A Study on Appropriate Health Care Financing and Health Service System for Migrants -
Case Studies from SamutSakhon and Rayong Provinces

by

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Migrant workers in Thailand come primarily from Burma, with significant amounts also coming from Cambodia and Lao PDR. They mostly work in jobs that are dirty, difficult and dangerous - jobs that need unskilled workers but are unable to find Thai workers to fill these jobs such as deep-sea fishing and seafood processing. In the year 2011, the “Illegal Alien Labor Administrative Committee” estimated that there were 3 million migrant workers in Thailand. These migrant workers contribute in part to Thailand’s economic development and growth, but on the other hand create a health risk. Together, the Ministry of Labor and the Ministry of Public Health formulated a policy that provides a health exam and health insurance for a cost of 1,900 Baht as well as a work permit and a 38/1 ID card from the Ministry of Interior. There is no formal health insurance system for undocumented migrants. To address this gap, Raks Thai Foundation, an organization that works to support marginalized groups, and the Thai Health Insurance Development Research Institute, supported this research to find ways to support the health needs of all migrants.

There were many organizations at the ministry and provincial levels, NGOs and GOs that supported this study. The research team needs to thank the Samutsakon and Rayong Provincial Health Offices and all the hospitals, as well as the Provincial Labor Authority, Provincial Social Security Office, national police office, employers, Migrant Health Workers, migrants and families in both provinces, as well as the Ministry of Labor and Ministry of Public Health for the support and providing information that helped to complete the study.

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Objective

The objective of the research included studying migrant workers’ health insurance and benefits, understanding health-seeking behaviors and utilization of health services, assessing the cost and burden for health facilities, and to propose appropriate health insurance choices and the possibility of expanding and increasing access to antiretroviral therapy.

Methodology

A quantitative and qualitative study was designed. The relevant literature was reviewed, and information was collected directly from Provincial Health Offices and hospitals in the provinces of Rayong and Samutsakon. A questionnaire was administered with migrants using non-randomized purposive sampling, and the sample size was determined by using the Taro Yamane method and the questionnaire validity was approved by provincial and central experts. The Test-Retest for reliability was done in 30 migrants and reliability value was 0.91. Other information was collected from focus group in the two provinces.

Results

Migrant workers in Rayong and Samutsakon who had health insurance understood their rights to medical services 92.59% and 87.63% respectively, but only 21.36% and 25.16% knew about medical emergency services and just 30.19% and 27.88% knew about health promotion and disease prevention services. Most of the migrants in both provinces got medicine from a drug store or just rested when they felt discomfort. But when they got sick, 73.51% of the Rayong insured migrants and 51.15% of the Samutsakon insured migrants went to the hospital, while only 22.60% and 29.60% of uninsured migrants in Rayong and Samutsakon visited the hospital. Most of the insured migrants could access the hospitals and on average paid 137.15 Baht per visit in Rayong and 73.83 Baht per visit in Samutsakon, but the uninsured migrants paid a lot more, with the average cost per visit being 711.70 Baht and 459.66 Baht for Rayong and Samutsakon respectively.

Health Care Financing for Migrants
In Rayong Province, 32.19% of the insured migrants and 22.94% of the uninsured migrants had received pre-test counseling for VCT, but in Samutsakon only 9.85% of the insured migrants and 15.44% of the uninsured migrants had received these services. From the groups that had received pre-test counseling in Rayong, 96.46% of the insured migrants and 95.52% of the uninsured migrants underwent testing for HIV, while only 85.10% of the insured migrants and 15.79% of the uninsured migrants in Samutsakon underwent HIV testing. So the opportunity to extend accessibility to ARV could be increased by expanding proper VCT with counseling services to migrants, and the VCT counseling could be effectively provided by migrant health workers.

This study demonstrates the benefits of the compulsory migrant health insurance scheme for reducing the medical costs of insured migrants. This scheme also provides health promotion and disease prevention, in part through the migrant community’s participation as initiated by migrant health workers. The hospital’s financial burden mostly originates from the higher proportion of uninsured migrants seeking services. The compulsory migrant health insurance scheme should therefore be chosen as it provides insured migrants with health and medical services which can be extended to the uninsured migrants as well as family members. Expansion of ARV coverage could be promoted by increasing the VCT activities provided by trained migrant health workers. The financing for ARV drug expansion could be possible by expanding the NAPHA target group, and there are some migrants infected with HIV who could subsidize the cost of ARV drugs by themselves, raising another possibility of formulating pool financing to purchase ARV among migrants.

There was also evidence that showed the average duration of migrants staying in Thailand was four years, and most could speak and understand Thai language, with Thai literacy improving significantly with the duration of stay in Thailand.
Chapter 1

Introduction

Thailand has faced various impacts on its economy, society, and public health as a result of the presence of documented and undocumented migrant workers from neighboring countries. There are many push factors in the countries of origin that encourage migrants to go abroad. Thailand is now an “Aging Society” (where those older than 65 years account for 7% of the population), and is fast moving into the Aged Society (where those older than 65 years account for 14% of the population). The Thai Fertility Rate is now 1.5, which means that a Thai woman has an average of 1.5 children, which is below the 2.1 children average sufficient to maintain the Thai population. As a result, the decrease in proportion of working age population has created a labor shortage in Thailand. The demand for low-cost, unskilled labor in Thailand has increased to maintain competitiveness with other low-cost labor countries, such as China, India, and Vietnam. Employers have been unable to find Thai workers to fill these jobs. The quality of life including economic, social, and political conditions in migrants’ countries of origin are very different compared to Thailand. Civil war between the government and the ethnic minorities in Myanmar has reinforced migration. The Thai - Myanmar border is 2,401 Kilometers long, the Thai – Laos border is 1,810 Kilometers long (1,108 Kilometers of which runs along the Mekong River), and the border between Thailand – Cambodia is 803 Kilometers long. People of these countries have been crossing the border to find work in Thailand for a very long time without effective legal enforcement (1).

The report in December 2010 from the Office of Foreign Administration, Department of Employment, Ministry of Labour, showed that the number of three nationalities with work permits who either registered with a 38/1 ID, passed the Nationality Verification or were imported under the Memorandum Of Understanding between Thailand was 1,168,824 migrant workers in total.
They came from Myanmar (940,376), Lao PDR (105,955) and Cambodia (122,493). Three provinces with the most migrant workers were Bangkok, Samutsakhon and Chiang Mai. There were 844,329 general laborers, 148,211 in the agricultural sector, 171,857 in construction and 101,849 in fisheries, and another 87,926 migrants, primarily women, worked as domestic workers (2).

Migrant workers are permitted to work in the occupational categories below. Each occupation has a color code on the work permit.
1. Fishermen - blue
2. Farmers - green
3. Construction - yellow
4. Seafood processing - orange
5. Domestic worker - gray
6. Others registered under the miscellaneous category (19 types of jobs including animal husbandry, agricultural processing, small factories) - pink

**Impact on Public Health Services**

Some cross-border migrants may have carried communicable diseases with them from their home countries. The study of Chirawat Nijnate (3) from the Phuket Provincial Health Office migrant health checkup in 2004 showed that 763 migrants needed treatment for the following diseases: tuberculosis 565, Elephantiasis 14, syphilis 178 and 6 cases of malaria. In PhangNga province, a health status study by Uraiwan Tantariya (4) showed that out of 12,253 registered migrant workers, 94.4% were healthy, 2.6% needed to be followed up for disease control and another 2.4% were prohibited to be in Thailand because of their advanced condition. The most common conditions rated as “prohibited” included severe contagious tuberculosis with a prevalence of 563.3 per 100,000, Leprosy 73.5, Elephantiasis 1167.1, syphilis 612.1, Drug Addiction 24.5, Alcoholism 49.0 and Psychosis 8.2. The prevalence for conditions considered under the “follow-up” status included out of a population of 100,000 - malaria 24.5, Flu 32.7, pregnancy 253.0 and cardiovascular problem 16.3. Other diseases treated include dermatitis, respiratory and circulatory system diseases, digestive system disorders, childbirth and abortion.

Concerning reproductive health, most female migrant workers did not know about family planning options, and as a result there was a high rate of unplanned pregnancy and abortion. Junchai Tragoondee (5) reported that most migrant women had low knowledge of general health and women's health, and moderate knowledge of basic self-care. Most had low levels of knowledge regarding reproductive health and where to access health information resources.
Sompong SaKaeo\(^{(6)}\) reported that migrant workers’ lifestyle patterns affected their health. The work patterns of migrant workers in SamutSakhon, most of who work on fishing boats and in fishery related businesses, cause health problems and physical stress due the hard work and long working hours of up to 10-12 hours per day depending on demand and the type of product. As a result, working conditions are not conducive to health or relaxation. Migrants’ patterns of recreation also affect their health status. Risk behaviors such as drinking alcohol and engaging in unprotected sex with sex workers, mostly from karaoke and other venues, increases risk of sexually transmitted infections and HIV. Once they become sick from a sexually transmitted infection, they are likely to self-treat from a drug store or nearby clinic. They usually go to see a doctor only when their symptoms do not improve. These migrants are also exposed to poor environmental health and poor sanitation. They often live in a house near sewage and waste and wastewater flooding, which are sources for the breeding and spreading of infectious diseases including mosquito borne diseases as well as diarrhea, skin diseases and respiratory diseases. There are not enough toilets and there is poor air circulation in their rooms.

Samrit Srithamrongsawat\(^{(7)}\) discussed the impact of migration to health and various social problems such as crime, drugs and trafficking, which are commonly highlighted by the media. Some migrants have re-introduced certain diseases that were already under control in Thailand, for example, Leprosy, Elephantiasis, and Polio. These health problems are difficult to follow-up due to the lack of migrants’ personal data.

The accessibility to health services and health seeking behaviors of registered and unregistered migrant workers was also studied by Sompong SaKaeo in SamutSakhon.\(^{(6)}\) When migrants become ill they rarely visit a health service delivery unit; most purchase drugs from the drug store until their symptoms become severe and then visit a private clinic. If their symptoms do not improve, then they go to a public health delivery unit such as a health center or hospital. Busarat Kan-chanadit\(^{(6)}\) reported that the main obstacles that prevent access to the public hospital are a lack of familiarity, fear, a lack of understanding their health insurance rights, lack of Thai literacy, the long distance to hospitals from the workplace or residence, the expense of travel costs, and discrimination by health care workers.
Suthat Khongkunthot\textsuperscript{(9)} identified problems of accessibility as reported by health providers as including communication gaps, lack of legal knowledge, increased workload, lack of skills to deal with migrants’ different cultures and the public regulation that restricts the hiring of foreign translators and assistants.

Part of the barrier to accessing health services lies with the migrants and their families.\textsuperscript{(10)}

- Many do not understand the concept of insurance, its benefits and how to use it. Migrants are unfamiliar with health care providers and are not able to communicate because of different languages.

- Some migrants experienced trouble when traveling to the hospital such as being arrested by police, extorted, assaulted or being overcharged for the travel costs. So many went for treatment at nearby providers where they had to pay out of pocket instead of going to hospitals where they were covered by insurance.

- Many migrants preferred unsafe methods of self-medication and self-care until their condition became severe, and then they would have to go to the hospital requiring more expensive care.

The obstacles that migrants infected with HIV face in accessing Antiretroviral (ARV) drugs and treatment, even when they were registered with a work permit, included the need for provision of easy to access ARV that is continuous and uninterrupted. The Thailand HIV situation report\textsuperscript{(11)} showed that the prevalence of HIV infection among fishermen was at 1.53% in the year 2009, compared to migrants generally which was at 1.25% (Figure 1.1). The high number of migrants needing ART would eventually become an issue.

\textbf{Figure 1.1 Prevalence of HIV Infection among Migrant Workers and Fishermen in Thailand 2540 – 2550 (1997-2007)}
The NAPHA Extension Program operation guidance identifies that the psychosocial factors influence HIV patients’ adherence to ARV drugs. These factors include:

- **Language** - the ability of migrant workers to communicate with the health care professional is problematic due to language differences;

- **Low health literacy** - some migrant workers, for example, believed that pulmonary tuberculosis was a genetic disease;

- **Work conditions** - demanding work conditions including low income, long hours, and unpredictable work schedules;

- **Undocumented migrants** - working illegally, migrants fear exposure to the health service system because of the chance of being arrested and sent back home;

- **Social discrimination** - a common complaint among Thais is that migrant workers encroach on the country’s resources, and are a burden on services;

- **Fear of stigma and discrimination** - migrant workers infected with HIV fear being arrested when seeking treatment, fear being deported, and fear being ostracized by the community and friends and being fired from their jobs;

- **Health workers’ attitudes** - many health workers feel and act that migrant workers who seek health services are a burden;

- **Employers** - do not cooperate with the health service providers to provide continuous, long-term treatment.

All of these factors make ARV difficult to access for migrants, especially the unregistered migrants and their families. Even though the Global Fund provides ARV for migrants infected with HIV, there are still a lot of challenges to overcome before being able to provide universal ARV to this marginalized group. How to overcome these obstacles is an interesting research question.
Health Care Fees and Health Insurance

Hospitals estimated their financial burden of providing health services to migrants. In order to generate enough revenue to cover these expenses, the insurance fee was established at 1,300 Baht for one year of health and medical care coverage, and included a health check up fee at 600 Baht per person. The total insurance fees and the health check-up fees collected are shown in table 1.1.

Table 1.1 Estimated Revenue from the Insurance and Health check-up Fees Calculated from Registered Migrants in Thailand 2006-2008 (13)

<table>
<thead>
<tr>
<th>Year</th>
<th>Cabinet Approved (Migrant Workers 3 Nationalities)</th>
<th>Revenue of Insurance fee 1,300 (Baht)</th>
<th>Revenue of Health check up fee 600 (Baht)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>668,576</td>
<td>869,148,800</td>
<td>401,145,600</td>
</tr>
<tr>
<td>2007</td>
<td>535,732</td>
<td>696,451,600</td>
<td>321,439,200</td>
</tr>
<tr>
<td>2008 (August)</td>
<td>501,570</td>
<td>652,041,000</td>
<td>300,942,000</td>
</tr>
</tbody>
</table>

Source: Calculated from registered migrants data by Department of Migrant Development and Control, Office of Foreign Administration, Ministry of Labour 2007-2008.

“The Ministry of Public Health still bears the burden of 700,000 unregistered migrants,” said Dr. Supachai Kunaratanaapruk, the Director General of Health Service Support Department, at the Second National Health Service System for Migrant Population Conference entitled, Universal Access to Health and Medical Services for Health Security. The MoPH also reported that in the year 2007, out of the 462,236 migrants who received a health check up, 4,915 were found to have a condition that required follow-up for treatment mostly for pulmonary tuberculosis,
while the number that needed to be sent back home was 113.\(^{(14)}\) In the first half of the year 2008, the number of migrants that needed to be followed-up for treatment was 3,147 with 77 prohibited to stay due to their condition, and 7,000 migrant women found to be pregnant. In the year 2007, the insurance fees collected from 343,527 registered migrants was 446 million Baht, but the health and medical expenditure for migrants was 1,343 million Baht, of which, services for registered migrants was about 947 million Baht, and 396 million Baht for unregistered uninsured migrants. This means that the MoPH’s annual financial burden for providing health services to migrants is about 214 million Baht.

**Table 1.2 Summarized Income and Expenditure for High Cost Care for Migrants, Health Scheme Fund during Year 2004-2008**

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Number of Insurants (Person)</th>
<th>Amount of Income (Baht)</th>
<th>Number of Insurants (Person)</th>
<th>Amount of Expenditure (Baht)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2547</td>
<td>263,875</td>
<td>8,444,017.00</td>
<td>261</td>
<td>1,395,419.00</td>
</tr>
<tr>
<td>2548</td>
<td>713,688</td>
<td>35,684,410.00</td>
<td>359</td>
<td>2,277,377.25</td>
</tr>
<tr>
<td>2549</td>
<td>726,478</td>
<td>36,323,879.00</td>
<td>500</td>
<td>6,552,464.45</td>
</tr>
<tr>
<td>2550</td>
<td>534,481</td>
<td>26,724,048.00</td>
<td>587</td>
<td>7,793,826.58</td>
</tr>
<tr>
<td>2551</td>
<td>443,489</td>
<td>22,174,440.00</td>
<td>855</td>
<td>15,173,859.67</td>
</tr>
<tr>
<td>Total</td>
<td>2,682,011</td>
<td>129,350,794.00</td>
<td>2,562</td>
<td>33,190,946.95</td>
</tr>
</tbody>
</table>

*Source: Office of the permanent Secretary for Ministry of Public Health, Department of Health Insurance, September 30, 2008.*

The income from the migrant health insurance scheme increased in the year 2005-2006 from 8.4 million Baht to 35.6 million Baht, in part because the Cabinet approved a new registration in the year 2004.
that allowed coverage of migrant workers and their family. This policy briefly solved the problem of revenue for health costs of unregistered migrant families, but soon after that the policy swung towards a more security focused policy and the families were prohibited from registering, resulting in a decrease in revenue.\(^{(15)}\) This was confirmed by Samrit Srithamrongsawat\(^{(7)}\) who found that the high cost care for migrant workers increased from 2,294,277 Baht, to 8,958,417 Baht and 15,796,429 Baht in the years 2005, 2006, 2007 respectively, and that the number of high-cost care cases were 366 persons, 502 persons, and 914 persons respectively. But the income for the high cost care fund decreased from 44,159,340 Baht, 30,411,900 Baht and 21,721,478 Baht in the years 2005, 2006 and 2007 respectively. (see Table 1.3)

Table 1.3 Revenue and Reimbursement of High Cost Care for Migrant Workers

<table>
<thead>
<tr>
<th>Year 2005-2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>Revenue (Baht)</td>
</tr>
<tr>
<td>Number of patients approved for high cost care</td>
</tr>
<tr>
<td>Outpatient</td>
</tr>
<tr>
<td>Inpatients</td>
</tr>
<tr>
<td>Cost reimbursements (Baht)</td>
</tr>
<tr>
<td>Percentage of high cost reimbursement from revenue</td>
</tr>
</tbody>
</table>
The study also showed that the most expensive costs of migrant high-cost health care were for treatment of injuries, poisoning and other conditions from external causes. Treatment for neoplasm and diseases of the eye and adnexa cost 69.3%, 10.0% and 4.6% in the year 2006 and 65.2%, 16.3% and 4.9% in the year 2007 respectively. (as shown in table 1.4)

Table 1.4  Amount and Percentage of High cost Care Category by Disease During Year 2006-2007

<table>
<thead>
<tr>
<th>Category</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent</td>
</tr>
<tr>
<td>Infectious diseases</td>
<td>8</td>
<td>1.9</td>
</tr>
<tr>
<td>Neoplasm</td>
<td>41</td>
<td>10.0</td>
</tr>
<tr>
<td>Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>Endocrine, nutritional and metabolic diseases</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>Diseases of the nervous system</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td>Diseases of the eye and adnexa</td>
<td>19</td>
<td>4.6</td>
</tr>
<tr>
<td>Diseases of the circulatory system</td>
<td>14</td>
<td>3.4</td>
</tr>
<tr>
<td>Diseases of the respiratory system</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Diseases of the digestive system</td>
<td>10</td>
<td>2.4</td>
</tr>
<tr>
<td>Diseases of the musculoskeletal system and connective tissue</td>
<td>19</td>
<td>4.6</td>
</tr>
<tr>
<td>Diseases of the genitourinary system</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>Pregnancy, childbirth and the puerperium</td>
<td>1</td>
<td>0.2</td>
</tr>
<tr>
<td>Congenital malformations, deformations and chromosomal abnormalities</td>
<td>2</td>
<td>0.5</td>
</tr>
<tr>
<td>Injuries, poisoning and certain other consequences of external causes</td>
<td>283</td>
<td>69.3</td>
</tr>
<tr>
<td>Factors influencing health status and contact with health services</td>
<td>7</td>
<td>1.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>411</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Health Financing Office, MOPH
Chirawat Nijnat and Adul Ratanaso (3) reported that the health conditions of migrant workers in Phuket potentially had an impact on the health of the Thai population.

1. Without having gone through the health checkup, communicable diseases from unregistered migrants were difficult to control.

2. Migrant’s crowded workplaces and household conditions caused poor environmental sanitation, which promoted dissemination of communicable diseases.

3. The migrant birth rate annually increased because many migrants are in their reproductive ages. Without proper vaccination of these newborns the children were susceptible to illnesses that resulted in delayed growth and development.

4. The re-emerging diseases that had been under control in Thailand several years ago increased and became uncontrollable again.

5. The migrants’ health needs for medical services had an impact on health workers who were already over-worked serving the Thai population, and was a financial burden to hospitals with poor liquidity. The MoPH needed to subsidize millions of Baht in expenditures for migrant health services, and this increased annually.

In the year 2004, the Phuket Hospital subsidized 1,895,609 Baht in health service expenses for uninsured migrants, and 3,754,653 Baht for just 8 months of the year in 2005. At the same time, registered migrant workers increasingly sought health and medical services at the cost of 15 million Baht in the year 2005.

Sanon Sangpapan (17) found that the hospitals which provided uninsured migrants health and medical services subsidized 84.14% of in-patient expenses by migrants, compared to the outpatient expenses that uninsured migrants could mostly pay themselves. (see Table 1.5)

Table 1.5  Health Expenses Paid Out of Pocket - Klang, Hospital Rayong, Fiscal Year 2007

<table>
<thead>
<tr>
<th>Cost of Care (Baht)</th>
<th>Paid</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Amount (Baht)</td>
<td>Percentage</td>
<td>Amount (Baht)</td>
<td>Percentage</td>
<td></td>
</tr>
<tr>
<td>Outpatients</td>
<td>1,558,351</td>
<td>1,477,212</td>
<td>54.79</td>
<td>81,139</td>
<td>5.21</td>
</tr>
<tr>
<td>Inpatients</td>
<td>1,625,776</td>
<td>257,809</td>
<td>15.86</td>
<td>1,367,967</td>
<td>84.14</td>
</tr>
<tr>
<td>Total</td>
<td>3,184,127</td>
<td>1,735,021</td>
<td>54.49</td>
<td>1,449,106</td>
<td>45.51</td>
</tr>
</tbody>
</table>
**Research Questions**

1. What is migrants’ knowledge and understanding of health insurance benefits and rights, including knowledge on how to use these rights to seek health and medical services?
2. What are insured and uninsured migrants’ health seeking behaviors, health and medical service utilization patterns, and the differences between behaviors of the insured and uninsured?
3. How is the financial management of migrant health care services at the provincial and hospital levels? How does this affect services, and how do we improve management to be more effective?
4. What is migrants living with HIV access to ARV? How do we improve access to this group and their access to ARV? How much does it cost, and what are the alternatives and possibilities?

**Objectives of the Study**

1. To determine migrants’ knowledge and understanding of health insurance benefits and rights, including knowledge on how to use these rights when seeking health and medical services.
2. To study insured and uninsured migrants’ health seeking behaviors, health and medical services utilization patterns and distinguish the differences between them.
3. To determine the rate of utilization of health care and medical services by migrants, assess costs and compare between insured and uninsured migrants.
4. To analyze the financial management and effectiveness of health care services for migrants at the provincial and hospital level, and propose improvements.
5. To analyze the ability of migrants infected with HIV to access ARV and propose improvements and alternative or other possibilities for better access.

**Definition**

The migrant population refers to labor migrants, their families and dependents who primarily come from the countries of Myanmar, Lao PDR, and Cambodia. The term includes those who have been registered with the Ministry of Interior (with a 13-digit identification number) or are legally registered as a migrant through the MOU or Nationality Verification, and those who have not been registered (referred to as undocumented or unregistered or illegal). This term does not include persons displaced from civil conflict who are residing in temporary shelters.
Scope of Study

1. Migrant workers and families who are documented or undocumented and may or may not have insurance coverage, and come from either Myanmar or Cambodia, but not including migrants from Lao PDR, and who are working in the provinces of Rayong and SamutSakhon.

2. Migrant health information from the Provincial Health Offices and hospitals in Rayong and SamutSakhon Provinces.

3. Migrant health information from the Health Administration Bureau, Health Insurance Division, Office of Permanent Secretary, Bureau of AIDS and Sexual Transmitted Diseases, Department of Disease Control and the Bureau of Foreigner Labor Administration, Ministry of Labour.
Chapter 2

Migrant Worker and Family Situation

Most migrant workers in Thailand come from Myanmar, Laos and Cambodia respectively. They work in “Dirty, Difficult and Dangerous” unskilled jobs that Thai workers no longer chose to work in or that pay too low of wages, such as the fishery and related seafood industry. The Foreign Labor Administrative committee estimated that there were 3 million registered and unregistered migrant workers and their family members in Thailand from the three countries in the year 2011.

The situation of migrant workers and their families was reported in December 2010 by the Bureau of Foreign Labor Administration, Department of Employment, Ministry of Labour as shown in table 2.1

Table 2.1 Legal and Illegal Migrant Workers in Thailand categories from Immigration on December 2010 (18)

<table>
<thead>
<tr>
<th>Region</th>
<th>Total Number (person)</th>
<th>Legal Migrant Worker</th>
<th>Illegal Migrant Worker</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Article 9</td>
<td>Article 11</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lifetime</td>
<td>General</td>
</tr>
<tr>
<td>Whole kingdom</td>
<td>3,300,283</td>
<td>210,044</td>
<td>26,025</td>
</tr>
<tr>
<td>Bangkok</td>
<td>329,097</td>
<td>160,655</td>
<td>40,263</td>
</tr>
<tr>
<td>Office of Foreign Administration</td>
<td>159,502</td>
<td>7,306</td>
<td>39,985</td>
</tr>
<tr>
<td>Office of Provincial employment</td>
<td>169,998</td>
<td>1,153</td>
<td>-</td>
</tr>
<tr>
<td>Provinces</td>
<td>971,184</td>
<td>184,031</td>
<td>30,186</td>
</tr>
<tr>
<td>Provinces around Bangkok</td>
<td>284,881</td>
<td>56,200</td>
<td>5,848</td>
</tr>
<tr>
<td>Central Region</td>
<td>240,393</td>
<td>77,936</td>
<td>6,077</td>
</tr>
</tbody>
</table>

Health Care Financing for Migrants 13
In the year 2010, the number of “Nationality Approved” migrant workers (through the Nationality Verification process) was 210,044, increasing from 60,995 in the year 2009; and in 2010, the number of migrant workers entering legally under the MOU was 26,525, increasing from 18,883 in 2009. (18, 19, 20)

Migrants’ Knowledge and Understanding of Health Insurance Benefits

Migrant workers and their families were unaware of their rights to health insurance or the benefits. The migrant workers in SamutPrakan and SamutSakhon provinces did not hold their own health insurance cards and work permits because their employers took these documents to ensure that they would stay and work for that employer and not move on to find work elsewhere. Withholding their documents became a major barrier to accessing health services. Sometimes migrant workers who were uninsured borrowed the health insurance card of another migrant to receive services, which was easy to do when there was no picture on the health insurance card. (21)

Migrant workers identified through the health check as having a disease of concern and in need of follow-up for treatment often moved away after knowing the result of the health check up because of fear of being sent back to their country of origin. (22)

Abortion is high among migrant women generally, but many pregnant migrant women are known to terminate their pregnancy before the health check up, and some switched their urine sample with the others who were not pregnant (23) because of the fear of losing their jobs and being sent back home.

Health Conditions among Migrants

Migrant workers and family members may carry diseases from their country of origin, and they also may face health problems in the destination country including maternal and child health, and diseases arising from poor environmental sanitation. (24)

Survival rates of pregnant migrant women giving birth at hospitals were lower than for the Thai population. The maternal mortality rate during pregnancy or within
42 days after giving birth among migrant women was 160 cases from 10,332 of the migrant pregnant women or 1.5%, as compared to 48 cases of maternal mortality out of every 100,000 live births among the Thai population (World Bank, 2008). Another problem was teenage pregnancy with 12% of all pregnant migrant women under the age of 20 years. (25)

The communicable diseases that were found among migrant workers and families included respiratory tract infections such as Influenza, Pneumonitis and Pulmonary Tuberculosis, vector-borne diseases such as Malaria and Elephantiasis, and diseases arising from poor sanitation, food and water included Diarrhea, Typhoid, Amoebiasis, and skin diseases.

