nations accounting for 280.6 million international migrants [1]. They produce more than 9% of the global Gross Domestic Product (GDP) [2]. Two-third are labour migrants. Various factors contribute to this mobility trend, including the shortage of low-skilled labour workforces in receiving countries, deteriorating economic situation and political conflicts in sending countries, climate change, improved transportation worldwide, and human trafficking. During the last decade, migration is increasingly being recognised as an important social determinant of health and health inequities. The different phases of the mobility continuum (pre-departures, travel and transit, arrival at the destination, integration and regularisation of the migration status, interception and return) can place migrants in working, housing, social, legal or economic conditions that may increase or decrease the vulnerability to ill health [3-5]. When integrating in their new environment and social support networks, undocumented migrants, for example, commonly end up living in slums deprived from basic water and sanitation infrastructure and quality health services and are forced to make a living by working in the informal economy [6]. Low skilled migrant workers (LSMW) are often employed in the most dangerous, difficult and demanding sectors (so-called 3D-jobs), with low wages, harsh and hazardous working conditions, and absence of social protection rights and occupational health and safety regulations [7]. Hence, one of the many challenges in migrants' health seems to obtain universal health coverage (UHC) in the host countries.

Approximately 4.9 million non-Thai population were residing in Thailand in 2018. This population includes stateless people, asylum seekers, refugees, international students and high-skilled professional, but about 80% are LSMW. With its stable economic growth (an annual GDP growth rate of around 4.1% pre-COVID-19). Thailand is one of the countries in the Greater Mekong Subregion attracting the highest number of LSMW. The economic growth together with a steeply declined fertility rate and a fast-aging population creates a high unfilled demand for labourers. Migrant workers played a crucial role in Thai workforces for more than two decades and accounted for 10% of the

workforce and they will continue to be crucial human workforces in the next decades [8]. The Royal Thai government signed therefore the Memorandum of Understanding (MOU) with the governments of Cambodia, Laos and Myanmar in order to recruit migrant workers. These migrant workers are engaged in 3D jobs in the informal sectors such as construction, seafood industries, agriculture, and domestic workers.

Currently, there are approximately 4 million LSMW from Cambodia, Laos, and Myanmar residing in Thailand (8). However, this number is likely to be underestimated as undocumented migrant workers who cross borders, stays and works without the necessary legal documents and work permits, are often not included in these estimations. The number of undocumented migrant workers is currently estimated to be as high as 800,000 to 1 million including their dependents.

Despite the evolvement of Thailand's migrant health policy and the development of two major public health insurance schemes, many challenges in accessing health services still exist among migrant workers, especially among the undocumented. According to the Thai migration report in 2019, the utilization rate of public health services was low among migrants due to social and financial barriers [9]. An estimated number of two million of LSMW are enrolled in the two main public health insurance schemes, accounting for 64% of the total LSMW. This number drops to 51% when undocumented migrant workers are included [10].

In this paper we focus on the UHC policy for undocumented migrant in Thailand. The initial hypothesis of our study is that an important number of UMW is not covered by any public health insurance scheme due to various barriers. Till now, few studies were performed in Thailand to describe and evaluate these barriers. Most publications focus on the political aspect of the migrant health policies [3,11-13].

This paper will, therefore, describe the implementation of the migrant health policy in Thailand using the UHC cube and a political economy perspective and analyse the challenges undocumented migrants face in daily life. It aims to provide recommendations to policymakers to enhance the coverage of social protection, increase the level of responsiveness of its policies and reinforce the access to health care among the undocumented migrants in Thailand [11].

Materials and Methods

A document review was carried out to collect relevant policy documents, national and international reports of different actors such as the International Organization of Migration (IOM), the International Labour Organization (ILO) and World Health Organization (WHO), and national reports from the Ministry of Public Health, Ministry of Labour and Ministry of Interior. Relevant reports and monthly meeting minutes from the local authorities, the district hospital and the provincial public health office were included. The document review was complemented by a systematic review of the published academic literature using the search engines of PubMed, Biomed Central and Google Scholar. For PubMed and Biomed Central, the search terms used were Thailand, undocumented migrants, universal coverage, and health policy. In a second stage we also identified articles, reports, and grey literature through snowballing, citation, and reference tracking from previous PubMed and Biomed Central search via google scholar platform. Both peer-reviewed articles as research reports and grey literature that have a free full text, are published in the English language during 2010 and 2020 are included.

Inclusion criteria were papers with focus on health policy, universal health care and undocumented migrants; free full text papers in English; papers geographically oriented to Thailand.

Exclusion criteria were papers with specific focus on disease management; papers not related to undocumented migrants (with specific focus on refugees, asylum seeker and displaced migrants or with specific focus on universal health care to the Thai population); inaccessible papers; papers written in another language as English; duplicate papers. Therefore, a total of 40 documents were included in the review.