The Re-Emerging Disease Bureau, Department of Disease Control analyzed the trend of re-emerging diseases in Thailand as summarized in table 2.2 (26)

Table 2.2 Re-Emerging Diseases in Thailand (2004) (27)

<table>
<thead>
<tr>
<th>Group 1: Re-emerging diseases in Thailand</th>
<th>Group 2: Re-emerging diseases transmitted from Foreign countries</th>
<th>Group 3: Re-emerging diseases in Thailand from cross-border</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Influenza A (H1N1) 2009 with risk of disease more severe in first Infection</td>
<td>5. Nipah Virus Meningitis</td>
<td>10. Neisseria meningitides from serogroup W135 and other</td>
</tr>
<tr>
<td>2. Avian Influenza H5N1</td>
<td>6. West Nile virus Meningitis</td>
<td>11. type transmission from migrant worker</td>
</tr>
<tr>
<td>3. Hand-foot-and mouth disease from Enterovirus 71</td>
<td>7. Viral Hemorrhagic Fever such as Ebola virus, Marburg Virus.</td>
<td>12. Acute hemorrhagic conjunctivitis from EV70, CossackieA24, Adenovirus etc.</td>
</tr>
<tr>
<td>4. Legionellosis</td>
<td>8. Zoonotic Disease: Monkey Smallpox (African green monkey)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9. Biological Terrorism Disease such as Bacillus Anthrax, Smallpox, Plague etc.</td>
<td></td>
</tr>
</tbody>
</table>

Health Care Financing for Migrants
Migrants and HIV Prevention

In the evaluation of The Prevention of HIV Among Migrant Workers In Thailand Project (PHAMIT) by Apichat Chamratrithirong and Watinee Boonchalaksi, it was reported that migrant workers’ general knowledge and positive attitude towards HIV prevention was already high in the year 2004 and increased over the course of the project. In the year 2008, knowledge about using condoms for HIV prevention increased from 79% to 89% among fisherman and from 76% to 95% among migrant women in coastal provinces.

The safe sex behaviors of migrant workers who were sampled had also increased: condom use with a regular sex partner increased from 1.6% to 7%, condom use with casual sex partners increased from 42% to 90%, and condom use with sex workers increased from 91% to 97%. The STI and HIV knowledge also increased from 56% to 85%. The prevalence rate of STIs in male migrant workers decreased from 2.7% to 1.2% but increased a little bit among the female migrants.

There was evidence that the migrant workers surveyed could increasingly access disease prevention and health promotion services under the PHAMIT Project and that this was a direct result of project activities. However, there was not enough information about migrants accessing ARV at the time of the evaluation period.

Health Services for Migrants and their Families

The registration for migrant workers from Myanmar was first approved by the Cabinet in 1992, but it was not until 1996 that the registration covered migrants from all three countries: Myanmar, Laos PDR and Cambodia. In that year, health insurance for migrant workers was initiated with a 500 Baht fee.

1. Migrant Policies and Regulations

As most migrant workers from Myanmar, Laos PDR and Cambodia do not cross the border legally and have no identification documents, the Cabinet developed regulations to let these
undocumented (commonly referred to as “illegal”) migrants temporarily work in Thailand on a year to year basis since 1992. This yearly approval process has resulted in policy swings each year according to the socioeconomic and political situation, with policy divided by two main priorities - security and the economy. Health and human rights have never featured as a priority but are considered as supplementary to migrant policy.

In the year 2004, the government started to take a more systematic approach to the dual issues of insufficient manual labor for unskilled jobs and the rising numbers of migrant workers. The Ministry of Labor, Government Security Organization, Ministry of Public Health and also other stakeholders formulated strategies of migrant worker management that aimed to cover considerations of security, the economy and health. Migrant workers and their families already in the country were then allowed to register for an ID, get a health check-up accompanied by one-year coverage with health insurance, and a work permit. This registration process aimed at changing migrant workers and families status as “illegal” into “semi-legal.” Another policy was the bilateral agreement MOU between Thailand and Laos PDR, Thailand and Cambodia and Thailand and Myanmar, to develop a formal recruitment system for bringing migrant workers into the country with passports and a visa through official channels. As the uptake of this recruitment system was slow and inadequate to fill labor needs, a “nationality verification” process was passed that allowed registered migrant workers already in the country to get temporary passports and a visa, making them fully “legal” migrant workers.

The “Foreign Labor Management Committee” consisting of representatives from various government agencies formulates migrant policy and proposes it to the cabinet for approval annually. The policy in 2004, which allowed for an open registration was highly successful with 1,284,920 migrant workers and family members registering. Because the management needed Cabinet Approved policy year by year policy interests were pulled between security, economy and health and human rights. After the year 2004, the government’s security organizations dominated migrant management policy making migrant families prohibited to register. In the year 2007, with the security focused policy the number of registered migrant workers was less than 500,000. The numbers of unregistered migrant workers and families increased, causing more problems with security, the economy and health and human rights issues.

1.1 Cabinet Approved Regulation

The Cabinet Approved Regulation consisted of migrant workers and their family registering with the Ministry of Interior with 100 Baht registration fee, and then the Ministry of Public Health provided a health examination for 600 Baht and health insurance for one year for 1300 Baht. Then workers could get a one year work permit for 3800 Baht. The foreign labor administration committee changed the policy so that workers could voluntarily become “legal” with passports. The Cabinet Approved this...
policy to implement in the year 2009, but the process was complicated and the Myanmar Government didn’t co-operate so very few migrant worker passed the process of nationality approved. In the year 2010, the government changed this nationality verification system as compulsory.

1.2 Nationality verification by original country (33)

The nationality verification process of Myanmar, Laos PDR and Cambodia were different according to the regulation of each country. Laos PDR needed a request form, work permit or Civil registration 38/1 and receipt for work permit fee in that year, migrant worker’s picture and 2500 Baht fee to start the process; but Cambodia needed country’s Certificate Identification (CI), work permit or Civil registration 38/1 and receipt for work permit fee in that year, migrant worker’s picture and 2000 Baht fee to start the process. Myanmar needed more Myanmar’s documents, work permit or Civil registration 38/1 and receipt for work permit fee in that year, migrant worker’s picture and about 100 Baht (3000 Kyat) fee to start the process. Then the employer and national approved migrant worker could apply for the visa and Thai Ministry of Foreign Affair needed employer’s documents, the migrant worker documents, 500 Baht fee to provide the VISA L-A. After that, they needed to reapply for the new temporary work permit at the Department of Employment, Ministry of Labor.

1.3 Memorandum of Understanding for Importing Legal Migrant (34)

For Thai employers who chose to hire totally legal migrant workers who entered through the MOU policy, they have to request to the Department of Employment and then they will get the permission documents. The documents included the specific recruitment company in the origin country. The Department of Employment then sends all documents and requests to the origin country’s embassy. Then the embassy processes these documents to their Ministry of Labor who contacts the recruitment company to prepare the workers list and the permission to work aboard for these workers, and then contacts the Thai employers. The Thai employers process the worker lists to get permission from the Department of Employment to work in Thailand, and after permission is granted contacts the Thai embassy in the original country to permit the Non-Immigrant VISA L-A for these workers. After that the employers take these workers into Thailand, they need to contact the MoPH hospitals within 3 days for health checkup before they can get the work permit.

1.4 Social Security Act and Benefits (35)

The Social Security Act of 1990, modified in the year 1994 and 1999, is designated to support social insurance and welfare to the formal sector’s private workers who contribute their income to the Social Security Fund, which collects money from the employer, employee and government budget.

The social insurance has seven benefits including: 1) Medical services for non-work related injury or
illness after 3 months contribution within 15 months, 2) compensation for non-work related disability after 3 months contribution within 15 months, 3) Labor compensation after 7 months contribution within 15 months, 4) Death compensation after 1 month within 6 months, 5) Child support after 1 year contribution, 6) Pension at 55 years old up after 15 years contribution, 7) Unemployment support after 6 months contribution within 15 months.

The social security insurance does not cover work related injury and illness because there is another work related fund that employers contribute to. This scheme does not cover health promotion and disease prevention activities.

Migrant and Family Health Service Management (36)

1. Compulsory Health Insurance by MoPH

According to the Cabinet Approved Regulation, the migrant workers who want to get a temporary work permit must be registered by the MoI and have their health check from the MoPH along with health insurance. (40) The MoPH’s mission for the registered migrant workers includes the following activities.

- Health check up
- Health and Medical services provision
- Health promotion and disease prevention
- Disease surveillance

While the Cabinet approved regulation focuses on the registered migrant workers, the MoPH also has a public health mission to prevent the dissemination of communicable diseases among the unregistered migrants too according to the Public Health Act. (37, 38) Accordingly, the MoPH is not allowed to deny medical services to anyone who needs them according to the Medical Service Provider Act. (39) In this way MoPH hospitals practically provide health checkups and health insurance for unregistered migrant workers and families voluntarily.

Sompong Srakaew (40) found that in SamutSakhon province, even though the registered migrant workers already had health check-ups to show at the provincial labor office and already got work permit, they might not purchase health insurance. So when they got sick, they could not receive medical services.

2 Health Care Financial Management

Samrit Srithamrongswat et al(7) studied the current health care financing sources for migrant workers in Thailand. They summarized their finding that compulsory Migrant Health Insurance (CMHI) (41) is a primary financial source for migrant workers’ health care. However, its role has been
declining as a result of the decreased number of registered migrant workers. Dependence on hospital exemptions financing health care for migrant workers has increased significantly as have OOP expenses. The CMHI was established through the MOPH's effort to relieve the financial burden of public hospitals. This is partly achieved by providing curative care to migrant workers as well as supporting public hospitals to provide active health prevention and promotion services. In general, however, some of the major issues of concern raised among policy makers have focused on securing sufficient budgets to finance hospitals, rather than focusing on equitable financing of health care for migrant workers.

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

Following are major findings from this study:

Access to health care for registered migrant workers under the CMHI has improved over time for both outpatient and inpatient services. However, outpatient service utilization rates by CMHI members were still far below those of the SSS and UC schemes. Self-medicating is common among migrant workers despite being in possession of a CMHI card. In relation to inpatient services, hospitalization rates of registered migrant workers were comparable with that of SSS. CMHI members also accessed medical referrals and high cost health services.

Health promotion and prevention services are provided to both registered and unregistered migrant workers including their dependents. However, some expensive vaccines such as Japanese Encephalitis and Hepatitis B virus are not universally provided to migrant children.

An increased health care utilization rate by CMHI members resulted in an increase in the cost of curative services provided to members, however the rate remains below that of the collected premium. If exemption for unregistered migrants were assumed as expenses of the scheme, overall costs of the scheme were greater than the curative budget in 2006.

Cost recovery of the scheme varied from province to province. Border provinces were more likely to experience a significant burden from exemptions for unregistered migrants as well as cross-country cases.
Performance of the CMHI

Access to health care under the CMHI scheme has demonstrated improvements for registered migrant workers. However, the utilization rate of outpatient care was still found to be far below that of the UC and Social Security Schemes. Self-medicating continues to be more common among stateless / displaced persons and migrants than their Thai counterparts. Language and cultural barriers partly explain the relatively low utilization of outpatient care, even though many hospitals provide translation services. The complexity of hospital service systems coupled with the limited number of translators is likely to impact on the quality and effectiveness of available assistance to migrant workers when receiving care in hospital. However, the comparable inpatient utilization rate of migrant workers with that of the Social Security Scheme beneficiaries suggests that once seriously ill, migrants will take up the benefits of the scheme. At present, the insurance policy also enables access to some high cost care and referrals. Health promotion and prevention services are provided to all migrant workers regardless of their registration status. Japanese Encephalitis vaccine and Hepatitis B vaccine are not generally provided in the four studied provinces even though they are included in the benefit package. This is probably due to the relatively high cost of these vaccines and a lack of clarity in regards to their impact on the epidemics. In order to achieve more effective control of the two diseases, both vaccines should be provided to migrant children. The active provision of health prevention and promotion services in migrant populated areas partly comes from funding supported by international organizations and various non-governmental organizations.

A relatively low service utilization rate has resulted in high cost recovery of the scheme due to the incurred costs being lower than the collected revenue. Costs of curative care services have increased in accordance with an increase in the service utilization rate of beneficiaries, despite being less than overall revenue. If exemption for unregistered migrants were assumed as expenses of the CMHI, overall costs of the scheme in 2006 would be greater than the curative budgets of the CMHI. Cost recovery of the scheme varied from province to province. Border provinces had relatively low cost recovery due to the high number of unregistered patients in addition to cross-border patients. System administration, particularly governance of the scheme, is a further issue that needs to be addressed. A conflict of interest exists and active purchasing functions have not yet been performed since the MOPH acts as both the provider and purchaser of the scheme. Only one private hospital in SamutSakhon province provides services to migrant workers under the CMHI. The exclusion of private providers limits the available choice and access to health services among migrant workers. In addition, monitoring and evaluation of the scheme’s performance is limited as reflected by a decline in the number of provinces reporting to the MOPH. Therefore, active purchasing functions including monitoring, evaluation and information systems are identified as areas that could be strengthened. Guidance and Recommendations from Literature Review
1 International Guidance and Recommendation

IOM(42) Recommendations:

Strengthen data collection at the MOI, MOFA and MOL and work toward a joint database inclusive of all categories of foreign immigrants, both working and staying in Thailand, and Thai emigrants. Among immigrants, students, retirees and spouses (preferably to be differentiated by gender) should receive more attention in view of their growing significance for Thailand. In due time, data gathered from other ministries such as the MOE and MOPH could also be included to further enhance the comprehensiveness of the database and reduce the possibility of overlaps. It is also worth experimenting with strategies to link national and local information systems, as local government agencies, if properly equipped, may be in a better position to capture migratory movements, especially in localities with large immigrant and emigrant populations.

Promote comparative studies of migrant populations with the Thai population. Efforts to compare disease burden and case fatalities of different migrant groups and the Thai population are worthy and should be expanded to other sectors to better understand relative conditions, especially with regards to wages and other benefits.

Devote attention to migrants’ occupational health. It is somewhat surprising that not much is known in this field considering the many risks labour migrants encounter in the work place. Again, comparison with the Thai population could be instructive in this context to determine whether responses should be focused only on the migrant population or should address all population groups working in unsafe settings.

Integrate migration concerns into regional cooperation programs under ESCAP, ASEAN, the GMS and ACMECS, and work at developing region-wide mechanisms specifically devoted to regular interaction and cooperation on migration in the context of regional development and stability. Since international migration in Thailand is especially embedded in regional dynamics, responses need to occur in a multi-lateral fashion within existing regional frameworks. Linking migration to regional economic integration will contribute to ensuring that development projects launched as part of cooperation efforts lead to a reduction in poverty and inequities and do not cause displacement or have unintended consequences on disadvantaged groups. Gradually, Thailand could move toward a regional management system, possibly under ASEAN, which would expand AFAS to include low-skilled workers and would complement and integrate existing bilateral agreements for Thai workers abroad, as well as GMS workers in Thailand. The regional system should cover all aspects of migration, and balance economic considerations with the imperative of protecting and respecting the rights of migrants, irrespective of the skill levels involved (see also Huguet and Punpuing, 2005).
Ensure adequate labour protection to migrant workers irrespective of their legal status. The Labor Protection Act B.E. 2541 is an important tool to ensure employee protection for all employment contracts and could be maximized if expanded to those sectors where low-skilled migrant workers are concentrated, namely agriculture, fishing and domestic work. Labour protection mechanisms also need to be developed for the informal sector, to ensure enforcement of labour rules. Guidelines should be disseminated widely among employers, government officials, migrants and other parties, and regular inspections of labour sites intensified to ensure that employers are complying with labour standards (Pearson et al., 2006). Employers who are found in violation should be consistently reprimanded and punished in accordance with Thai labour law. Employers also need to be told not to seize migrants’ IDs and work permits and should be fined if they continue to do so, considering that these documents are the only legal protection GMS migrant workers have (FTUB, 2006). Special efforts should be directed at eliminating the worst forms of child labour through both educational and punitive measures. Complaint channels should be created for migrants to safely report exploitation in the workplace and they should be allowed to organize to strengthen their negotiating position with employers (Pearson et al., 2006). Exploitative cases should be brought to court, and migrants who are victims or witnesses be ensured of protection and exempted from arrest and deportation. That exploitation of workers is unacceptable, whether the workers are Thais or immigrants, should be emphasized through national media campaigns to raise awareness among employers and society. The value of both high-skilled and low-skilled migrant workers for the Thai economy and Thai society should be stressed, and evidence countering prevalent misconceptions should be spread widely to foster a more positive attitude towards migrant workers. By contributing to decent work conditions, all these proposed interventions also benefit the many Thais working side-by-side with migrants.

Review existing registration, MOUs and provincial decrees taking into account the dignity and human needs of low-skilled GMS migrant workers and their families. In particular, the prohibition against changing employers and moving between provinces should be seriously assessed in view of the growing evidence in Thailand, as in other countries, that such measures indirectly increase the vulnerability of migrants in addition to depriving them of a full social life (see Chapter III and IV). Newly introduced provisions under the Alien Employment Act B.E.2551, such as the repatriation fund, the rewarding of informants, and the lengthy detention for irregular migrants who are caught, will also need to be closely monitored in order to intervene if they produce negative results as many NGOs fear (Irrawaddy, 2008). As for the provincial decrees, Thailand should urgently gauge their constitutionality and consistency with national laws and international conventions to which it is a party. Informed discussion should also be fostered about their societal effects. As previously recommended for Thai contract labour, MOUs with neighbouring GMS countries should not tolerate HIV and pregnancy testing of prospective migrant workers (MMN and AMC, 2007). It would also be a commendable change to
allow couples to migrate together or to reunite. Common, albeit not legal, practices, such as terminating employment of migrant workers because of marriage and pregnancy should be formally disallowed since they do not conform with Thai labour law. With the growth of the migrant children population, it has become crucial to address issues related to birth registration and the right to nationality of migrant children in GMS fora and to arrive at joint regulatory frameworks in order to avoid making them stateless. The important step taken with the Civil Registration Act B.E. 2551 which makes children of registered migrants eligible to receive birth certificates in Thailand should be formally expanded to children of unregistered migrants. Barriers discouraging irregular migrants to come to hospital and medical centres where delivery certificates are issued or to the local government offices to register their children, should also be addressed. A database of migrant children born in the absence of a birth registration system should be established, eventually with the assistance of neutral organizations, such as the Thai or International Red Cross (MMN and AMC, 2007).

Improve the management system for seasonal and daily cross-border migrant workers. The introduction of provincial cross-border agreements has opened the way to regularization of short-span migration, but there is a need to establish a transparent administrative system that ensures safe crossing and employment. Information offices servicing both employers and migrants could be established at key checkpoints, and cross-border collaborations initiated to enhance legal protection of seasonal and daily migrant workers on both sides of the border (PDSALVY and SILAKA, 2006).

Continue to expand access to education and health to migrants and their children. As a result of the inclusive Thai policies in health and education, significant progress has been made in enhancing the reach and quality of services. In health, a number of model interventions, such as the introduction of MCHVs and MHVs and provincial initiatives to devise private insurance schemes, seem promising and should be regularly monitored, improved as needed and, if found effective, scaled-up nationally. Health financing schemes for unregistered migrants, eventually cross-subsidized by the migrant health funds paid by registered workers, should be considered, and formal ways to regularize the position of health volunteers examined. Public health efforts should go beyond their current emphasis on communicable diseases to include promotion of occupational health and mental health, and HIV efforts should be integrated with other sexual and reproductive health concerns, especially prevention of unwanted pregnancies and unsafe abortion. More structural approaches in improving the living conditions of migrants are recommended given their impact on TB, malaria, diarrhea and many other diseases. This shift toward a setting-based approach, besides being more sustainable in the long run, would help take away much of the stigmatization of migrants as “carriers” of diseases brought about by a narrow behavioral approach. In education, to enable the realization of universal coverage, the education system needs to be better prepared. Efforts should be made to disseminate information about the Education for All policy to schools, teachers and migrant parents and to improve the financial and
administrative support system. In provinces with many migrants, experimentation is recommended with dual language education and standardization of migrant schools’ curricula. The issue of certification of diplomas granted by migrant schools (as well as schools in the border camps) is crucial to enable students to take advantage of future occupational and educational opportunities.

**WHO Recommendations**

**Current circumstances:**
1. Effectiveness of the border control measure still remains a challenge.
2. The RTG is not able to limit the movement of migrants; a migrant “zone policy” is still not feasible.
3. Implementing the policy on dependants of migrant workers effectively is still unrealized.

**Policy Recommendations**
- At central level, it is recommended to develop a mechanism to utilize the five established committee/subcommittees on migrants’ health to effectively support MHIS development on technical support through M&E periodically.
- Advocate and maintain the developed system into the existing MOPH structure in order to ensure the use of the information, plan for health information systems resources, and monitor and evaluate the system.
- It is further recommended to establish a migrant unit within the PHO structure with proper resource allocation, in particular in provinces which are hosting large numbers of migrants.
- Establish a Task Force (TF) to develop a minimal data set required as well as to develop a community based surveillance system. The Task Force should include technical staffs from various backgrounds of the MOPH, NGO and institutes involved with migrants.
- Identify focal point/person from each relevant bureau within the MOPH as well as an appropriate mechanism to coordinate the migrant health information sharing.
- Develop concrete mechanisms to strengthen the coordination and collaboration among all stakeholders from government, non government and private sectors in order to (i) avoid duplication of services and over/under funding, (ii) allocate sufficient financial support to further develop MHIS, and (iii) ensure the completeness of information required.
- Further, advocate for official permission to hire migrants as Migrant Health Workers.
- Continue to seek cooperation from the neighbouring countries to establish a pilot project on bi-national epidemiological surveillance and control along the border between two countries.

**Technical Operational Recommendations**

Recommendations are divided into three phases based on the priority and complexity of the systems.
1) Short term: Strengthen existing systems
   a. Malaria vertical programme
   b. Summary TB Reporting system of TB cluster
   c. Health Screening
   d. Sero-Sentinel Surveillance among migrants
   e. Disease Surveillance-506 (506/1) reporting system

2) Medium term: Develop a complimentary system for disease prevention and control
   a. Develop a community based Disease Surveillance System for priority diseases e.g. AI, Meningitis, Cholera, TB, Dengue and Malaria

3) Long term: Improve the more complex system including
   a. EPI data collection and reporting system
   b. RH data collection and reporting system
   c. Demographic data collection and reporting system
   d. EH data collection and reporting system

In order to fulfill the proposed tasks, additional technical staffs are required at the provincial level to coordinate and provide technical support to the implementing units. Furthermore, pilot health centers should be equipped with necessary equipment such as computers.

2 Recommendation and Guidance from other studies

Health Service System Management

Kritiya Archavanichakul (44) proposed that the MoPH formulate a long term policy and strategy because the Burmese, Laotian and Cambodian migrant workers would become long term problems. During the years 1996-2006, the Thai government’s cabinet approved regulations year by year, but has no long term public health policy and strategy. Even though there was MoPH health checkups and health insurance, there was no long term strategy that was more efficient and effective.

Another problem included the number of migrant workers who got health checkups from MoPH were outnumbered by the migrant workers who got work permits from the MoL (44).

Kritiya Archavanichakul (45) also reported that there was no policy and regulation for HIV prevention in the migrant workers during the year 1996-2004, but some provinces already implemented the specific plan for HIV prevention in the migrant workers supported and co-operated in the local area by International Funds and NGOs. The public sector reform in the year 2001-2003 terminated Sexual Transmitted Infection (STI) clinics in the Provincial Health Office and delegated this mission to the...
general or regional hospital in the province. This was not the priority mission of the hospitals who already bore an extra work burden from 30 Baht program services, leaving the HIV and STI prevention weak in every aspect.

Kritiya Archavanichakul, et al (46) also found that some hospitals where there were a lot of unregistered migrant workers in the area were in a condition of financial crisis. Some provinces, for example Kanchanaburi, Phang-nga and Rayong, allocated migrant health insurance according to the workload so that the profitable hospitals subsidized the hospitals that had inadequate funds.

Another report by Kritiya Archavanichakul (47) demonstrated the improvement of the MoPH migrant health policy and strategy to be more advanced and pro-active. The Migrant Health Strategy was formulated as was the National HIV Plan for mobile populations. Accordingly, there were many activities at the provincial level, co-operation among Public organizations, NGOs, and Local Authorities. The mobile clinic for migrant workers, the Migrant Health Worker and Volunteer migrant health worker, who were trained and who provided preventive and health promotional activities to both registered and unregistered migrant workers and families were established. A problem was that some of the registered and insured migrant workers and families, had their health card kept by their employer to ensure that they could not move to another place, making them unable access the hospital for illness and health problems. The health care personnel's attitude also was a problem, as the services for migrant workers and families were seen as more of an additional burden to work under the universal coverage of health care for Thai people. Some saw the workload and migrant workers and families as a threat to national security, especially the unregistered and uninsured migrant workers and families, some of who were reported to the police after treatment. In terms of systematic approach, the MoPH and MoL should prepare the practical standard guidelines and recommendation for necessary activities such as the guideline for provision of ARV drugs to migrant worker and family who are infected with HIV, and the guidelines for recruitment of the Migrant Health Workers and provide these to the provincial health office and labor office.

Kritiya Archavanichakul, et al (48) proposed improvement for migrant health through the following:
1. The policy and budget allocation for migrant health problems such as maternal and child health should be formulated according to the fact that the prevalence rate was higher than the Thai population.
2. The disease prevention and health promotion activities need co-operation with the NGOs and other parties who are familiar with the migrant culture and language, so the health education training and empowerment among the parties should be supported.
3. The migrant health insurance fee for disease prevention and health promotion should be managed by encouraging activities among multi-sector and multi-disciplinary parties and also formulating the participatory process from the migrant workers and families by promoting of the Migrant Health Worker. The conflict among provincial health office and hospitals should be mitigated.
4. There should be guidance on management of health insurance fees to subsidize the hospitals to improve the migrant health service and also allocate some budget for specific diseases such as pulmonary tuberculosis, HIV, disability from injuries.

5. The migrant health insurance should have more options suitable for attracting the migrant workers and families according to their working and living conditions, including whole family insurance, the right to access any hospital in the health service network and more private hospitals involvement, etc.

6. The integrated services for migrant workers and families among the departments in the contracted hospitals should be encouraged for better access to the health and medical services.

7. The adequate health and medical infrastructure, including the migrant health worker and volunteer migrant health worker, should be prepared to assist in handling the increased workload.

8. The communication and co-operation among the origin and destination countries should be developed between governments and ministries, as information sharing among countries could improve better health care for the migrant workers and families.

9. The evaluation system should be established to monitor migrant health problems and the effectiveness of interventions.

Other specific interventions were recommended including the following.\(^{(49,50)}\)

1. ARV drugs should be provided to the HIV migrant pregnant women.

2. The counseling system for HIV infection should be formulated to improve the competency of the migrant health worker and also NGO personnel.

3. The birth certification of the migrant’s newborn should be provided.

4. Migrant language competency should be required to improve access and communication.

5. The co-operation with NGOs to participate with the migrant service system should be stabilized to reach the migrant workers and families in the community.

Lessons Learned from Specific Provinces

**Tak Province case study.**\(^{(51)}\)

1. The information on migrants from the MoPH and Provincial Health was different, so the situation analysis was inaccurate.

2. The co-operation among NGOs and public organization was a problem at the provincial level because of the different working cultures.

3. The policy and duration for registering were not feasible for the real environment because there were many limitations including the incompatible duration between the MoL work permits and MoPH health insurance.

4. Migrant reproductive health activities needed budget from NGOs which was not sustainable.
5. The prevalence of communicable diseases among the migrant workers and families was higher than the Thai population, and the effective preventive activities need to be implemented by the community through support from public organization and NGOs.

6. Migrant workers and families with HIV were not able to access ARV drugs, especially pregnant migrant women infected with HIV.

7. Hospitals at the border had high expenditures because the uninsured migrant workers and families outnumbered the registered ones.

8. The migrant women prefer to give birth by traditional midwives.

9. The migrant newborns face stateless condition.

10. The sex workers eradication policy and the pulmonary tuberculosis control were not compatible.

Kanchanaburi case study

There was high mobility among migrants as they moved to find work with better wages in other provinces.

1. There was no standard guidance for the health insurance fee management, so the provincial health office centralized the management and pay for services to the hospitals.

2. There was no cooperation among the NGOs and public sector.

UbonRachathani case study

1. There should be a feasible and sustainable policy and strategy to provide health services to the migrant workers and families, and the prevention and health promotion should be provided to all groups of migrant workers and their families.

2. The hospitals should be encouraged to spend more on the migrant health promotion and disease prevention, especially the pro-active activities with initiation through a participatory process, including the migrant health worker could be very helpful.