Data Analysis

A political economy perspective was added to the WHO's universal health coverage (UHC) cube to analyse the secondary data retrieved from the literature and document review. In recent years, the WHO's Cube Diagram has been widely used to illustrate the health system reform choices in moving toward UHC with the three axes defined by the *services* covered by the pooled funds, the *population* covered, and the *proportion of costs* covered. However, the simplicity that makes the initial Cube an good advocacy tool also limits its use for comprehensive policy analysis [12,13]. No dimension of coverage can be truly universal without ensuring equity. Equity should not only be at the core of each dimension, but an equitable (re-)design of coverage policies is prerequisite for expansion [13,14]. Similarly, a service coverage as such is insufficient where quality of care is sub-standard [14].

Moving toward UHC involve complex negotiations and decisions on fairness, societal values, resource distribution and trade-offs that are not always addressed in transparent or deliberative ways. Analysing the political economy of a health financing reform can help explain the broader forces that affect the design and implementation of policies to (re)distribute of health and resources within and across populations [15]. Recently, Nannini et al. (2021). proposed a circular and dynamic political economy framework inspired by existing knowledge about the politics sphere and UHC shown in figure 1[16]. UHC policies are a product of, and constructed through, political processes of interactions between different public and private sector and civil society stakeholders where ideas, knowledge, interests, power and institutions are influential [16]. The different stakeholders try to influence UHC policies at different stages of the policy cycle, each using their role, power, societal and political position and relation to politicians and policymakers in seeking to minimize losses and maximize gains [15]. At next dimension is the policy making and implementation of the UHC reform where leadership and the governance structure (cf. institutional design, organisational practice and implementation capacity [17,18] interacts with the health system inputs (infrastructure, human resources, equipment and supplies and the functions of the health

financing (collection, pooling, purchasing [12] and social protection (prevention, protection, promotion, transformation [19] system to determine the policy outcomes [16]. Also at the level of policymaking policy arenas can be identified in which stakeholders interact and influence the implementation process exist. Based on a review of the literature on health policy implementation in low and middle income countries, Campos and Reich (2019) [20] identified six domains on which stakeholders group which each other to impact the implementation: interest group politics, bureaucratic politics, budget politics, political leadership politics, beneficiary politics, and external actor and international scene politics.

The adoption of a political economy perspective contributes to the understanding on the main processes shaping a country's context-dependent trajectory towards UHC [16]. To verify whether health reforms bring about advancement towards UHC with regard to undocumented migrants, changes in the coverage dimensions of population, services, and costs will be described in detail. The population coverage entails the proportion of the population that has equitable access to essential health services. The financial coverage dimension evaluates the level of protection over catastrophic health expenditure and out of pocket payment (OOP). Lastly, quality health services should be equitably available and accessible.

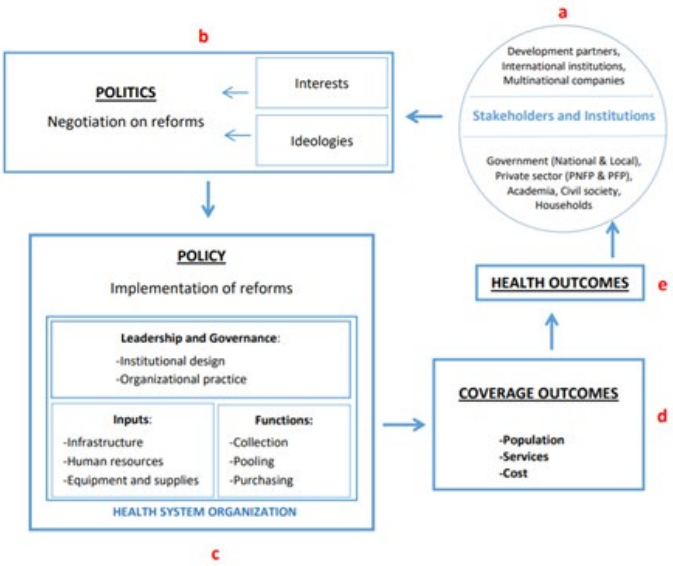

Figure 1: The Political Economy of Health Financing Reforms (16).

Results

Thailand's migrant health policy has been evolving under both political and economic pressure. Political pressure was strong from the communism era in the 1970s onwards and continued during several periods of internal conflicts and political instability in the 2000s [21-23].

In the following paragraphs, first, a description of the evolution of the migrants' policies in Thailand during the 1970s to 2014 will be provided. Secondly, the development of the health insurance schemes for undocumented migrant workers will be described. Lastly, we will analyse the policies using the UHC cube as a framework

Evolution of Thailand's Migration Policy

Despite the fact that migrant workers are crucial to the Thai economy, the National Council for Peace and Order attempted to change the irregular pattern of migration along Thai borders in 2014 by criminalizing undocumented migrant workers. Employers would be fined for up to 24,000 USD per undocumented migrant worker while the migrants would be fined from 60 – 3000 USD and/or imprisoned up to 5 years [24]. The intension was to push employers to legalize the undocumented workers via the national verification process, however unexpected results emerged. More than one third of Cambodian workers left Thailand within 2 weeks after the announcement [25], which had important repercussions on the socioeconomic system within months. In 2017, The government, therefore, launched new laws and regulations to ensure undocumented migrant workers were not arrested and deported. In addition, they would be able to register for migrant health insurance.