3. The unit cost and financial analysis and study should be promoted to plan for better insurance system.

4. The migrant health information should be established, shared and updated as one logical database among stakeholders include MoI, MoL and also MoPH so the government strategic formulation is united.

SamutSakhon and SamutPrakan case study

The health insurance fee in SamutSakhon and SamutPrakan provinces were adequate and could provide services for the migrant children and older people. There was enough income to recruit the migrant health workers and also improve the environment to be more accessible for migrant such as the migrant language signs and leaflets.
The financial management improved the effectiveness and efficiency of the prevention and health promotion activities in SamutSakhon Province. The model consists of the respective allocation of all the migrant health insurance prevention and promotion budgets to all hospitals, 96 Baht for Samut-Sakhon Hospital, 80 Baht for Sriwichai 5 Hospital and 30 Baht for provincial health office. This allowed them to have a proactive role for communicable diseases without concern for cost, and they could respond to migrant reproductive health and family planning and also migrant's newborn birth certification.

STI and HIV were still problems because the hospitals did not prioritize these as main issues and the provincial health office, which used to care for these diseases in the past, was changed to be just the management office. Considering this, the recommendations include the following:

1. The health insurance should be encouraged to all migrant workers and families and might be customized to be more feasible for example the whole family package, etc.
2. The more accessible services should be provided to improve the access, such as the "green channel," to reduce waiting time, and encourage not for profit private hospitals to provide the services.
3. Competition to provide services to migrants should be encouraged.
4. The biological identification data system should be collected to improve access to the health service system in case of insured migrant workers who do not carry their health cards because their employers kept them.
5. The uninsured migrant workers and families should be provided services by the separate system and the budget allocation should support this and also the high cost for chronic care such as HIV.
6. Translators should be provided at the health service delivery unit and also provide documents in migrant language.
7. The traditional midwives should have their skills improved, including safety services and information to reduce the postpartum hemorrhage and abortion, and also improve the information system.
8. The migrant health worker should be encouraged and have their skills and knowledge improved including collecting specific information, for example giving birth at home, abortion and also the HIV suspected cases.

**PhangNga and Phuket case study**

Most of the migrant workers in PhangNga were in agriculture, mostly rubber and fisheries, but in Phuket they worked in construction and in small shops. The health insurance fees were adequate but the prevention and promotion activities still were problematic because of the frequent movement by migrant workers, communication difficulties and being unable to reach migrant workers. The recommendations included the following.
1. The information system should improve the quality, accuracy, and be updated for better utilization.

2. The health infrastructure should be better prepared for the workload of health and medical services for migrant workers and families, and the standard guidance should be provided or else services would be provided according to decisions made for each situation.

3. The NGOs could support the public sector for better services so the co-operation would be initiated, especially the recruitment of Migrant Health Worker which was not permitted by public hospitals.

4. The strategic cooperation between NGOs and public sectors was challenging.

**Rayong and Trad case study** (55)

The health service infrastructure should be improved especially the Migrant Health Workers to improve communication and increase accessibility, and improve co-operation between governments of the origin and destination countries.

1. The migrant management system should be adjusted to be more feasible to accommodate the migrant workers’ situations and context, the strategy and guidance should be more sustainable for the long term management and the health insurance should be varied and have more options for all migrant workers and families, for example allowing registration all year round.

Kritiya Archavanichakul, et al, summarized that the MoPH policy currently consisted of the following:

1. Compulsory migrant health checkup
2. Compulsory migrant health insurance
3. Prevention and health promotion especially the HIV program
4. Migrant family planning

*Yet, the MoPH still faced the following problems:*

1. Communicable diseases among migrant workers and families
2. Health and medical expenditures for migrant workers and families
3. Migrant maternal and child health and reproductive health
4. Migrant sanitation and environment
5. Migrant health management expenditure
6. Effective information systems

There were some problems in the migrant health service system that needed to be improved, including disease prevention, health promotion, migrant information and migrant health insurance as follows:
1. The provincial health office structure was not supportive to the migrant health strategy because of rotating provincial personnel versus long standing problems and the need for continuous co-operation among parties.

2. The frequently moving migrant workers and families caused difficulty to follow up especially those infected with communicable diseases. There was one province that had 200 pulmonary tuberculosis cases found but had no system and no plan to follow up and provide medication. Some provinces such as Tak, SamutSakhon, Ranong and some districts in Kanchanaburi were very strong in preventive activities.

3. The workplace environment and conditions do not support good health for the migrant and it is easy to disseminate communicable diseases. Most of the employers do not cooperate in disease prevention, especially healthy workplace promotion.

4. The HIV and STI clinics in the provincial health offices were terminated and transferred to be the hospitals' responsibility, but the skill and experienced personnel stayed in the provincial health office; and the hospital environment was different and needed identification that made it difficult for the sex workers to access the preventive services, so the disease prevention was weak. Some provinces, such as Supanburi, maintained their STI clinics and could demonstrate the effective prevention activities.

5. The health personnel did not get co-operation from employers and factories and did not have enough budget to support an active role in workplace health prevention.

6. International communicable disease prevention needed knowledge and experience, but there were not enough health personnel in the inner provinces. The transfer of knowledge and experience between the border provinces and inner provinces would be helpful.

7. The effective and efficient information system needs to be improved, especially the 506 report for communicable diseases in migrant workers and families. After the public sector reform there was a lot of gaps due to the discontinuation and moving among new divisions of health personnel.

The maternal and child health recommendations included the following:

1. There was evidence that some migrant women avoided pregnancy tests, had abortions or sent other non-pregnant women to test (or used their urine).

2. There were more migrant women giving births than Thai women in some provinces, especially where migrant workers were more than 10% of the total population such as Ranong 33.7%, Tak 24.2%, SamutSakhon 22.7%, PhangNga 12.7% and Phuket 11.3%.

3. The still birth, spontaneous abortion and illegal abortion rates were very high among migrant women, especially at the border such as Mae-Sai, Chiang Rai because of the lack of family planning and communication problems. As a result, the ANC uptake rate was just 1/3 of the total pregnancies among migrant women. Some areas could demonstrate better outcomes by
more active health promotion programs, increasing traditional midwives skills and knowledge, and by having Migrant Health Workers support the health service system.

4. The Migrant Health Workers and voluntary migrant health workers could reduce the communication problem and also contact migrant communities through outreach, so the policy should empower and encourage these migrant health workers by allowing the public hospitals and provincial health offices to legally recruit them.

5. The migrant newborn birth certification was still a problem and needed resolution.

6. The migrant HIV infected pregnant women were not accessing ARV drugs.

7. There was evidence that family planning could reduce the migrant birth rate from 12.9/1000 in the year 2002 to 11.9/1000 in the year 2004 after the migrant birth control rate increased from 1.8% of total migrant population in the year 2003 to 2.1% in the year 2004.

Other recommendations included the following:

1. The health insurance card format was not standard.

2. There were many Thai people holding color identification cards who did not get any health insurance or rights to access to the health and medical services.

3. The migrant information system was not integrated, was incomplete and of poor quality, especially because migrant workers’ names were changed for convenience. Even the MoI civil identification system let other ministries connect to their system but they needed ministry to ministry co-ordination.

4. Some “illegal” migrant workers were deported to the wrong country because of miscommunication, for example some Cambodians were sent to Sanklaburi in Kanchanaburi Province on the border with Myanmar.

5. The migrant health and medical services expenditure caused more burden to the hospitals who provided health and medical care.

6. There was no sustainable strategy and guidance for health provision for migrant families.

The National Socioeconomic Advisory Council also proposed the policy for migrant as follows:  

1. There should be long term strategy and master plan for the long term management of migrant workers formulated by all parties, with the policy focused on human rights, labor protection, and feasibility to operate and customize to the migrant work environment and conditions, such as keeping registration open the whole year.

2. Migrants’ families should be prohibited because the more migrant families there are, the more migrant community settlement could be a threat to Thailand’s security in the long run, even though migrant workers’ health and human rights should be taken care of.
3. Provincial regulations that violate human rights should be stopped.
4. The temporary work permit should be more accessible for migrant workers by reduction of the steps to register and improved efficiency in operation.

Other recommendations were as follows:
1. The migrant regulation should be customized according to each province’s context to be more feasible in each area and more flexible.
2. The employers and government officers who employed and brought the illegal migrant workers should be punished. The law should be enforced.
3. The labor right protection should be enforced according to the labor act and also the minimum wages should be applied for migrant workers employment equal to Thai workers. Workplace and environmental safety should be implemented and enforced.
4. The registration, the health checkup and health insurance, along with the temporary work permit provided should be supported with adequate budgets and workforce.
5. The specific integrated task forces in each area should be established, for example security task force, labor task force and health task force, and also the evaluation system for these task forces reporting directly to the cabinet.
6. The integrated information system connected among all related ministries should be formulated, and utilized in one logical database.
7. Migrant problems should be effectively and efficiently solved, and there should be an assigned authority to take responsibility.

The recommendations for regulations include the following:
Sirikanchana Patanasak(59) from the Ministry of Labor reported and recommended the following:
1. Migrant workers should be on the national agenda and a national organization should take responsibility. The law and regulation should be improved and enforce, especially the punishment for employers who hire unregistered migrants.
2. There should be policy and management for the unregistered migrant workers, and improve the labor law to accommodate the international labor laws, including endorsing all relevant international labor laws.
3. The migrant workers management mechanism should be more efficient and transparent, with the participation among NGOs and GOs encouraged.
4. The employers and consumers should receive communications that improve their knowledge and realization of the human and labor rights, and everyone should co-operate to solve this problem.
5. The migrant workers should be empowered and encouraged to know the labor law and human rights in order to have a better quality of life.
6. MoL should improve the process for migrants requesting temporary work permits to be more efficient including extending the duration and frequency of registrations, and by minimizing the fee.

7. The unregistered migrant workers should be promoted to register and also get health checkup and health insurance to be protected by human right by reduce or exclude the levy and fee for the first registration.

8. The employers, who would like to recruit the migrant workers, should be registered and get an employers card with reasonable fee.

9. The law enforcement should be encouraged to reduce the number of unregistered migrant workers and their employers by encouraging the registration of migrant workers and their employers.

10. Migrant workers’ labor rights should be monitored and improved by increasing the number of labor inspectors and through dissemination of the guidelines for migrant workers inspection.

11. The migrant workers participation in their right protection should be established especially the volunteer migrant worker for labor and human right capacity building.

12. The socialization to resist illegal employment especially oppression should be initiated.

13. Prevention of illegal migrant workers entering the country should be done at the border, and human trafficking should be eradicated.


15. The human and labor rights protection according to international law should be enforced equally to all workers, Thai or migrant, registered or unregistered.

16. The human rights and labor protection in Thailand should be communicated among other countries, internationally or globally to be recognized.

Samrit Srithamrongsawat, et al (7) also proposed the policy recommendations as follows:

1. Expansion of the UC scheme to cover stateless/displaced persons is recommended as their contribution to society is equal to that of Thai people. In addition, given that the majority are poor and that they used to be covered by the Low Income Card, facilitating access to appropriate care is likely to provide positive outcomes to society in general. Expansion of the UC scheme requires an additional budget of 1,080 million Baht per year.

2. Improvements to the current CMHI scheme, and its management, are urgently required. In addition, management boards should be established at both the central and provincial levels to develop coordinated strategies which aim to improve the overall performance of the scheme, to monitor, evaluate and enhance the scheme, and to facilitate collaboration amongst all related organizations and stakeholders.
3. Two healthcare financing options are proposed for unregistered migrant workers:

a. Additional budget allocations are required to support hospital exemption for migrant workers in communities where many unregistered migrants reside. Theoretically, health care costs incurred by migrant workers should be paid by those who benefit from the presence of migrant workers, including employers, local communities, the local and national economy, as well as local and national governments. Given that these groups already pay taxes, either directly or indirectly, a public subsidy scheme is recommended. According to the 2006 exemptions, this would require approximately 17 - 170 million Baht per year.

b. Health is a basic human right and to observe this on a national level, health security is recommended to include an expansion of the CMHI to cover all migrant workers and their dependents. Such an expansion would require all migrants to identify themselves in order to pay their contribution. It is unlikely that all migrants could be covered on a voluntary basis, so it is therefore recommended as a compulsory scheme. In order to achieve this expansion, an explicit and liberal government policy is required to ensure a fair registration process, humane enforcement of the law, and improved coordination between various government organizations and stakeholders. There are no anticipated financial constraints should the government adopt this option.
Chapter 3  Method and Materials

Figure 3.1 Conceptual Framework

Scope of Study, Source of Information, Tools

1. The level of knowledge and understanding of health insurance benefits and rights, health seeking behaviors, and health and medical services utilization of migrants who are registered, unregistered, insured, uninsured, under the nationality verification or imported through the Memorandum Of Understanding and their families, who are from Myanmar and Cambodia, not including Laotians, in Rayong and SamutSakhon Provinces will be collected through sampling using the individual primary information questionnaire format.

2. The migrant health care utilization rate, health and medical services and costs, migrant health care financial management and also migrant health service at the provincial and hospital level will be collected using electronic medical records and reports from provincial health office and hospitals in Rayong and SamutSakhon Provinces and also from the Health Administration Bureau, Health
3. Migrants infected with HIV access to ARV and relative cost will be collected from the Migrant Health Information system from the Bureau of AIDS and Sexual Transmitted Diseases, Department of Disease Control and also Provincial Health Offices and hospitals in Rayong and SamutSakhon Provinces.

Unit of Analysis

Rayong and SamutSakhon Provinces were selected by Non Randomized (Purposive) Sampling because they were under the PHAMIT Project, and most of the migrants worked in the fishing or seafood processing industry.

1. In Rayong Province, there were 20,117 registered migrants who already had civil registration 38/1 and work permits; 3,962 had the nationality verification and 589 were imported through the MOU; 56.55% of the migrants sampled were Cambodian. The sample size calculated by the Taro Yamane method at 95% confidence was a sample size of 394.

2. In SamutSakhon province, there were 124,454 registered migrants who already had civil registration 38/1 and work permits, with no report of the nationality verification and also no report of the imported migrants according to the MOU; 84.25% of these migrants were from Myanmar. The sample size calculated by the Taro Yamane method at 95% confidence was a sample size of 400.

Migrant workers and their family

The distribution of migrant workers in Rayong and SamutSakhon was not normal, so the samples were selected by non-randomized stratified sampling. The stratified samples were selected by purposive sampling to cover all groups of migrant workers and families as shown below.

1. The migrant workers from Myanmar and Cambodia who were imported legally according to the MOU between Thai and Myanmar and also Thai and Cambodia.

2. The migrant workers from Myanmar and Cambodia who were registered by the Ministry of Interior and already had a Civil Registration 38/1 form, and also passed the nationality verification from their countries of origin.
3. The migrant workers from Myanmar and Cambodia who were registered by the Ministry of Interior and already had a Civil Registration 38/1 form, but had not passed the nationality verification from their countries of origin.

4. The migrant workers from Myanmar and Cambodia who were not registered by the Ministry of Interior and did not have a Civil Registration 38/1 form.

Groups 1 and 2 might have either social security benefits because of their formal employment; or MoPH health insurance if they were hired in the informal sector. Groups 3 and 4 might have MoPH health insurance or not. Each group was selected through the purposive method to cover the primary 6 job categories, with the 6th group identified into 19 subgroups in Rayong and SamutSakhon, as dictated by the Ministry of Labor.

**Tools for collecting information**

The “Modifies Health Seeking Behavior and Health System Response Model” that was proposed by Susanna Hausmann-Muela (59) was adjusted and validated by 10 experts from public agencies and NGOs in Rayong and SamutSakhon. The Ministry of Public Health assisted with two information collecting form questionnaires – one for migrant workers who already had documents and were legally registered with work permits, and one for undocumented migrant workers and the migrant families who were not registered.

Because of limitations in communication, the rating scale answers were avoided, and the health seeking behaviors and health system response questions were personal issues where the interviewer and the migrant worker being interviewed had to be familiar in order to get accurate and reliable information.(60)

The reliability of questionnaires was tested, and test-retest methods were used in 20 samples from SamutSakhon Province and 9 samples from Rayong Province. The Pearson product moment correlation was applied to test reliability, with R=0.91

**Methodology**

The study was conducted from January 2010 to May 2011. To accomplish the established objectives the following activities were pursued:

1. Literature review of Thai laws and regulations related to migration, a literature search of published material on international migration and health insurance in Thailand both in Thai and English.
2. The questionnaires for measuring the migrant’s knowledge and understanding of health insurance benefits, rights and health seeking behaviors and health and medical services utilization were developed, validated, reliability tested and improved.

3. The research committees in Rayong and SamutSakhon Provinces were established.

4. A comprehensive desk review was undertaken and complemented with informal interviews and field visits in Rayong and SamutSakhon.

5. The samples were selected in Rayong and SamutSakhon, and the Migrant Health Workers in Rayong and SamutSakhon were introduced and trained for collecting information from the samples.

6. The survey was conducted in both provinces.

7. The electronic records of migrants and records of those receiving ARV or who were indicated as being migrants infected with HIV were collected from the hospitals in Rayong and SamutSakhon and from Provincial Health Offices.

8. The information from the Bureau of Health Service Systems Development, the Insurance Division, Bureau of HIV and Sexually Transmitted Diseases, and Bureau of Foreign Labor Administration were collected.

9. All information was analyzed, and a financial management model and migrant health service model were formulated.

10. Field visits and informal interviews were conducted with various stakeholders, including representatives of migrant field officers working for NGOs on how to adapt the models and how to fill knowledge gaps.

11. The proposals of the models were analyzed for feasibility and finalized.
Chapter 4 Results of the Study

1. Trend of the Migrant workers from Myanmar, Laos PDR and Cambodia

The data collection by the office of Foreign Worker Administration presented in table 4.1 shows the amount of illegal migrant workers from the three countries of Myanmar, Lao and Cambodia who got work permits from the Office of Foreign Workers Administration in the years 2004-2010.

The systematic collection of information on migrant workers was started in the year 2004. The amount of these workers then decreased in the years 2005 and 2006, and continued to decrease in 2007 and was at a minimum in 2008. The year 2011 the amount of registered migrant workers was impacted by the nationality verification and numbers of imported migrant workers through the MOU.

Table 4.1 Number of Migrant Workers (3 Nationalities) with work permits during 2004-2010

<table>
<thead>
<tr>
<th>Nationality</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myanmar</td>
<td>633,692</td>
<td>539,416</td>
<td>568,878</td>
<td>498,091</td>
<td>475,828</td>
<td>1,078,767</td>
<td>940,376</td>
<td>266,372</td>
</tr>
<tr>
<td>Lao</td>
<td>105,259</td>
<td>46,447</td>
<td>51,336</td>
<td>22,085</td>
<td>13,648</td>
<td>110,854</td>
<td>105,955</td>
<td>11,194</td>
</tr>
<tr>
<td>Cambodia</td>
<td>110,601</td>
<td>43,550</td>
<td>48,362</td>
<td>26,096</td>
<td>12,094</td>
<td>124,761</td>
<td>122,493</td>
<td>17,570</td>
</tr>
<tr>
<td>Total</td>
<td>849,552</td>
<td>629,413</td>
<td>668,576</td>
<td>546,272</td>
<td>501,570</td>
<td>1,314,382</td>
<td>1,168,824</td>
<td>295,136</td>
</tr>
</tbody>
</table>

Source: The Office of Foreign Worker Administration

The Office of Foreign Worker Administration reported that in the year 2005 there was a policy to charge a higher fee to employers who recruited illegal migrant workers for their business with the rate starting at 10,000 Baht up to 50,000 Baht per person. There was a strong negative response by NGOs, so the policy was changed but employers were not aware and so not many migrants were registered. The information also showed that the amount of Cambodian workers decreased from the year 2004 to 2005 around 60.62% as compared to 55.87% of the Laotian workers and 14.88% of the workers from Myanmar.

In the year 2007 and 2008 the cabinet-approved policy moved to a stronger security focus, creating less continuity in the numbers of migrant workers registered. Cambodian migrants proved to be more sensitive than migrants from Laos and Myanmar as the resulting number of migrants registering was reduced 89.07% in the year 2008 from the year 2004, compared to 87.03% from Laos and 24.91% from Myanmar.
The amount of migrant workers increased to a maximum in the year 2009 when there was the exemption of the regulation and an open registration allowed all illegal migrant workers to register. After the year 2009, the impact of the nationality verification process and numbers of migrant workers imported according to the MOU decreased the amount of migrant workers registered in the year 2010. Starting in the end of the year 2010 a security focused policy came into force and started to arrest the unregistered migrant workers, minimizing the amount of registered migrant workers in the year 2011 resulting in only 295,136 migrant workers registering.

The table 4.2 shows the percent of illegal migrant workers who got work permits in the year 2004-2010. Those from Myanmar were the highest number compared to the other two nationalities. The ratio of Laotians and Cambodians in the year 2008 indicated that these two nationalities would be less tolerant to a restrictive policy and less likely to work in Thailand in the future, meaning that those from Myanmar would became the main supply of cheap unskilled workers for Thailand.

Table 4.2 Percentage of Migrant Workers (3 Nationalities) with work permits: 2004-2010

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Myanmar</td>
<td>75%</td>
<td>86%</td>
<td>85%</td>
<td>91%</td>
<td>95%</td>
<td>82%</td>
<td>80%</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>12%</td>
<td>7%</td>
<td>8%</td>
<td>4%</td>
<td>3%</td>
<td>8%</td>
<td>9%</td>
</tr>
<tr>
<td>Cambodia</td>
<td>13%</td>
<td>7%</td>
<td>7%</td>
<td>5%</td>
<td>2%</td>
<td>10%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Source: The Office of Foreign Worker Administration

Trend of the illegal migrant workers and legal migrant workers

The government policy developed by the foreign labor administrative committee aimed to change the illegal migrant workers’ status to semi-legal through annual registration, and then change migrants with the semi-legal status into fully legal through the nationality verification process and the MOU system starting in the year 2005. The outcome of the policy only recently had an impact in the last 2 years. Figure 4.1 shows the number of legal migrants by age for the years 2006-2011.
The number of migrant workers imported through the MOU from Lao PDR and Cambodia in the year 2007 shows the potential effectiveness of this arrangement, however, this system did not work for the MOU between Thailand and Myanmar. This process was not supported during the time when the policy had a greater security focus starting in the year 2007, which also affected the nationality verification process resulting in less imported legal workers in the year 2008 while the numbers through the nationality verification process did not increase.

In the year 2009 the migrant policy moved back towards the economic focus, so the process of nationality verification and imported migrants were promoted again. The obstacle of the MOU between Thailand and Myanmar was overcome so the number of imported migrant workers from Myanmar started to increase in 2009 and rapidly increased in the year 2010 and 2011. The trend pointed to legal migrant workers from Myanmar would become the main source of unskilled migrant workers in Thailand.

2. Rayong Province Situation

2.1 Trend of the migrant workers from Myanmar, Lao PDR and Cambodia in Rayong Province

Table 4.3 shows the information from the Rayong Provincial Health Office that the number of migrant workers who got work permits was 31,690 in the year 2009 and 20,020 in the year 2010.
The greatest decrease in registered migrant workers was 7,920 Cambodians so the ratio of registered migrant workers in Rayong by nationality was Cambodia, Myanmar and Laos respectively 57.28: 32.47: 10.25 in the year 2009, and 51.11: 38.37: 10.52 in the year 2010. Most were male with female workers comprising only 37% of legal migrants workers in the year 2009 and 36% in the year 2010.

### 2.2 Trend of the illegal migrant workers and legal migrant workers in Rayong Province

The amount of legal and semi-legal migrant workers in Rayong Province decreased from 36,134 in the year 2009, to 29,033 in the year 2010 and 19,719 in the year 2011 corresponding with the national trend as shown in Table 4.4.

### Table 4.3 Registered Migrant Workers in Rayong: 2009-2010

<table>
<thead>
<tr>
<th></th>
<th>Male 2009</th>
<th>Female 2009</th>
<th>Total 2009</th>
<th>Male 2010</th>
<th>Female 2010</th>
<th>Total 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myanmar</td>
<td>6,185</td>
<td>4,106</td>
<td>10,291</td>
<td>4,699</td>
<td>2,983</td>
<td>7,682</td>
</tr>
<tr>
<td>Lao</td>
<td>1,732</td>
<td>1,515</td>
<td>3,247</td>
<td>1,117</td>
<td>989</td>
<td>2,106</td>
</tr>
<tr>
<td>Cambodia</td>
<td>12,181</td>
<td>5,971</td>
<td>18,152</td>
<td>6,912</td>
<td>3,320</td>
<td>10,232</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>20,098</td>
<td>11,592</td>
<td>31,690</td>
<td>12,728</td>
<td>7,292</td>
<td>20,020</td>
</tr>
</tbody>
</table>

*Source: Rayong Provincial Health Office.*

### Table 4.4 Legal and semi-legal migrant workers in Rayong during year 2009-2011

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rayong</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>36,134</td>
<td>29,033</td>
<td>19,719</td>
</tr>
<tr>
<td>Legal migrant workers</td>
<td>5,115</td>
<td>8,66</td>
<td>11,018</td>
</tr>
<tr>
<td>Long term work permit</td>
<td>9</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>General work permit</td>
<td>1,086</td>
<td>1,240</td>
<td>1,182</td>
</tr>
<tr>
<td>Nationality Approved</td>
<td>2,081</td>
<td>3,962</td>
<td>6,079</td>
</tr>
<tr>
<td>Imported according to the MOU</td>
<td>293</td>
<td>1,589</td>
<td>1,815</td>
</tr>
<tr>
<td>Investment support</td>
<td>1,646</td>
<td>1,868</td>
<td>1,962</td>
</tr>
<tr>
<td>Illegal</td>
<td>31,019</td>
<td>20,365</td>
<td>8,701</td>
</tr>
<tr>
<td>Ethnic group</td>
<td>168</td>
<td>248</td>
<td>281</td>
</tr>
<tr>
<td>Registered Migrant workers</td>
<td>30,851</td>
<td>20,117</td>
<td>8,420</td>
</tr>
</tbody>
</table>

*Source: Office of Foreign Worker Administration*
The nationality verification process for migrant workers and the import of migrant workers according to the MOU increased as shown in the above table. Most of these two groups of migrant workers are entitled to health services under the social security scheme. The social security benefits do not cover health promotion and disease prevention activities.

The amount of registered migrant workers decreased from 30,851 in the year 2009 to 20,117 in the year 2010 and 8,420 in the year 2011. This situation is problematic for the Rayong Provincial Health Office because the disease prevention and health promotion budget for migrants which is allocated from the registered migrant workers also decreased. The registered migrant worker health insurance fee in the year 2010 was only 65.21% of the budget in the year 2009 and in the year 2011 was only 41.86% of the year 2010.

Even though the amount of legal migrant workers increased during the 3 years, the registered migrant workers decreased as the number of legal migrant workers increased, thus affecting the structure of the health budget.

2.3 The health checkup and health insurance in Rayong Province

The information from Rayong Provincial Health Office in table 4.5 shows that in the year 2009 while 32,030 migrant workers got health checkups there were only 31,690 registered migrant workers who got work permits. Most of them had the checkup in Rayong Hospital 40.64%, with 21.54% in Klang hospital and 12.37% in Bankai hospital respectively. The rest were checked up by 5 other hospitals.