Four different phases within the development of the migrant policy in Thailand can be distinguished and are illustrated in Figure 2.

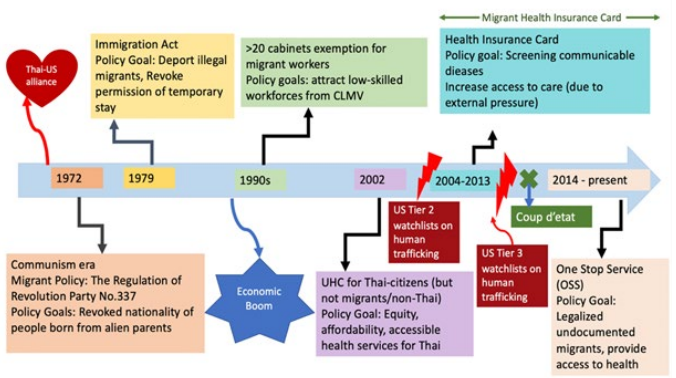

Figure 2: Timeline Of Migrant Policies Development In Thailand (1972 - Present)

Source: Adapted from Suphanchaimat R. et.al 2019: The Devil is in the detail [23]

The first phase started around the same time of the communism era in Southeast Asia in the 1970s. Thailand allied with the US to fight against communism. Hence, the first migration act was developed in 1972. It was designed to limit the rights of the migrant population in Thailand and revoked the nationality of people born from foreign parents, especially Chinese born [23]. During this phase the first public health insurance, the Low-Income Card Scheme (LICS), was launched for the poor and vulnerable people by the Ministry of Public Health (MOPH). Yet, migrants were not covered. In 1979, an immigration act was launched to deport undocumented migrants, including their dependents. Moreover, this act revoked the permission of temporary stay for migrants [21]. They were not entitled to any kind of social protection including health care, education, and social welfare.

The second phase occurred during the economic boom in the 1980s – 1990s. Due to the shortage of labour forces, the Thai

government set leniency in migration laws and regulations to exempt seasonal, irregular and undocumented migrant workers to attract low-skilled laborers from neighbouring countries. The Voluntary Health Insurance Card Scheme (VHC) was introduced in 1983 as a second public health insurance scheme by the MOPH [26]. It was a voluntary premium-based insurance that costed 18 euro/year and covered up to 5 family members. Nonetheless, migrants were still neither eligible for LICS nor VHC [27].

The third phase was when Thailand achieved universal health coverage in 2002. The government combined the LICS and the VHC into the successful universal coverage scheme (UCS) for Thai citizens. The UCS covered only Thai citizens who were identified by a national identification number. All migrants (both documented and undocumented), stateless people, refugees, and asylum seekers were left out. In 2004, the MOPH were designated to develop the Migrant Health Insurance Scheme (MHI) to cover undocumented migrants [23]. However, the intention of the policy was to register these migrants and to screen for communicable diseases by giving an incentive for health insurance with yet limited benefit packages [12].

Between 1992 and 2012, more than 20 resolutions were endorsed by the Thai cabinet to allow certain groups of undocumented workers to remain working temporarily in Thailand. Since 2004, however, the cabinet started to enquire them to complete a 13 steps nationality verification process to obtain a temporary passport/certificate of identity and a work permit (28). Only upon completion of this process, undocumented migrant workers could be enrolled in either the Social Security Scheme (SSS) or Migrant Health Insurance scheme (MHI).

The last phase started from 2014 onwards, after a period of political instability, internal conflicts and a coup d'état. The military government launched a new policy called "One Stop Service (OSS) registration", that aimed to legalize undocumented migrant workers and enrol them in the migrant health insurance (MHI) scheme

During the past 4 years, more than 3 million UMW were registered by the Ministry of Labour (MOL). Yet, only 1.9 million were registered in one of the two health insurances schemes (the SSS and the MHI), accounting for 64% of total registered LSMW [8].

The migrant's universal health coverage policy

Population Coverage and Equity Expansion

The first important dimension entails the description and analysis of the population coverage. Thailand has a 99% population coverage of UHC since 2002 for Thai citizens: setting an example for other countries in the Greater Mekong Subregion (GMS). However, the coverage for low skilled migrant workers (LSMW), especially when including UMW from neighbouring countries, is still low.

Latest data from the Thailand migration report 2019 showed that only 64% of the total registered migrant population were covered by one of the public health schemes. 36% remained uninsured. This gap increased to 51%, when undocumented migrant workers were added.