Table 4.5 Migrant Workers with Health Checkup in Rayong categorized by hospitals in year 2009

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Nationality</th>
<th>Total</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Myanmar</td>
<td>Lao</td>
<td>Cambodia</td>
</tr>
<tr>
<td>Rayong</td>
<td>4,927</td>
<td>1,074</td>
<td>7,017</td>
</tr>
<tr>
<td>Klang</td>
<td>1,803</td>
<td>546</td>
<td>4,550</td>
</tr>
<tr>
<td>Ban Kai</td>
<td>1,498</td>
<td>755</td>
<td>1,708</td>
</tr>
<tr>
<td>Banchang</td>
<td>470</td>
<td>190</td>
<td>1,261</td>
</tr>
<tr>
<td>Plukdang</td>
<td>426</td>
<td>69</td>
<td>1,981</td>
</tr>
<tr>
<td>Wangchan</td>
<td>393</td>
<td>198</td>
<td>965</td>
</tr>
<tr>
<td>Koachamou</td>
<td>239</td>
<td>85</td>
<td>95</td>
</tr>
<tr>
<td>Mabtapud</td>
<td>980</td>
<td>258</td>
<td>542</td>
</tr>
<tr>
<td>Total</td>
<td>10,736</td>
<td>3,175</td>
<td>18,119</td>
</tr>
</tbody>
</table>

Source: Rayong Provincial Health Office.
Table 4.6 Migrant Workers with Health Checkup in Rayong categorized by Hospitals in year 2010

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Nationality</th>
<th>Total</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Myanmar</td>
<td>Lao</td>
<td>Cambodia</td>
</tr>
<tr>
<td>Rayong</td>
<td>2,467</td>
<td>753</td>
<td>4,068</td>
</tr>
<tr>
<td>Klang</td>
<td>1,264</td>
<td>272</td>
<td>2,122</td>
</tr>
<tr>
<td>Bankai</td>
<td>650</td>
<td>360</td>
<td>617</td>
</tr>
<tr>
<td>Banchang</td>
<td>299</td>
<td>80</td>
<td>335</td>
</tr>
<tr>
<td>Plukdang</td>
<td>316</td>
<td>32</td>
<td>804</td>
</tr>
<tr>
<td>Wangchan</td>
<td>240</td>
<td>116</td>
<td>279</td>
</tr>
<tr>
<td>Koachamou</td>
<td>113</td>
<td>30</td>
<td>65</td>
</tr>
<tr>
<td>Mabtapud</td>
<td>703</td>
<td>151</td>
<td>219</td>
</tr>
<tr>
<td>Nicompatana</td>
<td>240</td>
<td>54</td>
<td>488</td>
</tr>
<tr>
<td>Total</td>
<td>6,082</td>
<td>1,794</td>
<td>8,609</td>
</tr>
</tbody>
</table>

Source: Rayong Provincial Health Office.

2.4 The Rayong health checkup migrant workers and families age distribution

The distribution of migrant workers age in the year 2009 in Rayong health checkup is shown in figure 4.2 and the year 2010 is in figure 4.3.

The most frequent health checkup migrant age group was 21 years old and the second most common was 26 years old in the year 2009.

Figure 4.2 Amount of Migrant Workers and Families with health checkup by age distribution in Rayong Province year 2009

Source: Rayong Provincial Health Office.

But in the year 2010, the most frequent health checkup migrant age group was 26 years old and the second most common was 21 years old. The age distribution in both years was not normal. The most fre-
quent health checkup age group was 21 years old. The high number of 26 years old showed that those who had immigrated to Thailand when the new registration started in the year 2004 were 21 years old at the time, and thus, five years later showed a similar peak in the number of 26 year olds.

Figure 4.3 Amount of Migrant Workers and Families with health checkup by age distribution in Rayong Province year 2010

There were more newborns in the year 2010 than in the year 2009, but there were few older migrants in both years.

The health checkup by Rayong Province’s hospitals was distributed by month over the year 2009, showing the most frequent checkup was during June to August, and the peak was July (figure 4.4).

Figure 4.4 Amount of Migrant Workers and Families with Health Checkup distributed by month in Rayong in year 2009

The health checkup by Rayong Province’s hospitals was distributed by month over the year 2010, showing the most frequent checkup was during February to April, and the peak was March as shown in figure 4.5.
Figure 4.5 Amount of Migrant Workers and Families with Health Checkup distributed by month in Rayong in year 2010

Source: Rayong Provincial Health Office.

2.5 The result of health checkup in Rayong Province

Table 4.7 Results of Health Checkup in Rayong During Years 2009-2010

<table>
<thead>
<tr>
<th>Migrant Workers Health Results</th>
<th>2009</th>
<th>Percentage</th>
<th>2010</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal (type 1)</td>
<td>26,534</td>
<td>96.26</td>
<td>16,492</td>
<td>95.51</td>
</tr>
<tr>
<td>Need to follow up (type 2)</td>
<td>478</td>
<td>1.73</td>
<td>264</td>
<td>1.53</td>
</tr>
<tr>
<td>Prohibited from work (type 3)</td>
<td>23</td>
<td>0.08</td>
<td>31</td>
<td>0.18</td>
</tr>
<tr>
<td>Pregnancy (type 4)</td>
<td>531</td>
<td>1.93</td>
<td>480</td>
<td>2.78</td>
</tr>
<tr>
<td>Total</td>
<td>27,566</td>
<td>100.00</td>
<td>17,267</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 4.8 Diseases for follow up (type 2) from Health Checkup in Rayong Province 2009-2010

<table>
<thead>
<tr>
<th>Disease needed to follow up</th>
<th>2009</th>
<th>Percentage</th>
<th>2010</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis</td>
<td>54</td>
<td>11.30</td>
<td>10</td>
<td>25.64</td>
</tr>
<tr>
<td>Elephantiasis</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Leprosy</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Syphilis</td>
<td>75</td>
<td>15.69</td>
<td>28</td>
<td>71.79</td>
</tr>
<tr>
<td>Malaria</td>
<td>1</td>
<td>0.21</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Intestinal Parasitic Infection</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other Disease</td>
<td>348</td>
<td>72.80</td>
<td>1</td>
<td>2.56</td>
</tr>
<tr>
<td>Total</td>
<td>478</td>
<td>100</td>
<td>39</td>
<td>100.00</td>
</tr>
</tbody>
</table>
### Table 4.9 Results of Health Checkup with Work Prohibition (type 3) in Rayong during 2009-2010

<table>
<thead>
<tr>
<th>Disease prohibited from work</th>
<th>2009 /amount</th>
<th>percentage</th>
<th>2010 /amount</th>
<th>percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Pulmonary Tuberculosis</td>
<td>13</td>
<td>56.52</td>
<td>3</td>
<td>50</td>
</tr>
<tr>
<td>Elephantiasis present symptom</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Leprosy disgusting period</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Syphilis (phase 3)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Substance Use Disorders</td>
<td>1</td>
<td>4.35</td>
<td>3</td>
<td>50</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Psychosis / Mental Retardation</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>39.13</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>23</strong></td>
<td><strong>100</strong></td>
<td><strong>6</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

### 2.6 HIV and ARV Situation in Rayong Province

The number of people infected with HIV who already are accessing ARV through the government in Rayong Province in the year 2010 is shown in table 4.10. Mostly they were covered by social security scheme (7 cases), universal health care coverage scheme (6 cases), and there was no civil servant medical benefit scheme.

### Table 4.10 Migrants’ Access to ARV in Rayong, year 2010

<table>
<thead>
<tr>
<th>Rayong</th>
<th>HCS (Health Care Scheme)</th>
<th>SSS (Social Security scheme)</th>
<th>CSMBS</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>At present Patient</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Cumulative Patient</td>
<td>6</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>13</td>
</tr>
</tbody>
</table>

*Source: Bureau of Sexually Transmitted Diseases and HIV*
Those infected with HIV who could not access ARV at Rayong province in the year 2010 is shown in table 4.11. Mostly they were under an unknown health scheme or waiting for approval (Thai people 53 cases; unregistered migrant workers 40 cases), or under the health insurance for migrant workers (25 cases).

Table 4.11 Migrants with HIV who could not access ARV at Rayong in year 2010

<table>
<thead>
<tr>
<th>Rayong HIV</th>
<th>Unknown Scheme/ Waiting to Approve</th>
<th>Registered Migrant Workers</th>
<th>Unregistered Migrant Workers</th>
<th>Health Insurance Migrant Workers</th>
<th>Refugee</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>At Present Patient</td>
<td>42</td>
<td>18</td>
<td>33</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>114</td>
</tr>
<tr>
<td>Accumulated Patient</td>
<td>53</td>
<td>21</td>
<td>40</td>
<td>25</td>
<td>0</td>
<td>0</td>
<td>139</td>
</tr>
</tbody>
</table>

Source: Bureau of Sexually Transmitted Diseases and HIV

3. SamutSakhon Province Situation

3.1 Trend of the Migrant workers from Myanmar, Lao PDR and Cambodia in SamutSakhon Province Table

Table 4.12 Amount of Registered Migrant Worker with work permit in Samut Sakhon During Year 2009-2010

<table>
<thead>
<tr>
<th>Nationality</th>
<th>Year 2009</th>
<th>Year 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Myanmar</td>
<td>78,398</td>
<td>69,344</td>
</tr>
<tr>
<td>Lao</td>
<td>3,251</td>
<td>2,549</td>
</tr>
<tr>
<td>Cambodia</td>
<td>1,306</td>
<td>751</td>
</tr>
<tr>
<td>Total</td>
<td>82,955</td>
<td>72,644</td>
</tr>
</tbody>
</table>

Source: Samut Sakhon Provincial Health Office.
### 3.2 Trend of the illegal migrant workers and legal migrant workers in SamutSakhon Province

The amount of legal and semi-legal migrant workers in SamutSakhon Province decreased from 289,531 in the year 2009, to 124,849 in the year 2010 and 58,053 in the year 2011 as shown in table 4.13.

**Table 4.13 The legal and Semi-legal Migrant Workers in SamutSakhon during years 2009-2011**

<table>
<thead>
<tr>
<th>Category</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal migrant workers</td>
<td>289,531</td>
<td>124,849</td>
<td>5,8053</td>
</tr>
<tr>
<td>Long term work permit</td>
<td>39,680</td>
<td>336</td>
<td>18,320</td>
</tr>
<tr>
<td>General work permit</td>
<td>1,191</td>
<td>74</td>
<td>0</td>
</tr>
<tr>
<td>Nationality Approved</td>
<td>8,039</td>
<td>214</td>
<td>200</td>
</tr>
<tr>
<td>Imported according to the MOU</td>
<td>18,530</td>
<td>0</td>
<td>18,077</td>
</tr>
<tr>
<td>Investment support</td>
<td>5,908</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Illegal</td>
<td>6,012</td>
<td>48</td>
<td>43</td>
</tr>
<tr>
<td>Ethnic group</td>
<td>249,851</td>
<td>124,513</td>
<td>39,733</td>
</tr>
<tr>
<td>Registered Migrant workers</td>
<td>1,474</td>
<td>59</td>
<td>31</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>248,377</td>
<td>124,454</td>
<td>39,702</td>
</tr>
</tbody>
</table>

*Source: Office of Foreign Worker Administration*

But the nationality verification migrant workers and imported migrant workers according to the MOU decreased from 8,039 in the year 2009 to 214 in the year 2010 as shown in the table, and decreased from 214 in the year 2010 to 200 in the year 2011. The imported migrant workers according to the MOU decreased from 18,530 in the year 2009 to 0 in the year 2010 then increased back to 18,077 in the year 2011.

The amount of registered migrant workers decreased from 248,377 in the year 2009, to 124,454 in the year 2010, and again to 39,720 in the year 2011. This situation is even more problematic for the Samut Sakhon Provincial Health Office than Rayong because the registered migrant worker’s health insurance fee in the year 2010 was only 50.11% of the budget in the year 2009 and in the year 2011 was only 31.90% of the year 2010 - even worse than Rayong province.
3.3 The health checkup and health insurance in SamutSakhon Province

Table 4.14 Migrant Workers Health Checkup in SamutSakhon by Hospital in Year 2009

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Nationality</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Myanmar</td>
<td>Lao</td>
<td>Cambodia</td>
</tr>
<tr>
<td>SamutSakhon</td>
<td>51,453</td>
<td>1,808</td>
<td>665</td>
</tr>
<tr>
<td>Banpaew</td>
<td>2,140</td>
<td>117</td>
<td>30</td>
</tr>
<tr>
<td>Katumban</td>
<td>17,311</td>
<td>2,016</td>
<td>596</td>
</tr>
<tr>
<td>Srivichai</td>
<td>76,838</td>
<td>1,859</td>
<td>766</td>
</tr>
<tr>
<td>Total</td>
<td>147,742</td>
<td>5,800</td>
<td>2,057</td>
</tr>
</tbody>
</table>

Source: SamutSakhon Provincial Health Office.

Table 4.15 Migrant Workers Health Checkup in SamutSakhon by Hospital in Year 2010

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Nationality</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Myanmar</td>
<td>Lao</td>
<td>Cambodia</td>
</tr>
<tr>
<td>SamutSakhon</td>
<td>46,675</td>
<td>1,183</td>
<td>365</td>
</tr>
<tr>
<td>Banpaew</td>
<td>1,952</td>
<td>60</td>
<td>7</td>
</tr>
<tr>
<td>Katumban</td>
<td>15,528</td>
<td>2,016</td>
<td>596</td>
</tr>
<tr>
<td>Srivichai</td>
<td>57,979</td>
<td>1,060</td>
<td>283</td>
</tr>
<tr>
<td>Total</td>
<td>122,134</td>
<td>3,566</td>
<td>1,130</td>
</tr>
</tbody>
</table>

Source: SamutSakhon Provincial Health Office.

3.4 The SamutSakhon health checkup migrant workers and families age distribution

The distribution of SamutSakhon’s health checkup for migrant workers by age in the year 2009 is shown in figure 4.6, and in the year 2010 showed in figure 4.7.

The most frequent age group for migrant health checkup was 21 years old, and the second most common was 26 years old in the year 2009, the same as Rayong.
Figure 4.6 Migrant Workers Health Checkup by Age distribution in SamutSakhon in year 2009

![Graph showing health checkup by age distribution in SamutSakhon in 2009.](image)

Source: Samut-Sakhon Provincial Health Office.

There were more newborns in the year 2009 than in the year 2010, different from Rayong, and there were few older migrants in both years, the same as Rayong.

The health checkup by SamutSakhon province hospitals distributed by month in the year 2009 showed that the checkup was most frequent during June to August.

Figure 4.7 SamutSakhon Health Checkup Migrant Workers and Families Age’s distribution in year 2010

![Graph showing health checkup by age distribution in SamutSakhon in 2010.](image)
3.5 The results of health checkup in SamutSakhon Province

Table 4.16 Results of Health Checkup in SamutSakhon during Year 2009-2010

<table>
<thead>
<tr>
<th>Amount of Migrant Workers Health Checkup</th>
<th>2009 Amount</th>
<th>Percentage</th>
<th>2010 Amount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal (type 1)</td>
<td>153,626</td>
<td>98.73</td>
<td>124,552</td>
<td>98.20</td>
</tr>
<tr>
<td>Needed to follow up (type 2)</td>
<td>340</td>
<td>0.22</td>
<td>165</td>
<td>0.13</td>
</tr>
<tr>
<td>Prohibited from work (type 3)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pregnancy (type 4)</td>
<td>1,633</td>
<td>1.05</td>
<td>2,113</td>
<td>1.67</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>155,599</strong></td>
<td><strong>100</strong></td>
<td><strong>126,830</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 4.17 Results of Health Checkup with Disease Needed to follow up (type 2) in SamutSakhon during 2009-2010

<table>
<thead>
<tr>
<th>Disease need to follow up</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>number</td>
<td>percentage</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>185</td>
<td>54.41</td>
</tr>
<tr>
<td>Elephantiasis</td>
<td>23</td>
<td>6.77</td>
</tr>
<tr>
<td>Leprosy</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Syphilis</td>
<td>132</td>
<td>38.82</td>
</tr>
<tr>
<td>Malaria</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Intestinal Parasitic Infection</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Disease</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>340</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

There were no cases of “work prohibition” (type 3) found in SumutSakhon in the year 2009-2010.
3.6 HIV and ARV situation in SamutSakhon Province

Those HIV infected patients who already could access ARV at SamutSakhon Province in the year 2010 are shown in table 4.19. Mostly, they were covered by the social security scheme (15 cases), universal coverage of health care scheme (9 cases), civil servant medical benefit scheme (2 cases) and others (3 cases).

Table 4.19 Number of those receiving ARV in SamutSakhon in year 2010

<table>
<thead>
<tr>
<th>SamutSakhon province</th>
<th>HCS (Health Care Scheme)</th>
<th>SSS (Social Security scheme)</th>
<th>CSMBS</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>At present Patient</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Cumulative Patient</td>
<td>9</td>
<td>15</td>
<td>2</td>
<td>3</td>
<td>29</td>
</tr>
</tbody>
</table>

Source: Bureau of Sexually Transmitted Diseases and HIV

The HIV infected patients who could not access ARV in SamutSakhon Province in 2010, shown in table 4.20, were mostly under the health insurance for migrant workers (31 cases), registered migrant workers (25 cases), unregistered migrant workers (17 cases), unknown scheme or waiting for approval (16 cases).

Table 4.20 HIV Patients without Access to ARV in SamutSakhon in year 2010

<table>
<thead>
<tr>
<th>SamutSakhon province</th>
<th>Unknown Scheme/Waiting to Approve</th>
<th>Registered Migrant Workers</th>
<th>Unregistered Migrant Workers</th>
<th>Health Insurance Migrant Workers</th>
<th>Refugee</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>At Present Patient</td>
<td>2</td>
<td>14</td>
<td>10</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>46</td>
</tr>
<tr>
<td>Cumulative Patient</td>
<td>16</td>
<td>25</td>
<td>17</td>
<td>31</td>
<td>0</td>
<td>0</td>
<td>89</td>
</tr>
</tbody>
</table>

Source: Bureau of Sexually Transmitted Diseases and HIV
4. Migrant Workers and Families’ Health Seeking Behavior and Health Care Utilization

4.1 Migrant workers and families’ characteristics in this study

The 1,243 questionnaires for registered migrant workers and unregistered migrants were collected as follows: 643 questionnaires from Rayong Province were mostly Cambodian, and 600 questionnaires from SamutSakhon Province were mostly from Myanmar. The details are shown in Table 4.21

Table 4.21 Characteristics of migrant workers and families in this study

<table>
<thead>
<tr>
<th></th>
<th>Rayong</th>
<th>SamutSakhon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered and Insured</td>
<td>351</td>
<td>477</td>
</tr>
<tr>
<td>Male:Female</td>
<td>140:211 (1:1.50)</td>
<td>221:256 (1:1.16)</td>
</tr>
<tr>
<td>Age</td>
<td>17-56 (mean 30.39)</td>
<td>17-54 (mean 28.66)</td>
</tr>
<tr>
<td>Myanmar: Cambodia</td>
<td>132:219</td>
<td>473:4</td>
</tr>
<tr>
<td>Unregistered and uninsured</td>
<td>292</td>
<td>123</td>
</tr>
<tr>
<td>Male:Female</td>
<td>137:155 (1:1.13)</td>
<td>84:39 (1:0.46)</td>
</tr>
<tr>
<td>Age</td>
<td>13-60 (avg. age 28.8)</td>
<td>14–50 (avg. age 28.70)</td>
</tr>
<tr>
<td>Myanmar: Cambodia</td>
<td>46:246</td>
<td>123</td>
</tr>
</tbody>
</table>

Registered migrant workers were found to have higher income than the unregistered as shown in table 4.22. In Rayong, registered migrant workers’ average income was 5,606 Baht a month, and unregistered migrants’ average income was 4,518 Baht a month. (Independent Samples test, \( t=5.124, \) \( \text{df}=638.113, \) \( p<0.01 \))

Table 4.22 Rayong registered and unregistered migrant workers average income

<table>
<thead>
<tr>
<th>Rayong Migrants</th>
<th>Amount</th>
<th>Averaged Income (Baht) Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
<th>( t )</th>
<th>( p )</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered and Insured</td>
<td>351</td>
<td>5,606.62</td>
<td>3,029.73</td>
<td>161.715</td>
<td>5.124</td>
<td>0.00*</td>
</tr>
<tr>
<td>Unregistered</td>
<td>292</td>
<td>4,518.18</td>
<td>2,353.90</td>
<td>137.752</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Again, the registered migrant workers were found to have higher income than the unregistered migrants as shown in table 4.23. In SamutSakhon, registered migrant workers’ average income was 6,225 Baht per month, and unregistered migrants’ average income was 5,755 Baht. (Independent Samples test, t=3.170, df=165.521, p<0.05)

Table 4.23 SamutSakhon registered and unregistered migrant workers average income

<table>
<thead>
<tr>
<th>Rayong Migrants</th>
<th>Amount</th>
<th>Averaged Income (Baht) Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered and Insured</td>
<td>477</td>
<td>6,225.66</td>
<td>1232.784</td>
<td>56.445</td>
<td>3.170</td>
<td>0.024*</td>
</tr>
<tr>
<td>Unregistered</td>
<td>123</td>
<td>5,755.12</td>
<td>1522.581</td>
<td>137.286</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Most of the migrants and families in Rayong were in Thailand more than 4 years. The 565 migrants who stayed an average 4.13 years could listen and understand Thai. The 78 migrants who stayed an average 2.86 years, could not understand Thai. Overall, the migrants who could listen and understand Thai ended up staying longer than the migrants who could not. (Independent Samples test, t=-5.810, df=641, p<0.01)

The 536 migrants who stayed 4.23 years on average could speak Thai. The 107 migrants who stayed an average 2.75 years could not speak Thai. The migrants who could speak Thai were found to stay longer than the migrants who could not speak Thai as shown in Table 4.24. (Independent Samples test, t=-7.837, df=641, p<0.01)

Table 4.24 Rayong migrants’ Thai literacy and average duration of stay in Thailand

<table>
<thead>
<tr>
<th>Rayong Migrants</th>
<th>Amount</th>
<th>Duration (Avg number of years)</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listen / understand</td>
<td>No</td>
<td>78</td>
<td>2.86</td>
<td>1.771</td>
<td>.201</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>565</td>
<td>4.13</td>
<td>1.824</td>
<td>.077</td>
<td></td>
</tr>
<tr>
<td>Speak</td>
<td>No</td>
<td>107</td>
<td>2.75</td>
<td>1.738</td>
<td>.168</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>536</td>
<td>4.23</td>
<td>1.790</td>
<td>.077</td>
<td></td>
</tr>
</tbody>
</table>

Most of the migrants and families sampled in SamutSakhon stayed in Thailand more than 4 years. The 444 migrants who had stayed an average of 4.52 years could listen and understand Thai. The 156 migrants who had stayed an average 3.01 years could not understand Thai. The migrants who could listen and understand Thai were found to stay longer than the migrants who could not understand Thai (Independent Samples test, t=-10.091, df=598, p<0.01).
The 527 migrants who stayed an average 4.36 years could speak Thai. The 73 migrants who stayed on average 2.41 years could not speak Thai. The migrants who could speak Thai were found to stay longer than the migrants who could not speak Thai as shown in Table 4.25. (Independent Samples test, t=-9.642, df=598, p<0.01).

Table 4.25 SamutSakhon migrants’ Thai literacy and average duration of stay in Thailand

<table>
<thead>
<tr>
<th>Rayong Migrants</th>
<th>Amount</th>
<th>Duration (Year)</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listen / understand</td>
<td>No</td>
<td>156</td>
<td>3.01</td>
<td>1.762</td>
<td>1.762</td>
<td>-10.09</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>444</td>
<td>4.52</td>
<td>1.556</td>
<td>1.556</td>
<td>-9.642</td>
</tr>
<tr>
<td>Speak</td>
<td>No</td>
<td>73</td>
<td>2.41</td>
<td>1.606</td>
<td>1.606</td>
<td>-9.642</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>527</td>
<td>4.36</td>
<td>1.624</td>
<td>1.624</td>
<td>-9.642</td>
</tr>
</tbody>
</table>

4.2 Migrant workers and families realization of insurance benefit packages

Most of the registered migrant workers in Rayong and SamutSakhon were able to realize their medical benefits such as health, accident and emergency services, health promotion and disease prevention. 95% knew that they could use their insurance card for services at the hospital. 92.59% of Rayong registered migrant workers knew their medical services benefit package compared to 87.63% of SamutSakhon registered migrant workers. The details are shown in table 4.26.

Table 4.26 Registered migrant workers knowledge of health benefit packages

<table>
<thead>
<tr>
<th>Benefits package knowledge</th>
<th>Rayong</th>
<th></th>
<th></th>
<th>SamutSakhon</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not know</td>
<td>Know</td>
<td>Not know</td>
<td>Know</td>
<td>Not know</td>
<td>Know</td>
</tr>
<tr>
<td>Bring insurance card to hospital</td>
<td>12 (3.51%)</td>
<td>338 (96.49%)</td>
<td>20 (4.19%)</td>
<td>457 (95.80%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Services</td>
<td>26 (7.40%)</td>
<td>325 (92.59%)</td>
<td>59 (12.37%)</td>
<td>418 (87.63%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health promotion, Disease prevention</td>
<td>106 (30.19%)</td>
<td>245 (69.80%)</td>
<td>133 (27.88%)</td>
<td>344 (72.12%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accident, Emergency</td>
<td>75 (21.36%)</td>
<td>27 (78.63%)</td>
<td>120 (25.16%)</td>
<td>357 (74.84%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Most of the unregistered migrants in Rayong were able to utilize medical, accident and emergency services, health promotion and disease prevention benefits of the insurance. But of the unregistered migrants in SamutSakhon that were able to realize their medical services benefits, more than half of them did not know about the health promotion and disease prevention nor the accident and emergency benefits. Details are shown in table 4.27.

Table 4.27 Unregistered migrant workers knowledge of health benefit packages

<table>
<thead>
<tr>
<th>Benefits package knowledge</th>
<th>Rayong</th>
<th>SamutSakhon</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not know</td>
<td>Know</td>
</tr>
<tr>
<td>Bring the insurance card to hospital</td>
<td>61 (20.89%)</td>
<td>231 (79.11%)</td>
</tr>
<tr>
<td>Medical Services</td>
<td>112 (38.36%)</td>
<td>180 (61.64%)</td>
</tr>
<tr>
<td>Health promotion, Disease prevention</td>
<td>101 (34.59%)</td>
<td>191 (65.41%)</td>
</tr>
</tbody>
</table>

4.3 Migrant workers and families health seeking behavior

When the migrants in Rayong and SamutSakhon suffer minor illness, most treat themselves by purchasing drugs from pharmacies, but some visited the hospital where they are insured when they got minor illness as shown in table 4.28.
Table 4.28 Migrants’ health seeking behaviors for minor illness

<table>
<thead>
<tr>
<th>Health seeking behaviors</th>
<th>Rayong</th>
<th></th>
<th></th>
<th>SamutSakhon</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Insured</td>
<td>Uninsured</td>
<td>Insured</td>
<td>Uninsured</td>
<td></td>
</tr>
<tr>
<td>Rest</td>
<td>20 (5.70%)</td>
<td>41 (14.04%)</td>
<td>32 (6.70%)</td>
<td>9 (7.32%)</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>136 (38.74%)</td>
<td>116 (39.73%)</td>
<td>161 (33.75%)</td>
<td>22 (17.89%)</td>
<td></td>
</tr>
<tr>
<td>Rest and Pharmacy</td>
<td>61 (17.37%)</td>
<td>59 (20.21%)</td>
<td>153 (32.08%)</td>
<td>32 (26.02%)</td>
<td></td>
</tr>
<tr>
<td>Health Center</td>
<td>55 (15.67%)</td>
<td>33 (11.30%)</td>
<td>21 (4.40%)</td>
<td>9 (7.32%)</td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>46 (13.11%)</td>
<td>22 (7.53%)</td>
<td>40 (8.38%)</td>
<td>19 (15.45%)</td>
<td></td>
</tr>
<tr>
<td>Traditional Medicine</td>
<td>3 (0.85%)</td>
<td>5 (1.71%)</td>
<td>18 (3.77%)</td>
<td>10 (8.13%)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>30 (8.55%)</td>
<td>16 (5.48%)</td>
<td>52 (10.98%)</td>
<td>22 (17.87%)</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>351 (100%)</td>
<td>292 (100%)</td>
<td>477 (100%)</td>
<td>123 (100%)</td>
<td></td>
</tr>
</tbody>
</table>

When migrants get a serious illness, 75.51% of those registered migrant workers in Rayong and 51.15% of those in SamutSakhon visited the hospital where they are insured, but only 22.60% of the unregistered migrants in Rayong and 29.70% of those in SamutSakhon visited public hospitals as shown in table 4.29.