Several factors contribute to the low insurance coverage of undocumented migrant workers. Although undocumented migrant workers are entitled to public health insurance, both public insurance schemes require legal documentation (valid passport/work permits/temporary identification number). In order to obtain legal documents, undocumented migrant workers must pass the national verification process which is complex and variable from one year to another. The process requires inter-country and inter-ministries collaboration and due to the political instability in the South Asian Region, it could take up to 6 months to finish the national verification request [21]. Such delay discourages the employers as well as the migrant workers to apply. Private brokers offer services to mitigate this application process, increasing the cost to register the UMW [28]. A cost that could be deducted from the wages of the migrant worker. However, if the migrant fails the verification process, they are not able to acquire work permits. Therefore, employers are hesitant to put the undocumented migrant worker through this system.

Despite the effort of simplifying the NV process and developing the OSS, the number of migrants who enrolled in the MHI was estimated to be lower than reality. Data from MOPH showed only 862,870 enrolments in the MHI while 1.28 million low skilled migrant workers were registered by the Ministry of Interior in 2018 [8]. Institutional deficiencies hamper the undocumented migrants to enrol. The mandatory two-year enrolment with an annual premium of 50 USD does not fit with the low wages earned by the undocumented migrant workers and the high mobility in the informal sector [29]. The undocumented migrant workers cannot afford the MHI premium which is payable for 2 years upfront once the migrant registers. Usually, the employers will pay in advance but later deduct from the daily wages with interests [30]. Moreover, the nature of undocumented migrant workers is the high mobility especially within the informal sector. They tend to move from one job to another because of higher wages or better job opportunities. Therefore, they prefer to remain undocumented as long as they do not get arrested. The national verification process and the MFI registration would tie them to the employer that files the request or pays the premium respectively.

Financial Protection And Equity Expansion

Data from research conducted in Thailand showed that the out-of-pocket payments among uninsured migrants at both outpatient and inpatient departments was significantly higher than those who have MHI [31]. The mean out-of-pocket payment of insured migrants was 1 USD/visit while the mean out-of-pocket payment of uninsured UMW was as high as 75 USD/visit [31]. Children born from migrants are able to enrol in the MHI but limited till 7 years old. Therefore, parents pay 100% out-of-pocket payment if their children age over 7 years old are sick. For example, the cost of a normal delivery at the district hospital is estimated at 300 USD/patient, including 2 days hospital admission and post-natal care. Migrant women without insurance have to pay the total amount out-of-pocket payment at the point of service. They often try to borrow money from friends or em-

ployers, but if they cannot, they will not attend ANC and/or will only go to the emergency service when labour starts, as emergency care is free of charge. However, in case of complications, their debt can increase with a cost for a caesarean section as high as 500-1000 USD/patient. Additional indirect costs such as the transportation to the provincial hospital, caregiver, hospital admission fees, etc. are also out-of-pocket payment.

Catastrophic health expenditure is especially high if undocumented migrants have chronic diseases. Although most migrant workers are young and healthy, they often are exposed to unhealthy working and living conditions [32], for example, a high risk of spreading pulmonary TB. They are not able to receive proper treatment since the cost is relatively high in comparison to their low wages and anti-TB drugs are only available at hospital level. Uninsured undocumented migrant workers are less likely to visit a public hospital out of fear of deportation. Instead, they often seek medical care elsewhere including self-medication, private clinics or they return to their countries. Working in 3D jobs increases the risk of work-related injuries, or work-related illness leading to disablement, mental, sexual and behavioural disorders [33]. Disabled migrants may lose their jobs without awareness of the disabled fund and unemployment benefits they are entitled to. The MHI extended the benefit packages in 2013 in order to cover some catastrophic health expenditure (CHE) such as HIV treatment and renal replacement therapy [21]. Nevertheless, there are indirect costs incurring from chronic diseases which are not covered by the health insurance such as sick leaves, work-related injuries benefits, and unemployment benefits.

The gap in equitable expansion of financial protection is also observed among migrant's dependents, especially children over 7 years old. They are required to pay the same annual premium of MHI as adults [23]. However, they are not eligible for MHI since one needs a work permit to register as adults. Children less than 15 years are not allowed to work by Thai law. Due to this unclear policy, some hospitals stop selling the MHI card to children over 7 years old [23]. Therefore, when migrant children have a serious illness, the parents pay 100% OOP, putting the family at risk for financial hardship.

Service Coverage

Public health facilities are the main service providers for both Thai and migrant workers. Insured migrants can access public health services regardless of their nationality or insurance coverage. However, uninsured migrants have to pay OOP at point of service, varying from less than 5 USD to more than 100 USD, depending on the severity of the illnesses. Several factors contribute to the lower utilization among undocumented migrant workers.

The first significant obstacle is the language barrier (34). A systematic review of reported challenges in health care delivery to migrants and refugees showed that the language barrier leads to a lower utilization of services and misunderstandings between providers and patients [35]. Although UMW can access first line health centres (FLHC) across Thailand at a fairly low cost (usually less than 5 USD/visit), most are non-migrant friendly. To mitigate, The MOPH has started a training program for migrant health volunteer (MHV) since 2003, in collaboration with IOM and the United States Agency for International Development in 6 provinces [36]. They are trained to assist migrant workers to access hospital services, by translating and facilitating the dialogue with the providers [8]. The MHV helped in the provision of preventive and reproductive health services [36]. However, as a voluntary based program, the scaling up of this program to national level is still a challenge [22].

Secondly, public health care resources are shared among the Thai and migrant population [37]. Data from Khaoyoi hospital in 2017-2018 showed that 80% of the ANC visits were migrant women. Yet, the hospital does not have the resources to hire a translator (source: health record from Khaoyoi hospital). This leads to frustrations among nurses. At the outpatient department, around 10% of the patients are non-Thai speaking migrants. According to the author's experience, as a director of the district hospital, complaints were filed about the fact that migrants take over the resources for out- and inpatient care at least once a year (source: Khaoyoi hospital monthly report). Migrant workers are seen as a burden to the system [37].

Furthermore, there is a mismatch between operating hours of public hospitals and the long working hours of undocumented migrant workers. The hospitals as well as FLHC operating hours are from 8am to 4pm on weekdays. Normally, migrants work from 7am to 8pm. Therefore, if they are not severely ill, they often prefer self-medication, bought in local drugstores, or traditional medicine [37].

Distance from the workplace and the nature of the job entails additional barriers. For example, migrant female sex workers often work in remote areas along the Thai borders where FLHC is inaccessible [38]. Another example are the migrant fishermen who have been in a situation of exploitation in Thai fishing industries for decades. The high mobility of fishermen and the nature of their work, far from the mainland, are barriers in accessing health services (39). Both migrant sexual workers and fishermen are more likely to visit private health providers where they pay 100% out of pocket.

Fear of arrest and deportation is another challenge in accessing health services especially at public health facilities [34]. Moreover, the lack of awareness of their rights are common in both insured and uninsured migrant [34]. These issues are largely due to the widespread of human trafficking in commercialised seafood industry, constructions, manufacturing industries in Southeast Asia [39].

Discussion

Thailand has been progressing towards providing UHC to all people regardless of their nationality since 2004; yet, gaps in policy implementation persist [8,21-23].Several migrant policies have been endorsed by the Royal Thai government in response to the national security situation, the economic pressure, and the burden it entails for the public health system in the past decades. The progress in population coverage for low-skilled migrant workers has significantly improved with a coverage of 64% in 2018 [8]. However, our analysis showed that there were challenges and limitations in providing UHC to undocument-

ed migrants. The accessibility to basic health services remained limited. Indeed, ensuring social protection in health for the vulnerable population is more than providing population and financial coverage [44]. The registration of the non-Thai population and enrolment in a public health insurance scheme is not sufficient to expand UHC in an equal manner.

Our analysis showed that barriers in accessing health services exist among both uninsured and insured migrant workers. Obstacles are arising due to limitations in terms of communication because of language barriers, differences in sociocultural background, lack of financial and social support, discrimination, institutional deficiencies and fear of arrest and deportation, to name a few. Data from literature reviews across Asia Pacific countries and Europe showed similar barriers among migrant workers in access to care [37,47-57]. Loganathan et al pointed out that in Malaysia health services were mostly inaccessible for migrant workers [49], therefore the latter would only seek health care when seriously ill. This is similar to the results observed in Thailand. The preference among undocumented migrant workers, to rather seek health care from private providers, was also observed in other receiving countries in SEA such as Malaysia and Singapore [45].Migrant workers are often unaware of their rights in terms of health insurance coverage [38]. The ILO report in 2011 stated that 71% of the male migrant workers in Singapore did not have or were unaware that they were entitled to health insurance [51]. According to the study, the underpaid migrant workers were not sure who should pay for health insurance [46].

Despite its efforts, Thailand has not yet been able to "leave no one behind". Analysis shows that there are critical challenges to include UMW into the famous Thai UHC [21-23,52]. The notion of providing UHC to everyone residing in Thailand has its advantages within a public health and economic perspective. However, adding the low-skilled migrant population into its health system is politically and socially sensitive.

The conflict between the Thai national security and the claim for human rights had a remarkable impact on the migrant policies. The main philosophies behind most migrant related policies since the 1970s were either restriction or legalization of the LSMW rather than empowerment of their human rights [21-23,52]. The post-coup policies, focusing on criminalizing measures for the UMW and their employers, has put the UMW in a more fragile status than ever [24]. Providing LSMW equal rights in social health protection has not yet been the priority of the Royal Thai government. However, its growing economy will most likely continue to depend on young and healthy LSMW from neighbouring countries in the next decade. Long-term commitments in migrant policy such as strengthening the bilateral MOU for formal recruitment with CLM countries [28], the development of co-financing mechanisms in health insurance for LSMW between countries [45], and migrant-friendly services have been developed [53], but challenges persist.