Table 4.29 Migrants’ health seeking behaviors for serious illness

<table>
<thead>
<tr>
<th>Health seeking behaviors</th>
<th>Rayong</th>
<th></th>
<th></th>
<th>SamutSakhon</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Insured</td>
<td>Uninsured</td>
<td>Insured</td>
<td>Uninsured</td>
<td></td>
</tr>
<tr>
<td>Health Center</td>
<td>27 (7.40%)</td>
<td>40 (13.70%)</td>
<td>10 (2.09%)</td>
<td>5 (3.06%)</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>10 (2.86%)</td>
<td>52 (17.80%)</td>
<td>15 (3.14%)</td>
<td>14 (10.38%)</td>
<td></td>
</tr>
<tr>
<td>Private Clinic</td>
<td>18 (5.19%)</td>
<td>50 (17.12%)</td>
<td>61 (12.79%)</td>
<td>16 (12.50%)</td>
<td></td>
</tr>
<tr>
<td>Insured/ Public hospitals</td>
<td>258 (73.51%)</td>
<td>66 (22.60%)</td>
<td>244 (51.15%)</td>
<td>39 (29.70%)</td>
<td></td>
</tr>
<tr>
<td>Other/Private hospital</td>
<td>7 (1.99%)</td>
<td>43 (14.74%)</td>
<td>5 (1.05%)</td>
<td>13 (10.56%)</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td>31 (8.85%)</td>
<td>41 (14.04%)</td>
<td>142 (29.77%)</td>
<td>46 (34.39%)</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>351 (100%)</td>
<td>292 (100%)</td>
<td>477 (100%)</td>
<td>123 (100%)</td>
<td></td>
</tr>
</tbody>
</table>
4.4 Migrant workers and families medical services utilization

In Rayong, registered and unregistered migrants average outpatient visits at 2.094 visits/migrant and 2.037 visits/migrant per year respectively, compared to SamutSakhon where registered migrant workers and unregistered migrants average outpatient visits per year were 1.447 visits/migrant and 1.618 visits/migrant respectively. In SamutSakhon Province, 76.94% of the registered migrant workers and 88.61% of unregistered migrants had visited the OPD, and 61.38% of the registered migrant workers but only 31.19% of the unregistered migrants had visited insured or public hospitals. In Rayong Province, 50.14% of the registered migrant workers and 53.08% of unregistered migrants had visited the OPD, and 37.60% of the registered migrant workers but only 8.90% of the unregistered migrants had visited insured or public hospitals. The details are shown in table 4.30.

Table 4.30 Migrant workers and families medical services utilization

<table>
<thead>
<tr>
<th>Health seeking behaviors</th>
<th>Rayong</th>
<th>SamutSakhon</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Insured</td>
<td>Uninsured</td>
</tr>
<tr>
<td>Average OPD utilization/year</td>
<td>2.094</td>
<td>2.037</td>
</tr>
<tr>
<td>Have utilized OPD</td>
<td>176 (50.14%)</td>
<td>155 (53.08%)</td>
</tr>
<tr>
<td>Visited to the insured or public hospital OPD</td>
<td>132 (37.60%)</td>
<td>26 (8.90%)</td>
</tr>
<tr>
<td>Had been admitted to IPD</td>
<td>38 (10.82%)</td>
<td>28 (9.58%)</td>
</tr>
<tr>
<td>Total</td>
<td>351</td>
<td>292</td>
</tr>
</tbody>
</table>

4.5 Migrants medical expenditures

In Rayong Province, 83.76% of the registered migrant workers had paid for medical services in hospitals compared to 47.26% of the unregistered, whereas only 5.48% of them could not fully pay. In SamutSakhon Province, 74.63% of the registered migrant workers had paid for medical services in the hospitals compared to 98.37% of the unregistered and only 8.94% of who could not fully pay.
In Rayong Province, 84.33% of the registered migrant workers paid only 30 Baht and 3.13% paid more than 30 Baht (ranging from 40-3500 Baht), while only 1.71% of the unregistered paid 30 Baht and 38.71% of them paid 50-15,000 Baht. In SamutSakhon Province, 67.92% of the registered migrant workers paid only 30 Baht and only 6.92% paid more than 30 Baht (50-1620 Baht) and 34.69% of the unregistered paid only 30 Baht while 36.58% of them paid 40-3,000 Baht. The details are shown in table 4.31.

Table 4.31 Migrant workers and families medical services expenditure burden

<table>
<thead>
<tr>
<th>Medical services expenditure burden</th>
<th>Rayong</th>
<th>SamutSakhon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured</td>
<td>Uninsured</td>
<td>Insured</td>
</tr>
<tr>
<td>Paid to the hospital (migrants)</td>
<td>294 (83.76%)</td>
<td>138 (47.26%)</td>
</tr>
<tr>
<td>Not fully paid (migrants)</td>
<td>16 (5.48%)</td>
<td>14 (8.94%)</td>
</tr>
</tbody>
</table>

The amount paid to hospitals

<table>
<thead>
<tr>
<th>Migrants who paid 30 Baht / standard fee for insured</th>
<th>Rayong</th>
<th>SamutSakhon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insured</td>
<td>Uninsured</td>
<td>Insured</td>
</tr>
<tr>
<td>Paid to the hospital (migrants)</td>
<td>296 (84.33%)</td>
<td>5 (1.71%)</td>
</tr>
<tr>
<td>Not fully paid (migrants)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Migrants who paid more than</th>
<th>Rayong</th>
<th>SamutSakhon</th>
</tr>
</thead>
<tbody>
<tr>
<td>standard fee for insured</td>
<td>11 (3.13%)</td>
<td>113 (38.71%)</td>
</tr>
<tr>
<td>40-3,500 Baht</td>
<td>50-15,000 Baht</td>
<td>50-1,620 Baht</td>
</tr>
</tbody>
</table>

The average expense for total medical services of registered migrant workers in Rayong was 137.15 Baht/migrant, and for unregistered migrants was 711.70 Baht/migrant. The registered migrant workers were found to have more medical services expenses than the unregistered migrants (Independent Samples test, t=-5.598, df=329.776, p<0.01). The average expense for total medical services of registered migrant workers in SamutSakhon was 73.83 Baht/migrant, and for unregistered migrants was 459.66 Baht/migrant. The registered migrant workers were found to have more total medical services expense than the unregistered migrants (Independent Samples test, t=-8.923, df=124.860, p<0.01).
The average transportation cost to the hospital for registered migrant workers in Rayong was 70.11 Baht/migrant and for unregistered migrants was 64.10 Baht/migrant. The average vehicle cost to the hospital for SamutSakhon registered migrant workers was 42.11 Baht/migrant and 56.50 Baht/migrant for unregistered migrants as shown in table 4.32.

Table 4.32 Average expenses for medical services and transportation, comparing registered and unregistered migrants

<table>
<thead>
<tr>
<th>Expenses</th>
<th>Rayong</th>
<th>SamutSakhon</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Insured</td>
<td>Uninsured</td>
</tr>
<tr>
<td>Drugs, Clinic (Baht)</td>
<td>67.04</td>
<td>175.70</td>
</tr>
<tr>
<td>Hospital expense (Baht)</td>
<td>(0–3,500)</td>
<td>471.90</td>
</tr>
<tr>
<td>Transportation (Baht)</td>
<td>70.11</td>
<td>64.10</td>
</tr>
<tr>
<td>Total expense (Baht)</td>
<td>137.15</td>
<td>711.70</td>
</tr>
<tr>
<td>Total migrants</td>
<td>351</td>
<td>292</td>
</tr>
</tbody>
</table>

Health Care Financing for Migrants 63
5. Migrants HIV Situation in Rayong and SamutSakhon Provinces

5.1 Counseling and VCT

Most of the migrants in Rayong and SamutSakhon Provinces never received counseling for HIV testing. Only 32.19% of the registered migrant workers and 22.94% of the unregistered migrants had been counseled in Rayong, and 9.85% of the registered migrant workers and 15.44% of the unregistered received counseling in SamutSakhon as shown in table 4.33.

Table 4.33 Migrants and HIV Counseling / VCT

<table>
<thead>
<tr>
<th>Medical service</th>
<th>Rayong</th>
<th>SamutSakhon</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Insured</td>
<td>Uninsured</td>
</tr>
<tr>
<td>Received counseling (VCT)</td>
<td>113</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>32.19%</td>
<td>22.94%</td>
</tr>
<tr>
<td>Did not receive counseling</td>
<td>238</td>
<td>225</td>
</tr>
<tr>
<td></td>
<td>67.80%</td>
<td>75.05%</td>
</tr>
<tr>
<td>Total</td>
<td>351</td>
<td>292</td>
</tr>
</tbody>
</table>

In Rayong Province, 59.29% of the registered migrant workers and 55.32% of those unregistered received counseling and VCT from a nurse, but in SamutSakhon Province, 52.24% of the registered migrant workers and 100% of the unregistered who received counseling and VCT did so from a Migrant Health Worker as shown in table 4.34.

Table 4.34 Service Providers of Counseling and VCT for Migrants

<table>
<thead>
<tr>
<th>Counseling and VCT Provider</th>
<th>Rayong</th>
<th>SamutSakhon</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Insured</td>
<td>Uninsured</td>
</tr>
<tr>
<td>Migrant Health Worker</td>
<td>44</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>38.93%</td>
<td>52.24%</td>
</tr>
<tr>
<td>Nurse</td>
<td>67</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>59.29%</td>
<td>47.76%</td>
</tr>
<tr>
<td>Total</td>
<td>113</td>
<td>67</td>
</tr>
</tbody>
</table>
In Rayong, 96.46% of the registered migrant workers and 95.52% of the unregistered migrants consented to an HIV blood test, but in SamutSakhon, 85.10% of the registered migrant workers and 15.79% of the unregistered migrants consented to having an HIV blood test as shown in table 4.35.

Table 4.35 Migrants Consenting to a Blood Test for HIV after Consultation

<table>
<thead>
<tr>
<th>Consultation and VCT provider</th>
<th>Rayong</th>
<th>SamutSakhon</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Insured</td>
<td>Uninsured</td>
</tr>
<tr>
<td>Voluntary Blood test for HIV</td>
<td>109</td>
<td>64</td>
</tr>
<tr>
<td></td>
<td><strong>96.46%</strong></td>
<td><strong>95.52%</strong></td>
</tr>
<tr>
<td>No Blood test for HIV</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Consultation for VCT</td>
<td>113</td>
<td>67</td>
</tr>
<tr>
<td>No Consultation for VCT</td>
<td>238</td>
<td>225</td>
</tr>
</tbody>
</table>

5.2 Access to Antiretrovirals

In Rayong Province, there are 139 migrants reported as being infected with HIV in the year 2010 by Bureau of AIDS, TB and STIs, Department of Disease Control as shown in table 4.36.

Table 4.36 Status of Migrants Infected with HIV in Rayong Province, 2010

<table>
<thead>
<tr>
<th>Rayong</th>
<th>People waiting for proof of citizenship</th>
<th>Migrants with immigration documents</th>
<th>Unregistered migrants</th>
<th>Registered migrants</th>
<th>Refugee</th>
<th>Others</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Patients</td>
<td>42</td>
<td>18</td>
<td>33</td>
<td>21</td>
<td>0</td>
<td>0</td>
<td>114</td>
</tr>
<tr>
<td>Cumulative patients</td>
<td>53</td>
<td>21</td>
<td>40</td>
<td>25</td>
<td>0</td>
<td>0</td>
<td>139</td>
</tr>
<tr>
<td>Total infected patients</td>
<td>95</td>
<td>39</td>
<td>73</td>
<td>46</td>
<td>0</td>
<td>0</td>
<td>253</td>
</tr>
</tbody>
</table>
In the year 2010, the Rayong Provincial Health Office collected information on 141 migrants infected with HIV who receive ARV drugs, where 97 cases (68.79%) receive ARV from the NAPHA project, the rest (44 cases, 31.21%) paid for ARV by themselves as shown in table 4.37.

### Table 4.37 Number of migrants infected with HIV on ARV in Rayong Province, 2010

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Cases</th>
<th>ARV from NAPHA(cases)</th>
<th>Out of pocket (cases)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rayong</td>
<td>110</td>
<td>70</td>
<td>40</td>
</tr>
<tr>
<td>Glang</td>
<td>9</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>Bankai</td>
<td>3</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Pluakdang</td>
<td>4</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Banchang</td>
<td>10</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Wanjan</td>
<td>3</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Maptaput</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Koachamou</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nikompattana</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>141</td>
<td>97 (68.79%)</td>
<td>44 (31.21%)</td>
</tr>
</tbody>
</table>

In SamutSakhon Province, there were 89 migrants infected with HIV in the year 2010 reported by the Bureau of AIDS, TB and STIs, Department of Disease Control as shown in table 4.38.

### Table 4.38 Number of migrants infected with HIV on ARV in SamutSakhon Province, 2010

<table>
<thead>
<tr>
<th>Samut Sakhon</th>
<th>People wait for proof of citizenship</th>
<th>Migrant with immigration documents</th>
<th>Unregistered migrants</th>
<th>Registered migrant</th>
<th>Refugee</th>
<th>Others</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing Patients</td>
<td>2</td>
<td>14</td>
<td>10</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>46</td>
</tr>
<tr>
<td>Accumulated patients</td>
<td>16</td>
<td>25</td>
<td>17</td>
<td>31</td>
<td>0</td>
<td>0</td>
<td>89</td>
</tr>
<tr>
<td>Total infected patients</td>
<td>18</td>
<td>39</td>
<td>27</td>
<td>51</td>
<td>0</td>
<td>0</td>
<td>135</td>
</tr>
</tbody>
</table>
In the year 2010, the SamutSakhon Provincial Health Office collected information on 100 migrants infected with HIV who receive ARV drugs, of which only 63 cases (63%) got ARV from the NAPHA project, while out of the remaining 36 cases only 19 cases could pay for ARV by themselves, and another 18 cases could not afford to pay as shown in table 4.39.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Cases</th>
<th>ARV from NAPHA (cases)</th>
<th>Out of pocket (cases)</th>
<th>Could not afford</th>
</tr>
</thead>
<tbody>
<tr>
<td>SamutSakhon</td>
<td>70</td>
<td>40</td>
<td>15</td>
<td>15</td>
</tr>
<tr>
<td>Kratumban</td>
<td>24</td>
<td>17</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Banpaew</td>
<td>6</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
<td><strong>63</strong></td>
<td><strong>19</strong></td>
<td><strong>18</strong></td>
</tr>
</tbody>
</table>

### Table 4.39 Number of migrants infected with HIV on ARV in SamutSakhon Province, 2010

6. Health Service System and Health Financing for Migrants and Families

The Ministry of Public Health (MOPH) provides a physical health check, health services and health insurance for registered migrant workers according to the year by year cabinet resolution. The fee for physical checkup is 600 Baht, and 1,300 Baht for the health insurance. The Provincial Health Office took responsibility to assign public and private hospitals in each province to provide health and medical services to migrants.

#### 6.1 Health checkup and health insurance income from registered migrants

In Rayong Province, there were 31,690 registered migrants in the year 2009 but there were 31,704 migrants who received a physical checkup and purchased health insurance. After deduction for high cost services and management expenses, the income for Rayong Province was 39,312,960 Baht, of which 28,977,456 Baht was allocated for hospital medical services, 5,224,819 Baht was allocated for hospitals’ health promotion and disease prevention activities, 1,306,205 Baht was allocated for health promotion and disease prevention activities in the Provincial Health Office, and the allocation for management was 3,804,480 Baht as shown in table 4.40.
Table 4.40 Health checkup and health insurance fee and resource allocation in Rayong, 2009

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Physical Checkup/insurance (migrant)</th>
<th>Allocation for Hospitals</th>
<th>Allocation for Provincial Health Office</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medical Services (Baht)</td>
<td>Health promotion/Disease prevention (Baht)</td>
<td>Total hospital Income</td>
</tr>
<tr>
<td>Rayong</td>
<td>12,578</td>
<td>11,498,292</td>
<td>2,072,854</td>
</tr>
<tr>
<td>Glang</td>
<td>7,112</td>
<td>6,500,368</td>
<td>1,172,057</td>
</tr>
<tr>
<td>Bankai</td>
<td>4,211</td>
<td>3,848,854</td>
<td>693,972</td>
</tr>
<tr>
<td>Banchang</td>
<td>1,848</td>
<td>1,689,072</td>
<td>304,550</td>
</tr>
<tr>
<td>Phukdang</td>
<td>2,439</td>
<td>2,229,246</td>
<td>401,947</td>
</tr>
<tr>
<td>Wankan</td>
<td>1,299</td>
<td>1,187,286</td>
<td>214,075</td>
</tr>
<tr>
<td>Koachamou</td>
<td>431</td>
<td>393,934</td>
<td>71,028</td>
</tr>
<tr>
<td>Mapatput</td>
<td>1,786</td>
<td>1,632,404</td>
<td>294,332</td>
</tr>
<tr>
<td>Total</td>
<td>31,704</td>
<td>28,977,456</td>
<td>5,224,819</td>
</tr>
</tbody>
</table>

In the year 2010 in Rayong Province, there were 20,020 registered migrants but there were 17,267 migrants who received a physical checkup and purchased health insurance. After deducting high cost services and management costs, the income for Rayong Province was 21,411,080 Baht, 15,782,038 Baht was allocated to hospitals for medical services, the allocation for health promotion and disease prevention activities in hospitals was 2,845,602 Baht, the allocation for health promotion and disease prevention activities in provincial health office was 711,400 Baht, and the allocation for management was 2,072,040 Baht as shown in table 4.41.
<table>
<thead>
<tr>
<th>Hospital</th>
<th>Physical Checkup/insurance (migrant)</th>
<th>Allocation for Hospitals</th>
<th>Allocation for Provincial Health Office</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Medical Services (Baht)</td>
<td>Health promotion / Disease prevention (Baht)</td>
</tr>
<tr>
<td>Rayong</td>
<td>7,288</td>
<td>6,661,232</td>
<td>1,201,062</td>
</tr>
<tr>
<td>Glang</td>
<td>3,658</td>
<td>3,343,412</td>
<td>602,838</td>
</tr>
<tr>
<td>Bankai</td>
<td>1,657</td>
<td>1,514,498</td>
<td>273,073</td>
</tr>
<tr>
<td>Banchang</td>
<td>714</td>
<td>652,596</td>
<td>117,667</td>
</tr>
<tr>
<td>Phaakdung</td>
<td>1,252</td>
<td>1,144,328</td>
<td>206,329</td>
</tr>
<tr>
<td>Wanjan</td>
<td>635</td>
<td>580,390</td>
<td>104,648</td>
</tr>
<tr>
<td>Koachamou</td>
<td>208</td>
<td>190,112</td>
<td>34,278</td>
</tr>
<tr>
<td>Maptaput</td>
<td>1,073</td>
<td>980,722</td>
<td>176,630</td>
</tr>
<tr>
<td>Nikomputan</td>
<td>782</td>
<td>714,748</td>
<td>128,873.60</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>17,267</td>
<td>15,782,038</td>
<td>2,845,602</td>
</tr>
</tbody>
</table>

In SamutSakhon Province, there were 155,599 registered migrants who underwent the physical checkup and purchased health insurance in the year 2009. After deducting high cost services and management costs, the income for SamutSakhon Province was 192,942,760.00 Baht. Of this, 142,217,486 Baht was allocated for hospital medical services, and the allocation for health promotion and disease prevention activities in hospitals was 25,642,715.20 Baht, of which, Sriwichai 5, a private hospital, got the biggest share. The allocation for health promotion and disease prevention activities in the Provincial Health Office was 6,410,678.80 Baht, and the allocation for management was 18,671,880 Baht as shown in table 4.42.
In Samut Sakhon Province, there were 126,830 registered migrants who underwent the physical checkup and purchased health insurance in the year 2010. After deduction for high cost services and management costs, the income for Samut Sakhon Province was 157,269,200 Baht. Of this, 115,922,620 Baht was allocated for hospital medical services, the allocation for health promotion and disease prevention activities in hospitals was 20,901,584 Baht, of which Sriwichai 5 Hospital got the biggest share, and the allocation for health promotion and disease prevention activities in the Provincial Health Office was 5,225,396 Baht, with 15,219,600 Baht allocated for management as shown in Table 4.43.

Table 4.42 Health checkup and Health insurance fee and resource allocation in SamutSakhon, 2009

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Physical Checkup/insurance (migrant)</th>
<th>Allocation for Hospitals</th>
<th>Allocation for Provincial Health office</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Medical Services (Baht)</td>
<td>Health promotion/ Disease prevention (Baht)</td>
</tr>
<tr>
<td>Samut Sakhon</td>
<td>53,926</td>
<td>49,288,364</td>
<td>8,887,004</td>
</tr>
<tr>
<td>Sriwichai 5</td>
<td>79,463</td>
<td>72,629,182</td>
<td>13,095,302</td>
</tr>
<tr>
<td>Banpaew</td>
<td>2,287</td>
<td>2,090,318</td>
<td>376,897</td>
</tr>
<tr>
<td>Kratumban</td>
<td>19,923</td>
<td>18,209,622</td>
<td>3,283,310</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>155,599</strong></td>
<td><strong>142,217,486</strong></td>
<td><strong>25,642,715</strong></td>
</tr>
</tbody>
</table>

Table 4.43 Health checkup and health insurance fee and resource allocation in SamutSakhon, 2010

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Physical Checkup/insurance (migrant)</th>
<th>Allocation for Hospitals</th>
<th>Allocation for Provincial Health office</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Medical Services (Baht)</td>
<td>Health promotion/ Disease prevention (Baht)</td>
</tr>
<tr>
<td>Samut Sakhon</td>
<td>48,223</td>
<td>44,075,822</td>
<td>7,947,150</td>
</tr>
<tr>
<td>Sriwichai 5</td>
<td>59,322</td>
<td>54,220,308</td>
<td>9,776,265</td>
</tr>
<tr>
<td>Banpaew</td>
<td>2,019</td>
<td>1,845,366</td>
<td>332,731</td>
</tr>
<tr>
<td>Kratumban</td>
<td>17,266</td>
<td>15,781,124</td>
<td>2,845,436</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>126,830</strong></td>
<td><strong>115,922,620</strong></td>
<td><strong>20,901,584</strong></td>
</tr>
</tbody>
</table>

70 Health Care Financing for Migrants
6.2 Medical services and hospital expenditures for migrants in selected hospitals

There were 782 registered migrant workers insured at Nikompattana Hospital in the year 2010. The hospital’s income from migrant health insurance was 843,621.60 Baht, but the hospital provided medical services for 1,973 registered and unregistered migrant visits. The hospital expenditure was 883,602.00 Baht as shown in table 4.42. If the unregistered migrant did not pay for their medical services, the hospital health insurance budget would have been a deficit.

Table 4.44 Medical service and hospitals expenditure for migrants in Nikompattana Hospital, 2010

<table>
<thead>
<tr>
<th>Medical services for migrants from</th>
<th>Hospital visits</th>
<th>Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodia</td>
<td>1,159</td>
<td>566,425</td>
</tr>
<tr>
<td>Cambodia Koh Kong</td>
<td>6</td>
<td>2,248</td>
</tr>
<tr>
<td>Myanmar</td>
<td>659</td>
<td>254,608</td>
</tr>
<tr>
<td>Laos</td>
<td>149</td>
<td>60,321</td>
</tr>
<tr>
<td>Total</td>
<td>1,973</td>
<td>883,602</td>
</tr>
</tbody>
</table>

There were 685 registered migrant workers insured at Wangjan Hospital in the year 2010. The hospital health insurance income was 685,038 Baht, but the hospital provided medical services for 2,220 registered and unregistered migrant visits. The hospital expenditure was 752,744 Baht, but only 449 visits were the registered migrant worker utilization and caused the hospital a deficit of about 137,957 Baht as shown in table 4.45.

Table 4.45 Medical service and hospitals expenditure for migrants in Wangjan Hospital, 2010

<table>
<thead>
<tr>
<th>Medical services for migrants from</th>
<th>Wangjan Medical Services Provision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Registered Migrants (Visits)</td>
</tr>
<tr>
<td>Cambodia</td>
<td>224</td>
</tr>
<tr>
<td>Cambodian Koh Kong</td>
<td>1</td>
</tr>
<tr>
<td>Myanmar</td>
<td>148</td>
</tr>
<tr>
<td>Laos</td>
<td>76</td>
</tr>
<tr>
<td>Total</td>
<td>449</td>
</tr>
</tbody>
</table>
All hospitals in SamutSakhon Province combined, provided medical services for 104,785 OPD visits by migrants in the year 2009 (287 visits/day). This increased to 140,673 OPD visits (385 visits/day) in the year 2010. There were 5,831 IPD admissions (18,400 hospital days) in the year 2009, and this increased to 6,349 IPD admissions (28,248 hospital days) as shown in table 4.46.

Table 4.46 Medical services for migrants in SamutSakhon Province, 2010

<table>
<thead>
<tr>
<th>Year</th>
<th>OPD (Visits)</th>
<th>OPD Visits/day</th>
<th>Hospital IPD admissions</th>
<th>Hospital days for IPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>104,785</td>
<td>287</td>
<td>5,831</td>
<td>18,400</td>
</tr>
<tr>
<td>2010</td>
<td>140,673</td>
<td>385</td>
<td>6,349</td>
<td>28,248</td>
</tr>
</tbody>
</table>

SamutSakhon Hospital’s medical services expenditure in the year 2009 was 19,674,669 Baht for registered migrants, and 6,061,986 Baht for the unregistered migrants who were unable to pay for medical services. The total expenditure for providing medical services to migrants that year was 25,736,655 Baht.

Kratumban Hospital’s medical services expenditure in the year 2009 was 3,131,405 Baht for registered migrants, and 2,378,848 Baht for the unregistered migrant who were unable to pay for medical services. The total expenditure for providing medical services to migrants that year was 5,510,253 Baht.

Banpaew Hospital’s expenditure for registered migrants was 828,658 Baht, and Srijwichai 5 hospital was 42,662,233 Baht. So the total expenditure for health services for registered and unregistered migrants in SamutSakhon was 74,737,799 Baht as shown in table 4.47.

Table 4.47 Hospital expenditures for medical services to migrants in SamutSakhon Province, 2009

<table>
<thead>
<tr>
<th>Hospital</th>
<th>(1) Expenditure for registered migrants (Baht)</th>
<th>(2) Expenditure for unregistered migrants and those unable to pay (Baht)</th>
<th>(3=1+2) (Baht)</th>
<th>(4) Unregistered migrants paid for medical services (Baht)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SamutSakhon</td>
<td>19,674,669</td>
<td>6,061,986</td>
<td>25,736,655</td>
<td>1,778,928</td>
</tr>
<tr>
<td>Kratumban</td>
<td>3,131,405</td>
<td>2,378,848</td>
<td>5,510,253</td>
<td>550,080</td>
</tr>
<tr>
<td>Banpaew</td>
<td>828,658</td>
<td>0</td>
<td>828,658</td>
<td>1,736,791</td>
</tr>
<tr>
<td>Srijwichai 5</td>
<td>42,616,854</td>
<td>45,379</td>
<td>42,662,233</td>
<td>1,026,442</td>
</tr>
<tr>
<td>Total</td>
<td>66,251,586</td>
<td>8,486,213</td>
<td>74,737,799</td>
<td>5,092,241</td>
</tr>
</tbody>
</table>
Medical services expenditure by the SamutSakhon Hospital in the year 2010 was 14,567,908 Baht for registered migrants and 1,214,909 Baht for the unregistered migrants who were unable to pay for the medical services, making the total expenditure for providing medical services to migrants 15,782,817 Baht in 2010.

Kratumban Hospital's medical services expenditure in the year 2010 was 2,787,201 Baht for registered migrant and 1,297,777 Baht for the unregistered migrant who were unable to pay for medical services, making the total expenditure for providing medical services to migrants 4,084,978 Baht.

In 2010, the Banpaew Hospital expenditure for registered migrants was 962,722 Baht and Sriwichai 5 Hospital was 65,089,190 Baht. So in 2010, SamutSahkon Province's total expenditure for registered and unregistered migrants was 85,919,707 Baht as shown in table 4.48.

Table 4.48 Hospital expenditures for medical services to migrants in SamutSakhon Province, 2010

<table>
<thead>
<tr>
<th>Hospital</th>
<th>(1) Expenditure for registered migrants (Baht)</th>
<th>(2) Expenditure for unregistered migrants and those unable to pay (Baht)</th>
<th>(3=1+2) (Baht)</th>
<th>(4) Unregistered migrants paid for medical services (Baht)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SamutSakhon</td>
<td>14,567,908</td>
<td>1,214,909</td>
<td>15,782,817</td>
<td>17,396,501</td>
</tr>
<tr>
<td>Kratumban</td>
<td>2,787,201</td>
<td>1,297,777</td>
<td>4,084,978</td>
<td>798,123</td>
</tr>
<tr>
<td>Banpaew</td>
<td>962,722</td>
<td>0</td>
<td>962,722</td>
<td>1,956,267</td>
</tr>
<tr>
<td>Sriwichai 5</td>
<td>64,827,882</td>
<td>261,308</td>
<td>65,089,190</td>
<td>706,279</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>83,145,713</strong></td>
<td><strong>2,773,994</strong></td>
<td><strong>65,089,190</strong></td>
<td><strong>20,856,170</strong></td>
</tr>
</tbody>
</table>

7. Focus Group and In-depth Interview Results

The following are results of the focus groups and interviews with provincial health administrators, migrant health personnel, migrant health workers, provincial labor administrators, and employers.
7.1 Medical service area for migrants in the hospital

The hospital services area for migrants was limited to a confined space because the provision of services for this group of people was unexpected and unplanned. Rayong Hospital tried to solve the problem by arranging OPD services at the four corners of Rayong City for Thai people. They could not provide medical services for migrants in this way because of the limited number of Migrant Health Workers and issues of documentation. The hospital did separate the ANC clinic for migrants in the main hospital so that the Migrant Health Workers could be pooled at the migrant ANC clinic to assist with communication and provide health literacy. There were many complaints from the Thai population because they needed to visit the four corners OPD before they could get services at the Rayong Hospital.

In SamutSakhon Hospital there were 7,500 admissions and 200 OPD visits per day from migrants in the year 2010. Myanmar migrant OPD visits were 10.8% of the total OPD visits. The IPD, especially for child deliveries, averaged 3,000 migrant cases per year, overloading the ANC clinic, labor room and the obstetrics ward. This made Thai people seeking medical services irritable, which had a negative impact on the perception of migrants as reflected in local newspapers and monks, where there were statements like Thai people got poorer services than migrants in hospitals.

7.2 Communication and the role of Migrant Health Workers

Migrant Health Workers are migrants who can communicate in the Thai language and could read and write in their own language, and were often times more educated than average migrant laborers. After completing a training program, their roles included interpretation, communication, primary care health counseling, supporting hospital activities such as health promotion, disease prevention, and follow up as well as having a specialized role in assisting with HIV counseling and VCT.

In Rayong Province, most of the migrants who stayed in Thailand more than 1 year could speak and understand Thai language. Rayong Hospital hired Migrant Health Workers, who were migrants, using their own revenue, but the Glang Hospital, using revenue from the Provincial Health Office hired Migrant Health Workers who were Thai and could speak Cambodian and Burmese. Overall it was assessed that there was the ability to communicate with migrants in Rayong.

The migrant health workers effectively assisted health service providers and the Provincial Health Office in providing public health activities, especially the Thai migrant health workers. For example, when there was a migrant case that tested positive for elephantiasis in one of the hospitals, the employer could not find him, but the Thai Migrant Health Worker could and helped provide...
treatment. Unfortunately, the Migrant Health Workers mentioned that their role of taking care of both the Thai and migrant communities, acting as translators and outreach overloaded their workload, so they were exhausted.

There were only three Migrant Health Workers in the Rayong Hospital - 2 Cambodians and 1 Burmese. They followed the migrant cases in the community by mobile telephone and through their networks in the communities, but many migrants frequently changed their phone numbers.

In SamutSakhon Province there were many courses on Thai language for migrants so they could speak and understand Thai, and some could clearly sing the Thai National Anthem. Most of the hospitals in this province hired Migrant Health Workers for communication and to support public health activities. The Migrant Health Workers at the Banpaew Hospital had already resigned though. The number of Migrant Health Workers in SamutSakhon Province is shown in table 4.49.

Table 4.49 Migrant Health Workers in SamutSakhon Province according to hospitals

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Migrant Health Workers (persons)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SamutSakhon</td>
<td>18</td>
</tr>
<tr>
<td>Kratumban</td>
<td>1</td>
</tr>
<tr>
<td>Banpaew</td>
<td>-</td>
</tr>
<tr>
<td>Sriwichai</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>28</strong></td>
</tr>
</tbody>
</table>

The Ministry of Labor representative in SamutSakhon Province commented that the migrants’ Thai literacy would become a security issue because they could understand the Thai employers’ discussions but the employers did not understand their employees. Now there are Burmese language courses in SamutSakhon so that Thai people who need to work with migrants could communicate, with the community college now giving language courses.

The Migrant Health Workers in SamutSakhon worked initially as volunteer health workers, progressively advancing by participating in a variety of public health activities for example, home visit, interpretation, and co-operation with Thai Health Volunteers. Migrant Health Workers were hired under the regulation that allowed migrants to be hired as social workers under the list of 19 occupational categories specified by the Ministry of Labor regulation. This allowed public organization such as provincial court and schools to hire migrant workers as requested.
7.3 Health promotion and disease prevention

Disease prevention programs are important for migrants because some migrants may carry contagious diseases that have been controlled in Thailand with them from their country of origin. Another important activity is follow-up with those who are infected with a communicable disease to ensure proper treatment and that the disease is not disseminated to other migrants or the Thai population.

In Rayong Province, the health promotion and disease prevention activities for migrants were priorities, and there was cooperation with NGOs working in the area in order to refer cases to each other. The most difficult challenge to address was the high mobility of migrants, especially those who worked in temporary jobs from other provinces.

For example, there was a cholera outbreak on December 2009, when 30-40 migrants and 2 Thais working on a fishing boat from Pattani Province were the source of infection. There were 2 deaths before the boat arrived at Rayong because there was no treatment on the boat. When the boat docked, the cholera infection spread and was found in the Rayong River. The Epidemic Bureau, Ministry of Public Health was called in to control the infection. During the 2009 Flu epidemic in Thailand, there was an epidemic in Rayong where most of the cases were students and workers. There have also been a couple of cases of death from Malaria among migrants in Rayong Province.

The health personnel in SamutSakhon Province reported that the migrants’ health seeking behaviors were different from Thai people, for example, they never missed an ANC appointment; they believed the hospital staffs and their Migrant Health Workers very much; and they supported each other not to forget any appointments for the hospital. Migrants with pulmonary Tuberculosis also never missed an appointment to receive their drugs. This support and positive behavior included the Well Baby Clinic too. Employers and migrant workers supported other migrants with pulmonary Tuberculosis to get full treatment, as compared to Thai cases which regularly resulted in loss follow up. Even when migrant cases suffered drug allergy symptoms such as jaundice they did not stop taking their medication, but the Thai cases would not tolerate even small symptoms from Tuberculosis medication and would discontinue the medication. The main problem with migrants’ adherence related to their mobility as they changed employers but without the new employers realizing the migrant worker was infected with TB.

The SamutSakhon Provincial Health Office delegated hospitals responsibilities for health promotion and disease prevention activities in their coverage areas. The SamutSakhon Hospital took care of the Meung District, except for Tasai District which was taken care of by Sriwichai 5, while
the Kratumban Hospital took care of the Kratumban District and Banpaew hospital took care of the Banpaew District.

The SamutSakhon Provincial Labor authority proposed that the Provincial Health Office inform them when there were cases where infected migrants needed continuous medication so they could help to support the migrants for continuous medication. The employers’ representatives proposed that migrants should not change employers for 1 year because they already paid for the migrants’ health checkup, health insurance and work permit fee.

The Sriwichai 5 and SamutSakhon Hospital provided activities at the workplaces, providing knowledge about the common diseases among migrants. Employers could request activities from the two hospitals. The hospitals provided knowledge and vaccination for migrants in communities. There was a cholera epidemic incident in the year 2010, where infected migrant workers from other provinces arrived in SamutSakhon for the shrimp peeling temporary work. Most arrived at night and worked until morning then moved to another workplace. Most of them were unregistered, so it was very difficult to control and helped contribute to the creation of a health surveillance system for migrants.

### 7.4 Referral system for migrants

Rayong Province set the criteria for referral of migrant cases within the province and made the payment rate 700 Baht per OPD referral visit and 9,000 Baht per RW referral admission. The National Health Security Office rate was only 7,300 Baht for Universal Coverage referral admission. In the case of cross provincial referral of migrant cases, Rayong Province would pay the referral hospital’s price. Most migrant cases were referred to Rajvithi Hospital and Chantaburi Hospital. Rayong Province also claimed the high cost cases to the Insurance Division, Office of Permanent Secretary, Ministry of Public Health, but most claims were incomplete.

SamutSakhon Province referred migrant cases to private hospitals or the Children’s National Institute without problem. This was often the case with migrants moving to another district, as they developed a system to change contracted hospitals in other districts according to the migrants’ needs. The migrant referral system was the same as Thai referral system, where the contracted hospital took responsibility to pay for the treatment in the referral hospitals according to that hospital's rate. The high cost cases were covered by the high cost revenue from the Insurance Division, Office of Permanent Secretary, Ministry of Public Health, but most of the migrants could be treated by the contracted hospitals.
7.5 Adequacy of health insurance fee

Rayong Health Provincial Offices and hospital personnel commented that the 1,300 Baht health insurance fee and 600 Baht health checkup fee were adequate to provide services to the registered migrant workers because the migrants rarely got sick. The problem in this province was that unregistered migrants burdened the health service system because they were more severely ill when coming for treatment and needed more expensive treatment compared to registered migrant workers.

In Rayong migrants who were injured in accidents and were registered and insured from private hospitals were sent to Rayong Hospital. When Rayong Hospital claimed for medical services from the contracted hospital, the contract hospital did not pay.

The Rayong Social Security Organization reported that there were more migrant workers with Nationality Verification and those legally imported according to the MOU. These two groups of migrant workers should be under the social security system except for the fishing and agriculture industries.

The employers representatives were unwilling to co-operate with the Social Security System because migrants were too mobile and changed employers, and because the Social Security System was too complicated, with monthly deductions from migrant’s salary sent to the Social Security Office, and the benefits package needing a formal request. The employers preferred to support the compulsory health insurance by the Ministry of Public Health, and thought that even unregistered migrants should be insured under this scheme. Some employers pooled the 1,300 Baht per migrant together to pay for their unregistered migrants’ medical services bill when the hospital did not provide health insurance for the unregistered migrants.

The SamutSakhon Hospital’s personnel reported that complicated migrant cases preferred to insure at SamutSakhon Hospital. The normal labor cost 3,000 Baht, so the 1,300 Baht health insurance fee was worth it. The chronically ill migrants preferred to insure at SamutSakhon. The 1,300 Baht health insurance fee was adequate if it did not include medical services for unregistered migrants who could not afford to pay.

The employers were willing to pay a little bit more for the health insurance fee according to specific groups of migrants, and would like to see better quality of medical services for the migrants in public hospitals for example for pregnancy or chronic diseases.

The migrants believed that child delivery in Thailand was safer for mother and child than in their own countries, so they planned to have two children while working in Thailand.
The Rayong Provincial Health Office preferred the Social Security Scheme because of the less frequent visits. Compared to other schemes, the compulsory health insurance for migrant workers and the Universal Coverage health care were the worst systems because they paid by medical services cost, and therefore the hospitals lost money. This was problematic for undocumented migrants receiving services as well.

The Social Security officer reported that most of the social security beneficiaries at Rayong Province also purchased insurance from private hospitals as they preferred to seek medical services from private hospitals more than the contracted hospitals under the social security system, resulting in less cases than average.

SamutSakhon Province preferred the Compulsory Health Insurance for migrants because the income was higher than the cost of services delivered. Some private hospitals that focused on the Social Security System started to lose money. The Universal Coverage health care scheme caused all hospitals losses.

Both Rayong and SamutSakhon would like to maintain the compulsory health insurance for migrants (1,300 Baht for health insurance fee and 600 Baht for health checkup fee) because of better management, better benefits package and because costs are covered. The scheme also provides flexibility with health promotion and disease prevention programs, and flexibility in allocating resources in response to the provincial context. The scheme also supports Migrant Health Workers, who proactively provide health promotion and disease prevention services in the migrant communities and workplaces.

Most health providers believed that the health insurance fee was adequate and could cover a good part of fees incurred by services for unregistered migrants.

Out of the disease prevention and health promotion budget that comes from the migrant compulsory health insurance, which is 206 Baht, the Rayong Provincial Health Office apportions 80% (164.80 Baht) of the budget and the related responsibilities to the hospitals, keeps 20% (41.20 Baht) and keeps all 120 Baht of the administrative budget.
The SamutSakhon Provincial Health Office apportions 95% of the prevention and promotion budget to the hospitals and keeps 5% of the 206 Baht, and keeps all of the 120 Baht of the administrative budget.

### 7.8 Problems with systems management

The security organizations, such as the National Police, separated security policies without integration with other ministries. The police policy included arresting 2,600 migrants within 3 months at SamutSakhon Province, and similar targets for other provinces. In some provinces the police arrested migrants seeking medical services in front of the hospital so they could meet their target.

The Provincial Health Office lacked authority to take responsibility for this important problem, even though there were more and more migrants and more and more risks for Thai people.

The inadequate provision of ARV for migrants infected with HIV was another problem, as there was no budget to support either registered or unregistered migrants. So, the hospitals bore the burden in order for HIV infected migrants to access ARV.

There was complete HIV data available at the provincial, but these reports were only sent to different central organizations. For example, the 506/1 report was sent to the Epidemic Bureau, the CD4 results was reported to the AIDS TB and STIs Bureau, and the HIV cases under the Universal Coverage Health Care scheme were reported to the National Health Security Office. Similarly, HIV cases that were beneficiaries under the Social Security scheme were reported to the Social Security Organization.
1. Migrant knowledge and understanding of health insurance benefits and rights

1.1 Knowledge and understanding gap
There was evidence demonstrated by Junthai Tragoondee, Uraiwan Tantariya, Chirawat Nijante, and also Samrit Srithamrongsawat that there was knowledge and understanding gaps among migrant workers and families in these areas including the following:

1.1.1 Family planning, reproductive health, women's health
1.1.2 General knowledge on self care
1.1.3 Human trafficking, Violence
1.1.4 Human rights to access and treat equally by health services providers

These knowledge gaps impacted on migrant workers and families health status as evidence showed a high prevalence rate of many communicable diseases and behavioral induced diseases.

1.2 There was evidence by Kritiya Archavanichakul, et al., Apichat Gamrad-ritirong and Watinee Boonchalaksi and also the IOM that the health risk behaviors and knowledge gaps could be filled through providing improved communications and appropriate education to migrant workers and families so that they could change their lifestyle and improve healthy behaviors such as condom usage and safe sex, etc.

1.3 This study found that the registered migrant workers in Rayong and Samut Sakhon Provinces realized their medical services benefits as high as 92.59% and 87.63% respectively, and 96.49% and 95.80% of them understood that they needed to bring their health card to identify themselves at the hospitals. However, 21.36% and 25.16% of them did not know about the accident and emergency benefits and 30.19% and 27.88% did not know about the health promotion and disease prevention benefits, which were very important to reduce the health risks and decrease communicable diseases dissemination.

Even 79.11% and 75.61% of the unregistered migrants in Rayong and Samut Sakhon Provinces knew of the medical services benefits. In Rayong Province, 65.41% of the unregistered migrants knew of the accident and emergency benefits, and 61.64% of them knew of the health promotion and disease prevention benefits, as compared to in Samut Sakhon Province where only...
47.97% knew of the accident and emergency benefits, and 37.39% of them knew about the health promotion and disease prevention benefits.

1.4 Communication problems of migrant workers and families' have decreased as more than half of those in this study could understand and speak Thai. This study also showed that the average duration of migrant workers and families stay in Thailand was more than 5 years and the migrant's Thai literacy was significant related to the average duration to stay in Thailand at 95% confidence.

1.5 Although migrants' Thai literacy was improved in Rayong and SamutSakhon Provinces, the hospitals and provincial health offices still hired the migrant health workers using the health insurance fee to assist with co-ordination, communication and supporting public health activities in communities. In this way they effectively worked as one of the public health team, freeing the NGOs of the need to hire migrant health workers for the hospitals and the Provincial Health Offices in these provinces.

1.6 The information from the focus groups at Rayong and SamutSakhon Provinces supported the research of Kritiya Archavanichakul et al, Aphichat Chamratrithirong and Watinee Boonchaluksi and also the IOM, which reported that migrants' knowledge gaps and health risk behaviors could be improved. This study showed that the migrants' health behaviors were better than Thai people's, especially pregnant migrants who needed to attend ANC, as they attended regularly, and those with pulmonary Tuberculosis who needed continuous medication but never missed their follow up or stopped their medication, even when they had drug reactions. The migrants also supported each other in following up for ANC and getting medication as per their appointment.

2. Health and medical services seeking behavior.

2.1 Sompong SaKaeo in SamutSakhon (6), Busarat Kanchanadit (8) reported the obstacle of health and medical seeking of the migrant workers and families included the following.

2.1.1 The migrant workers and families' attitudes caused obstacle as the ill migrants rarely visited to health service delivery unit, mostly they were self-treated by purchasing drugs from the drug store until their symptoms were severe; and then they visited private clinics. If not improved, then they would go to the public health delivery units such as health centers and hospitals.
2.1.2 The main obstacles preventing access to the public hospital were unfamiliarity, fear, lack of awareness of their health insurance rights, and lack of Thai language skills.

2.1.3 Long distances to the hospital added extra expense for travel costs that were prohibitive.

2.1.4 Extra cost of Medical services and Health Services according to service and facility.

This study supported Sompong SaKaeo and Busarat Kanchanadit’s finding that 56.11% of registered migrant workers and 59.94% of unregistered migrants in Rayong Province would purchase drugs from pharmacies for minor illness. In SamutSakhon Province, 65.83% of the registered migrant workers and 43.91% of unregistered migrants would purchase drugs from pharmacies for minor illness because of the convenience. But when they were seriously sick, their health seeking behavior changed with 73.51% and 51.15% of the registered migrant workers in Rayong and SamutSakhon Provinces visiting the hospital, but only 22.60% and 29.70% of the unregistered migrants in Rayong and SamutSakhon Provinces visiting the hospital.

This study showed evidence that different researches had similar findings that the obstacles of migrants’ health and medical seeking behaviors could be overcome, including Thai literacy, transportation costs and also migrants’ attitudes. This study found that most of the migrants could understand and speak Thai, most of them knew their right as the insurance card holders, such as they could access to the hospital for medical services with just 30 Baht payment, and that hospitals provided Migrant Health Workers to help with communication. The study also showed that the average cost of transportation to the hospital for registered and unregistered migrants was 70.11 Baht per visit and 64.10 Baht per visit respectively in Rayong Province, and 42.11 Baht per visit and 56.50 Baht per visit in SamutSakhon Province, which were within reasonable limits.

2.2 Another finding of this study was Thai attitudes of being reversely discriminated against by health care workers. The result of focus groups showed that in Rayong Province, the Rayong Hospital separated migrants’ ANC from the Thai so they could provide migrant health workers and also foreign language documents and signs for migrants; and the migrants could access Rayong hospital directly compared to Thai patients who need to be screened at the 4 corners clinics before visiting the Rayong Hospital. Thai people were not happy with this discrimination and felt that migrants got better services. In SamutSakhon Province, the medical services were delivered to the migrants as same as Thai patients except emergency, so the local mass media wrote satire about this because of the hospital treat Thai and migrants equally.
2.3 The information from the focus group in Rayong and SamutSakhon Provinces found that most of the hospitals would like to provide medical services to the migrants using the compulsory health insurance for migrants from the Ministry of Public Health.

2.4 The Security Government Officers were the main obstacle for health and medical seeking of migrants as found in other studies. The focus groups in Rayong and SamutSakhon Provinces showed that most of the migrants and families had money extorted by police, even when ill and on the way to the hospital.

3. Health and medical utilization patterns and the difference between the insured and uninsured.

3.1 There was evidence Sarinya Pungpan, et al (11) Uraiwan Tantariya(4) showed that the social security workers and migrant workers and families got illness by preventable, communicable diseases and dangerous diseases such as pulmonary tuberculosis, HIV more than other groups of patients. This study found that there were 146 HIV infected migrant cases compared to 5,315 total cases in Rayong Province and there were 32 pulmonary Tuberculosis migrant cases in the year 2009 and 44 cases in the year 2010. The average registered and unregistered migrants OPD visit were 2.094 visits/migrant and 2.037 visits/migrant respectively, compared to 1.447 visits/migrant and 1.618 visits/migrant in SamutSakhon Province.

3.2 This study found that 84% of the registered migrant workers in Rayong Province paid 30 Baht/visit and only 3.13% of them paid more than 30 Baht, around 40-3,500 Baht, but that 67.92% of the registered migrant workers in SamutSakhon Province paid 30 Baht/visit and 6.92% of them paid more than 30 Baht, around 50-1,620 Baht. The registered migrant workers in Rayong paid average 67.04 Baht/migrant for medical services plus transportation costs to the hospital of 70.11 Baht/migrants, so the average total cost was 137.15 Baht/migrant. The registered migrant workers in SamutSakhon Province paid an average 31.72 Baht/migrant for medical plus transportation costs to the hospital that was 42.11 Baht/migrants, so the average total cost was 73.83 Baht/migrant. In Rayong, 38.71% of the unregistered migrants paid around 50-15,000 Baht, they paid 175.70 Baht for drug costs and 471.90 Baht for hospital costs, and 64.10 Baht for transportation costs so that the average total cost was 711.70 Baht/migrants. In SamutSakhon, 36.58% of the unregistered migrants paid around 40-3,000 Baht, they paid 281.36 Baht for drug cost and 121.80 Baht for hospital cost and also 56.50 Baht for vehicle cost so the average total cost was 459.66 Baht/migrants. When compared between the registered and the unregistered migrants, this study found that the registered migrant workers paid less than the unregistered significantly at 95% confidence. Only
5.48% and 8.94% of the unregistered migrants in Rayong and SamutSakhon province paid partially so the hospital bore their burdens.

4. Financial management model and health services provided by provincial health offices and hospitals, recommendations to improve effectiveness according to the registered and unregistered migrants context.

4.1 Report of Kritiya Archavanichakul, et al and Samrit Srithamrongsawat, et al, demonstrated that the access to health care for registered migrant workers has improved over time for both outpatient and inpatient services so these caused burden to the hospitals. The finding in this study supported those researches. The migrant OPD visit in SamutSakhon Province increased from 104,785 visits in the year 2009 to 140,673 visits in the year 2010 and IPD admission increased from 18,400 hospital days to 28,248 hospital days in the year 2010. The migrants medical services expense in SamutSakhon province was 74,737,799 Baht in the year 2009 and increased to 85,919,707 in the year 2010, even though the registered migrant workers decreased from 155,599 in the year 2009 to 126,830 in the year 2010.

4.2 This study showed that the small hospitals in the area where there were less registered than unregistered migrants would be the most trouble, for example Nikompattana hospital which had 782 registered migrant workers in the year 2010 and received health insurance fee about 843,621.60 Baht, but the hospital needed to provide 1,973 visits to all of the migrants who were mostly unregistered. The hospital expenditure was 883,602 Baht, so the health insurance fee nearly covered medical services for registered and unregistered migrants. The study showed that only 5.48% of the unregistered migrants in Rayong province could partly pay so most of the unregistered could pay for the medical services fee to the hospitals. This information demonstrated that the hospitals financial problem was not initiated by the medical services for unregistered migrants and families. Another small hospital, Wangjan hospital had 635 registered migrants so the hospital got 685,038.00 Baht as the health insurance fee in the year 2010. The medical services were provided to 449 visits of registered migrant workers so the expense was 137,957 Baht and 2,220 visits of unregistered migrants, so the expense was 752,744 Baht, but most of the unregistered migrants could pay out of pocket.

The health insurance fee could cover all cost to provide medical services for registered migrant workers and unregistered migrants in every hospital in SamutSakhon Province, except Sriwichai 5 Hospital that reported 64,827,882 Baht expenditure in the year 2010 increased from 42,616,854 Baht in the year 2009. The Sriwichai 5 hospital lost 831,308.40 Baht in the year 2010 but gained 43,107,830.40 Baht in the year 2009.
This study concluded that the health insurance fee for registered migrant workers could cover the costs of medical services for registered and unregistered migrants. The hospitals that provide health and medical services for migrants increase workload burden but not financial burden.

4.3 This study found that the trend of the migrants and families would move in these directions.

4.3.1 Migrants from Myanmar will increase but those from Laos and Cambodia will decrease or be stable because of the rapid GDP growth in these 2 countries compared to Myanmar. The political conflict between Thailand and Cambodia affected the amount of Cambodian migrants in Thailand.

4.3.2 The registered migrant workers were being forced to enter the Nationality Verification process or legally imported through the MOU by the Thai government policy, so the registered migrant worker were shifting into the social security scheme.

4.3.3 The unregistered migrants in Rayong and SamutSakhon increased. This study showed that the registered migrant worker were decreased the nationality verification migrants and legally imported migrants according to MOU were not increased even though the labor requirement in these 2 province would be higher. There was evidence that there were more unregistered migrants using medical services at every hospital in these 2 provinces, which meant that there were more unregistered migrants.

4.4 There were two main health insurance schemes for these migrants.

4.4.1 Social security scheme according to the social security act 1987 and amended in the year 1991 and 1996. This scheme states that a legal migrant worker who is an employe of the legal formal employer needs to be under the social security system.

The advantage of the social security system included the medical services, labor, injury, disability, work related injuries and disability, cash compensation for unemployment, death and pension benefits. The system was well established and well structured and also had significant finances. The problems are that there are gaps in the amount of time it takes for benefits to kick in related to the contribution period. Prevention and promotion services are not included in the medical services benefits. There are long-term benefits that migrants who stay a short time would not receive, such as retirement. The major problem was that most of the migrant workers work in the informal sector so they are not eligible to be covered by the social security scheme.
4.4.2 Compulsory health insurance by MoPH according to the cabinet resolution year by year. The advantage of this scheme includes the flexibility and ability to adjust services to the provincial context. Most of the participants were familiar with this scheme including the registered migrants, hospitals, provincial health office, NGO, etc. The hospitals and the provincial health offices were autonomous to manage the finance system. The scheme also had resources for health promotion and disease prevention.

The problems include the financial burden of the number of unregistered migrants. The benefits do not cover work-related disability and death; there was no compensation for unemployment compensation and also other long term and cash benefits. Also, the scheme depends on the cabinet resolution year by year.

4.4.3 Samrit Srithamongsawat, et al (7) proposed that the universal coverage of health care scheme should be appropriate to these migrant workers and families, because this scheme already helped the poor and provided equal access to services. The scheme receives a government budget so the migrants and families had no need to pay, but the government would bear the burden.

There was no definition for individuals by the national health insurance act 2003 so the application of this scheme to cover migrants needs to identify 'individual' by other laws. However, all other laws do not endorse individual status of other nationalities and non-Thais, and the budget bureau does not want to bear the burden of migrants. The scheme was rigid and inflexible compared to the compulsory health insurance by MoPH, so it is very difficult to apply this scheme for the migrants at this moment.

4.5 Many researches (7, 41,25,46,21,53,22,55,56) proposed the preferable health insurance and health service system for migrants and families as consisting of the following characteristics.

- Sustainable long term policy and management.
- A comprehensive health care financial system which could cover registered and unregistered migrant workers and families.
- Increase the coverage of the compulsory health insurance by MoPH.
- Improve the information system to be more integrated and share as a network.
- The work permission fee and other fees should not be too expensive for migrants and families.
- The registration, the work permission and also the health checkup and health insurance should be opened for access throughout the year.
• The system should be flexible to adjust according to the provincial context.
• Health and medical services should include family planning and sexual and reproductive health.
• The financial management guidelines should be provided to the Provincial Health Office.
• The migrants’ individual, families and communities self care and participation in health should be promoted.
• Multi-sectoral, multi-ministry approach using private and public participation and also migrants and family should be encouraged for cooperation.
• Update regulations and adjust to fit each provincial context and promote law enforcement.

It was also recommended to avoid the following situations.
• Security focused policy.
• Increase in fees such as registration fee, work permit fees, health insurance and health checkup fee.
• Increase steps and make the process too complicated or create obstacle to access.
• The employers refuse to co-operate.

4.6 The information from focus group in this study showed that most of the provincial health offices, hospitals, employers, and migrants would like to continue the compulsory health insurance by MoPH. No one agreed to apply the universal coverage of health care scheme for migrants and families.

4.7 The desirable model for appropriate health insurance and health service system to provide health and medical services for registered and unregistered migrants and families was considered among the compulsory health insurance scheme by MoPH, the social security scheme and the universal coverage of health care scheme.