Eventually, the socially excluded UMW have been marginalized in every aspect of life, let alone their rights in accessing health services [29].

Our analysis showed a certain level of discrimination as well towards migrant workers as they are seen as a burden to the Thai health system [37]. The stigmatization of LSMW in health care providers' perspective is that they are source of communicable diseases [53]. Some health care providers and native population look down on LSMW since they are from low-income country engaging in the 3D jobs. Social medias have influences in Thai population's negative attitudes towards LSMW as they are 'illegally' work and stay in Thailand [53].

Conclusion

Through the short-term policies on migrant workers, the health system has not yet been designed and adjusted for the extra 4 million LSMW. The sociocultural differences and health seeking behaviour were rarely documented. Most policies regarding migrant's health are added onto the existing health infrastructures, leading to a shortage of resources at all levels. The norms for public resources, including human resources, are based on an estimated target population within the Thai community. Migrants are not included [54].

The MOPH has started migrant-friendly services since 2013 to improve access for migrant workers regardless of their insurance coverage [22]. Until recently, migrant-friendly services are only available in six provinces [53]. Based on the previous evaluation of the services, there are possibilities in reducing gaps in access to care, providing affordable services, and increasing participation of other actors such as migrant's family members, employers and health providers [53]. The accomplishment of the services mainly caused by the public-private collaboration between health sectors and NGO's. Nevertheless, there were challenges in providing migrant-friendly services such as the cultural insensitive of health care providers, limited number of MHV, and lack of financial support from the government to scale up the services.

List of Abbreviation

ANC	Antenal Care
CHE	Catastrophic Health Expenditure
CLM	Cambodian, Laos, Myanmar
DOE	The Department of Employment
FLHC	First Line Health Centres
GDP	Gross Domestic Product
GMS	Greater Mekong Subregion
HISO	Health Information System Development Office
HIV	Human Immunodeficiency Virus
ILO	The International Labour Organization
IOM	The International Organization of Migration
IPD	Inpatient Department
LICS	Low-income Card Scheme
LSMW	Low-Skilled Migrant Workers
MHI	Migrant Health Insurance
MHV	Migrant Health Volunteers
MOI	The Ministry of Interior
MOL	The Ministry of Labour
MOPH	The Ministry of Public Health
MOU	Memorandum of Understanding
NCPO	the National Council for Peace and Order
NGO	Non-governmental Organisation

NV	National Verification
OOP	Out of Pocket Payment
OPD	Outpatient Department
OSS	One Stop Service
PHC	Primary Health Care
SDG	Sustainable Development Goal
SEA	Southeast Asia
SHA	Social Health Assistance
SPH	Social Protection in Health
SSO	The Social Security Office
SSS	Social Security Insurance Scheme
STI	Sexually Transmitted Infection
TB	Tuberculosis
UCS	Universal Coverage Scheme
UMW	Undocumented Migrant Workers
UN	United Nations
USD	United States Dollar
VHC	Voluntary Health Insurance Card Scheme
WHO	World Health Organization

Declarations

Ethics approval and consent to participate

Not applicable (No participants nor interview)

Consent for publication

Not applicable (No participants nor interview)

Competing interests

Not applicable

Funding

Not applicable

Author's contribution

100% of the article done by the author and co-author

Acknowledgement

I would like to express my gratitude and appreciation for Joris Michelsen, Kirsten Accoe and Professor Dr.Bart Criel, whose guidance, support and encouragement has been invaluable throughout this study. Especially, Joris Michelsen who has been editing, providing more resources, and adding more information to the latest version of this article. I also wish to thank the team of Institute of Tropical Medicine, Antwerp, Belgium for their support. Lastly, I would like to pay my deepest gratitude to my family who always support me no matter what I want to do.