After comparing the three schemes, the compulsory health insurance by the MoPH was more flexible by allowing the Provincial Health Office and hospitals to adjust according to the provincial context to be adjusted to meet the “desirable” model as shown in table 5.1.
### Table 5.1 The desirable model compared among 3 migrant health insurance schemes

<table>
<thead>
<tr>
<th>Objective of desirable model</th>
<th>Universal coverage of health care scheme</th>
<th>Social security scheme</th>
<th>Compulsory health insurance scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>There would be sustainable long term policy and management.</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>The comprehensive health care financial system which could cover registered and unregistered migrant workers and families.</td>
<td>No</td>
<td>No</td>
<td>Possible</td>
</tr>
<tr>
<td>Improve the compulsory health insurance by MoPH to have more coverage.</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Improve the information system to be more integrated and sharing among networks.</td>
<td>No</td>
<td>No</td>
<td>Possible</td>
</tr>
<tr>
<td>The work permission fee and other fee should not be too expensive for the migrants and families.</td>
<td>No</td>
<td>No</td>
<td>Less Burden</td>
</tr>
<tr>
<td>The registration, the work permission and also the health checkup and health insurance should be open for access throughout the year.</td>
<td>No</td>
<td>Yes</td>
<td>Possible</td>
</tr>
<tr>
<td>The system should be flexible to adjust according to the provincial context.</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>The health and medical services should include family planning and sexual and reproductive health.</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>The financial management guidelines should be provided to the Provincial Health Office.</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>The migrants’ individual, families and communities self care and participation should be promoted.</td>
<td>Possible</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Multisectoral, multi-ministry approach, including private and public participation and also migrants and family should be integrated and encouraged</td>
<td>No</td>
<td>No</td>
<td>Possible</td>
</tr>
<tr>
<td>Update the regulation and adjust to each provincial context and also promote law enforcement.</td>
<td>No</td>
<td>No</td>
<td>Possible</td>
</tr>
</tbody>
</table>
4.8 The undesirable characteristics of the desirable model should be prevented. After comparing the three schemes, the compulsory health insurance by MoPH was more flexible and open so the scheme could be adjusted to prevent the desirable characteristic as shown in table 5.2.

**Table 5.2 The undesirable characteristics of the migrant health insurance model**

<table>
<thead>
<tr>
<th>Undesirable characteristic</th>
<th>Universal coverage of health care scheme</th>
<th>Social security scheme</th>
<th>Compulsory health insurance scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Security focused policy.</td>
<td>Possible</td>
<td>Possible</td>
<td>Possible</td>
</tr>
<tr>
<td>Increase fee such as registration fee, work permission fee, health insurance and health checkup fee.</td>
<td>No</td>
<td>Yes</td>
<td>Possible</td>
</tr>
<tr>
<td>Increase steps and make too complicated process or obstacle to access.</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>The employers deny to co-operate</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

4.9 Other suggestions to improve the health insurance and health service system for registered and unregistered migrants and families were shown in the following items.

4.9.1 Develop employers to voluntarily support and participate in the health promotion and disease prevention for migrant workers and families. The results of the focus group showed that the employers were willing to co-operate and support treatment and follow up of sick migrants who need regular treatment. The guideline and information sharing should be done and could reduce high mobility among migrants.

4.9.2 The migrant health workers should have a role starting with the health checkup so they can provide information and knowledge and also improve health literacy of the registered migrant workers to prevent diseases.

4.9.3 The sharing risk management system should be implemented at the provincial level to mitigate the hospitals which bear burden from the outnumbered unregistered migrants.
5. The access of ARV for HIV infected migrants should be expanded.

5.1 The study showed that there were 67.80% of registered migrants and 75.05% of unregistered migrants in Rayong Province, and 88.67% of registered migrants and 84.55% of unregistered migrants in SamutSakhon Province who did not get counseling and VCT. Most of the migrants, 96.46% and 95.52%, of the registered and unregistered migrants in Rayong Province and 85.10% of the registered but only 15.79% of unregistered in SamutSakhon province who received counseling and VCT consented to an HIV blood test, reducing the possibility of those testing positive to access ARV drugs on a timely fashion. There was no chance to get the ARV drugs for the migrants who did not access counseling and VCT unless the signs and symptoms of HIV infection were manifest.

5.2 The migrants' financial burden of paying for ARV drugs was demonstrated in the study. 68.79% of the HIV infected migrants (97) in Rayong Province got ARV drugs from the NAPHA Project, but 31.21% of them (44) paid out of pocket for ARV drugs. In SamutSakhon Province, 63% of the HIV infected migrants (63) got ARV drugs from the NAPHA Project but 18% of them (18) did not get treatment, and 19% of them (19) paid out of pocket for ARV drugs. So the information from AIDs TB and STIs Bureau was different from Rayong and SamutSakhon Provinces, but the NAPHA Project still could not provide ARV drugs for all HIV infected migrants who needed them.

5.3 The possibility to improve the accessibility of ARV drugs for HIV infected migrants.

• The integrated information system should be developed, linked and shared among the ministerial and provincial levels.
• The counseling and VCT should be promoted to increase the chance for HIV blood testing, and would increase the chance to access for ARV drugs. This study showed that the migrant health workers could provide effective and efficient consultation and VCT, so the NGOs and migrant health workers should be strengthened to fill these gaps.
• An inadequate amount of ARV drugs are provided by the NAPHA Project. This study found that the HIV infected migrants in Rayong Province bore burden of the ARV drugs expense by themselves, and the unregistered migrants in Rayong and SamutSakhon could pay out of pocket for their own medical services expenses and very few paid partially. So one of the possibilities to increasing access to ARV drugs among HIV infected migrants is the establishment of the effective and efficient system to sharing risk and pooling resources among migrants to support ARV drugs for those migrants who are infected but unable to access ARV through the public schemes.
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Appendix A

Questionnaire Thai Version
ภาคผนวก ก

แบบสัมภาษณ์ชุดที่ 1

การสอบถามแรงงานข้ามชาติ (ผู้ถิ่นที่มา)

(รหัสจังหวัด) (รหัสอำเภอ) รหัสโรงพยาบาล

[ ] [ ] [ ] [ ] [ ]

เลขที่แบบสัมภาษณ์ [ ] [ ] [ ]

แบบ A สำหรับแรงงานข้ามชาติที่มีใบอนุญาตทำงาน

โปรดระบุชื่อในช่องว่างหรือใส่เครื่องหมายลงในช่องที่ตรงกับความเป็นจริงของผู้ตอบ

ข้อมูลทั่วไป
1. ผู้ให้สัมภาษณ์ ชื่อ นามสกุล ..................................................
2. เพศ  [ ] ชาย  [ ] หญิง
3. สัญชาติ  [ ] พม่า  [ ] กัมพูชา
4. การใช้ภาษาของตนเอง  [ ] อ่านไม่ออกเขียนไม่ได้  [ ] อ่านออก  [ ] เขียนได้
5. การใช้ภาษาไทยในการพูด  [ ] พูดไม่ได้  [ ] พูดได้
   การฟัง  [ ] ฟังไม่รู้เรื่อง  [ ] ฟังรู้เรื่อง
6. ท่านทำงานอยู่ในประเทศไทยมาเป็นปี  [ ] 1 ปี [ ] 2 ปี [ ] 3 ปี [ ] 4 ปี [ ] 5 ปีมากกว่า 5 ปีขึ้นไป
7. ที่พำคาดี [ ] โรงงาน / สถานีจิ้น  [ ] ที่อยู่ส่วนตัว  [ ] ที่อยู่กับเพื่อน  [ ] ที่อยู่กับญาติ
8. สมาชิกที่อาศัยอยู่ด้วยกัน (ระบุรายละเอียด ของคนนั้น) .......
9. สมาชิกที่อาศัยอยู่ด้วยกันมีมีมาตรฐานสุขภาพหรือไม่?  [ ] มี  [ ] ไม่มี  .......
10. สมาชิกที่อาศัยอยู่ด้วยกันมีตัวตนที่เกี่ยวข้องกับท่านโดยเป็น  [ ] พ่อแม่ [ ] เพื่อน [ ] สามี/ภรรยา [ ] ญาติ
    (ข้อ 10 ตอบได้มากกว่า 1 ข้อ)

ข้อมูลการทำงาน
11. ประเภทของการทำงานตามใบอนุญาตอยู่ในกลุ่มอาชีพใด ระบุ ........................................
12. ปีที่ผ่านมา (พ.ศ.2553) ท่านได้ทำงานมาแล้วครั้ง [ ] ไม่เคย
    [ ] ครั้งละ 1 ครั้ง / ปี [ ] ครั้งละ 2 ครั้ง / ปี [ ] ครั้งละ 3 ครั้ง / ปี [ ] มากกว่า 3 ครั้ง / ปี
13. สาเหตุที่ท่านทำงานอยู่ข้ามชาติ  [ ] มีงานทำอยู่ [ ] ขาดงานในเมือง [ ] ขาดงานในบ้าน [ ] ขาดงานในต่างประเทศ
14. ท่านได้รับค่าจ้างเดือนละเท่าไร ระบุ [ ] บาท

ข้อมูลด้านสุขภาพและพฤติกรรมการใช้บริการ
15. ถ้ามีโรคประจำตัว  [ ] ไม่  [ ] มี ถ้ามีโรคอะไร ระบุ  [ ] พบโรคต่าง ๆ
16. ท่านมีโรคประจำตัวหรือไม่?  [ ] ไม่มี  [ ] มี ถ้ามีโรคมีอะไร  [ ] ขาดงานในบ้าน [ ] ขาดงานในต่างประเทศ

100 Health Care Financing for Migrants
ถ้าเคยนอนรักษาตัวในโรงพยาบาลในรอบปีที่ผ่านมา ท่านรู้จักพนักงานสาธารณสุขต่างด้าวเมื่อท่านไม่สบายมากยากินที่ได้มาจากโรงพยาบาลในรอบปีที่ผ่านมา ถ้าท่านเคยไปตรวจโรคที่กินยาไม่หมดเพราะพนักงานสาธารณสุขต่างด้าวเมื่อท่านไม่สบายเล็กน้อยท่านคิดว่าโรงพยาบาลรักษาโรคหายหรือไม่ การนอนรักษาตัวในโรงพยาบาลในครั้งนี้หมดอาทิตย์ โรงพยาบาลที่ประกันสุขภาพไว้และระบบปัสสาวะไปที่โรงพยาบาลที่ประกันสุขภาพไว้ ไปตรวจที่คลินิกระดูกไปที่โรงพยาบาลที่ประกันสุขภาพไว้ ไปตรวจที่คลินิกกระเพาะอาหารไปที่โรงพยาบาลอื่นๆ ท่านป่วยกี่ครั้ง ท่านเคยนอนรักษาตัวในโรงพยาบาล(PD)หรือไม่ ท่านเคยนอนรักษาตัวในโรงพยาบาล(POD)หรือไม่ พยาบาลได้ให้คำแนะนำการปฏิบัติตัวตอนป่วยหรือไม่ ท่านเคยนอนรักษาตัวในโรงพยาบาล(POD)หรือไม่ พยาบาลได้ให้คำแนะนำการปฏิบัติตัวตอนป่วยหรือไม่ ท่านเคยนอนรักษาตัวในโรงพยาบาล(POD)หรือไม่ พยาบาลได้ให้คำแนะนำการปฏิบัติตัวตอนป่วยหรือไม่
ต้องได้รับบริการให้คำปรึกษา (VCT)เพื่อเจาะเลือดตรวจเชื้อเอดส์หรือไม่?
☑ ไม่ได้ ตอบข้อ 35 ตอบข้อ 33,34

ถ้าท่านเคยได้รับค่าปรึกษา (เพื่อเจาะเลือดตรวจเชื้อเอดส์) ท่านได้รับจากใคร?
☑ พนักงานสาธารณสุขต่างด้าว (พสต./อสต.)
☑ พยาบาล

หลังจากที่ท่านได้รับคำปรึกษา (VCT)แล้ว ท่านยินยอมเจาะเลือดตรวจเชื้อเอดส์หรือไม่?
☑ ไม่ยอม ตอบข้อ 38

ความรู้ความเข้าใจในสิทธิประโยชน์ของการมีบัตรประกันสุขภาพ

ท่านมีบัตรประกันสุขภาพของโรงพยาบาลอะไร? ระบุชื่อโรงพยาบาล

35.

ท่านมีบัตรประกันสุขภาพ 1,300 บาท และเงินสำรองสุขภาพบางกล่องไปออม เมื่อสิ้นสุดงบประมาณ 600 บาท (รวม 1,900 บาท)

36.

ใช้เป็นบุคคลที่มี (ตอบข้อ 37) บริษัทประกันสุขภาพ ( บัตรใดไปตอบข้อ 38 )

37.

ถ้ามีการจ่ายเงินให้โรงพยาบาล ท่านจ่ายไปเท่าไร? ระบุจำนวนเงิน

38.

ท่านทราบหรือไม่ว่า เมื่อไปรับบริการที่โรงพยาบาลท่านต้องนั่งรถไปโรงพยาบาลเพื่อเจ็บป่วย หรือไม่?
☑ ไม่ทราบ ตอบข้อ 40

40.

ท่านทราบหรือไม่ว่า เมื่อไปรับบริการที่โรงพยาบาล ท่านต้องจ่ายเงินไม่เกิน 100 บาท ระยะสั้นเริ่มต้น

41.

ท่านทราบหรือไม่ว่า เมื่อไปรับบริการที่โรงพยาบาล ท่านต้องจ่ายเงินไม่เกิน 300 บาท ระยะยาวเริ่มต้น

ความรู้ความเข้าใจในสิทธิประโยชน์ของการมีบัตรประกันสุขภาพ

ท่านทราบหรือไม่ว่า เมื่อไปรับบริการที่โรงพยาบาล มีการจ่ายเงินให้โรงพยาบาลอย่างไร?

42.

ท่านทราบหรือไม่ว่า เมื่อไปรับบริการที่โรงพยาบาล มีการจ่ายเงินให้โรงพยาบาลอย่างไร?

43.

ท่านทราบหรือไม่ว่า เมื่อไปรับบริการที่โรงพยาบาล มีการจ่ายเงินให้โรงพยาบาลอย่างไร?

44.

ท่านทราบหรือไม่ว่า เมื่อไปรับบริการที่โรงพยาบาล มีการจ่ายเงินให้โรงพยาบาลอย่างไร?

45.

ท่านทราบหรือไม่ว่า เมื่อไปรับบริการที่โรงพยาบาล มีการจ่ายเงินให้โรงพยาบาลอย่างไร?

46.

ท่านทราบหรือไม่ว่า เมื่อไปรับบริการที่โรงพยาบาล มีการจ่ายเงินให้โรงพยาบาลอย่างไร?

47.

ท่านทราบหรือไม่ว่า เมื่อไปรับบริการที่โรงพยาบาล มีการจ่ายเงินให้โรงพยาบาลอย่างไร?

48.

ท่านทราบหรือไม่ว่า เมื่อไปรับบริการที่โรงพยาบาล มีการจ่ายเงินให้โรงพยาบาลอย่างไร?

49.

ท่านทราบหรือไม่ว่า เมื่อไปรับบริการที่โรงพยาบาล มีการจ่ายเงินให้โรงพยาบาลอย่างไร?
ชื่อผู้เก็บข้อมูลการอัปฉาณ์  นาย/นาง/นางสาว……………………………………………………
เก็บข้อมูลที่ชุมชน...............หมู่ที่............... ตำบล...............อำเภอ...............
ลงชื่อ นาย/นาง……………………………………...ที่หน้าที่ล่าง

หมายเหตุ : modified from Health Seeking Behavior and Health System response Model

Health Care Financing for Migrants 103
แบบสัมภาษณ์ชุดที่ 2
การสอบถามแรงงานข้ามชาติ (พม่า/กัมพูชา)

แนวข้อ เจาะลึกแรงงานและผู้ดูแลที่ไม่มีใบอนุญาตทำงานมีตอนหรือไม่มีติดป้ายประกันสุขภาพ
โปรดเติมในช่องว่างหรือใส่เครื่องหมาย / ในช่องที่ตรงกับความเป็นจริงของผู้ตอบ

1.  pleas fill the answers. ชื่อ นามสกุล ............................................................
2. เพศ □ชาย □หญิง ............................. ปี
3. สัญชาติ □พม่า □กัมพูชา
4. การใช้ภาษาของตนเอง □อ่านไม่ออกเขียนไม่ได้ □อ่านออก เขียนได้
5. การใช้ภาษาไทยในการพูด □พูดไม่ได้ □พูดได้
6. การฟัง □ฟังไม่รู้เรื่อง □ฟังรู้เรื่อง
7. ที่ทำงานอยู่ในประเทศไทยมากี่ปี? □1 ปี □2 ปี □3 ปี □4 ปี □5 ปี □มากกว่า 5 ปีขึ้นไป
8. สมาชิกที่อาศัยอยู่ด้วยกัน (รวมผู้ถูกสัมภาษณ์ด้วย) ................. คน
9. สมาชิกที่อาศัยอยู่ด้วยกันมีบัตรประกันสุขภาพหรือไม่? □มี ............. คน □ไม่มี ............ คน
10. สมาชิกที่อาศัยอยู่ด้วยกันมีบัตรประกันสุขภาพหรือไม่? □มี ............. คน □ไม่มี ............ คน

ข้อมูลการทำงาน
11. ประเภทของงานที่ทำอยู่ปัจจุบัน ระบุ ............................................................
12. ในปีที่ผ่านมา(พ.ศ.2553) ท่านทำงานมาอยู่ที่กี่ครั้ง □ไม่เคย □เคยครั้ง 1 □เคยครั้ง 2 □เคยครั้ง 3 □เคยครั้ง 4 □เคยครั้ง 5 □มากกว่า 5 ครั้งขึ้นไป (ตอบได้มากกว่า 1 ข้อ)
13. สาเหตุที่ท่านทำงานมาอยู่ที่กี่ครั้ง □งานจ่ายเงินดี □จ่ายเงินดีขึ้นไป □ช่วงเวลาที่รู้จะดี □เวลาที่รู้จะดีขึ้นไป (ตอบได้มากกว่า 1 ข้อ)
14. ท่านได้รับการให้ตัวเลือกในการทำงานมากี่ครั้ง? □ไม่เคย □เคยครั้ง 1 □เคยครั้ง 2 □เคยครั้ง 3 □เคยครั้ง 4 □มากกว่า 3 ครั้ง
15. ท่านเคยถูกส่งตัวกลับไปประเทศตนเองหรือไม่? □ไม่เคย □เคยครั้ง 1 □เคยครั้ง 2 □เคยครั้ง 3 □มากกว่า 3 ครั้ง
16. หากเคยถูกส่งตัวกลับไปประเทศตนเองหรือไม่? □ไม่เคย □เคยครั้ง 1 □เคยครั้ง 2 □เคยครั้ง 3 □มากกว่า 3 ครั้ง

ข้อมูลสุขภาพและพฤติกรรมการใช้บริการ
17. หากมีโรคร้ายจริงหรือไม่? □ไม่มี □มี □ที่นี้ระบุโรค □บางท่าน □ความดื้อต่อสุรา □โรคหัวใจ □เบาหวาน �□โรคกระเพาะอาหาร □โรคระบบทางเดินหายใจ □โรคหลอดเลือด �□โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคฝีผิว □โรคกระเพาะอาหาร □โรคระบบทางเดินหายใจ □โรคหลอดเลือด �□โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้อักเสบ □โรคระบบทางเดินหายใจ □โรคผิวหนัง □โรคหัตถการได้
19. ในรอบปีที่ผ่านมา (2553) ท่านป่วยกี่ครั้ง?

- 1 ครั้ง
- 2 ครั้ง
- 3 ครั้ง
- 4 ครั้ง
- 5 ครั้ง
- มากกว่า 5 ครั้งขึ้นไป

20. ในรอบปีที่ผ่านมา (2553) ท่านเคยไปตรวจโรค (OPD) แบบผู้ป่วยนอกบ้างหรือไม่?

- ไม่เคย
- เคย (ถ้าเคยตอบข้อ 18, ตอบได้หลายข้อ)

21. ถ้าเคยท่านไปตรวจและรักษาโรคกี่ครั้ง?

- 1 ครั้ง
- 2 ครั้ง
- 3 ครั้ง
- 4 ครั้ง
- 5 ครั้ง
- มากกว่า 5 ครั้งขึ้นไป

22. ถ้าท่านเคยที่จะตรวจและรักษาโรคแบบผู้ป่วยนอก ท่านไปที่ใด?

- โรงพยาบาลส่งเสริมสุขภาพตําบล (รพสต./สอ)
- คลินิคเอกชน
- โรงพยาบาลที่ประกันสุขภาพไว้
- โรงพยาบาลอื่นๆ

23. เมื่อท่านไม่สบาย ท่านตัดสินใจดูแลตนเองอย่างไรบ้าง?

- นอนพักเฉยๆ (ถ้ามีแล้วตอบข้อ 24, 25, 26)
- ไปหาพสต./อสต.
- ไปโรงพยาบาลส่งเสริมสุขภาพตําบล (รพสต./สอ)
- ไปคลินิคเอกชน
- ไปโรงพยาบาลที่ประกันสุขภาพไว้
- ไปโรงพยาบาลอื่นๆ (ข้อ 22 ตอบได้หลายคำตอบ)

24. เมื่อท่านไม่สบาย ท่านตัดสินใจดูแลตนเองอย่างไร?

- นอนพักเฉยๆ (ข้อ 23 ตอบได้หลายคำตอบ)
- ไปหาพสต./อสต.
- ไปโรงพยาบาลส่งเสริมสุขภาพตําบล (รพสต./สอ)
- ไปคลินิคเอกชน
- ไปโรงพยาบาลที่ประกันสุขภาพไว้
- ไปโรงพยาบาลอื่นๆ (ข้อ 22 ตอบได้หลายคำตอบ)

25. ถ้าท่านไม่สบายมาก ท่านตัดสินใจดูแลตนเองอย่างไร?

- นอนพักเฉยๆ (ข้อ 23, 24 ตอบได้หลายคำตอบ)
- ไปหาพสต./อสต.
- ไปโรงพยาบาลส่งเสริมสุขภาพตําบล (รพสต./สอ)
- ไปคลินิคเอกชน
- ไปโรงพยาบาลที่ประกันสุขภาพไว้
- ไปโรงพยาบาลอื่นๆ (ข้อ 22 ตอบได้หลายคำตอบ)

26. เมื่อท่านไม่สบายมาก ท่านตัดสินใจดูแลตนเองอย่างไร?

- นอนพักเฉยๆ (ข้อ 23, 24 ตอบได้หลายคำตอบ)
- ไปหาพสต./อสต.
- ไปโรงพยาบาลส่งเสริมสุขภาพตําบล (รพสต./สอ)
- ไปคลินิคเอกชน
- ไปโรงพยาบาลที่ประกันสุขภาพไว้
- ไปโรงพยาบาลอื่นๆ (ข้อ 22 ตอบได้หลายคำตอบ)

27. ในรอบปีที่ผ่านมา ท่านติดต่อเพื่อนบ้านหรือไม่?

- ไม่เคย (ข้อ 28, 29, 30, 31)

28. ถ้าเคยติดต่อเพื่อนบ้าน ท่านติดต่อเพื่อนบ้านกี่ครั้ง?

- 1 ครั้ง
- 2 ครั้ง
- 3 ครั้ง
- 4 ครั้ง
- 5 ครั้ง
- มากกว่า 5 ครั้งขึ้นไป

29. การติดต่อเพื่อนบ้านที่ได้รับเกี่ยวกับโรคเป็นอะไร?

- ไม่ทราบ
- ทราบ .......................

30. หน่วยงานที่ได้รับการติดต่อกับเพื่อนบ้านเกี่ยวกับโรคเป็นอะไร?

- ไม่ได้มี
- ได้มี ...........................

31. ในช่วงเวลาที่ได้รับการติดต่อกับเพื่อนบ้านเกี่ยวกับโรคเป็นอะไร?

- ไม่ได้มี
- ได้มี ...........................

32. ในช่วงเวลาที่ได้รับการติดต่อกับเพื่อนบ้านเกี่ยวกับโรคเป็นอะไร?

- ไม่ได้มี
- ได้มี ...........................

33. ในช่วงเวลาที่ได้รับการติดต่อกับเพื่อนบ้านเกี่ยวกับโรคเป็นอะไร?

- ไม่ได้มี
- ได้มี ...........................

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34. ท่านได้รับบริการให้คำปรึกษา (VCT) เพื่อจะได้เลือกตรวจชื่อเธอหรือไม่? ไม่ได้ (ตอบขอ 35, 36)

35. ท่านเคยได้รับบริการ (VCT) เพื่อจะได้เลือกตรวจชื่อเธอท่านได้รับจากใคร? พนักงานสาธารณสุขต่างด้าว (พสต./อสต.) พยาบาล

36. หลังจากที่ท่านได้รับคำปรึกษา (VCT) เหล่านี้ ท่านยินยอมเจาะเลือดตรวจหาเชื้อแอดส์หรือไม่? ไม่ยอม ยอม

37. เมื่อท่านป่วยไปปรับบริการที่คลินิกเอกชน ท่านค่าเข้าเรียนไม่เท่าไร? ระดุจำนวนเงิน .................บาท

38. เมื่อท่านป่วยไปโรงพยาบาล ท่านค่าเข้าเรียนไม่เท่าไร? ระดุจำนวนเงิน .................บาท

39. การจ่ายเงินให้โรงพยาบาล หามจ่ายเงินตามที่โรงพยาบาลกำหนดหรือไม่? จ่ายตรง จ่ายไม่ครบ

40. ท่านจ่ายเงินเป็นค่าตรวจไปกลับโรงพยาบาลสั้นและเท่าไร? ระดุจำนวนเงิน .................บาท

ความรู้ความเข้าใจในสิทธิประโยชน์ของการมีบัตรประกันสุขภาพ

41. ท่านมีบัตรประกันสุขภาพหรือไม่? มี (ตอบขอ 42) ไม่มี (ข้ามไปตอบขอ 43.44)

42. ท่านมีบัตรประกันสุขภาพ ท่านออกมามั่นใจหรือไม่? มั่นใจ ไม่มั่นใจ

43. ท่านมีบัตรประกันสุขภาพของโรงพยาบาลใด? ระบุชื่อโรงพยาบาล.................

44. เมื่อท่านมีบัตรประกันสุขภาพในสถานที่อยู่ แต่เดิม (ข้ามไปตอบขอ 45) บริษัทธนาคารของท่านให้ (ข้ามไปตอบขอ 46)

45. ท่านไม่ได้รับการรักษาที่ท่านรับบริการในโรงพยาบาลที่มี](ตอบขอ 42) ไม่มี (ข้ามไปตอบขอ 43.44)

46. ท่านอยู่ที่ธนาคารมั่นใจในการจ่ายเงินของท่านหรือไม่? มั่นใจ ไม่มั่นใจ

47. ตามความคิดของท่าน ท่านจะต้องจ่ายเงินในการประกันสุขภาพ มีความมั่นใจกับการอุปกรณ์ต่างๆ

สุขภาพตามสิทธิประโยชน์? คุมต่ำกว่าเงินที่สูงเงินในการประกันสุขภาพ มีความมั่นใจกับการอุปกรณ์ต่างๆ

48. ท่านทราบหรือไม่ว่า การมีบัตรประกันสุขภาพที่มีแล้วไม่ได้รับการรักษาโรคตามสิทธิในโรงพยาบาลที่มีประกันสุขภาพไว้? ไม่ทราบ ทราบ

49. ท่านทราบหรือไม่ว่า การมีบัตรประกันสุขภาพ สามารถใช้สิทธิเพื่อการตรวจคัดกรองโรคได้? ไม่ทราบ ทราบ

50. ท่านทราบหรือไม่ว่า การมีบัตรประกันสุขภาพ เมื่อมีข้อบกพร่อง /อุบัติเหตุ ท่านสามารถใช้บริการที่โรงพยาบาลไม่ได้ (ตอบขอ 43,44)

51. ท่านทราบหรือไม่ว่า การมีข้อบกพร่องในการใช้บริการที่โรงพยาบาล หรือไม่? ไม่มี ไม่มี (ข้ามไปตอบขอ 43.44)

52. ท่านมีข้อเสนอแนะให้โรงพยาบาลที่ท่านไปปรับบริการปรับปรุง/พัฒนาบริการหรือไม่? ไม่ได้ ได้ (ข้ามไปตอบขอ 43.44)

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53. ท่านต้องการมีสิทธิรับบริการแบบใด? ประกันสุขภาพแรงงานต่างด้าว ประกันสุขภาพ
ชื่อผู้เก็บข้อมูลการสัมภาษณ์ นาย/นาง/นางสาว……………………………………………………
เก็บข้อมูลที่ชุมชน…………หมู่ที่…………… ตำบล…………………… อาเภอ………………………….
ลงชื่อ นาย/นาง………………………………………………………….พยาบาลที่ด้าน
หมายเหตุ : modified from Health Seeking Behavior and Health System response Model
Appendix B

Questionnaire Cambodia and Burmese Version
ការបង្កើត ដូច្នេះ 1
ទាន់សម័យសម្រាប់ស្ត្រីសំខាន់ (ធនាដីរីកម្ម/ឈឺ)
(ឈ្នះមាននៅពេលសម្រាប់ស្ត្រីសំខាន់ក្នុងស្ត្រីសំខាន់មុន)

1. អ្នកប្រឈមសម្រាប់ស្ត្រីសំខាន់ បានបង្កើតដូច្នេះ ...........................
2. ដែល បង្កើត ទឹក ពំ ............................................
3. ម្រែក  ទឹក ពំ ..........................
4. អ្នករកឃើញក្រោមកិច្ចការស្ត្រី ដោយស្វែងមក ទឹក ពំ 
5. អ្នករកឃើញក្រោមកិច្ចការស្ត្រី ដោយស្វែងមក ទឹក ពំ 
6. ដោយស្វែងមកប្រឈមសម្រាប់ស្ត្រីសំខាន់ ទឹក ពំ .......... ទឹក ពំ 
7. ដោយស្វែងមកប្រឈមសម្រាប់ស្ត្រីសំខាន់ ទឹក ពំ 
8. ដោយស្វែងមកប្រឈមសម្រាប់ស្ត្រីសំខាន់ ទឹក ពំ ..............
9. ដោយស្វែងមកប្រឈមសម្រាប់ស្ត្រីសំខាន់ ទឹក ពំ ..............
10. ដោយស្វែងមកប្រឈមសម្រាប់ស្ត្រីសំខាន់ ទឹក ពំ ..............
11. ដោយស្វែងមកប្រឈមសម្រាប់ស្ត្រីសំខាន់ ទឹក ពំ ..............
12. ដោយស្វែងមកប្រឈមសម្រាប់ស្ត្រីសំខាន់ ទឹក ពំ ..............
13. ដោយស្វែងមកប្រឈមសម្រាប់ស្ត្រីសំខាន់ ទឹក ពំ ..............
14. ដោយស្វែងមកប្រឈមសម្រាប់ស្ត្រីសំខាន់ ទឹក ពំ ..............

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16. ដំណើរការអ្នកប្រឈមក្នុងប្រទេសអ្វី? ៖ 
   □ ប្រកប 
   □ ប្រកប បំពង់ក្រុងស៊ីនហ្គុយ 
   □ អ្នកប្រកបបឹង 
   □ អ្នកប្រកបក្រុងស៊ីនហ្គុយ 
   □ អ្នកប្រកបក្រុងស៊ីនហ្គុយ 
   □ អ្នកប្រកបស៊ីនហ្គុយ/អ្នកប្រកបក្រុងស៊ីនហ្គុយ 
   □ អ្នកប្រកបស៊ីនហ្គុយ/អ្នកប្រកបក្រុងស៊ីនហ្គុយ 
   □ អ្នកប្រកបក្រុងស៊ីនហ្គុយ/អ្នកប្រកបស៊ីនហ្គុយ 
   □ អ្នកប្រកបក្រុងស៊ីនហ្គុយ/អ្នកប្រកបម៉ាក់ 
   □ អ្នកប្រកបប៊ីត្រី 
   □ អ្នកប្រកបដូចគ្នា 
   □ អ្នកប្រកបដូចគ្នា/អ្នកប្រកបប៊ីត្រី 
   □ អ្នកប្រកបដូចគ្នា/អ្នកប្រកបប៊ីត្រី 

17. អ្នកប្រឈមក្នុងប្រទេសអ្វី (ឆ្នាំ2010) អ្នកប្រឈមទៅឆ្នាំនេះ? ៖ 
   □ មិន  □ ទៅ  □ ទៅ 
   □ 2ឆ្នាំ  □ 3ឆ្នាំ 
   □ 4ឆ្នាំ  □ 5ឆ្នាំ  □ អ្នកប្រកបប៊ីត្រី 

18. អ្នកប្រឈមក្នុងប្រទេសអ្វី (ឆ្នាំ2010) អ្នកប្រឈមទៅឆ្នាំនេះ? 
   □ ប៊ីត្រី (ស្ថាក់ស្ថាក់ឆ្នាំ21)  □ មិន (ម្រែមប្រឈមឆ្នាំសំរាប់ដី21,20) 

19. អ្នកប្រឈមក្នុងប្រទេសអ្វី (ឆ្នាំ2010) អ្នកប្រឈមទៅឆ្នាំនេះ? 
   □ មិន  □ ទៅ  □ ទៅ 
   □ 2ឆ្នាំ  □ 3ឆ្នាំ  □ 4ឆ្នាំ  □ 5ឆ្នាំ  □ អ្នកប្រកបប៊ីត្រី 

20. អ្នកប្រឈមក្នុងប្រទេសអ្វី (ឆ្នាំ2010) អ្នកប្រឈមទៅឆ្នាំនេះ? 
   □ មិន  □ ទៅ  □ ទៅ 
   □ 2ឆ្នាំ  □ 3ឆ្នាំ  □ 4ឆ្នាំ  □ 5ឆ្នាំ  □ អ្នកប្រកបប៊ីត្រី 

21. តែនេះទៅរហ័សអ្នកប្រឈមទៅឆ្នាំនេះ? 
   □ ប៊ីត្រី (ស្ថាក់ស្ថាក់ឆ្នាំ21)  □ មិន (ស្ថាក់ស្ថាក់ឆ្នាំសំរាប់ដី21,20) 
   □ អ្នកប្រកបប៊ីត្រី 

22. តែនេះទៅរហ័សអ្នកប្រឈមទៅឆ្នាំនេះ? 
   □ ប៊ីត្រី (ស្ថាក់ស្ថាក់ឆ្នាំ21)  □ មិន (ស្ថាក់ស្ថាក់ឆ្នាំសំរាប់ដី21,20) 
   □ អ្នកប្រកបប៊ីត្រី 

23. ប្រកបដោយអ្នកប្រឈមស្ថាក់ដីអ្វី? 
   □ មិន (ស្ថាក់ស្ថាក់ឆ្នាំសំរាប់ដី24)  □ មិន (ស្ថាក់ស្ថាក់ឆ្នាំសំរាប់ដី24) 

24. អ្នកប្រឈមទៅឆ្នាំនេះ? មិន:  អ្នកប្រឈម 
   □ ប្រកបដោយក្រុមហ៊ុនអ្នកប្រឈម 
   □ ប្រកបដោយអ្នកប្រឈម  

25. អ្នកប្រឈមក្នុងប្រទេសអ្វី (ឆ្នាំ2010) អ្នកប្រឈមដែលអ្នកប្រឈមទៅឆ្នាំនេះ? 
   □ ប៊ីត្រី (ស្ថាក់ស្ថាក់ឆ្នាំ20)  □ មិន (ស្ថាក់ស្ថាក់ឆ្នាំសំរាប់ដី20,27,38,29) 

26. អ្នកប្រឈមដែល អ្នកប្រឈមដែលអ្នកប្រឈមទៅឆ្នាំនេះ? ប៊ីត្រី/មុន  អ្នកប្រឈម 
   □ 2ឆ្នាំ □ 3ឆ្នាំ □ 4ឆ្នាំ □ 5ឆ្នាំ □ អ្នកប្រកបប៊ីត្រី
27. ប្រធានបទកិច្ចការបញ្ជាក់អ្នកក្រុមសិក្រុមបញ្ជាក់ពីរៀនពពលពេលដែលទំនាក់ទំនងប្រកួតប្រជែងពីរៀនពេលដែលបញ្ហាស្ថានិភ័យ។

28. ប្រធានបទកិច្ចការបញ្ជាក់អ្នកក្រុមសិក្រុមបញ្ជាក់ពីរៀនពពលពេលដែលបញ្ហាស្ថានិភ័យអាចប្រកួតប្រជែងក្នុងពេលប្រកួតប្រជែងនេះអាចទំនងពេលដែលបញ្ហាស្ថានិភ័យ។

29. ប្រធានបទកិច្ចការបញ្ជាក់អ្នកក្រុមសិក្រុមបញ្ជាក់ពីរៀនពពលពេលដែលបញ្ហាស្ថានិភ័យអាចទំនងពេលដែលបញ្ហាស្ថានិភ័យ។

30. ប្រធានបទកិច្ចការបញ្ជាក់អ្នកក្រុមសិក្រុមបញ្ជាក់ពីរៀនពពលពេលដែលបញ្ហាស្ថានិភ័យ។

31. ប្រធានបទកិច្ចការបញ្ជាក់អ្នកក្រុមសិក្រុមបញ្ជាក់ពីរៀនពពលពេលដែលបញ្ហាស្ថានិភ័យអាចប្រកួតប្រជែងក្នុងពេលប្រកួតប្រជែងនេះអាចទំនងពេលដែលបញ្ហាស្ថានិភ័យ។

32. ប្រធានបទកិច្ចការបញ្ជាក់អ្នកក្រុមសិក្រុមបញ្ជាក់ពីរៀនពពលពេលដែលបញ្ហាស្ថានិភ័យអាចប្រកួតប្រជែងក្នុងពេលប្រកួតប្រជែងនេះអាចទំនងពេលដែលបញ្ហាស្ថានិភ័យ។

33. ប្រធានបទកិច្ចការបញ្ជាក់អ្នកក្រុមសិក្រុមបញ្ជាក់ពីរៀនពពលពេលដែលបញ្ហាស្ថានិភ័យអាចប្រកួតប្រជែងក្នុងពេលប្រកួតប្រជែងនេះអាចទំនងពេលដែលបញ្ហាស្ថានិភ័យ។

34. ប្រធានបទកិច្ចការបញ្ជាក់អ្នកក្រុមសិក្រុមបញ្ជាក់ពីរៀនពពលពេលដែលបញ្ហាស្ថានិភ័យអាចប្រកួតប្រជែងក្នុងពេលប្រកួតប្រជែងនេះអាចទំនងពេលដែលបញ្ហាស្ថានិភ័យ។

35. ប្រធានបទកិច្ចការបញ្ជាក់អ្នកក្រុមសិក្រុមបញ្ជាក់ពីរៀនពពលពេលដែលបញ្ហាស្ថានិភ័យអាចប្រកួតប្រជែងក្នុងពេលប្រកួតប្រជែងនេះអាចទំនងពេលដែលបញ្ហាស្ថានិភ័យ។

36. ប្រធានបទកិច្ចការបញ្ជាក់អ្នកក្រុមសិក្រុមបញ្ជាក់ពីរៀនពពលពេលដែលបញ្ហាស្ថានិភ័យអាចប្រកួតប្រជែងក្នុងពេលប្រកួតប្រជែងនេះអាចទំនងពេលដែលបញ្ហាស្ថានិភ័យ។

37. ប្រធានបទកិច្ចការបញ្ជាក់អ្នកក្រុមសិក្រុមបញ្ជាក់ពីរៀនពពលពេលដែលបញ្ហាស្ថានិភ័យអាចប្រកួតប្រជែងក្នុងពេលប្រកួតប្រជែងនេះអាចទំនងពេលដែលបញ្ហាស្ថានិភ័យ។

38. ប្រធានបទកិច្ចការបញ្ជាក់អ្នកក្រុមសិក្រុមបញ្ជាក់ពីរៀនពពលពេលដែលបញ្ហាស្ថានិភ័យអាចប្រកួតប្រជែងក្នុងពេលប្រកួតប្រជែងនេះអាចទំនងពេលដែលបញ្ហាស្ថានិភ័យ។

39. ប្រធានបទកិច្ចការបញ្ជាក់អ្នកក្រុមសិក្រុមបញ្ជាក់ពីរៀនពពលពេលដែលបញ្ហាស្ថានិភ័យអាចប្រកួតប្រជែងក្នុងពេលប្រកួតប្រជែងនេះអាចទំនងពេលដែលបញ្ហាស្ថានិភ័យ។

40. ប្រធានបទកិច្ចការបញ្ជាក់អ្នកក្រុមសិក្រុមបញ្ជាក់ពីរៀនពពលពេលដែលបញ្ហាស្ថានិភ័យអាចប្រកួតប្រជែងក្នុងពេលប្រកួតប្រជែងនេះអាចទំនងពេលដែលបញ្ហាស្ថានិភ័យ។

41. ប្រធានបទកិច្ចការបញ្ជាក់អ្នកក្រុមសិក្រុមបញ្ជាក់ពីរៀនពពលពេលដែលបញ្ហាស្ថានិភ័យអាចប្រកួតប្រជែងក្នុងពេលប្រកួតប្រជែងនេះអាចទំនងពេលដែលបញ្ហាស្ថានិភ័យ។
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20. និងបើប្រទេសមានប្រសិទ្ធភាពកើនឡើងវិញមកពីរៀងរាល់ឆ្នាំ គ្រប់ប្រភេទអំពីនិម្រិចត្រូវត្រូវការខុសដូចខ្លួនឯងឬសេរីរបស់ខ្លួនឯងត្រូវការខុសដូចខ្លួនឯង។ ត្រូវបានការដំណឹងពីការផ្ទុះជីវិតប្រសិទ្ធភាព។

(1) សហគោលបណ្តាលអំពីការផ្ទុះជីវិតប្រសិទ្ធភាព (ប្រសិទ្ធភាពយឺតពីវិស័យវិជ្ជាសាស្ត្រ) ។

(2) កើតឡើងការផ្ទុះជីវិតប្រសិទ្ធភាពជាមួយនឹងការផ្ទុះជីវិតប្រសិទ្ធភាពនៃអំពីការផ្ទុះជីវិតប្រសិទ្ធភាព។

(3) នឹងការផ្ទុះជីវិតប្រសិទ្ធភាពជាមួយនឹងការផ្ទុះជីវិតប្រសិទ្ធភាពនៃអំពីការផ្ទុះជីវិតប្រសិទ្ធភាព។

(4) នឹងការផ្ទុះជីវិតប្រសិទ្ធភាពជាមួយនឹងការផ្ទុះជីវិតប្រសិទ្ធភាពនៃអំពីការផ្ទុះជីវិតប្រសិទ្ធភាព។

21. ដូច្នេះ នៅពេលប្រទេសមានប្រសិទ្ធភាពកើនឡើងវិញមកពីរៀងរាល់ឆ្នាំ គ្រប់ប្រភេទអំពីនិម្រិចត្រូវត្រូវការខុសដូចខ្លួនឯងឬសេរីរបស់ខ្លួនឯងត្រូវការខុសដូចខ្លួនឯង។

(1) សហគោលបណ្តាលអំពីការផ្ទុះជីវិតប្រសិទ្ធភាព (ប្រសិទ្ធភាពយឺតពីវិស័យវិជ្ជាសាស្ត្រ) ។

(2) កើតឡើងការផ្ទុះជីវិតប្រសិទ្ធភាពជាមួយនឹងការផ្ទុះជីវិតប្រសិទ្ធភាពនៃអំពីការផ្ទុះជីវិតប្រសិទ្ធភាព។

(3) នឹងការផ្ទុះជីវិតប្រសិទ្ធភាពជាមួយនឹងការផ្ទុះជីវិតប្រសិទ្ធភាពនៃអំពីការផ្ទុះជីវិតប្រសិទ្ធភាព។

(4) នឹងការផ្ទុះជីវិតប្រសិទ្ធភាពជាមួយនឹងការផ្ទុះជីវិតប្រសិទ្ធភាពនៃអំពីការផ្ទុះជីវិតប្រសិទ្ធភាព។

22. ដូច្នេះ នៅពេលប្រទេសមានប្រសិទ្ធភាពកើនឡើងវិញមកពីរៀងរាល់ឆ្នាំ គ្រប់ប្រភេទអំពីនិម្រិចត្រូវត្រូវការខុសដូចខ្លួនឯងឬសេរីរបស់ខ្លួនឯងត្រូវការខុសដូចខ្លួនឯង។

(1) សហគោលបណ្តាលអំពីការផ្ទុះជីវិតប្រសិទ្ធភាព (ប្រសិទ្ធភាពយឺតពីវិស័យវិជ្ជាសាស្ត្រ) ។

(2) កើតឡើងការផ្ទុះជីវិតប្រសិទ្ធភាពជាមួយនឹងការផ្ទុះជីវិតប្រសិទ្ធភាពនៃអំពីការផ្ទុះជីវិតប្រសិទ្ធភាព។

(3) នឹងការផ្ទុះជីវិតប្រសិទ្ធភាពជាមួយនឹងការផ្ទុះជីវិតប្រសិទ្ធភាពនៃអំពីការផ្ទុះជីវិតប្រសិទ្ធភាព។

(4) នឹងការផ្ទុះជីវិតប្រសិទ្ធភាពជាមួយនឹងការផ្ទុះជីវិតប្រសិទ្ធភាពនៃអំពីការផ្ទុះជីវិតប្រសិទ្ធភាព។

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26. ប្រើប្រាស់បន្ថែមទាំងនេះនិង តម្លៃឈ្មោះបានមាន។ ប្រការ្ងលំដាប់ប្រការ្ង គឺជាមួយនឹងប្រការ្ងប្រការ្ងប្រការ្ងដែលបានបង្កើតឡើង។

☐ ១ ថ្ងៃ ៣ ខែ ៣ ខែ ៤ ខែ ៥ ខែ ៦ ខែ

☐ បានប្រការ្ង ៧ ខែ ៨ ខែ ៩ ខែ ១០ ខែ ១១ ខែ ១២ ខែ

27. សមាជ្រូរប្រហារ្ងប្រការ្ងប្រការ្ងសុខភាព៖ ប្រការ្ងប្រការ្ងប្រការ្ងប្រការ្ងជាសុខភាពបាន។

☐ មិនបានប្រការ្ង ១ ខែ ២ ខែ ៣ ខែ ៤ ខែ ៥ ខែ ៦ ខែ

28. ប្រការ្ងប្រការ្ងប្រការ្ងប្រការ្ងប្រការ្ង ឬ ប្រការ្ងប្រការ្ងប្រការ្ងប្រការ្ងប្រការ្ង ឬ ប្រការ្ងប្រការ្ង ឬ ប្រការ្ងប្រការ្ង ឬ ប្រការ្ង ដ៏ពេញនិយមប្រការ្ងប្រការ្ងប្រការ្ង ឬ ប្រការ្ង ឬ ប្រការ្ង ឬ ប្រការ្ង ឬ ប្រការ្ង ដ៏ពេញនិយមប្រការ្ង ឬ ប្រការ្ង ដ៏ពេញនិយមប្រការ្ង ឬ ប្រការ្ង ដ៏ពេញនិយមប្រការ្ង ឬ ប្រការ្ង ដ៏ពេញនិយមប្រការ្ង ដ៏ពេញនិយម?

☐ មិនបានប្រការ្ង ១ ខែ ២ ខែ ៣ ខែ ៤ ខែ ៥ ខែ ៦ ខែ

29. ប្រការ្ងប្រការ្ងប្រការ្ងប្រការ្ងប្រការ្ងប្រការ្ង ប្រការ្ងប្រការ្ងប្រការ្ងប្រការ្ងប្រការ្ងប្រការ្ង ឬ ប្រការ្ងប្រការ្ង ឬ ប្រការ្ងប្រការ្ង ឬ ប្រការ្ង ដ៏ពេញនិយមប្រការ្ងប្រការ្ងប្រការ្ង ឬ ប្រការ្ង ដ៏ពេញនិយមប្រការ្ɡ ឬ ប្រការ្ង ដ៏ពេញនិយមប្រការ្ង ឬ ប្រការ្ង ដ៏ពេញនិយមប្រការ្ង ឬ ប្រការ្ង ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយម?

☐ មិនបានប្រការ្ង ១ ខែ ២ ខែ ៣ ខែ ៤ ខែ ៥ ខែ ៦ ខែ

30. ប្រការ្ងប្រការ្ងប្រការ្ងប្រការ្ងប្រការ្ង ឬ ប្រការ្ងប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមត្រូវបានប្រការ្ងប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេញនិយមប្រការ្ɡ ដ៏ពេ祁 Liam
Health Care Financing for Migrants
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☐ ไม่ทราบ ☐ ทราบ ถึงครั้ง

46. ท่านทราบหรือไม่? การมีสิทธิประกันสุขภาพ เมื่อเข้าประเทศต่างประเทศ / อุบัติเหตุ ท่านสามารถใช้บริการที่โรงพยาบาล

☐ ไม่ทราบ ☐ ทราบ ถึงครั้ง

47. ท่านมีปัญหาอุปสรรคในการใช้บริการที่โรงพยาบาลหรือไม่?

☐ ไม่มี ☐ มี ถึงครั้ง

48. ท่านมีข้อเสนอแนะให้โรงพยาบาลที่ประกันสุขภาพไว้ปรับปรุง / ฟื้นฟูบริการหรือไม่?

☐ ไม่มี ☐ มี ถึงครั้ง

49. ท่านเห็นว่าการมีสิทธิ์ป่วยจนขาดงานสูงสุด ท่านมีสิทธิ์ประกันสุขภาพในประเทศต่างประเทศหรือไม่?

☐ ไม่มี ☐ มี ถึงครั้ง

ข้อกำหนดของสัญญาประกันสุขภาพ 30,000-35,000 - ที่จดทะเบียน

บาท ๑,๐๐๐/- กระทำต่อเนื่อง 10 ปี

ขอขอบคุณที่รับชม 30,000-35,000 - ที่จดทะเบียน ที่มีไว้ ณ วันที่ ณ วันที่ ต.บ. / ที่อยู่

บาท ๑,๐๐๐/- กระทำต่อเนื่อง 10 ปี

หมายเหตุ : modified from Health Seeking Behavior and Health System response Model

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17. ដែលបានប្រការឬប្រឹកតាមការសិក្សាចុះឈ្មោះឬសំរែព័ែកដ៏អស្ចារ្យ? តុលិច បាន តែប្រការឬប្រឹកតាមការសិក្សាចុះឈ្មោះឬសំរែព័ែកដ៏អស្ចារ្យ
18. ដែលបានប្រការឬប្រឹកតាមការសិក្សាចុះឈ្មោះឬសំរែព័ែកដ៏អស្ចារ្យ? តុលិច បាន ប្រការឬប្រឹកតាមការសិក្សាចុះឈ្មោះឬសំរែព័ែកដ៏អស្ចារ្យ
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19. តុលិចឈ្មោះនំអតិថិជន (ឆ្នាំ2010) ដែលបានប្រការឬប្រឹកតាមការសិក្សាចុះឈ្មោះឬសំរែព័ែកដ៏អស្ចារ្យ? យ៉ាងហីរ យ៉ាងហីរ យ៉ាងហីរ
   យ៉ាងហីរ យ៉ាងហីរ យ៉ាងហីរ
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   អតិថិជន (ឆ្នាំ២០២៣) អតិថិជន (ឆ្នាំ២០២៣)
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   អតិថិជន (ឆ្នាំ២០២៣) អតិថិជន (ឆ្នាំ២០២៣)
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   យ៉ាងហីរ យ៉ាងហីរ យ៉ាងហីរ
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29. ការបញ្ជាក់បានទីក្សារធ្វើឱ្យអ្នកទទួលបានខោសិក្ខារអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិนបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នកចង់ធ្វើអំពីប្រសិនបើអ្នक
45. ប្រការព័ត៌មានទីតាំងស្ថានភាព ដែលស្ថានភាពដេលបានប្រការព័ត៌មានពីរាប់ពាក្យព័ត៌មានដែលបានប្រការព័ត៌មានពីស្ថានភាព។

☐ ស្ថានភាពច្រើន ☐ ស្ថានភាពមិនច្រើន

46. ប្រការព័ត៌មានទីតាំងស្ថានភាព ដែលស្ថានភាពកំពុងត្រូវបានប្រការព័ត៌មានដែលបានប្រការព័ត៌មានពីស្ថានភាព។

☐ មាន ☐ មិនមាន

47. ប្រការព័ត៌មានទីតាំងស្ថានភាពដែលស្ថានភាពកំពុងត្រូវបានការព័ត៌មានពីស្ថានភាពរបស់ប្រការព័ត៌មានដែលបានប្រការព័ត៌មានពីស្ថានភាពបានប្រការព័ត៌មានពីរាប់ពាក្យព័ត៌មានដែលបានប្រការព័ត៌មានពីស្ថានភាព។

☐ មាន ☐ មិនមាន

48. ប្រការព័ត៌មានទីតាំងស្ថានភាពដែលស្ថានភាពកំពុងត្រូវបានប្រការព័ត៌មានពីស្ថានភាពរបស់ប្រការព័ត៌មានដែលបានប្រការព័ត៌មានពីស្ថានភាពបានប្រការព័ត៌មានពីរាប់ពាក្យព័ត៌មានដែលបានប្រការព័ត៌មានពីស្ថានភាព។

☐ មាន ☐ មិនមាន

49. ប្រការព័ត៌មានទីតាំងស្ថានភាពដែលស្ថានភាពកំពុងត្រូវបានប្រការព័ត៌មានពីស្ថានភាពរបស់ប្រការព័ត៌មានដែលបានប្រការព័ត៌មានពីស្ថានភាពបានប្រការព័ត៌មានពីរាប់ពាក្យព័ត៌មានដែលបានប្រការព័ត៌មានពីស្ថានភាព។

☐ មាន ☐ មិនមាន

50. ប្រការព័ត៌មានទីតាំងស្ថានភាពដែលស្ថានភាពកំពុងត្រូវបានប្រការព័ត៌មានពីស្ថានភាពរបស់ប្រការព័ត៌មានដែលបានប្រការព័ត៌មានពីស្ថានភាពបានប្រការព័ត៌មានពីរាប់ពាក្យព័ត៌មានដែលបានប្រការព័ត៌មានពីស្ថានភាព។

☐ មាន ☐ មិនមាន

51. ប្រការព័ត៌មានទីតាំងស្ថានភាពដែលស្ថានភាពកំពុងត្រូវបានប្រការព័ត៌មានពីស្ថានភាពរបស់ប្រការព័ត៌មានដែលបានប្រការព័ត៌មានពីស្ថានភាព។

☐ មាន ☐ មិនមាន

52. ប្រការព័ត៌មានទីតាំងស្ថានភាពដែលស្ថានភាពកំពុងត្រូវបានប្រការព័ត៌មានពីស្ថានភាពរបស់ប្រការព័ត៌មានដែលបានប្រការព័ត៌មានពីស្ថានភាពបានប្រការព័ត៌មានពីរាប់ពាក្យព័ត៌មានដែលបានប្រការព័ត៌មានពីស្ថានភាព។

☐ មាន ☐ មិនមាន

53. ប្រការព័ត៌មានទីតាំងស្ថានភាពដែលស្ថានភាពកំពុងត្រូវបានប្រការព័ត៌មានពីស្ថានភាព។

☐ មាន ☐ មិនមាន

Remark: Modified from Health Seeking Behavior and Health System response Model Susanna Hausman-Muela, Muela Riber. And Isaac Myamongo, August 2003.
1. ម្រេះថ្មី កូសុំ ជាអាចបញ្ឆំក្នុងប្រទេសថៃ 
   ក្នុងប្រទេសសិក្សាណាដល 
   ខាងលើ 

2. ម្រេះថ្មី កូសុំ ជាអាចបញ្ឆំក្នុងប្រទេសថៃ 
   ក្នុងប្រទេសសិក្សាណាដល 
   ខាងលើ 

3. ស្វែងរក 
   រករឿង 
   កូសុំ ជាអាចបញ្ឆំក្នុងប្រទេសថៃ 
   ក្នុងប្រទេសសិក្សាណាដល 
   ខាងលើ 

4. រករឿង 
   រករឿង 
   កូសុំ ជាអាចបញ្ឆំក្នុងប្រទេសថៃ 
   ក្នុងប្រទេសសិក្សាណាដល 
   ខាងលើ 

5. រករឿង 
   រករឿង 
   កូសុំ ជាអាចបញ្ឆំក្នុងប្រទេសថៃ 
   ក្នុងប្រទេសសិក្សាណាដល 
   ខាងលើ 

6. រករឿង 
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7. រករឿង 
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8. រករឿង 
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    ខាងលើ 

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50. Have you or anyone in your family been treated in a hospital or clinic in your country?
§ No □ Yes

51. Have you or anyone in your family gone to a hospital or clinic in the host country?
§ No □ Yes

52. Have you or anyone in your family sought health care from a health care provider or clinic in the host country?
§ No □ Yes

53. Have you or anyone in your family sought health care from a health care provider or clinic in your home country?
§ No □ Yes

The Study was modified from Health Seeking Behavior and Health System response Model