References

1. McAuliffe, M., & Khadria, B. (2019). Report overview: Providing perspective on migration and mobility in increasingly uncertain times. World migration report. Geneva, Switzerland: International Organization for Migration.
2. Tawaytibhongs, O. (2022). Universal Health Coverage for Undocumented Migrant Workers in Thailand: Challenges in Policy Implementation.
3. Wickramage, K., Vearey, J., Zwi, A. B., Robinson, C., & Knipper, M. (2018). Migration and health: a global public health research priority. BMC public health, 18(1), 1-9.
4. Chung, R. Y., & Griffiths, S. M. (2018). Migration and health in the world: a global public health perspective. Public Health, 158, 64-65.
5. Abubakar, I., Aldridge, R. W., Devakumar, D., Orcutt, M., Burns, R., Barreto, M. L., ... & Zhou, S. (2018). The UCL–Lancet Commission on Migration and Health: the health of a world on the move. The Lancet, 392(10164), 2606-2654.
6. Ross, A. G., Zaman, K., & Clemens, J. D. (2019). Health concerns in urban slums: a glimpse of things to come?. JAMA, 321(20), 1973-1974.
7. Thomas, F. (Ed.). (2016). Handbook of migration and health. Edward Elgar Publishing.
8. Tawaytibhongs, O. (2022). Universal Health Coverage for Undocumented Migrant Workers in Thailand: Challenges in Policy Implementation.
9. Suphanchaimat, R., Putthasri, W., Prakongsai, P., & Tangcharoensathien, V. (2017). Evolution and complexity of government policies to protect the health of undocumented/illegal migrants in Thailand–the unsolved challenges. Risk management and healthcare policy, 10, 49.
10. Kyaw, P. P., & Geater, A. F. (2021). Healthcare seeking preferences of Myanmar migrant seafarers in the deep south of Thailand. International Maritime Health, 72(1), 1-9.
11. Soors, W., De Man, J., Dkhimi, F., Van de Pas, R., Criel, B., & Ndiaye, P. (2016). Towards universal coverage in the majority world: the cases of Bangladesh, Cambodia, Kenya and Tanzania.
12. Chisholm D, Kutzin J, Russell S, Saksena P, Xu K, Doetinchem O, et al. WHO Library Cataloguing-in-Publication Data. In 2010. Available from: http://edeltripp.daportfolio.com
13. Roberts, M. J., Hsiao, W. C., & Reich, M. R. (2015). Disaggregating the universal coverage cube: putting equity in the picture. Health Systems & Reform, 1(1), 22-27.
14. Soors, W., De Man, J., Dkhimi, F., Van de Pas, R., Criel, B., & Ndiaye, P. (2016). Towards universal coverage in the majority world: the cases of Bangladesh, Cambodia, Kenya and Tanzania.
15. Sparkes SP, Bump JB, Özçelik EA, Kutzin J, Reich MR. Political Economy Analysis for Health Financing Reform. Health Systems and Reform. 2019 Jul 3;5(3):183–94.
16. Nannini, M., Biggeri, M., & Putoto, G. (2021). Health coverage and financial protection in Uganda: a political economy perspective. International journal of health policy and management.
17. Mathauer, I., & Carrin, G. (2011). The role of institutional design and organizational practice for health financing performance and universal coverage. Health policy, 99(3), 183-192.
18. Mathauer, I., Saksena, P., & Kutzin, J. (2019). Pooling arrangements in health financing systems: a proposed classification. International journal for equity in health, 18(1), 1-11.
19. Schüring, E., & Loewe, M. (Eds.). (2021). Handbook on social protection systems. Edward Elgar.
20. Campos, P. A., & Reich, M. R. (2019). Political analysis for health policy implementation. Health Systems & Reform, 5 (3), 224–235.
21. Suphanchaimat, R., Putthasri, W., Prakongsai, P., & Tangcharoensathien, V. (2017). Evolution and complexity of government policies to protect the health of undocumented/illegal migrants in Thailand–the unsolved challenges. Risk management and healthcare policy, 10, 49.

22. Tangcharoensathien, V., Thwin, A. A., & Patcharanarumol, W. (2017). Implementing health insurance for migrants, Thailand. Bulletin of the World Health Organization, 95(2), 146.
23. Suphanchaimat, R., Pudpong, N., Prakongsai, P., Putthasri, W., Hanefeld, J., & Mills, A. (2019). The devil is in the detail—understanding divergence between intention and implementation of health policy for undocumented migrants in Thailand. International Journal of Environmental Research and Public Health, 16(6), 1016.
24. Bylander, M., & Reid, G. (2017). Criminalizing irregular migrant labor: Thailand's crackdown in context. Migration Information Source.
25. Dickson, B., & Koenig, A. (2016). Assessment report: profile of returned Cambodian migrant workers. International Organization for Migration (IOM): Phnom Penh.
26. Tangcharoensathien, V., Witthayapipopsakul, W., Panichkriangkrai, W., Patcharanarumol, W., & Mills, A. (2018). Health systems development in Thailand: a solid platform for successful implementation of universal health coverage. The Lancet, 391(10126), 1205-1223.
27. Harris, J. (2013). Uneven inclusion: consequences of universal healthcare in Thailand. Citizenship Studies, 17(1), 111-127.
28. GMS TRIANGLE Project, ARCM. Regulating recruitment of migrant workers: An assessment of complaint mechanisms in Thailand. 2013
29. Murphy, D. (2018). Hidden Chains: Rights Abuses and Forced Labor in Thailand's Fishing Industry. Human Rights Watch.
30. Tawaytibhongs, O. (2022). Universal Health Coverage for Undocumented Migrant Workers in Thailand: Challenges in Policy Implementation.
31. Suphanchaimat, R., Kunpeuk, W., Phaiyarom, M., & Nipaporn, S. (2019). The effects of the health insurance card scheme on out-of-pocket expenditure among migrants in Ranong Province, Thailand. Risk Management and Healthcare Policy, 12, 317.
32. Gray, L., Harding, S., & Reid, A. (2007). Evidence of divergence with duration of residence in circulatory disease mortality in migrants to Australia. European journal of public health, 17(6), 550-554.
33. McMichael, C., & Healy, J. (2017). Health equity and migrants in the Greater Mekong Subregion. Global health action, 10(1), 1271594.
34. Low, W. Y., Tong, W. T., & Binns, C. (2015). Migrant workers in Asia Pacific and their rights to health. Asia Pacific Journal of Public Health, 27(6), 584-587.
35. Brandenberger, J., Tylleskär, T., Sontag, K., Peterhans, B., & Ritz, N. (2019). A systematic literature review of reported challenges in health care delivery to migrants and refugees in high-income countries-the 3C model. BMC public health, 19(1), 1-11.
36. Sirilak, S., Okanurak, K., Wattanagoon, Y., Chatchaiyalerk, S., Tornee, S., & Siri, S. (2013). Community participation of cross-border migrants for primary health care in Thailand. Health Policy and Planning, 28(6), 658-664.
37. Health Information System Development Office. Migrant Workers and Thailand's Health Security System. Thai health 2013. 2013;131–7.
38. Barmania, S. (2013). Thailand's migrant sex workers struggle to access health care. The Lancet, 382(9891), 493-494.
39. Suphanchaimat, R., Pudpong, N., & Tangcharoensathien, V. (2017). Extreme exploitation in Southeast Asia waters: Challenges in progressing towards universal health coverage for migrant workers. PLoS medicine, 14(11), e1002441.
40. De Vito, E., De Waure, C., Specchia, M. L., Parente, P., Azzolini, E., Frisicale, E. M., ... & Ricciardi, W. (2016). Are undocumented migrants' entitlements and barriers to healthcare a public health challenge for the European Union?. Public Health Reviews, 37(1), 1-9.
41. PICUM. Access to health care for undocumented migrants in Europe. Vol. 370, Lancet. Brussels; 2007.
42. Tawaytibhongs, O. (2022). Universal Health Coverage for Undocumented Migrant Workers in Thailand: Challenges in Policy Implementation.
43. Brolan, C. E., Forman, L., Dagron, S., Hammonds, R., Waris, A., Latif, L., & Ruano, A. L. (2017). The right to health of non-nationals and displaced persons in the sustainable development goals era: challenges for equity in universal health care. International journal for equity in health, 16(1), 1-4.
44. Gea-Sánchez, M., Gastaldo, D., Molina-Luque, F., & Otero-García, L. (2017). Access and utilisation of social and health services as a social determinant of health: the case of undocumented L atin A merican immigrant women working in L leida (C atalonia, S pain). Health & social care in the community, 25(2), 424-434.
45. Keys, H. M., Kaiser, B. N., Foster, J. W., Burgos Minaya, R. Y., & Kohrt, B. A. (2015). Perceived discrimination, humiliation, and mental health: a mixed-methods study among Haitian migrants in the Dominican Republic. Ethnicity & health, 20(3), 219-240.
46. Guinto, R. L. L. R., Curran, U. Z., Suphanchaimat, R., & Pocock, N. S. (2015). Universal health coverage in 'One ASEAN': are migrants included?. Global health action, 8(1), 25749.
47. Lee, W., Neo, A., Tan, S., Cook, A. R., Wong, M. L., Tan, J., ... & Ho, C. (2014). Health-seeking behaviour of male foreign migrant workers living in a dormitory in Singapore. BMC health services research, 14(1), 1-10.
48. Agudelo-Suárez, A. A., Gil-González, D., Vives-Cases, C., Love, J. G., Wimpenny, P., & Ronda-Pérez, E. (2012). A metasynthesis of qualitative studies regarding opinions and perceptions about barriers and determinants of health services' accessibility in economic migrants. BMC health services research, 12(1), 1-13.
49. LeVoy, M., & Keith, L. (2014, December). Undocumented children's health–key challenges and local responses. In Italian Journal of Pediatrics (Vol. 40, No. 1, pp. 1-2). BioMed Central.
50. Loganathan, T., Rui, D., Ng, C. W., & Pocock, N. S. (2019). Breaking down the barriers: Understanding migrant workers' access to healthcare in Malaysia. PloS one, 14(7), e0218669.
51. Melberg, A., Onarheim, K. H., Spjeldnæs, A. O., & Miljeteig, I. (2018). Towards universal health coverage for undocumented migrants?. Tidsskriftet den Norske Laegeforening, 138(1).
52. Lee, K., McGuinness, C., & Kawakami, T. (2011). Research on occupational safety and health for migrant workers in five Asia and the Pacific countries: Australia, Republic of

Korea, Malaysia, Singapore and Thailand. ILO DWT for East and South-East Asia and the Pacific.
53. Ruíz AA, Blandón. From Burden to Challenges: A Decade of Learning and Development. Vol. 3. Bangkok, Thailand; 2015
54. Suphanchaimat, R., Kantamaturapoj, K., Putthasri, W., & Prakongsai, P. (2015). Challenges in the provision of health-care services for migrants: a systematic review through providers' lens. BMC health services research, 15(1), 1-14.